General Assembly **Substitute Bill No. 841**

January Session, 2021

AN ACT CONCERNING THE INSURANCE DEPARTMENT'S RECOMMENDED CHANGES TO THE INSURANCE STATUTES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-1 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2021*):

3 Terms used in this title <u>and sections 2 and 4 of this act</u>, unless it
4 appears from the context to the contrary, shall have a scope and
5 meaning as set forth in this section.

6 (1) "Affiliate" or "affiliated" means a person that directly, or indirectly
7 through one or more intermediaries, controls, is controlled by or is
8 under common control with another person.

9 (2) "Alien insurer" means any insurer that has been chartered by or
10 organized or constituted within or under the laws of any jurisdiction or
11 country without the United States.

12 (3) "Annuities" means all agreements to make periodical payments
13 where the making or continuance of all or some of the series of the
14 payments, or the amount of the payment, is dependent upon the
15 continuance of human life or is for a specified term of years. This
16 definition does not apply to payments made under a policy of life
17 insurance.

18 (4) "Commissioner" means the Insurance Commissioner.

19 (5) "Control", "controlled by" or "under common control with" means
20 the possession, direct or indirect, of the power to direct or cause the
21 direction of the management and policies of a person, whether through
22 the ownership of voting securities, by contract other than a commercial
23 contract for goods or nonmanagement services, or otherwise, unless the
24 power is the result of an official position with the person.

25 (6) "Domestic insurer" means any insurer that has been chartered by,
26 incorporated, organized or constituted within or under the laws of this
27 state.

28 (7) "Domestic surplus lines insurer" means any domestic insurer that
29 has been authorized by the commissioner to write surplus lines
30 insurance.

31 (8) "Foreign country" means any jurisdiction not in any state, district
32 or territory of the United States.

33 (9) "Foreign insurer" means any insurer that has been chartered by or
34 organized or constituted within or under the laws of another state or a
35 territory of the United States.

36 (10) "Insolvency" or "insolvent" means, for any insurer, that it is
37 unable to pay its obligations when they are due, or when its admitted
38 assets do not exceed its liabilities plus the greater of: (A) Capital and
39 surplus required by law for its organization and continued operation;
40 or (B) the total par or stated value of its authorized and issued capital
41 stock. For purposes of this subdivision "liabilities" shall include but not
42 be limited to reserves required by statute or by regulations adopted by
43 the commissioner in accordance with the provisions of chapter 54 or
44 specific requirements imposed by the commissioner upon a subject
45 company at the time of admission or subsequent thereto.

46 (11) "Insurance" means any agreement to pay a sum of money,
47 provide services or any other thing of value on the happening of a

48 particular event or contingency or to provide indemnity for loss in
49 respect to a specified subject by specified perils in return for a
50 consideration. In any contract of insurance, an insured shall have an
51 interest which is subject to a risk of loss through destruction or
52 impairment of that interest, which risk is assumed by the insurer and
53 such assumption shall be part of a general scheme to distribute losses
54 among a large group of persons bearing similar risks in return for a
55 ratable contribution or other consideration.

56 (12) "Insurer" or "insurance company" includes any person or
57 combination of persons doing any kind or form of insurance business
58 other than a fraternal benefit society, and shall include a receiver of any
59 insurer when the context reasonably permits.

60 (13) "Insured" means a person to whom or for whose benefit an
61 insurer makes a promise in an insurance policy. The term includes
62 policyholders, subscribers, members and beneficiaries. This definition
63 applies only to the provisions of this title and does not define the
64 meaning of this word as used in insurance policies or certificates.

65 (14) "Life insurance" means insurance on human lives and insurances
66 pertaining to or connected with human life. The business of life
67 insurance includes granting endowment benefits, granting additional
68 benefits in the event of death by accident or accidental means, granting
69 additional benefits in the event of the total and permanent disability of
70 the insured, and providing optional methods of settlement of proceeds.
71 Life insurance includes burial contracts to the extent provided by
72 section 38a-464.

73 (15) "Mutual insurer" means any insurer without capital stock, the
74 managing directors or officers of which are elected by its members.

75 (16) "Person" means an individual, a corporation, a partnership, a
76 limited liability company, an association, a joint stock company, a
77 business trust, an unincorporated organization or other legal entity.

78 (17) "Policy" means any document, including attached endorsements

79 and riders, purporting to be an enforceable contract, which
80 memorializes in writing some or all of the terms of an insurance
81 contract.

82 (18) "State" means any state, district, or territory of the United States.

83 (19) "Subsidiary" of a specified person means an affiliate controlled
84 by the person directly, or indirectly through one or more intermediaries.

85 (20) "Unauthorized insurer" or "nonadmitted insurer" means an
86 insurer that has not been granted a certificate of authority by the
87 commissioner to transact the business of insurance in this state or an
88 insurer transacting business not authorized by a valid certificate.

89 (21) "United States" means the United States of America, its territories
90 and possessions, the Commonwealth of Puerto Rico and the District of
91 Columbia.

92 Sec. 2. (NEW) (*Effective October 1, 2021*) No insurer, health care center
93 or fraternal benefit society doing business in this state shall:

94 (1) In connection with the issuance, withholding, extension or
95 renewal of an annuity or an insurance policy for life, credit life,
96 disability, long-term care, accidental injury, specified disease, hospital
97 indemnity or credit accident insurance, request, require, purchase or use
98 information obtained from an entity providing direct-to-consumer
99 genetic testing without the informed written consent of the individual
100 who has been tested; or

101 (2) Condition insurance rates, the provision or renewal of insurance
102 coverage or benefit or other conditions of insurance for an individual
103 on:

104 (A) Any requirement or agreement that the individual undergo
105 genetic testing; or

106 (B) The results of any genetic testing of a member of the individual's

107 family unless the results are contained in the individual's medical
108 record.

109 Sec. 3. Section 38a-816 of the general statutes is repealed and the
110 following is substituted in lieu thereof (*Effective October 1, 2021*):

111 The following are defined as unfair methods of competition and
112 unfair and deceptive acts or practices in the business of insurance:

113 (1) Misrepresentations and false advertising of insurance policies.
114 Making, issuing or circulating, or causing to be made, issued or
115 circulated, any estimate, illustration, circular or statement, sales
116 presentation, omission or comparison which: (A) Misrepresents the
117 benefits, advantages, conditions or terms of any insurance policy; (B)
118 misrepresents the dividends or share of the surplus to be received, on
119 any insurance policy; (C) makes any false or misleading statements as
120 to the dividends or share of surplus previously paid on any insurance
121 policy; (D) is misleading or is a misrepresentation as to the financial
122 condition of any person, or as to the legal reserve system upon which
123 any life insurer operates; (E) uses any name or title of any insurance
124 policy or class of insurance policies misrepresenting the true nature
125 thereof; (F) is a misrepresentation, including, but not limited to, an
126 intentional misquote of a premium rate, for the purpose of inducing or
127 tending to induce to the purchase, lapse, forfeiture, exchange,
128 conversion or surrender of any insurance policy; (G) is a
129 misrepresentation for the purpose of effecting a pledge or assignment of
130 or effecting a loan against any insurance policy; or (H) misrepresents
131 any insurance policy as being shares of stock.

132 (2) False information and advertising generally. Making, publishing,
133 disseminating, circulating or placing before the public, or causing,
134 directly or indirectly, to be made, published, disseminated, circulated or
135 placed before the public, in a newspaper, magazine or other publication,
136 or in the form of a notice, circular, pamphlet, letter or poster, or over any
137 radio or television station, or in any other way, an advertisement,
138 announcement or statement containing any assertion, representation or

139 statement with respect to the business of insurance or with respect to
140 any person in the conduct of his insurance business, which is untrue,
141 deceptive or misleading.

142 (3) Defamation. Making, publishing, disseminating or circulating,
143 directly or indirectly, or aiding, abetting or encouraging the making,
144 publishing, disseminating or circulating of, any oral or written
145 statement or any pamphlet, circular, article or literature which is false
146 or maliciously critical of or derogatory to the financial condition of an
147 insurer, and which is calculated to injure any person engaged in the
148 business of insurance.

149 (4) Boycott, coercion and intimidation. Entering into any agreement
150 to commit, or by any concerted action committing, any act of boycott,
151 coercion or intimidation resulting in or tending to result in unreasonable
152 restraint of, or monopoly in, the business of insurance.

153 (5) False financial statements. Filing with any supervisory or other
154 public official, or making, publishing, disseminating, circulating or
155 delivering to any person, or placing before the public, or causing,
156 directly or indirectly, to be made, published, disseminated, circulated or
157 delivered to any person, or placed before the public, any false statement
158 of financial condition of an insurer with intent to deceive; or making any
159 false entry in any book, report or statement of any insurer with intent to
160 deceive any agent or examiner lawfully appointed to examine into its
161 condition or into any of its affairs, or any public official to whom such
162 insurer is required by law to report, or who has authority by law to
163 examine into its condition or into any of its affairs, or, with like intent,
164 wilfully omitting to make a true entry of any material fact pertaining to
165 the business of such insurer in any book, report or statement of such
166 insurer.

167 (6) Unfair claim settlement practices. Committing or performing with
168 such frequency as to indicate a general business practice any of the
169 following: (A) Misrepresenting pertinent facts or insurance policy
170 provisions relating to coverages at issue; (B) failing to acknowledge and

171 act with reasonable promptness upon communications with respect to
172 claims arising under insurance policies; (C) failing to adopt and
173 implement reasonable standards for the prompt investigation of claims
174 arising under insurance policies; (D) refusing to pay claims without
175 conducting a reasonable investigation based upon all available
176 information; (E) failing to affirm or deny coverage of claims within a
177 reasonable time after proof of loss statements have been completed; (F)
178 not attempting in good faith to effectuate prompt, fair and equitable
179 settlements of claims in which liability has become reasonably clear; (G)
180 compelling insureds to institute litigation to recover amounts due under
181 an insurance policy by offering substantially less than the amounts
182 ultimately recovered in actions brought by such insureds; (H)
183 attempting to settle a claim for less than the amount to which a
184 reasonable man would have believed he was entitled by reference to
185 written or printed advertising material accompanying or made part of
186 an application; (I) attempting to settle claims on the basis of an
187 application which was altered without notice to, or knowledge or
188 consent of the insured; (J) making claims payments to insureds or
189 beneficiaries not accompanied by statements setting forth the coverage
190 under which the payments are being made; (K) making known to
191 insureds or claimants a policy of appealing from arbitration awards in
192 favor of insureds or claimants for the purpose of compelling them to
193 accept settlements or compromises less than the amount awarded in
194 arbitration; (L) delaying the investigation or payment of claims by
195 requiring an insured, claimant, or the physician of either to submit a
196 preliminary claim report and then requiring the subsequent submission
197 of formal proof of loss forms, both of which submissions contain
198 substantially the same information; (M) failing to promptly settle claims,
199 where liability has become reasonably clear, under one portion of the
200 insurance policy coverage in order to influence settlements under other
201 portions of the insurance policy coverage; (N) failing to promptly
202 provide a reasonable explanation of the basis in the insurance policy in
203 relation to the facts or applicable law for denial of a claim or for the offer
204 of a compromise settlement; (O) using as a basis for cash settlement with
205 a first party automobile insurance claimant an amount which is less than

206 the amount which the insurer would pay if repairs were made unless
207 such amount is agreed to by the insured or provided for by the
208 insurance policy.

209 (7) Failure to maintain complaint handling procedures. Failure of any
210 person to maintain complete record of all the complaints which it has
211 received since the date of its last examination. This record shall indicate
212 the total number of complaints, their classification by line of insurance,
213 the nature of each complaint, the disposition of these complaints, and
214 the time it took to process each complaint. For purposes of this
215 subsection "complaint" means any written communication primarily
216 expressing a grievance.

217 (8) Misrepresentation in insurance applications. Making false or
218 fraudulent statements or representations on or relative to an application
219 for an insurance policy for the purpose of obtaining a fee, commission,
220 money or other benefit from any insurer, producer or individual.

221 (9) Any violation of any one of sections 38a-358, 38a-446, 38a-447, 38a-
222 488, 38a-825, 38a-826, 38a-828 and 38a-829. None of the following
223 practices shall be considered discrimination within the meaning of
224 section 38a-446 or 38a-488 or a rebate within the meaning of section 38a-
225 825: (A) Paying bonuses to policyholders or otherwise abating their
226 premiums in whole or in part out of surplus accumulated from
227 nonparticipating insurance, provided any such bonuses or abatement of
228 premiums shall be fair and equitable to policyholders and for the best
229 interests of the company and its policyholders; (B) in the case of policies
230 issued on the industrial debit plan, making allowance to policyholders
231 who have continuously for a specified period made premium payments
232 directly to an office of the insurer in an amount which fairly represents
233 the saving in collection expense; (C) readjustment of the rate of premium
234 for a group insurance policy based on loss or expense experience, or
235 both, at the end of the first or any subsequent policy year, which may be
236 made retroactive for such policy year.

237 (10) Notwithstanding any provision of any policy of insurance,

238 certificate or service contract, whenever such insurance policy or
239 certificate or service contract provides for reimbursement for any
240 services which may be legally performed by any practitioner of the
241 healing arts licensed to practice in this state, reimbursement under such
242 insurance policy, certificate or service contract shall not be denied
243 because of race, color or creed nor shall any insurer make or permit any
244 unfair discrimination against particular individuals or persons so
245 licensed.

246 (11) Favored agent or insurer: Coercion of debtors. (A) No person
247 may (i) require, as a condition precedent to the lending of money or
248 extension of credit, or any renewal thereof, that the person to whom
249 such money or credit is extended or whose obligation the creditor is to
250 acquire or finance, negotiate any policy or contract of insurance through
251 a particular insurer or group of insurers or producer or group of
252 producers; (ii) unreasonably disapprove the insurance policy provided
253 by a borrower for the protection of the property securing the credit or
254 lien; (iii) require directly or indirectly that any borrower, mortgagor,
255 purchaser, insurer or producer pay a separate charge, in connection
256 with the handling of any insurance policy required as security for a loan
257 on real estate or pay a separate charge to substitute the insurance policy
258 of one insurer for that of another; or (iv) use or disclose information
259 resulting from a requirement that a borrower, mortgagor or purchaser
260 furnish insurance of any kind on real property being conveyed or used
261 as collateral security to a loan, when such information is to the
262 advantage of the mortgagee, vendor or lender, or is to the detriment of
263 the borrower, mortgagor, purchaser, insurer or the producer complying
264 with such a requirement.

265 (B) (i) Subparagraph (A)(iii) of this subdivision shall not include the
266 interest which may be charged on premium loans or premium
267 advancements in accordance with the security instrument. (ii) For
268 purposes of subparagraph (A)(ii) of this subdivision, such disapproval
269 shall be deemed unreasonable if it is not based solely on reasonable
270 standards uniformly applied, relating to the extent of coverage required

271 and the financial soundness and the services of an insurer. Such
272 standards shall not discriminate against any particular type of insurer,
273 nor shall such standards call for the disapproval of an insurance policy
274 because such policy contains coverage in addition to that required. (iii)
275 The commissioner may investigate the affairs of any person to whom
276 this subdivision applies to determine whether such person has violated
277 this subdivision. If a violation of this subdivision is found, the person in
278 violation shall be subject to the same procedures and penalties as are
279 applicable to other provisions of section 38a-815, subsections (b) and (e)
280 of section 38a-817 and this section. (iv) For purposes of this section,
281 "person" includes any individual, corporation, limited liability
282 company, association, partnership or other legal entity.

283 (12) Refusing to insure, refusing to continue to insure or limiting the
284 amount, extent or kind of coverage available to an individual or
285 charging an individual a different rate for the same coverage because of
286 physical disability, mental or nervous condition as set forth in section
287 38a-488a or intellectual disability, except where the refusal, limitation or
288 rate differential is based on sound actuarial principles or is related to
289 actual or reasonably anticipated experience.

290 (13) Refusing to insure, refusing to continue to insure or limiting the
291 amount, extent or kind of coverage available to an individual or
292 charging an individual a different rate for the same coverage solely
293 because of blindness or partial blindness. For purposes of this
294 subdivision, "refusal to insure" includes the denial by an insurer of
295 disability insurance coverage on the grounds that the policy defines
296 "disability" as being presumed in the event that the insured is blind or
297 partially blind, except that an insurer may exclude from coverage any
298 disability, consisting solely of blindness or partial blindness, when such
299 condition existed at the time the policy was issued. Any individual who
300 is blind or partially blind shall be subject to the same standards of sound
301 actuarial principles or actual or reasonably anticipated experience as are
302 sighted persons with respect to all other conditions, including the
303 underlying cause of the blindness or partial blindness.

304 (14) Refusing to insure, refusing to continue to insure or limiting the
305 amount, extent or kind of coverage available to an individual or
306 charging an individual a different rate for the same coverage because of
307 exposure to diethylstilbestrol through the female parent.

308 (15) (A) Failure by an insurer, or any other entity responsible for
309 providing payment to a health care provider pursuant to an insurance
310 policy, to pay accident and health claims, including, but not limited to,
311 claims for payment or reimbursement to health care providers, within
312 the time periods set forth in subparagraph (B) of this subdivision, unless
313 the Insurance Commissioner determines that a legitimate dispute exists
314 as to coverage, liability or damages or that the claimant has fraudulently
315 caused or contributed to the loss. Any insurer, or any other entity
316 responsible for providing payment to a health care provider pursuant
317 to an insurance policy, who fails to pay such a claim or request within
318 the time periods set forth in subparagraph (B) of this subdivision shall
319 pay the claimant or health care provider the amount of such claim plus
320 interest at the rate of fifteen per cent per annum, in addition to any other
321 penalties which may be imposed pursuant to sections 38a-11, 38a-25,
322 38a-41 to 38a-53, inclusive, 38a-57 to 38a-60, inclusive, 38a-62 to 38a-64,
323 inclusive, 38a-76, 38a-83, 38a-84, 38a-117 to 38a-124, inclusive, 38a-129
324 to 38a-140, inclusive, 38a-146 to 38a-155, inclusive, 38a-283, 38a-288 to
325 38a-290, inclusive, 38a-319, 38a-320, 38a-459, 38a-464, 38a-815 to 38a-819,
326 inclusive, 38a-824 to 38a-826, inclusive, and 38a-828 to 38a-830,
327 inclusive. Whenever the interest due a claimant or health care provider
328 pursuant to this section is less than one dollar, the insurer shall deposit
329 such amount in a separate interest-bearing account in which all such
330 amounts shall be deposited. At the end of each calendar year each such
331 insurer shall donate such amount to The University of Connecticut
332 Health Center.

333 (B) Each insurer or other entity responsible for providing payment to
334 a health care provider pursuant to an insurance policy subject to this
335 section, shall pay claims not later than:

336 (i) For claims filed in paper format, sixty days after receipt by the

337 insurer of the claimant's proof of loss form or the health care provider's
338 request for payment filed in accordance with the insurer's practices or
339 procedures, except that when there is a deficiency in the information
340 needed for processing a claim, as determined in accordance with section
341 38a-477, the insurer shall (I) send written notice to the claimant or health
342 care provider, as the case may be, of all alleged deficiencies in
343 information needed for processing a claim not later than thirty days
344 after the insurer receives a claim for payment or reimbursement under
345 the contract, and (II) pay claims for payment or reimbursement under
346 the contract not later than thirty days after the insurer receives the
347 information requested; and

348 (ii) For claims filed in electronic format, twenty days after receipt by
349 the insurer of the claimant's proof of loss form or the health care
350 provider's request for payment filed in accordance with the insurer's
351 practices or procedures, except that when there is a deficiency in the
352 information needed for processing a claim, as determined in accordance
353 with section 38a-477, the insurer shall (I) notify the claimant or health
354 care provider, as the case may be, of all alleged deficiencies in
355 information needed for processing a claim not later than ten days after
356 the insurer receives a claim for payment or reimbursement under the
357 contract, and (II) pay claims for payment or reimbursement under the
358 contract not later than ten days after the insurer receives the information
359 requested.

360 (C) As used in this subdivision, "health care provider" means a person
361 licensed to provide health care services under chapter 368d, chapter
362 368v, chapters 370 to 373, inclusive, 375 to 383c, inclusive, 384a to 384c,
363 inclusive, or chapter 400j.

364 (16) Failure to pay, as part of any claim for a damaged motor vehicle
365 under any automobile insurance policy where the vehicle has been
366 declared to be a constructive total loss, an amount equal to the sum of
367 (A) the settlement amount on such vehicle plus, whenever the insurer
368 takes title to such vehicle, (B) an amount determined by multiplying
369 such settlement amount by a percentage equivalent to the current sales

370 tax rate established in section 12-408. For purposes of this subdivision,
371 "constructive total loss" means the cost to repair or salvage damaged
372 property, or the cost to both repair and salvage such property, equals or
373 exceeds the total value of the property at the time of the loss.

374 (17) Any violation of section 42-260, by an extended warranty
375 provider subject to the provisions of said section, including, but not
376 limited to: (A) Failure to include all statements required in subsections
377 (c) and (f) of section 42-260 in an issued extended warranty; (B) offering
378 an extended warranty without being (i) insured under an adequate
379 extended warranty reimbursement insurance policy or (ii) able to
380 demonstrate that reserves for claims contained in the provider's
381 financial statements are not in excess of one-half the provider's audited
382 net worth; (C) failure to submit a copy of an issued extended warranty
383 form or a copy of such provider's extended warranty reimbursement
384 policy form to the Insurance Commissioner.

385 (18) With respect to an insurance company, hospital service
386 corporation, health care center or fraternal benefit society providing
387 individual or group health insurance coverage of the types specified in
388 subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469,
389 refusing to insure, refusing to continue to insure or limiting the amount,
390 extent or kind of coverage available to an individual or charging an
391 individual a different rate for the same coverage because such
392 individual has been a victim of family violence.

393 (19) With respect to an insurance company, hospital service
394 corporation, health care center or fraternal benefit society providing
395 individual or group health insurance coverage of the types specified in
396 subdivisions (1), (2), (3), (4), (6), (9), (10), (11) and (12) of section 38a-469,
397 refusing to insure, refusing to continue to insure or limiting the amount,
398 extent or kind of coverage available to an individual or charging an
399 individual a different rate for the same coverage because of genetic
400 information. Genetic information indicating a predisposition to a
401 disease or condition shall not be deemed a preexisting condition in the
402 absence of a diagnosis of such disease or condition that is based on other

403 medical information. An insurance company, hospital service
404 corporation, health care center or fraternal benefit society providing
405 individual health coverage of the types specified in subdivisions (1), (2),
406 (3), (4), (6), (9), (10), (11) and (12) of section 38a-469, shall not be
407 prohibited from refusing to insure or applying a preexisting condition
408 limitation, to the extent permitted by law, to an individual who has been
409 diagnosed with a disease or condition based on medical information
410 other than genetic information and has exhibited symptoms of such
411 disease or condition. For the purposes of this subsection, "genetic
412 information" means the information about genes, gene products or
413 inherited characteristics that may derive from an individual or family
414 member.

415 (20) Any violation of sections 38a-465 to 38a-465q, inclusive.

416 (21) With respect to a managed care organization, as defined in
417 section 38a-478, failing to establish a confidentiality procedure for
418 medical record information, as required by section 38a-999.

419 (22) Any violation of sections 38a-591d to 38a-591f, inclusive.

420 (23) Any violation of section 38a-472j.

421 (24) Any violation of section 2 of this act.

422 Sec. 4. (NEW) (*Effective July 1, 2021*) (a) (1) Except as provided in
423 subsection (b) of this section, no insurer that delivers, issues for delivery,
424 renews, amends or endorses a homeowners insurance policy in this
425 state on or after July 1, 2021, that is subject to the requirements of
426 sections 38a-663 to 38a-696, inclusive, of the general statutes shall cancel
427 such policy unless:

428 (A) If such policy is not a renewal policy and has been in effect for
429 fewer than sixty days, such insurer sends a written cancellation notice
430 to the named insured:

431 (i) At least ten days before the effective date of such cancellation for

432 nonpayment of premium disclosing:

433 (I) Such cancellation;

434 (II) That the named insured may avoid such cancellation and
435 continue coverage under such policy by paying, before the effective date
436 of such cancellation, such unpaid premium; and

437 (III) That any excess premium, if not tendered by the insurer, shall be
438 refunded to the named insured upon demand by the named insured; or

439 (ii) At least thirty days before the effective date of such cancellation
440 for any reason other than nonpayment of premium disclosing:

441 (I) Such cancellation;

442 (II) The reason for such cancellation;

443 (III) The effective date of such cancellation; and

444 (IV) That any excess premium, if not tendered by the insurer, shall be
445 refunded to the named insured upon demand by the named insured; or

446 (B) If such policy is not a renewal policy and has been in effect for at
447 least sixty days, or if such policy is an effective renewal policy, such
448 insurer sends a written cancellation notice to the named insured:

449 (i) At least ten days before the effective date of such cancellation for
450 nonpayment of premium disclosing:

451 (I) Such cancellation;

452 (II) That the named insured may avoid such cancellation and
453 continue coverage under such policy by paying, before the effective date
454 of such cancellation, such unpaid premium; and

455 (III) That any excess premium, if not tendered by the insurer, shall be
456 refunded to the named insured upon demand by the named insured; or

457 (ii) At least thirty days before the effective date of such cancellation
458 for fraud or misrepresentation of any material fact made by the named
459 insured in obtaining coverage under such policy that, if discovered by
460 such insurer, would have caused such insurer not to issue or renew such
461 policy, as applicable, or any physical change in the covered property
462 that materially increases a hazard insured against under such policy
463 disclosing:

464 (I) The effective date of such cancellation; and

465 (II) That any excess premium, if not tendered by the insurer, shall be
466 refunded to the named insured upon demand by the named insured.

467 (2) No insurer may cancel a homeowners insurance policy described
468 in subparagraph (B) of subdivision (1) of this subsection for any reason
469 other than:

470 (A) Nonpayment of premium;

471 (B) Fraud or misrepresentation of any material fact made by the
472 named insured in obtaining coverage under such policy that, if
473 discovered by the insurer, would have caused the insurer not to issue or
474 renew such policy, as applicable; or

475 (C) Any physical change in the covered property that materially
476 increases a hazard insured against under such policy.

477 (3) No notice of cancellation required under subdivision (1) of this
478 subsection shall be effective unless such notice is sent to the named
479 insured by registered mail, certified mail or mail evidenced by a
480 certificate of mailing, or, if agreed by the insurer and the named insured,
481 by electronic means evidenced by a delivery receipt.

482 (b) No notice of cancellation is required under subsection (a) of this
483 section if the homeowners insurance policy is transferred from the
484 insurer to an affiliate of such insurer for another policy with no
485 interruption of coverage and the same terms, conditions and provisions,

486 including policy limits, as the transferred policy, except that the insurer
487 to which the policy is transferred shall not be prohibited from applying
488 such insurer's rates and rating plans at the time of renewal.

489 (c) The named insured under a homeowners insurance policy
490 described in subsection (a) of this section may cancel such policy at any
491 time by sending to the insurer that delivered, issued for delivery,
492 renewed, amended or endorsed such policy a written notice disclosing
493 the effective date of such cancellation.

494 Sec. 5. Section 38a-646 of the general statutes is repealed and the
495 following is substituted in lieu thereof (*Effective October 1, 2021*):

496 As used in sections 38a-645 to 38a-658, inclusive, except as otherwise
497 provided herein:

498 (1) "Credit life insurance" means insurance on the life of a debtor
499 pursuant to or in connection with a specific loan or other credit
500 transaction;

501 (2) "Credit accident and health insurance" means insurance on a
502 debtor to provide indemnity for payments becoming due on a specific
503 loan or other credit transaction while the debtor is disabled as defined
504 in the policy;

505 (3) "Creditor" means the lender of money or vendor or lessor of
506 goods, services, property, rights or privileges for which payment is
507 arranged through a credit transaction or any successor to the right, title
508 or interest of any such lender, vendor or lessor, and an affiliate, associate
509 or subsidiary of any of them or any director, officer or employee of any
510 of them or any other person in any way associated with any of them;

511 (4) "Debtor" means a borrower of money or a purchaser or lessee of
512 goods, services, property, rights or privileges for which payment is
513 arranged through a credit transaction;

514 (5) "Indebtedness" means the total amount payable by a debtor to a

515 creditor in connection with a loan or other credit transaction; [.] and

516 (6) "Loss ratio" means annual incurred claims divided by earned
517 premiums.

518 Sec. 6. Subsection (b) of section 38a-651 of the general statutes is
519 repealed and the following is substituted in lieu thereof (*Effective October*
520 *1, 2021*):

521 (b) The commissioner shall adopt regulations in accordance with the
522 provisions of chapter 54, establishing a procedure for review of such
523 policies, certificates of insurance, notices of proposed insurance,
524 applications for insurance, endorsements and riders, and shall
525 disapprove any such form at any time if: [the]

526 (1) The schedule of premium rates charged or to be charged is, by
527 reasonable assumptions and as determined according to benchmark
528 loss ratio calculations, excessive in relation to the benefits provided; or
529 [if it contains]

530 (2) Such form:

531 (A) Has a prima facie loss ratio of less than fifty per cent for any single
532 or joint credit life insurance or credit accident and health insurance
533 policy unless the commissioner approves a premium rate deviation for
534 such policy; or

535 (B) Contains provisions which (i) are unjust, unfair, inequitable,
536 misleading, deceptive, [or which] (ii) encourage misrepresentation of
537 the coverage, or [which] (iii) are contrary to any provision of the
538 insurance laws or of any rule or regulation promulgated thereunder.

539 Sec. 7. Subsection (e) of section 38a-702e of the general statutes is
540 repealed and the following is substituted in lieu thereof (*Effective October*
541 *1, 2021*):

542 (e) Each applicant for an insurance producer license shall, before

543 being admitted to an examination under subsection (a) of this section,
544 prove to the satisfaction of the commissioner that such applicant meets
545 one of the following prerequisites: (1) Successful completion of a course
546 approved by the commissioner requiring not less than **[**forty**]** <u>twenty</u>
547 hours for each line of insurance for which the applicant is applying to
548 be licensed; or (2) equivalent experience or training as determined by
549 the commissioner.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2021*	38a-1
Sec. 2	*October 1, 2021*	New section
Sec. 3	*October 1, 2021*	38a-816
Sec. 4	*July 1, 2021*	New section
Sec. 5	*October 1, 2021*	38a-646
Sec. 6	*October 1, 2021*	38a-651(b)
Sec. 7	*October 1, 2021*	38a-702e(e)

Statement of Legislative Commissioners:
In Section 1, "<u>sections 2 and 4</u>" was substituted for "<u>section 2</u>" for consistency.

INS *Joint Favorable Subst. -LCO*