

Chapter 743

1987 REPLACEMENT PART

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GENERAL PROVISIONS

743.003 Scope of chapter. This chapter applies as to all insurance policies delivered or issued for delivery in this state other than reinsurance and wet marine and transportation insurance policies [1967 c 359 §335]

743.006 Filing and approval of policy forms. (1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the director. This section does not apply to

(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject,

(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder, or

(c) Forms of group life or health insurance policies, or both, which have been agreed upon as a result of negotiations between the policyholder and the insurer

(2) The director shall within 30 days after the filing of any such form approve or disapprove the form. The director shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law

(3) The 30-day period referred to in subsection (2) of this section may be extended by the director for an additional period not to exceed 30 days if the director gives written notice within the first 30-day period to the insurer proposing to deliver the form that the director needs such additional time for the consideration of such form

(4) The director may at any time request an insurer to furnish the director a copy of any form exempted under subsection (1) of this section [Formerly 736 300]

743.009 Grounds for disapproval of policy forms. The director shall disapprove any form requiring the director's approval

(1) If the director finds it does not comply with the law,

(2) If the director finds it contains any provision, including statement of premium, or has any

label, description of its contents, title, heading, backing or other indication of its provisions, which is unintelligible, uncertain, ambiguous or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued,

(3) If, in the director's judgment, its use would be prejudicial to the interests of the insurer's policyholders,

(4) If the director finds it contains provisions which are unjust, unfair or inequitable,

(5) If the director finds sales presentation material disapproved by the director pursuant to ORS 743 021 is being used with respect to the form, or

(6) If, with respect to any of the following forms, the director finds the benefits provided therein are not reasonable in relation to the premium charged

(a) Individual health insurance policy forms subject to ORS 743 402 to 743 498, including benefit certificates issued by fraternal benefit societies,

(b) Health insurance policy forms issued by health care service contractors, except those forms issued under group health insurance coverages, or

(c) Credit life and credit health insurance forms subject to ORS 743 561 to 743 588 [1967 c 359 §337, 1969 c 336 §11, 1973 c 608 §1]

743.010 Director to adopt rules with respect to certain health insurance policy forms. (1) In addition to all other powers of the director with respect thereto, the director may issue rules with respect to policy forms described in ORS 743 009 (6)(a) and (b)

(a) Establishing minimum benefit standards,

(b) Requiring the ratio of benefits to premiums to be not less than a specified percentage in order to be considered reasonable, and requiring the periodic filing of data that will demonstrate the insurer's compliance, and

(c) Establishing requirements intended to discourage duplication or overlapping of coverage and replacement, without regard to the advantage to policyholders, of existing policies by new policies

(2) The director shall issue rules pursuant to subsection (1) of this section with respect to policy forms marketed as supplements to federal Medicare benefits, and such rules shall provide for a minimum loss ratio of 60 percent [1979 c 857 §2]

743.011 Director to develop standardized fact sheet, contents; uses, penalties for

failure to use. (1) By January 1, 1986, the director shall develop a standardized form of a fact sheet that shall be considered a policy form under ORS 743 010. The director shall consult with the Governor's Commission on Senior Services concerning the content and format of the fact sheet, especially in reference to the understandability and comparability of the form to senior citizen consumers.

(2) The health insurance fact sheet required by subsection (1) of this section shall include at least the following:

(a) An identification of the type and extent of hospital, skilled nursing home, physician and other medical services and prescriptions covered in whole or part by medicare,

(b) Premium information on the supplemental medicare coverage,

(c) A description of the extent to which medicare A and B covers the services described in paragraph (a) of this subsection,

(d) A description of the extent to which the supplemental medicare coverage offered by the insurer covers the same services described in paragraph (a) of this subsection or any other services and the extent to which it supplements the medicare coverage,

(e) Any limitation, restriction, condition, exclusion, renewability option or other factors affecting or influencing the amount of coverage available to an applicant, and

(f) A statement that, "The information contained in this fact sheet is approved for accuracy by the Director of the Department of Insurance and Finance."

(3) Insurers shall fill out the standardized form and have the completed information included on the form approved by the director before selling supplemental medicare coverage in this state after June 1, 1986.

(4)(a) In the purchase or renewal of any policy covered by this section and ORS 750 055, a copy of the fact sheet must be used in explaining policy coverage to a purchaser and shall be provided to the applicant at the time the sales presentation is made. The completed fact sheet shall be considered part of the sales presentation materials for purposes of ORS 743 021.

(b) In the case of renewals, if the policy or certificate is issued on a basis that is at variance with the previously delivered fact sheet, a revised fact sheet of coverage must accompany the policy or certificate when it is delivered. The revised fact sheet shall contain the following statement

in no less than 12-point type immediately above the insurer's name

NOTICE Read this fact sheet of coverage carefully. It is not identical to the fact sheet of coverage provided upon application and the coverage originally applied for has not been issued.

(5) Acknowledgment of receipt or certification of delivery of the fact sheet shall be obtained by the insurer at the time of sale.

(6) Failure to comply with the provisions of this section is subject to the civil penalties under ORS 731 988.

(7) As used in this section, "medicare supplement policy" means an individual or group policy of health insurance that is designed primarily to supplement the medicare coverage for hospital, medical or surgical expenses that are incurred by an insured person. "Medicare supplement policy" does not include:

(a) A policy only covering one or several specified diseases, nursing home care or daily indemnity for hospital confinement,

(b) Health maintenance organization coverage governed by contract between the organization and the federal Social Security Administration, or

(c) A group policy issued to

(A) One or more employers or labor organizations,

(B) The trustees of a fund established by one or more employers or labor organizations or combination thereof, for members or former members, or both, of the labor organizations, or

(C) A professional, trade or occupational association for its members or former members, or both, if the association

(i) Is composed only of individuals who are actively engaged in the same profession, trade or occupation,

(ii) Is maintained in good faith for purposes other than obtaining insurance, and

(iii) Has been in existence for at least two years before the date of its initial offering of the coverage to the members. [1985 c 827 §2]

Note 743 011 was added to and made a part of ORS chapter 743 but was not added to 743 003 to 743 012 by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.012 Director's withdrawal of approval. The director may, at any time after a hearing held not less than 20 days after written

notice to the insurer, withdraw the director's approval of any form on any ground set forth in ORS 743 009. The written notice of such hearing shall state the reason for the proposed withdrawal. No insurer shall deliver such form in this state after the effective date of such withdrawal, which shall be as the director may prescribe but not less than 30 days after the giving of notice of withdrawal [1967 c 359 §338]

743.015 Filing and approval of credit life and credit health insurance forms; filing of rates. (1) All credit life and credit health insurance policies subject to ORS 743 561 to 743 588, and all certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders used in connection with such kinds of policies, delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the director. Such forms shall be subject to approval, disapproval or withdrawal of approval by the director as provided in ORS 743 006, 743 009 and 743 012. Policies issued pursuant to ORS 731 442 shall be subject to the same regulation as other credit insurance policies.

(2) An insurer may revise such schedules of premium rates from time to time, and shall file such revised schedules with the director. No insurer shall issue any such credit life or credit health insurance policy for which the premium rate exceeds that determined by the schedules of such insurer as then on file with the director.

(3) If such a group policy of credit life or credit health insurance has been or is delivered in another state the insurer shall be required to file only the group certificate, the individual application and notice of proposed insurance delivered or issued for delivery in this state as specified in ORS 743 579 (2) and (4), and such forms shall be approved by the director if they conform with the requirements specified in such subsections and if the schedules of premium rates applicable to the insurance evidenced by such certificate or notice are not in excess of the insurer's schedules of premium rates filed with the director. (Formerly 739 595, 1969 c 336 §12, 1971 c 231 §20)

743.018 Life and health insurance, filing rates. Except for group life and health insurance, and except as provided in ORS 743 015, every insurer shall file with the director all schedules and tables of premium rates for life and health insurance to be used on risks in this state, and shall file any amendments to or corrections of such schedules and tables [1967 c 359 §340]

743.021 Regulation of sales material.

(1) The director, if the director considers it neces-

sary, may require the filing by an insurer or agent of any sales presentation material for use in the sale or the presentation for sale of any policy. The director, within 60 days after the filing of the sales presentation material, shall disapprove any such sales presentation material if the director finds that, in whole or in part, it is false, deceptive or misleading. Upon disapproval, such sales presentation material shall not be made, issued, circulated, displayed or given other use by the insurer or its agents.

(2) The director, by rule, shall require any agent who sells or attempts to sell insurance to provide to each prospective insured such information as the director considers necessary to adequately inform the prospective insured regarding the insurance transaction [1967 c 359 §341, 1971 c 231 §21, 1973 c 525 §1]

743.024 Insurable interest and beneficiaries, personal insurance. (1) Any individual of competent legal capacity may procure or effect an insurance policy on the individual's own life or body for the benefit of any person. However, except as provided in ORS 743 030, no person shall procure or cause to be procured any insurance policy upon the life or body of another unless the benefits under such policy are payable to the individual insured or the personal representatives of the individual, or to a person having, at the time such policy was entered into, an insurable interest in the individual insured.

(2) If the beneficiary, assignee or other payee under any policy made in violation of this section receives from the insurer any benefits thereunder accruing upon the death, disablement or injury of the individual insured, the individual insured or the individual's executor or administrator, as the case may be, may maintain an action to recover such benefits from the person so receiving them.

(3) An insurer shall be entitled to rely upon all statements, declarations and representations made by an applicant for insurance relative to the matter of insurable interest. No insurer shall incur legal liability, except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

(4) This section does not apply to annuity policies [1967 c 359 §342]

743.027 Consent of individual required for life and health insurance; exceptions. No life or health insurance policy upon an individual, except a policy of group life insurance or of group or blanket health insurance, shall be made or effectuated unless at the time of the making of the policy the individual insured, being of compe-

tent legal capacity to contract, applies therefor or has consented thereto in writing, except in the following cases

(1) A spouse may effectuate such insurance upon the other spouse

(2) Any person having an insurable interest in the life of a minor, or any person upon whom a minor is dependent for support and maintenance, may effectuate insurance upon the life of or pertaining to such minor

(3) Family policies may be issued insuring any two or more members of a family on an application signed by either parent, a stepparent, or by a husband or wife [1967 c 359 §342a]

743.028 Authority to prescribe uniform health insurance claim forms. The director shall prescribe uniform health insurance claim forms which shall be used by all insurers transacting health insurance in this state and by all state agencies that require health insurance claim forms for their records [1973 c 109 §2]

743.030 Life insurance for benefit of charity. (1) Life insurance policies may be effected although the person paying the consideration has no insurable interest in the life of the person insured if a charitable, benevolent, educational or religious institution is designated irrevocably as the beneficiary

(2) In making such policies the person paying the premium shall make and sign the application therefor as owner. The application also must be signed by the person whose life is to be insured. Such a policy shall be valid and binding between and among all of the parties thereto

(3) The person paying the consideration for such insurance shall have all rights conferred by the policy to loan value at any time during the premium-paying period, but not at maturity, notwithstanding such person has no insurable interest in the life of the person insured [Formerly 739 420]

743.033 Insurable interest, property insurance. No policy of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss [1967 c 359 §344]

743 036 [Formerly 736 330, 1973 c 823 §149, repealed by 1973 c 827 §83]

743.037 Nondiscriminatory health insurance coverage for women. Each policy of health insurance shall provide

(1) The same payments for costs of maternity to unmarried women that it provides to married

women, including the wives of insured persons choosing family coverage, and

(2) The same coverage for the child of an unmarried woman that the child of an insured married person choosing family coverage receives [1973 c 521 §2]

743.039 Alteration of application, life and health insurance. (1) An application for a life insurance policy may not provide for alterations by any person other than the applicant in either the application or the policy to be issued thereon with respect to the amount of insurance, classification of risk, plan of insurance or the benefits unless the application contains a statement that no such changes are effective until approved in writing by the applicant

(2) No alteration of any written application for any health insurance policy shall be made by any person other than the applicant without the written consent of the applicant, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant [1967 c 359 §346]

743.042 Representations in applications. (1) All statements and descriptions in any application for an insurance policy by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealments of facts and incorrect statements shall not prevent a recovery under the policy unless the misrepresentations, omissions, concealments of fact and incorrect statements

(a) Are contained in a written application for the insurance policy, and a copy of the application is indorsed upon or attached to the insurance policy when issued,

(b) Are shown by the insurer to be material, and the insurer also shows reliance thereon, and

(c) Are either

(A) Fraudulent, or

(B) Material either to the acceptance of the risk or to the hazard assumed by the insurer

(2) This section does not apply to surety insurance [1967 c 359 §347 1985 c 465 §1]

743.045 Policy constitutes entire contract; oral representations by insured. (1) Except as provided in ORS 743 075, every contract of insurance shall be construed according to the terms and conditions of the policy. When the contract is made pursuant to a written application therefor, if the insurer delivers a copy of such application with the policy to the insured, thereupon such application shall become a part of the

insurance policy Any application that is not so delivered to the insured shall not be a part of the insurance policy and the insurer shall be precluded from introducing such application as evidence in any action based upon or involving the policy Any oral representations by the insured that are not included in an application shall not be a part of the insurance policy and the insurer shall be precluded from introducing such representations as evidence in any action based upon or involving the policy

(2) If any life or health insurance policy is reinstated or renewed, and the insured or assignee or beneficiary with a vested interest under such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within 30 days after the receipt at its home or branch office of such request and of satisfactory evidence of such requesting beneficiary's vested interest, deliver or mail to the person making such request a copy of such application If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving such policy or its reinstatement or renewal

(3) This section does not apply to surety insurance [Formerly 736.305, 1971 c 231 §22 1985 c 465 §2]

743.048 Provision for construction according to foreign law prohibited No policy of insurance shall contain any condition, stipulation or agreement requiring such policy to be construed according to the laws of any other state or country Any such condition, stipulation or agreement shall be invalid [Formerly 736.315]

743.051 Standard provisions in general. (1) Insurance policies shall contain such standard or uniform provisions as are required by the applicable provisions of the Insurance Code However, the insurer may at its option substitute for one or more of such provisions corresponding provisions of different wording approved by the director which are in each instance not less favorable in any respect to the insured or the beneficiary

(2) If any standard or uniform provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy

(3) Except as provided in subsection (2) of this section, no policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used [1967 c 359 §350]

743.052 Reimbursement for certain surgical services performed by dentists. Notwithstanding any provision of a policy of health insurance, whenever the policy provides for payment of a surgical service, the performance for the insured of such surgical service by any dentist acting within the scope of the dentist's license is compensable if performance of that service by a physician acting within the scope of the physician's license would be compensable [1971 c 372 §2]

743.054 Contents of policies in general.

(1) Every policy shall specify

(a) The names of the parties to the contract

(b) The subject of the insurance

(c) The hazards or perils insured against

(d) The time when the insurance thereunder takes effect and the period during which the insurance is to continue

(e) The premium

(f) The conditions and provisions pertaining to the insurance

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included

(3) This section does not apply to surety insurance policies, or to group life or health insurance policies [1967 c 359 §351]

743.057 Underwriters' and combination policies. (1) Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names Any one insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer

(2) Two or more insurers may, with the approval of the director, issue a combination policy which shall contain provisions substantially as follows

(a) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy, and

(b) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers

(3) This section does not apply to co-surety obligations [1967 c 359 §352]

743.060 Additional policy contents. A policy may contain additional provisions not inconsistent with the Insurance Code and which are

(1) Required to be inserted by the laws of the insurer's domicile,

(2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract, or

(3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein [1967 c 359 §353]

743.063 Charter and bylaw provisions. No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer (other than the subscriber's agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid [1967 c 359 §354]

743.066 Assessment policies, special contents. Every policy issued on the assessment plan, and the form of any application for such a policy to be signed by the applicant, shall have conspicuously printed near the top of the face thereof in boldface type of a size not smaller than used for any caption in the policy or application, as applicable, the words "The policyholder is subject to assessment by the company" or such other words as the director may require [1967 c 359 §355, 1971 c 231 §23]

743.069 Validity and construction of noncomplying forms. (1) A policy in violation of the Insurance Code, but otherwise binding on the insurer, shall be held valid, but shall be construed as provided in the Insurance Code

(2) Any insurance policy issued and otherwise valid which contains any condition, omission or provision not in compliance with the Insurance Code, shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy been in full compliance with the Insurance Code [1967 c 359 §356]

743.072 Permissible classes of insurance in one policy. (1) Except as provided in

this section, when more than one class of insurance as defined in ORS 731 150 to 731 194 is effected by an insurer each class shall be written in a separate and distinct policy. Any such policy may be canceled, surrendered or otherwise terminated without affecting other premiums paid or policies held by the same insured

(2) Except as provided in this section, the same policy shall not include insurance coverages as to which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred or undetermined loss claims is estimated in a different manner

(3) Insurance in one policy may be effected upon automobiles and vehicles, and the accessories and other property transported upon and used in connection therewith, against loss or damage by fire, collision and explosion, and against loss by legal liability for damage to persons or property, or both, resulting from the maintenance, use or operation of such automobiles or vehicles, and against loss by burglary, embezzlement or theft, or any one or more of them. Premiums and losses for such insurance are to be reported to the director under the title "automobile insurance." For this purpose an insurer need not use the standard fire insurance policy required by ORS 743 606

(4) Insurance in one policy may be effected against loss or damage of property and against personal injury and death, and liability therefor, from explosion of steam boilers, tanks and engines, pipes and machinery connected therewith, and breakage of flywheels and machinery. Premiums and losses for such insurance are to be reported to the director under the title "steam boiler insurance"

(5) Insurance under the classes of life and health insurance may be effected in one policy

(6) Insurance in one policy effected against any physical loss or damage occurring to properties may include coverage as to other perils, either on an unspecified basis as to coverage or for a single premium

(7) Insurance in one policy effected against loss or destruction of baggage while traveling which is written on a single premium nonrenewable basis may include travel ticket health insurance benefits [Formerly 736 310, 1971 c 231 §24, 1973 c 149 §1]

743.075 Binders. (1) Binders or other contracts for temporary insurance may be made orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such

applicable indorsements as are designated in the binder, except as superseded by the clear and express terms of the binder

(2) Except as provided in subsection (3) of this section and ORS 746 195, within 90 days after issue of a binder a policy shall be issued in lieu thereof, including within its terms the identical insurance bound under the binder and the premium therefor

(3) If the policy has not been issued a binder may be extended or renewed beyond such 90 days with the written approval of the director, or in accordance with such rules relative thereto as the director may promulgate

(4) This section does not apply to life or health insurance [1967 c 359 §358, 1975 c 391 §1, 1977 c 742 §8]

743.078 Delivery of policy. (1) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance except where a condition required by the insurer has not been met by the insured

(2) In the event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum. This subsection does not apply to inland marine floater policies [1967 c 359 §359]

743.080 Effective date and time of coverage; applicability. (1) Except as provided in subsections (2), (4) and (5) of this section, every policy of insurance shall contain a provision stating that coverage commences at 12 01 a m of the date upon which the insurance takes effect

(2) A policy of insurance may provide that the time at which coverage commences shall not

be prior to the time at which the policy of insurance is applied for

(3) Any statement of time in a policy shall mean time according to the legal standard of time in effect

(a) If the policy insures real property, at the location of such property, or

(b) If the policy does not insure real property, at the principal place of business within Oregon of the insured, or, if the insured has no place of business within Oregon, at the residence within Oregon of the insured

(4) A binder or other contract for temporary insurance may commence coverage at an hour different from 12 01 a m in order to provide coverage from the agreed hour of commencement of coverage to 12 01 a m of the date on which the written policy as to which such binder or other contract was issued takes effect

(5) This section does not apply to life, health, mortgage, title, surety or wet marine and transportation insurance [1971 c 231 §5, 1983 c 249 §1]

743.081 Renewal by certificate. Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable, may be renewed or extended at the option of the insurer, if renewed or extended upon a currently authorized policy form at the premium rate then required therefor, for a specific additional period or periods by certificate or by indorsement of the policy, without requiring the issuance of a new policy [1967 c 359 §360]

743.084 Payment discharges insurer. Whenever the proceeds of or payments under a life or health insurance policy become payable in accordance with the terms of such policy, or the exercise of any right or privilege under such policy, and the insurer makes payment in accordance with the terms of the policy or in accordance with any written assignment of the policy, the person so designated as being entitled to the proceeds or payments shall be entitled to receive them and to give full acquittance therefor, and such payments shall fully discharge the insurer from all claims under the policy unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to such proceeds or payments or some interest in the policy [1967 c 359 §361]

743.087 Assignment of policies A policy may be assignable or not assignable, as provided by its terms. Subject to its terms relating to assignability, any life or health insurance policy, under the terms of which the beneficiary may be

changed upon the sole request of the insured or owner, may be assigned either by pledge or transfer of title, by an assignment executed by the insured or owner alone and delivered to the insurer, whether or not the pledgee or assignee is the insurer. Any such assignment shall entitle the insurer to deal with the assignee as the owner or pledgee of the policy in accordance with the terms of the assignment, until the insurer has received at its home office written notice of termination of the assignment or pledge, or written notice by or on behalf of some other person claiming some interest in the policy in conflict with the assignment. [1967 c 359 §362]

743 090 [Formerly 736 335 repealed by 1973 c 827 §83]

743.093 Forms for proof of loss. (1) An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance policy issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

(2) With respect to fire insurance, an insured shall have 90 days after receipt of proof of loss forms to furnish proof of loss, notwithstanding anything more restrictive contained in the policy. [1967 c 359 §364]

743.096 Certain conduct not deemed waiver. Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of or estoppel to assert any provision of a policy or of any defense of the insurer thereunder:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(3) Investigating any loss or claim under the policy or engaging in negotiations looking toward a possible settlement of any such loss or claim. [1967 c 359 §365]

743.099 Exemption of proceeds, individual life insurance other than annuities. (1) When a policy of insurance is effected by any person on any person's own life or on another life in favor of some person other than that person having an insurable interest in the life insured,

the lawful beneficiary thereof, other than that person or that person's legal representative, is entitled to its proceeds against the creditors or representatives of the person effecting the policy.

(2) The person to whom a policy of life insurance is made payable may maintain an action thereon in the person's own name.

(3) A policy of life insurance payable to a beneficiary other than the estate of the insured, having by its terms a cash surrender value available to the insured, is exempt from execution issued from any court in this state and in the event of bankruptcy of such insured is exempt from all demands in legal proceeding under such bankruptcy.

(4) Subject to the statute of limitations, the amount of any premiums paid in fraud of creditors for such insurance, with interest thereon, shall inure to their benefit from the proceeds of the policy. The insurer issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms unless, before such payment, the insurer has received at its home office written notice by or in behalf of some creditor, with specifications of the amount claimed, claiming to recover for certain premiums paid in fraud of creditors.

(5) The insured under any policy within this section shall not be denied the right to change the beneficiary when such right is expressly reserved in the policy.

(6) This section does not apply to annuity policies. [Formerly 739 405]

743 102 Exemption of proceeds, group life insurance. (1) A policy of group life insurance or the proceeds thereof payable to a person or persons other than the individual insured or the individual's estate shall be exempt from debts and claims of creditors or representatives of the individual insured and, in the event of bankruptcy of the individual insured, from all demands in legal proceedings under such bankruptcy.

(2) The provisions of subsection (1) of this section do not apply to group life insurance issued to a creditor covering the creditor's debtors to the extent that such proceeds are applied to payment of the obligation for the purpose of which the insurance was so issued. [1967 c 359 §367]

743.105 Exemption of proceeds, annuity policies; assignability of rights. (1) The benefits, rights, privileges and options which are due or prospectively due an annuitant under any annuity policy issued before, on or after June 8 1967, shall not be subject to execution, nor shall

the annuitant be compelled to exercise any such rights, powers or options, nor shall creditors be allowed to interfere with or terminate the policy, except

(a) As to amounts paid for or as premium on any such annuity with intent to defraud creditors, with interest thereon, and of which the creditor has given the insurer written notice at its home office prior to the making of the payments to the annuitant out of which the creditor seeks to recover. Any such notice shall specify the amount claimed or such facts as will enable the insurer to ascertain such amount, and shall set forth such facts as will enable the insurer to ascertain the annuity policy, the annuitant and the payments sought to be avoided on the ground of fraud

(b) The total exemption of benefits presently due and payable to any annuitant periodically or at stated times under all annuity policies under which the person is an annuitant shall not at any time exceed \$250 per month for the length of time represented by such instalments. Such periodic payments in excess of \$250 per month shall be subject to garnishee execution to the same extent as are wages and salaries

(c) If the total benefits presently due and payable to any annuitant under all annuity policies under which the person is an annuitant shall at any time exceed payment at the rate of \$250 per month, the court may order such annuitant to pay to a judgment creditor or apply on the judgment, in instalments, the portion of such excess benefits as to the court may appear just and proper, after due regard for the reasonable requirements of the judgment debtor and family, if dependent upon the judgment debtor, as well as any payments required to be made by the annuitant to other creditors under prior court orders

(2) If the policy so provides, the benefits, rights, privileges or options accruing under the policy to a beneficiary or assignee shall not be transferable nor subject to commutation, and if the benefits are payable periodically or at stated times, the same exemptions and exceptions contained in this section for the annuitant shall apply with respect to such beneficiary or assignee [1967 c 359 §368]

743.108 Exemption of proceeds, health insurance. Except as may otherwise be expressly provided by the policy, the proceeds or avails of all health insurance policies and of provisions providing benefits on account of the insured's disability which are supplemental to life insurance policies, issued before, on or after June 8, 1967, shall be exempt from all liability for any debt of the insured, and from any debt of the

beneficiary existing at the time the proceeds are made available for the use of the beneficiary [1967 c 359 §369]

743.111 Return of premium on destruction of property. (1) In the event of the total destruction of any insured property, if the total amount of loss or agreed loss is less than the total amount insured thereon, the insurer or insurers shall return to the insured the portion of insurance premium paid for the excess of the insurance over the loss. This amount shall be paid at the same time and in the same manner as the loss

(2) This section does not apply to insurance on stocks of merchandise or property of fluctuating values where the reduced rate percentage clause is made a part of the policy [Formerly 744 090]

743.114 Recovery of attorney fees in action on policy or contractor's bond. If settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought in any court of this state upon any policy of insurance of any kind or nature, and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the costs of the action and any appeal thereon. If the action is brought upon the bond of a contractor or subcontractor executed and delivered as provided in ORS 279 029 or 701 430 and the plaintiff's recovery does not exceed the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed and allowed to the defendant as part of the costs of the action and any appeal thereon. If in an action brought upon such a bond the surety is allowed attorney fees and costs and the contractor or subcontractor has incurred expenses for attorney fees and costs in defending the action, the attorney fees and costs allowed the surety shall be applied first to reimbursing the contractor or subcontractor for such expenses [Formerly 736 325 1971 c 123 §1 1981 c 667 §1]

743.115 Filing and approval of commercial liability form that includes cost of defense within limits of liability. (1) A commercial liability insurance form that provides that the cost of defending a claim is included within the stated limits of liability may not be delivered or issued for delivery in this state until the form has been filed with and approved by the director. In determining whether to approve or disapprove a form filed under this section, the director shall consider, in addition to the factors specified in ORS 743 009, the circumstances and insurance needs of the proposed insureds

(2) A commercial liability insurance form filed under this section may not be approved unless the form contains a statement approved by the director disclosing that the costs of defending a claim under the policy are included in the policy limits [1987 c 774 §46]

743.116 Reimbursement for services performed by state hospital or state approved program. No policy of health insurance shall exclude from payment or reimbursement losses incurred by an insured for any covered service because the service was rendered at any hospital owned or operated by the State of Oregon or any state approved community mental health program [1971 c 603 §2, 1981 c 422 §1, 1981 c 891 §2]

743.117 Reimbursement for services of optometrist. (1) Notwithstanding any provision of any policy of health insurance, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether such service is performed by a physician or duly licensed optometrist. Unless such policy shall otherwise provide, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses or appurtenances thereto

(2) The provisions of this section shall not apply to any policy in effect upon September 13, 1967 [1967 c 271 §2 3]

743.118 Reimbursement for diabetes self-management education programs. (1) Every group health insurance policy that covers hospital, medical or surgical expenses, other than coverage limited to expenses from accidents or specific diseases, shall provide coverage for diabetes self-management education programs

(2) In order to be covered, a diabetes self-management education program must be provided by health care professionals such as physicians, nurses, pharmacists or registered dietitians who are knowledgeable about the disease process of diabetes and treatment of a person with diabetes

(3) Coverage shall only be required to apply to the first diabetes self-management education program which the insured is certified as having successfully completed

(4) Coverage under this section shall allow insurers to require the insured to pay initially for the diabetes self-management education program as follows

(a) If the policy contains a deductible, and if the insured pays for the program and then main-

tains coverage, in each of the three subsequent deductible periods the deductible for the period shall be reduced by a credit not less than 25 percent of the cost of the program or \$40, whichever is the lesser. If such credit is greater than the deductible, the insurer shall apply to the deductible so much of the credit as equals the deductible and refund the excess to the insured

(b) If the policy does not contain a deductible, the insurer shall either provide immediate coverage for the program up to not less than 75 percent of the cost or \$120, whichever is the lesser, or refund to the insured not less than 25 percent of the cost of the program or \$40, whichever is the lesser, at the beginning of each of the three calendar years next following the year in which the insured paid for the program

(c) Nothing in this subsection prohibits any insurer from providing immediate reimbursement for the costs of a diabetes self-management education program. Such coverage must, however, provide reimbursement of not less than 75 percent of the cost of the program or \$120, whichever is the lesser, regardless of the deductible and coinsurance benefits applicable to other benefits under the plan

(5) As used in this section, "diabetes self-management education programs" means instruction on an outpatient basis for a person with diabetes to learn the disease and its control [1987 c 720 §2]

743.119 Reimbursement for maxillofacial prosthetic services. (1) The Legislative Assembly declares that all group health insurance policies providing hospital, medical or surgical expense benefits include coverage for maxillofacial prosthetic services considered necessary for adjunctive treatment

(2) As used in this section, "maxillofacial prosthetic services considered necessary for adjunctive treatment" means restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities when such restoration and management are performed for the purpose of

(a) Controlling or eliminating infection,

(b) Controlling or eliminating pain, or

(c) Restoring facial configuration or functions such as speech, swallowing or chewing but not including cosmetic procedures rendered to improve on the normal range of conditions

(3) The coverage required by subsection (1) of this section may be made subject to provisions of

the policy that apply to other benefits under the policy including, but not limited to, provisions relating to deductibles and coinsurance

(4) The services described in this section shall apply to individual health policies entered into or renewed on or after January 1, 1982 [1981 c 254 §2]

743.120 Health insurance coverage for newly born children. (1) All individual and group health insurance policies providing hospital, medical or surgical expense benefits that include coverage for a family member of the insured shall also provide that the health insurance benefits applicable for children in the family shall be payable with respect to a newly born child of the insured from the moment of birth

(2) The coverage of newly born children required by subsection (1) of this section shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities

(3) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of the birth of the child and payment of the premium be furnished the insurer within 31 days after the date of birth in order to have the coverage extended beyond the 31-day period [1975 c 135 §2]

743.123 Reimbursement for services provided by psychologist. Whenever any provision of any individual or group health insurance policy or contract provides for payment or reimbursement for any service which is within the lawful scope of a psychologist licensed under ORS 675 010 to 675 150

(1) The insured under such policy or contract shall be free to select, and shall have direct access to, a psychologist licensed under ORS 675 010 to 675 150, without supervision or referral by a physician or another health practitioner, and wherever such psychologist is authorized to practice

(2) The insured under such policy or contract shall be entitled to have payment or reimbursement made to the insured or on the insured's behalf for the services performed. Such payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be the same whether performed by a physician or a psychologist licensed under ORS 675 010 to 675 150 [1975 c 338 §2]

743.125 Denial or cancellation of health insurance because of diethylstilbestrol use by mother prohibited.

No policy of health insurance may be denied or canceled by the insurer solely because the mother of the insured used drugs containing diethylstilbestrol prior to the insured's birth [1979 c 268 §6]

743.128 Reimbursement for services of nurse practitioner. (1) Whenever any policy of health insurance provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed and certified nurse practitioner, including prescribing or dispensing drugs, the insured under the policy is entitled to reimbursement for such service whether it is performed by a physician licensed by the Board of Medical Examiners for the State of Oregon or by a duly licensed nurse practitioner

(2) This section does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act [1979 c 785 §20]

743.132 Reimbursement for services of dentist. Notwithstanding any provisions of any policy of insurance covering dental health, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a dentist, the insured under such policy shall be entitled to reimbursement for such service, whether the service is performed by a licensed dentist or a certified dentist. This section shall apply to any policy covering dental insurance which is issued after July 1, 1980. Policies which are in existence on July 1, 1980, shall be brought into compliance on the next anniversary date, renewal date, or the expiration date of the applicable collective bargaining contract, if any, whichever date is latest [1979 c 1 §15]

Note 743.132 was added to and made a part of the Insurance Code by the people in the exercise of their initiative power but was not added to or made a part of ORS chapter 743 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

743.135 Reimbursement for services of clinical social worker. Whenever any individual or group health insurance policy provides for payment or reimbursement for any service which is within the lawful scope of service of a clinical social worker registered under ORS 675 510 to 675 600

(1) The insured under the policy shall be entitled to the services of a clinical social worker registered under ORS 675 510 to 675 600, upon referral by a physician or psychologist

(2) The insured under the policy shall be entitled to have payment or reimbursement made to the insured or on behalf of the insured for the

services performed. The payment or reimbursement shall be in accordance with the benefits provided in the policy and shall be computed in the same manner whether performed by a physician, by a psychologist or by a clinical social worker, according to the customary and usual fee of clinical social workers in the area served [1981 c 422 §5]

743.138 Coverage for care in long term care facility; prior hospitalization requirement; notice. (1) If an insurer that offers coverage for care in a long term care facility, as defined in ORS 442 015, for not less than 12 consecutive months for each covered person requires as a condition of payment under the policy that the insured be admitted to a hospital prior to admission to the long term care facility, then the insurer shall also offer at least one option for such coverage that does not include the requirement of prior hospitalization

(2) A notice shall be appended to every application and all marketing materials for policies defined in subsection (1) of this section. The notice shall list all policies which are marketed by the insurer designed to provide coverage described in subsection (1) of this section or offered by entities described in this section and ORS 750 055. The notice shall list the benefits, premium costs, type of care and terms of coverage of each such policy available. The purpose of the notice is to provide consumers with informed choice of long term care policies which are available [1987 c 739 §§2 4b]

743 140 Coverage of children not residing in household of policyholder or employe of policyholder. (1) All policies providing health insurance as defined in ORS 731 162 and containing coverage for children of policyholders or children of employes of policyholders shall provide that children not residing in a policyholder's or employe's household shall be eligible for coverage to the same extent as children residing with the employe or policyholder, so long as the policyholder or employe is under a legal obligation to support or contribute to the ongoing support of the children not residing in the household and providing that there is not a court order to the contrary

(2) Subsection (1) of this section does not require a health maintenance organization as defined in ORS 442 015 to provide coverage for any children of a policyholder or employe who reside outside the service area of the health maintenance organization [1985 c 536 §1]

Note 743 140 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter

743 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation

743.143 Tourette Syndrome; reimbursement for treatment. For purpose of coverage by group health insurers, health care service contractors and health maintenance organizations, reimbursement for treatment of Tourette Syndrome shall be made on the basis of the diagnosis and treatment modality employed [1985 c 312 §2]

743.145 Automatic repeal of certain statutes on individual and group health insurance. (1) Any statute described in subsection (2) of this section that becomes effective on or after July 13, 1985, shall stand repealed on the sixth anniversary of the effective date of the statute, unless the Legislative Assembly specifically provides otherwise

(2) This section governs any statute that applies to individual or group health insurance policies and does any of the following

(a) Requires the insurer to include coverage for specific physical or mental conditions or specific hospital, medical, surgical or dental health services

(b) Requires the insurer to include coverage for specified persons

(c) Requires the insurer to provide payment or reimbursement to specified providers of services if the services are within the lawful scope of practice of the provider and the insurance policy provides payment or reimbursement for those services

(d) Requires the insurer to provide any specific coverage on a nondiscriminatory basis

(e) Forbids the insurer to exclude from payment or reimbursement any covered services

(f) Forbids the insurer to exclude coverage of a person because of that person's medical history

(3) A repeal of a statute under subsection (1) of this section shall not apply to any insurance policy in effect on the effective date of the repeal. However, the repeal of the statute shall apply to a renewal or extension of an existing insurance policy on or after the effective date of the repealer as well as to a new policy issued on or after the effective date of the repealer [1985 c 747 §59]

743.147 Payments for ambulance care and transportation. Any insurance policy issued or issued for delivery in this state that provides coverage for ambulance care and transportation shall provide that payments will be made jointly to the provider of the ambulance care and transportation and to the insured, unless

the policy provides for direct payment to the provider [1987 c 530 §2]

INDIVIDUAL LIFE INSURANCE AND ANNUITIES

(Generally)

743.150 Scope of ORS 743.150, 743.153 and 743.156. This section and ORS 743 153 and 743 156 apply only to policies of life insurance, other than group life insurance [1967 c 359 §372]

743.153 Statement of benefits. A life insurance policy shall contain a provision stating the amount of benefits payable or the method to be used or procedure to be followed in determining such amount, the manner of payment and the consideration therefor [Formerly 739 310]

743.156 Statement of premium. A life insurance policy shall contain a provision separately stating the premium for each benefit provision of the policy for which such separate statement is necessary, as determined by the director, to give adequate disclosure of the terms of the policy [1967 c 359 §374]

(Individual Life Insurance Policies)

743.159 Scope of ORS 743.162 to 743.243. ORS 743 162 to 743 243 apply only to policies of life insurance other than group life insurance, and do not apply to annuity or pure endowment policies. Such sections apply to such policies that are policies of variable life insurance, except to the extent the provisions of such sections are obviously inapplicable to variable life insurance or are in conflict with other provisions of such sections that are expressly applicable to variable life insurance [1967 c 359 §375, 1973 c 435 §16]

743.162 Payment of premium. A life insurance policy shall contain a provision relating to the time and place of payment of premium [1967 c 359 §376]

743.165 Grace period. A life insurance policy shall contain a provision that a grace period of 30 days, or, at the option of the insurer, of one month of not less than 30 days, or of four weeks in the case of industrial life insurance policies the premiums for which are payable more frequently than monthly, shall be allowed within which the payment of any premium after the first may be made, during which period of grace the policy shall continue in full force. The insurer may impose an interest charge not in excess of six percent per annum for the number of days of grace elapsing before the payment of the premium. If a claim arises under the policy during

such period of grace the amount of any premium due or overdue, together with interest and any deferred instalment of the annual premium, may be deducted from the policy proceeds [1967 c 359 §377]

743.168 Incontestability (1) A life insurance policy shall contain a provision that the policy shall be incontestable after it has been in force for two years from its date of issue during the lifetime of the insured, except for nonpayment of premiums. At the option of the insurer the two-year limit within which the policy may be contested shall not apply to the provisions for benefits in the event of total and permanent disability and provisions which grant additional insurance specifically against death by accident.

(2) A provision in a life insurance policy providing that such policy shall be incontestable after a specified period shall preclude only a contest of the validity of the policy, and shall not preclude the assertion at any time of defenses based upon provisions in the policy which exclude or restrict coverage, whether or not such restrictions or exclusions are excepted in such provision [1967 c 359 §378]

743.171 Incontestability and limitation of liability after reinstatement. (1) A reinstated policy of life insurance may be contested on account of fraud or misrepresentation of facts material to the reinstatement only for the same period following reinstatement, and with the same conditions and exceptions, as the policy provides with respect to contestability after original issuance.

(2) When any policy of life insurance is reinstated, such reinstated policy may exclude or restrict liability to the same extent that such liability could have been or was excluded or restricted when the policy was originally issued, and such exclusion or restriction shall be effective from the date of reinstatement [1967 c 359 §379]

743.174 Entire contract. A life insurance policy shall contain a provision that the policy constitutes the entire contract between the parties [1967 c 359 §380]

743.177 Statements of insured. A life insurance policy shall contain a provision that all statements made by or on behalf of the insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense of a claim under the policy unless contained in a written application and unless a copy of such application is indorsed upon or attached to the policy when issued [1967 c 359 §381]

743.180 Misstatement of age. A life insurance policy shall contain a provision that if it is found at any time before final settlement under the policy that the age of the insured or of any other person whose age is considered in determining the premium or benefit accruing under the policy has been misstated, the amount payable or benefit accruing under the policy shall be such as the premium would have purchased at the correct age or ages, or the premium may be adjusted and credit given to the insured or to the insurer, according to the insurer's published rate at date of issue [1967 c 359 §382]

743.183 Dividends. (1) A life insurance policy other than a nonparticipating policy shall contain a provision that the policy shall participate in the divisible surplus of the insurer annually, beginning not later than the end of the third policy year. Any policy containing provision for participation beginning at the end of the first or the second policy year may provide that dividends for either or both of such years shall be paid subject to the payment of the premium for the next ensuing year. The owner of the policy shall have the right each year to have the dividend arising from such participation paid in cash, and if the policy provides other dividend options, it shall further provide which dividend option is effective if the owner does not elect one of such options on or before the expiration of the period of grace allowed for the payment of the premium.

(2) In participating industrial life insurance policies, in lieu of the provision required in subsection (1) of this section, there shall be a provision that, beginning not later than the end of the fifth policy year, the policy shall participate annually in the divisible surplus in the manner set forth in the policy.

(3) This section does not apply to any form of paid-up insurance or temporary insurance or endowment insurance issued or granted in exchange for lapsed or surrendered policies [1967 c 359 §38.3]

743.186 Policy loan. (1) A life insurance policy shall contain a provision that after three full years' premiums have been paid and after the policy has a cash surrender value and while no premium is in default beyond the grace period for payment, the insurer will advance, on proper assignment or pledge of the policy and on the sole security thereof, an amount equal to or, at the option of the party entitled thereto, less than the loan value of the policy, at a rate of interest not exceeding the maximum rate permitted by the policy loan provision. The interest rate provision shall comply with ORS 743 187. The loan value of

the policy shall be equal to the cash surrender value at the end of the then current policy year, less any existing indebtedness not already deducted in determining such cash surrender value including any interest then accrued but not due, any unpaid balance of the premium for the current policy year, and interest on the loan to the end of the current policy year. The policy may also provide that

(a) If interest on any indebtedness is not paid when due it shall be added to the existing indebtedness and shall bear interest at the rate applicable to the existing indebtedness, and

(b) Except as provided in ORS 743 187, if the total indebtedness on the policy, including interest due or accrued, equals or exceeds the amount of the loan value of the policy, the policy shall terminate and become void upon 30 days' notice by the insurer mailed to the last-known address of the insured or other policy owner and of any assignee of record at the home office of the insurer.

(2) The policy shall reserve to the insurer the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for six months after application therefor.

(3) The policy, at the insurer's option, may provide for automatic premium loan.

(4) This section does not apply to term insurance policies or term insurance benefits provided by rider or supplemental policy provisions, or to industrial life insurance policies [1967 c 359 §384, 1975 c 575 §1, 1981 c 412 §18]

743.187 Maximum interest rate on policy loan; adjustable interest rate. (1) Except as provided otherwise in this section, the maximum interest rate in the policy loan provision required by ORS 743 186 shall be eight percent per year. The insurer may include in the policy loan provision, in lieu of a fixed maximum interest rate, a provision for an adjustable interest rate. The adjustable interest rate provision must comply with this section. A limitation on interest rates under state law, other than a limitation contained in the Insurance Code, shall not apply to interest rates for life insurance policy loans unless the limitation specifically applies to life insurance policy loans.

(2) The adjustable interest rate provision

(a) Shall state in substance that in accordance with the policy and the law of the jurisdiction in which the policy is delivered, the insurer will establish from time to time the interest rate for an existing or a new policy loan, and

(b) Shall set forth the dates on which the insurer will determine policy loan interest rates

These determination dates shall be at regular intervals no longer than one year and no shorter than three months

(3) The maximum interest rate permitted for a policy loan under the adjustable interest rate provision shall be established by the provision as the higher of

(a) The interest rate used to calculate cash surrender values under the policy during the same period, plus one percent, and

(b) The Moody's Corporate Bond Yield Average Monthly Average Corporates, as published by Moody's Investors Service, Inc., for the calendar month which precedes by two months the month in which the determination date for the policy loan interest rate falls. However, if the Moody's Corporate Bond Yield Average Monthly Average Corporates is no longer published by Moody's Investors Service, Inc., or if the National Association of Insurance Commissioners determines that the Moody's Corporate Bond Yield Average - Monthly Average Corporates is no longer an appropriate rate for this purpose, the director by rule may establish the method of determining the rate under this paragraph. The director's rule, to the maximum extent reasonable, shall be consistent with the pertinent actions of the National Association of Insurance Commissioners

(4) On any date specified in the adjustable interest rate provision of the policy for determining the policy loan interest rate

(a) The insurer may increase the existing rate if the maximum rate permitted by the provision exceeds the existing rate by at least one-half of one percent. The increase shall not be less than one-half of one percent or more than the amount by which the permitted maximum rate exceeds the existing rate, and

(b) The insurer shall decrease the existing rate if the existing rate exceeds the maximum rate permitted by the provision by at least one-half of one percent. The decrease shall not be less than the amount by which the existing rate exceeds the permitted maximum rate

(5) The insurer under the adjustable interest rate provision shall give notice of the policy loan interest rate and related matters to the policy owner and all other persons entitled to notice by the policy, as follows

(a) In the case of a loan other than for payment of a premium to the insurer, the insurer shall give notice of the initial interest rate on the loan when the loan is made

(b) In the case of a loan for payment of a premium to the insurer, the insurer shall give

notice of the initial interest rate on the loan as soon as reasonably practicable after the loan is made. However, the insurer need not give this notice when an additional premium loan is made at the same interest rate then applicable to an existing premium loan to the borrower

(c) In the case of a policy with an outstanding loan, the insurer shall give notice of each increase in the loan interest rate reasonably in advance of the increase

(d) Notices given under this subsection shall include in substance the information required by subsection (2) of this section

(6) Notwithstanding ORS 743.186, a policy shall not terminate in a particular policy year solely because a change in the policy loan interest rate during that year caused the total indebtedness under the policy to reach the policy loan value. The policy shall remain in force during that year unless and until it would have terminated in the absence of any policy loan interest rate change during that year. [1981 c 412 §20]

743.189 Reinstatement. A life insurance policy shall contain a provision that if in the event of a default in premium payments the value of the policy has been applied to provide a paid-up nonforfeiture benefit, and if this benefit is currently in force and the original policy has not been surrendered to the insurer and canceled, and if a period of not more than three years has elapsed since the default (or two years in the case of an industrial life insurance policy), the policy may be reinstated upon furnishing evidence of insurability satisfactory to the insurer and payment of arrears of premiums and payment or reinstatement of any other indebtedness to the insurer under the policy, with interest at a rate not exceeding the maximum permitted by the policy loan provision. [1967 c 359 §385, 1981 c 412 §21]

743.192 Payment of claim; payment of interest upon failure to pay proceeds. (1) A life insurance policy shall contain a provision that when the policy becomes a claim by the death of the insured, settlement shall be made upon receipt of due proof of death and of the interest of the claimant

(2) If the insurer fails to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and of the interest of the claimant, and if the beneficiary elects to receive a lump sum settlement, the insurer shall pay interest on any money due and unpaid after expiration of the 30-day period. The insurer shall compute the interest from the date of the insured's death until the date of payment, at a rate not lower than that paid by the insurer

on other withdrawable policy owner funds. At the end of the 30-day period, the insurer shall notify the named beneficiary or beneficiaries at their last-known address that interest at the applicable rate will be paid on the lump sum proceeds from the date of death of the insured.

(3) Nothing in this section shall be construed to allow an insurer to withhold payment of money payable under a life insurance policy to any named beneficiary for a period longer than reasonably necessary to transmit the payment. [1967 c 359 §386, 1983 c 754 §2]

743.195 Settlement option. A life insurance policy shall contain a table showing the amounts of instalments, if any, by which its proceeds may be payable. [1967 c 359 §387]

743.198 Title. A life insurance policy shall contain a title briefly and correctly describing the policy. If an industrial life insurance policy, it shall have the words "industrial policy" imprinted on the face thereof as part of the descriptive matter. [1967 c 359 §388]

743.201 Beneficiary, industrial policies. An industrial life insurance policy shall have the name of the beneficiary designated thereon, or in the application or other form if attached to the policy, with a reservation of the right to designate or change the beneficiary after the issuance of the policy unless such beneficiary has been irrevocably designated. The policy may also provide that no designation or change of beneficiary shall be binding on the insurer until indorsed on the policy by the insurer, and that the insurer may refuse to indorse the name of any proposed beneficiary who does not appear to the insurer to have an insurable interest in the life of the insured. The policy may also provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within the period stated in the policy, which shall not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment thereunder to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled thereto by reason of having been named beneficiary, or by reason of having incurred expense for the maintenance, medical attention or burial of the insured. The policy may also include a similar provision applicable to any other payment due under the policy. [1967 c 359 §389]

743.204 Standard Nonforfeiture Law for Life Insurance; applicability. (1) ORS 743 204 to 743 222 may be cited as the Standard Nonforfeiture Law for Life Insurance.

(2) The operative date of the Standard Nonforfeiture Law for Life Insurance as to any policy is the earlier of:

(a) January 1, 1948, or

(b) The date specified in a written notice, filed with the director by the insurer, of election to comply with the Standard Nonforfeiture Law for Life Insurance as to such policy as of the specified date.

(3) The Standard Nonforfeiture Law for Life Insurance shall not apply to:

(a) Any reinsurance, group insurance, pure endowment, annuity or reversionary annuity policy.

(b) Any term policy or renewal thereof, of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy. For this purpose, the age at death for a joint term life insurance policy shall be the age at death of the oldest life.

(c) Any term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, if each adjusted premium, calculated as specified in ORS 743 215 and 743 216, is less than the adjusted premium so calculated on a term policy or renewal thereof of uniform amount, which provides no guaranteed nonforfeiture benefits or endowment benefits, which is issued at the same age, for the same initial amount of insurance and for a term of 20 years or less that expires before age 71 and for which uniform premiums are payable during the entire term of the policy. For this purpose, the age at death for a joint term life insurance policy shall be the age at death of the oldest life.

(d) Any policy which provides no guaranteed nonforfeiture or endowment benefits, and for which policy the cash surrender value or present value of paid-up nonforfeiture benefit calculated for the beginning of any policy year as specified in ORS 743 210, 743 213, 743 215 and 743 216 does not exceed two and one-half percent of the amount of insurance at the beginning of such year. [Formerly 739 340, 1977 c 320 §13, 1981 c 609 §12]

743.207 Required provisions relating to nonforfeiture. (1) A life insurance policy shall contain in substance the following provisions, or corresponding provisions which in the opinion of the director are at least as favorable to

the defaulting or surrendering policyholder as are the minimum requirements specified in this section, and which are essentially in compliance with ORS 743 221

(a) That in the event of default in any premium payment the insurer will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of the amount required by ORS 743 213. In lieu of this stipulated benefit the insurer may substitute, upon proper request made not later than 60 days after the due date of the premium in default, another paid-up nonforfeiture benefit which is actuarially equivalent and provides a greater amount or longer period of death benefit or, if applicable, a greater amount or earlier payment of endowment benefit

(b) That upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary life insurance or five full years in the case of industrial life insurance, the insurer will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of the amount required by ORS 743 210

(c) That a specified paid-up nonforfeiture benefit will become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default

(d) That, if the policy has become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary life insurance or the fifth policy anniversary in the case of industrial life insurance, the insurer will pay, upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value of the amount required by ORS 743 210

(e)(A) In the case of all policies other than those provided for in subparagraph (B) of this paragraph, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter. Such values and benefits shall be calculated on the

assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the insurer on the policy. At the option of the insurer such table may also show such values and benefits for any year or years beyond the 20th policy year

(B) In the case of policies which provide, on a basis guaranteed in the policy, for unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than by change to a new policy, a statement of the mortality table, interest rate and method used in calculating cash surrender values and paid-up nonforfeiture benefits available under the policy

(f)(A) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered

(B) An explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the insurer on the policy

(C) If a detailed statement of the method of computation of the cash surrender values and paid-up nonforfeiture benefits shown in the policy is not stated in the policy, a statement that the method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered

(D) A statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are shown for consecutive years in the policy

(2) Any of the provisions set forth in subsection (1) of this section, or portions of the provisions, not applicable by reason of the particular plan of insurance may, to the extent inapplicable, be omitted from the policy

(3) The insurer shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy [Formerly 739 345, 1981 c 609 §13]

743.210 Determination of cash surrender values; applicability to certain policies. (1) Except as otherwise provided in subsections (2) and (3) of this section, any cash surrender value available under a life insurance policy in the event of default in a premium

payment due on any policy anniversary, whether or not required by ORS 743 207, shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of

(a) The present value on such anniversary of the adjusted premiums, as defined in ORS 743 215 and 743 216, corresponding to premiums which would have fallen due on and after such anniversary, and

(b) The amount of any indebtedness to the insurer on the policy

(2) This subsection applies to a life insurance policy issued on or after the operative date defined in ORS 743 215 which provides supplemental life insurance or annuity benefits by rider or supplemental policy provision at the option of the insured and for an identifiable additional premium. For such a policy, the cash surrender value shall be an amount not less than the cash surrender value required by subsection (1) of this section for a policy otherwise similar to the subject policy but without such rider or supplemental policy provision, plus the cash surrender value required by subsection (1) of this section for a policy which provides only the benefits provided by such rider or supplemental policy provision in the subject policy

(3) This subsection applies to a family life insurance policy issued on or after the operative date defined in ORS 743 215 which policy defines a primary insured and provides term insurance on the life of the spouse of the primary insured with a term that expires before age 71 of the spouse. For such a policy, the cash surrender value shall be an amount not less than the cash surrender value required by subsection (1) of this section for a policy otherwise similar to the subject policy but without such term insurance on the life of the spouse, plus the cash surrender value required by subsection (1) of this section for a policy which provides only the benefits provided by such term insurance on the life of the spouse in the subject policy

(4) Any cash surrender value available within 30 days after any policy anniversary under any policy which has been paid up by completion of all premium payments or any policy which has been continued under any paid-up nonforfeiture benefit, whether or not required by ORS 743 207, shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including

any existing paid-up additions, decreased by the amount of any indebtedness to the insurer on the policy [Formerly 739 350, 1981 c 609 §14]

743.213 Determination of paid-up nonforfeiture benefits. Any paid-up nonforfeiture benefit available under a life insurance policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by ORS 743 207 in the absence of the condition that premiums have been paid for at least a specified period [Formerly 739 355 1981 c 609 §15]

743.215 Calculation of adjusted premiums. (1) This section applies to all life insurance policies issued on or after the operative date defined in this subsection for the issuing insurer. After January 1, 1982, any insurer may file with the director a written notice of its election to comply with the provisions of this section with regard to any number of plans of insurance after a specified date before January 1, 1989. The specified date shall be the operative date of this subsection for the plan or plans, but if an insurer elects to make this subsection operative before January 1, 1989, for fewer than all plans, the insurer must comply with rules adopted by the director. There is no limit to the number of times that an insurer may make the election. If an insurer makes no such election, the operative date of this section for the insurer shall be January 1, 1989.

(2) Except as provided in subsection (8) of this section, the adjusted premiums referred to in ORS 743 210 for any life insurance policy to which this section applies shall be calculated as provided in this subsection, on an annual basis, as a uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and excluding any uniform annual contract charge or policy fee specified in the policy statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. This percentage shall be such that the present value, at the date of issue of the policy, of all such adjusted premiums shall equal the sum of

(a) The present value at the policy issue date of the future guaranteed benefits provided for by the policy,

(b) One percent of either the amount of insurance, if the insurance is uniform in amount,

or the average of the amounts of insurance at the beginning of each of the first 10 policy years, and

(c) One hundred twenty-five percent of the nonforfeiture net level premium as defined in subsection (3) of this section. For this purpose, any excess of the nonforfeiture net level premium over four percent of such uniform or average amount of insurance shall be disregarded.

(3) The nonforfeiture net level premium referred to in subsection (2) of this section shall equal the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue and on each anniversary of the policy on which a premium falls due.

(4) In the case of policies which provide, on a basis guaranteed in the policy, for unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than by change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated by the policy at the date of issue. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated as provided in subsection (5) of this section on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(5) Except as otherwise provided in subsection (8) of this section, the recalculated future adjusted premiums referred to in subsection (4) of this section shall be calculated as provided in this subsection, on an annual basis, as a uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards and excluding any uniform annual contract charge or policy fee specified in the policy statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits. This percentage shall be such that the present value, at the date of change to the newly defined benefits or premiums, of all such future adjusted premiums shall equal $A + B - C$, where these amounts are defined as follows:

(a) "A" equals the present value, as of the date of change, of the future guaranteed benefits provided for by the policy.

(b) "B" equals the additional expense allowance, if any, for the policy, as defined in subsection (6) of this section.

(c) "C" equals the cash surrender value under the policy, if any, or present value of any paid-up nonforfeiture benefit under the policy, as of the date of change.

(6) The additional expense allowance at the date of the change to the newly defined benefits or premiums, as referred to in subsection (5) of this section, shall equal the sum of:

(a) One percent of the excess, if positive, of the average of the amounts of insurance at the beginning of each of the first 10 policy years subsequent to the change, over the average of the amounts of insurance, as defined before the change, at the beginning of each of the first 10 policy years subsequent to the last previous change or the policy issue date if there has been no change.

(b) One hundred twenty-five percent of the change, if positive, in the amount of the nonforfeiture net level premium from the amount applicable prior to the change in policy benefits or premiums to the amount of the recalculated nonforfeiture net level premium determined from subsection (7) of this section as of the date of the change in policy benefits or premiums.

(7) The recalculated nonforfeiture net level premium referred to in subsection (6) of this section shall equal Y divided by Z , where these amounts are defined as follows:

(a) "Y" equals the sum of:

(A) The nonforfeiture net level premium applicable prior to the change times the present value at the date of change of an annuity of one per annum payable on each anniversary of the policy, on or subsequent to the date of the change, on which a premium would have fallen due had the change not occurred; and

(B) The present value at the date of change of the increase in future guaranteed benefits provided for by the policy.

(b) "Z" equals the present value at the date of change of an annuity of one per annum payable on each anniversary of the policy, on or subsequent to the date of change, on which a premium falls due.

(8) Notwithstanding any other provisions of this section, the provisions of this subsection shall apply in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance determined so that, in each policy year, the policy has the same tabular mor-

tality cost as for an otherwise similar policy of a higher nongraded amount or amounts of insurance issued on the standard basis. Adjusted premiums and present values for a policy on such a substandard basis may be calculated as if the policy were issued to provide such a higher nongraded amount or amounts of insurance on the standard basis.

(9) Except as provided in subsection (10) of this section, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, for all policies of life insurance to which this section applies, be calculated on the mortality and interest bases as follows:

(a) For ordinary life insurance mortality:

(A) The Commissioners 1980 Standard Ordinary Mortality Table shall be used, or

(B) At the option of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors may be used instead of such table without Ten-Year Select Mortality Factors.

(b) For industrial life insurance mortality, the Commissioners 1961 Standard Industrial Mortality Table shall be used.

(c) For all policies issued in a particular calendar year, an interest rate shall be used which does not exceed the nonforfeiture interest rate, as defined in subsection (11) of this section, for policies issued in that year.

(10) The following provisions shall also apply, for policies to which this section applies to the calculation of premiums and values referred to in the Standard Nonforfeiture Law for Life Insurance:

(a) At the option of the insurer, such calculations for all policies issued in a particular calendar year may be made on the basis of an interest rate which does not exceed the nonforfeiture interest rate, as defined in subsection (11) of this section, for policies issued in the last preceding calendar year.

(b) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by ORS 743.207, shall be calculated on the basis of the mortality table and interest rate used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions.

(c) An insurer shall calculate the amount of any guaranteed paid-up nonforfeiture benefit, including any paid-up additions, on the basis of

an interest rate no lower than that specified in the policy for calculating cash surrender values.

(d) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary life insurance, and not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial life insurance.

(e) For insurance issued on a substandard basis, the calculation of premiums and values may be based on appropriate modifications of the mortality tables referred to in subsection (9) of this section and in this subsection.

(f) Any ordinary life mortality tables adopted after 1980 by the National Association of Insurance Commissioners that are approved under rules issued by the director for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors, or for the Commissioners 1980 Extended Term Insurance Table.

(g) Any industrial life mortality tables adopted after 1980 by the National Association of Insurance Commissioners that are approved under rules issued by the director for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table.

(11) The nonforfeiture interest rate for any policy issued in a particular calendar year shall equal 125 percent of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearer one-quarter of one percent.

(12) Notwithstanding any other provision in this chapter, for any previously approved policy form, any refiling of nonforfeiture values or their methods of computation which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not of itself require refiling of any other provisions of that policy form. [1981 c 609 §17, 1983 c 282 §1]

743.216 Adjusted premiums; applicability. This section applies only to life insurance policies issued before the operative date defined in ORS 743.215. For such policies:

(1) Except as provided in subsection (3) of this section, the adjusted premiums referred to in

ORS 743 210 shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of

(a) The present value at the policy issue date of the future guaranteed benefits provided for by the policy

(b) Two percent of the amount of insurance if the insurance is uniform in amount, or of the equivalent uniform amount as defined in subsection (2) of this section if the amount of insurance varies with duration of the policy

(c) Forty percent of the adjusted premium for the first policy year. For this purpose, any excess of the adjusted premium over four percent of the amount of insurance or equivalent uniform amount shall be disregarded

(d) Twenty-five percent of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy for the same uniform or the same equivalent uniform amount of insurance with uniform premiums for the whole of life issued at the same age, whichever is less. For this purpose, any excess of the adjusted premium over four percent of the amount of insurance or equivalent uniform amount shall be disregarded

(2) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount of the subject policy for the purpose of this section shall be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the subject policy. However, in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the subject policy prior to the attainment of age 10 were the amount provided by the subject policy at age 10

(3) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be calculated in accordance with this subsection. The amounts specified in paragraphs (a) and (b) of this subsection shall be calculated separately. Each such amount shall be calculated as specified in subsections (1) and (2) of this section.

However, for the purposes of paragraphs (b), (c) and (d) of subsection (1) of this section, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in paragraph (b) of this subsection shall be equal to the excess of the uniform or equivalent uniform amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in paragraph (a) of this subsection. The adjusted premiums for the entire policy shall equal the sum of

(a) The adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, and

(b) During the period for which premiums for such term insurance benefits are payable, the adjusted premiums for such term insurance benefits

(4) Except as provided in paragraphs (a) and (b) of this subsection and subsection (5) of this section, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall for all policies of ordinary life insurance to which this section applies be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table. Such calculations for any category of ordinary life insurance issued on female lives may, however, be based on an age not more than six years younger than the actual age of the insured. Except as provided in paragraphs (a) and (b) of this subsection and subsection (7) of this section, such calculations of adjusted premiums and present values for all policies of industrial life insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. The following exceptions pertain

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130 percent of the rates of mortality according to the respective table

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director

(5) This subsection applies only to policies of ordinary life insurance to which this section applies and which are issued on or after the

operative date of this subsection as defined in subsection (6) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such calculations for any category of ordinary life insurance issued on female lives may, however, be based on an age not more than six years younger than the actual age of the insured. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table.

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

(6) After August 9, 1961, any insurer may file with the director a written notice of its election to comply with the provisions of subsection (5) of this section after a specified date before January 1, 1966. After the filing of such notice, such specified date shall be the operative date of subsection (5) of this section for the insurer with respect to the ordinary life policies it thereafter issues. If an insurer makes no such election, such operative date for the insurer shall be January 1, 1966.

(7) This subsection applies only to policies of industrial life insurance to which this section applies and which are issued on or after the operative date of this subsection as defined in subsection (8) of this section. For such policies, all adjusted premiums and present values referred to in the Standard Nonforfeiture Law for Life Insurance shall, except as provided in paragraphs (a) and (b) of this subsection, be calculated on the

basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Such rate of interest shall not exceed three and one-half percent, except that a rate of interest not exceeding four percent may be used for policies issued from January 1, 1974, to December 31, 1977, and a rate of interest not exceeding five and one-half percent may be used for policies issued on or after January 1, 1978, and with the further exception that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent may be used. The following exceptions pertain:

(a) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table.

(b) For insurance issued on a substandard basis, the calculation of adjusted premiums and present values may be based on such other table of mortality as may be specified by the insurer and approved by the director.

(8) After September 2, 1963, any insurer may file with the director a written notice of its election to comply with the provisions of subsection (7) of this section after a specified date before January 1, 1968. After the filing of such notice, such specified date shall be the operative date of subsection (7) of this section for the insurer with respect to the industrial life insurance policies it thereafter issues. If an insurer makes no such election, such operative date for the insurer shall be January 1, 1968. [Formerly 739 360 1973 c 636 §6, 1977 c 320 §14 1981 c 609 §16]

743.218 Requirements for determination of future premium amounts or minimum values. In the case of policies of life insurance which provide for determination of future premium amounts by the insurer on the basis of current estimates of future experience, or policies of life insurance which are of such a nature that minimum values cannot in the judgment of the director be determined by the methods otherwise described in the Standard Nonforfeiture Law for Life Insurance, the following requirements shall apply:

(1) The director must be satisfied that the policy benefits are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by the Standard Nonforfeiture Law for Life Insurance.

(2) The director must be satisfied that the benefits and the pattern of premiums of the

policy are not misleading to prospective policyholders or insureds, and

(3) The cash surrender values and paid-up nonforfeiture benefits provided by the policy must not be less than the minimum values and benefits required for the policy as calculated by a method consistent with the principles of the Standard Nonforfeiture Law for Life Insurance, as determined under rules issued by the director [1981 c 609 §18]

743.219 Supplemental rules for calculating nonforfeiture benefits. (1) Any cash surrender value and any paid-up nonforfeiture benefit available under a life insurance policy in the event of default in a premium payment due at any time other than on the policy anniversary date shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary

(2) All values referred to in the Standard Nonforfeiture Law for Life Insurance may be calculated on the assumption that any death benefit is payable at the end of the policy year of death

(3) The net value of any paid-up additions, other than paid-up term additions, shall not be less than the amounts used to provide the additions [Formerly 739 365, 1981 c 609 §19]

743.221 Cash surrender values upon default in premium payment. (1) This section shall apply to all life insurance policies issued on or after January 1, 1986

(2) Any cash surrender value available in the event of default in a premium payment due on any policy anniversary under a life insurance policy to which this section applies shall be in an amount which does not differ, by more than two-tenths of one percent of the amount of insurance, if uniform, or the average of the amounts of insurance at the beginning of each of the first 10 policy years, from A plus B minus C, where these amounts are defined as follows.

(a) "A" equals the basic cash value on such anniversary as defined in subsection (3) of this section

(b) "B" equals the present value on such anniversary of any existing paid-up additions

(c) "C" equals the amount of any indebtedness to the insurer under the policy on such anniversary

(3)(a) The basic cash value referred to in subsection (2) of this section shall equal the present value, on a particular subject policy anni-

versary, of the future guaranteed benefits which would have been provided for by the policy if there had been no premium default, excluding any existing paid-up additions and before deduction of any indebtedness to the insurer, less the present value on such anniversary of the nonforfeiture factors, as defined in subsection (4) of this section, corresponding to premiums which would have fallen due on and after such anniversary. The basic cash value shall be taken as zero if this calculation produces a negative result

(b) Supplemental life insurance or annuity benefits and family coverage, as described in ORS 743 210 or 743 216, whichever is applicable to the policy, shall affect the basic cash value in the same manner as is provided in ORS 743 210 or 743 216 for their effect on the cash surrender values

(4)(a) Except as provided in paragraph (b) of this subsection, the nonforfeiture factor referred to in subsection (3) of this section shall for each policy year equal a percentage of the adjusted premium for that policy year as defined in ORS 743 215 or 743 216, whichever is applicable to the policy. This percentage must

(A) Be uniform for each policy year between the second policy anniversary and the later of

(i) The fifth policy anniversary, and

(ii) The first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, at least equal to two-tenths of one percent of the amount of insurance, if uniform, or of the average of the amounts of insurance at the beginning of each of the first 10 policy years, and

(B) Be such that no percentage after the later policy anniversary defined in subparagraph (A) of this paragraph applies to fewer than five consecutive policy years

(b) No basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy as defined in ORS 743 215 or 743 216, whichever is applicable to the policy, were substituted for the nonforfeiture factors defined in this subsection in the calculation of the basic cash value

(5) All adjusted premiums and present values referred to in this section shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the compliance of the policy with the Standard Nonforfeiture Law for Life Insurance. The cash surrender values referred to in this section shall include any endowment benefits provided for by the policy

(6)(a) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment, shall be determined in a manner consistent with the manner specified for determining the analogous minimum amounts under the Standard Nonforfeiture Law for Life Insurance

(b) The amounts of any cash surrender values and any paid-up nonforfeiture benefits granted in connection with additional benefits such as those described in ORS 743 222 shall conform with the principles of this section [1981 c 609 §21]

743.222 Policy benefits and premiums that shall be disregarded in calculating cash surrender values and paid-up nonforfeiture benefits (1) Notwithstanding ORS 743 210, in ascertaining minimum cash surrender values and paid-up nonforfeiture benefits required by the Standard Nonforfeiture Law for Life Insurance, benefits and their respective premiums provided for in a life insurance policy shall be disregarded where the benefits are payable

(a) In the event of death or dismemberment by accident or accidental means,

(b) In the event of total and permanent disability,

(c) As reversionary annuity or deferred reversionary annuity benefits,

(d) As term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, the Standard Nonforfeiture Law for Life Insurance would not apply,

(e) As term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, is uniform in amount after the child's age is one, and has not become paid up by reason of the death of a parent of the child, or

(f) As other policy benefits additional to life insurance and endowment benefits

(2) No benefits such as are described in subsection (1) of this section are required to be included in any paid-up nonforfeiture benefits [Formerly 739 370, 1981 c 609 §20]

743.225 Prohibited provisions. No life insurance policy shall contain any of the following provisions

(1) A provision limiting the time within which any action at law or suit in equity may be

commenced to less than three years after the cause of action or suit accrues

(2) A provision by which the policy purports to be issued or to take effect more than six months before the original application for the insurance was made

(3) A provision for forfeiture of the policy for failure to repay any loan on the policy or any interest on such loan while the total indebtedness on the policy is less than the loan value thereof [Formerly 739 316]

743.228 Acts of corporate insured or beneficiary with respect to policy. (1) Whenever a corporation organized under the laws of this state or qualified to do business in this state has caused to be insured the life of any director, officer, agent or employe, or whenever such corporation is named as a beneficiary in or assignee of any life insurance policy, due authority to effect, assign, release, relinquish, convert, surrender, change the beneficiary or take any other or different action with reference to such insurance shall be sufficiently evidenced to the insurer by a written statement under oath showing that such action has been approved by a majority of the board of directors. Such a statement shall be signed by the president and secretary of the corporation and bear the corporate seal

(2) Such a statement shall be binding upon the corporation and shall protect the insurer concerned in any act done or suffered by it upon the faith thereof without further inquiry into the validity of the corporate authority or the regularity of the corporate proceedings

(3) No person shall be disqualified by reason of interest in the subject matter from acting as a director or as a member of the executive committee of such a corporation on any corporate act touching such insurance [Formerly 739 415]

743 230 Variable life policy provisions. A variable life insurance policy shall contain in substance the following provisions

(1) A provision that there will be a period of grace of 30 days within which payment of any premium after the first may be made, during which period of grace the policy will continue in full force. If a claim arises under the policy during such period of grace, the amount of any premiums due or overdue, together with interest not in excess of six percent per annum and any deferred instalment of the annual premium, may be deducted from the policy proceeds. The policy may contain a statement of the basis for determining any variation in benefits that may occur

as a result of the payment of premium during the period of grace

(2) A provision that the policy will be reinstated at any time within three years from the date of a default in premium payments, unless the cash surrender value has been paid or the period of extended insurance has expired, upon the production of evidence of insurability satisfactory to the insurer and the payment of an amount not exceeding the greater of

(a) All overdue premiums and any other indebtedness to the insurer upon said policy with interest at a rate not exceeding six percent per annum, and

(b) One hundred ten percent of the increase in cash surrender value resulting from reinstatement

(3) A provision for cash surrender values and paid-up insurance benefits available as nonforfeiture options in the event of default in a premium payment after premiums have been paid for a specified period. If the policy does not include a table of figures for the options so available, the policy shall provide that the insurer will furnish, at least once in each policy year, a statement showing the cash value as of a date no earlier than the next preceding policy anniversary

(a) The method of computation of cash values and other nonforfeiture benefits shall be as described either in the policy or in a statement filed with the director, and shall be actuarially appropriate to the variable nature of the policy

(b) The method of computation must result, if the net investment return credited to the policy at all times from the date of issue equals the specified investment increment factor, with premiums and benefits determined accordingly under the terms of the policy, in cash values and other nonforfeiture benefits at least equal to the minimum values required by the Standard Nonforfeiture Law for a policy with such premiums and benefits. The method of computation may disregard incidental minimum guarantees as to the dollar amounts payable. Incidental minimum guarantees include, but are not limited to, a guarantee which provides that the amount payable at death or maturity shall be at least equal to the amount that would be payable if the net investment return credited to the policy at all times from the date of issue is equal to the specified investment increment factor

(4) A provision specifying the investment increment factor to be used in computing the dollar amount of variable benefits or other vari-

able payments or values under the policy, and guaranteeing that expense and mortality results will not adversely affect such dollar amounts [1973 c. 435 §18]

743.231 "Profit-sharing policy" defined. "Profit-sharing policy" means

(1) A life insurance policy which by its terms expressly provides that the policyholder will participate in the distribution of earnings or surplus other than earnings or surplus attributable, by reasonable and nondiscriminatory standards, to the participating policies of the insurer and allocated to the policyholder on reasonable and nondiscriminatory standards, or

(2) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholder to the benefits described in subsection (1) of this section [Formerly 739 705]

743.234 "Charter policy" or "founders policy" defined. "Charter policy" or "founders policy" means

(1) A life insurance policy which by its terms expressly provides that the policyholder will receive some preferential or discriminatory advantage or benefit not available to persons who purchase insurance from the insurer at future dates or under other circumstances, or

(2) A life insurance policy the provisions of which, through sales material or oral presentations, are interpreted by the insurer to prospective policyholders as entitling the policyholder to the benefits described in subsection (1) of this section [Formerly 739 710]

743.237 "Coupon policy" defined "Coupon policy" means a life insurance policy which provides a series of pure endowments maturing periodically in amounts not exceeding the gross annual policy premiums. The term "pure endowment" or "endowment" is used in its accepted actuarial sense, meaning a benefit becoming payable at a specific future date if the insured person is then living [Formerly 739 715]

743.240 Profit-sharing, charter or founders policies prohibited. No profit-sharing, charter or founders policy shall be issued or delivered in this state [Formerly 739 720]

743.243 Restrictions on form of coupon policy. Coupon policies issued or delivered in this state shall be subject to the following provisions

(1) No detachable coupons or certificates or passbooks may be used. No other device may be

used which tends to emphasize the periodic endowment benefits or which tends to create the impression that the endowments represent interest earnings or anything other than benefits which have been purchased by part of the policyholder's premium payments

(2) Each endowment benefit must have a fixed maturity date and payment of the endowment benefit shall not be contingent upon the payment of any premium becoming due on or after such maturity date

(3) The endowment benefits must be expressed in dollar amounts rather than as percentages of other quantities or in other ways, both in the policy itself and in the sale thereof

(4) A separate premium for the periodic endowment benefits must be shown in the policy adjacent to the rest of the policy premium information and must be given the same emphasis in the policy and in the sale thereof as that given the rest of the policy premium information. This premium shall be calculated with mortality, interest and expense factors which are consistent with those for the basic policy premium [1967 c 359 §403]

743.245 Variable life insurance policy provisions. A variable life insurance policy shall contain a provision stating the essential features of the procedures to be followed by the insurer in determining benefits thereunder. Such a policy, and any certificate evidencing such a policy, shall contain on its first page a clear and prominent statement to the effect that benefits thereunder are variable [1973 c 435 §14]

743.247 Notice to variable life insurance policyholders. An insurer issuing individual variable life insurance policies shall mail to each policyholder at least once in each policy year after the first, at the last address of the policyholder known to the insurer

(1) A statement reporting the investments held in the applicable separate account

(2) A statement reporting as of a date not more than four months preceding the date of mailing

(a) In the case of an annuity policy under which payments have not yet commenced, the number of accumulation units credited to such policy and the dollar value of a unit, or the value of the policyholder's account, and

(b) In the case of a life insurance policy, the dollar amount of the death benefit [1973 c 435 §15]

(Individual Annuity and Pure Endowment Policies)

743.252 Scope of ORS 743.255 to 743.273. ORS 743 255 to 743 273 apply only to annuity and pure endowment policies, other than reversionary annuity policies except as provided in ORS 743 273, and other than group annuity policies, and shall not apply to reversionary or deferred annuity benefits included in life insurance policies. Such sections apply to such policies that are variable annuity policies, except to the extent the provisions of such sections are obviously inapplicable to variable annuities or are in conflict with other provisions of such sections that are expressly applicable to variable annuities [1967 c 359 §404 1973 c 435 §19]

743.255 Grace period, annuities. An annuity or pure endowment policy shall contain a provision that there shall be a period of grace of one month, but not less than 30 days, within which any stipulated payment to the insurer falling due after the first such payment may be made, subject at the option of the insurer to an interest charge thereon at the rate specified in the policy but not exceeding six percent per annum for the number of days of grace elapsing before such payment, during which period of grace the policy shall continue in full force. In case a claim arises under the policy on account of death prior to expiration of the period of grace before the overdue payment to the insurer or the deferred payments of the current policy year, if any, are made, the amount of such payments, with interest on any overdue payments, may be deducted from any amount payable under the policy in settlement [1967 c 359 §405]

743.258 Incontestability, annuities. If any statement other than those relating to age, sex and identity are required as a condition to issuing an annuity or pure endowment policy, the policy shall contain a provision that the policy shall be incontestable after it has been in force during the lifetime of the person or of each of the persons as to whom such statements are required, for a period of two years from its date of issue, except for nonpayment of stipulated payments to the insurer. At the option of the insurer the two year limit within which the policy may be contested shall not apply to any provisions relative to benefits in the event of disability and any provisions which grant insurance specifically against death by accident or accidental means [1967 c 359 §406]

743.261 Entire contract, annuities. An annuity or pure endowment policy shall contain a

provision that the policy, including a copy of the application if indorsed upon or attached to the policy when issued, shall constitute the entire contract between the parties [1967 c 359 §407]

743.264 Misstatement of age or sex, annuities. An annuity or pure endowment policy shall contain a provision that if the age or sex of the person or persons upon whose life or lives the policy is made, or of any of them, has been misstated, the amount payable or benefits accruing under the policy shall be such as the stipulated payment or payments to the insurer would have purchased according to the correct age or sex, and that if the insurer has made any overpayment or overpayments on account of any such misstatement, the amount thereof with interest at the rate specified in the policy but not exceeding six percent per annum may be charged against the current or next succeeding payment or payments to be made by the insurer under the policy [1967 c 359 §408]

743.267 Dividends, annuities. If an annuity or pure endowment policy is participating, it shall contain a provision that the insurer shall annually ascertain and apportion any divisible surplus accruing on the policy [1967 c 359 §409]

743.270 Reinstatement, annuities. An annuity or pure endowment policy shall contain a provision that the policy may be reinstated at any time within one year from a default in making stipulated payments to the insurer, unless the cash surrender value has been paid, but all overdue stipulated payments and any indebtedness to the insurer on the policy shall be paid or reinstated with interest at the rate specified in the policy but not exceeding six percent per annum, and in cases where applicable the insurer may also include a requirement of evidence of insurability satisfactory to the insurer [1967 c 359 §410]

743.271 Periodic stipulated payments, variable annuities. A variable annuity policy requiring periodic stipulated payments to the insurer shall contain in substance the following provisions

(1) A provision that there will be a period of grace of 30 days within which any stipulated payment to the insurer after the first may be made, during which period of grace the policy will continue in full force. The policy may include a statement of the basis for determining the date as of which any such payment received during the period of grace will be applied

(2) A provision that, at any time within one year from the date of a default in making periodic stipulated payments to the insurer during the life of the annuitant, and unless the cash surrender

value has been paid, the policy may be reinstated upon payment to the insurer of the overdue payments and all indebtedness to the insurer on the policy, with interest. The policy may include a statement of the basis for determining the date as of which the amount to cover such overdue payments and indebtedness will be applied

(3) A provision specifying the options available in the event of a default in a periodic stipulated payment. Such options may include an option to surrender the policy for a cash value as determined by the policy, and shall include an option to receive a paid-up annuity if the policy is not surrendered for cash, the amount of the paid-up annuity being determined by applying the value of the policy at the annuity commencement date in accordance with the terms of the policy [1973 c 435 §21]

743.272 Computing benefits, variable annuities (1) A variable annuity policy shall specify the investment increment factors to be used in computing the dollar amount of variable benefits or other variable payments or values under the policy, and may guarantee that expense or mortality results or both will not adversely affect such dollar amounts. In the case of an individual variable annuity policy under which the expense or mortality results may adversely affect the dollar amount of benefits, the expense and mortality factors shall be correspondingly specified in the policy. "Expense" as used in this subsection may exclude some or all taxes, as specified in the policy

(2) In computing the dollar amount of variable benefits or other policy payments or values

(a) The annual net investment increment assumption shall not exceed five percent, except with the approval of the director, and

(b) To the extent that the level of benefits may be affected by future mortality results, the mortality factor shall be determined from the Annuity Mortality Table for 1949, Ultimate, or any modification of that table not having a lower life expectancy at any age or, if approved by the director, from another table [1973 c 435 §22]

743.273 Standard provisions, reversionary annuities. A policy of reversionary annuity shall contain in substance the following provisions

(1) The provisions specified in ORS 743 255 to 743 267, except that under ORS 743 255 the insurer may at its option provide for an equitable reduction of the amount of the annuity payments in settlement of an overdue payment in lieu of providing for deduction of the overdue payment

from an amount payable upon settlement under the policy

(2) A provision that the policy may be reinstated at any time within three years from the date of default in making stipulated payments to the insurer, upon production of evidence of insurability satisfactory to the insurer, and upon the condition that all overdue payments and any indebtedness to the insurer on account of the policy be paid or reinstated with interest at the rate specified in the policy but not exceeding six percent per annum [1967 c 359 §411]

743.275 Standard Nonforfeiture Law for Individual Deferred Annuities; operative date; application. (1) ORS 743 275 to 743 295 may be cited as the Standard Nonforfeiture Law for Individual Deferred Annuities

(2) The operative date of the Standard Nonforfeiture Law for Individual Deferred Annuities for an insurer is the earlier of

(a) Two years after October 4, 1977, and

(b) The date specified in a written notice filed with the director by the insurer of election to comply with the Standard Nonforfeiture Law for Individual Deferred Annuities as of the specified date

(3) The Standard Nonforfeiture Law for Individual Deferred Annuities does not apply to

(a) Annuity benefits purchased under a group annuity policy issued in conjunction with a retirement or deferred compensation plan established or maintained by an employer, an employee organization, or both. This exclusion does not apply, however, to a retirement or deferred compensation plan providing individual retirement accounts or individual retirement annuities governed by section 408 of the federal Internal Revenue Code

(b) A premium deposit fund

(c) A variable annuity policy

(d) An investment annuity policy

(e) An immediate annuity policy

(f) A deferred annuity policy with respect to the period after annuity payments begin

(g) A reversionary annuity

(h) A policy issued before the operative date of the Standard Nonforfeiture Law for Individual Deferred Annuities for the insurer [1977 c 320 §2]

743 278 Required provisions in annuity policies; exception. (1) An annuity policy shall contain in substance the following provisions, or corresponding provisions that in

the opinion of the director are at least as favorable to the policyholder

(a) That upon the termination of consideration payments under the policy the insurer will grant a paid-up annuity benefit on a plan stipulated in the policy, of the value required by ORS 743 284

(b) That, if the policy provides for a lump sum settlement at maturity or any other time, the insurer will pay upon surrender of the policy on or before the start of annuity payments, in lieu of a paid-up annuity benefit, a cash surrender benefit of the amount required by ORS 743 284. The insurer shall reserve the right to defer the payment of the cash surrender benefit for a period of six months after demand therefor with surrender of the policy

(c) A statement of the mortality table, if any, and interest rates used in calculating minimum guaranteed paid-up annuity, cash surrender and death benefits under the policy, together with sufficient information to determine the amount of such benefits

(d) A statement that paid-up annuity, cash surrender and death benefits available under the policy are not less than the minimums required by the statutes of the jurisdiction in which the policy is delivered, with an explanation of the manner in which such benefits are altered by the existence of any additional amounts credited by the insurer to the policy, any indebtedness to the insurer on the policy or any prior withdrawals from or partial surrenders of the policy

(2) Notwithstanding subsection (1) of this section, the policy may provide that if no consideration payments have been received for two full years and the paid-up annuity benefit at maturity on the plan stipulated in the policy, arising from the considerations paid before such two-year period, is less than \$20 monthly, the insurer at its option may terminate the policy by payment in cash of the then present value of the paid-up annuity benefit. Such value shall be calculated on the basis of the mortality table, if any, and the interest rate specified in the policy for calculating the paid-up annuity benefit. By this payment the insurer will be relieved of further obligations under the policy [1977 c 320 §3]

743.281 Calculation of "minimum nonforfeiture amount." "Minimum nonforfeiture amount" as referred to in the Standard Nonforfeiture Law for Individual Deferred Annuities shall be calculated as follows

(1) For a policy providing for flexible consideration payments, the minimum nonforfeiture

amount at a given time equals the then accumulated value at three percent interest of the percentages specified in paragraph (b) of this subsection of the net considerations previously paid, decreased by the then accumulated value at three percent interest of previous withdrawals from or partial surrenders of the policy and the amount of any indebtedness to the insurer on the policy, and increased by any existing additional amounts credited by the insurer to the policy

(a) The net considerations used in calculating the minimum nonforfeiture amount equal, for a given policy year, the gross considerations credited to the policy during that year less a policy charge for the year of \$30 and less a collection charge of \$1.25 per consideration credited during that year, but the net considerations shall not be less than zero for any year

(b) The percentages shall be 65 percent of the net considerations for the first policy year, and 87-1/2 percent of the net considerations for the years thereafter, except that the percentage for years after the first policy year shall be 65 percent for the portion of the total net consideration in any such year that exceeds the sum, but does not exceed twice the sum, of the portions of net considerations in previous years for which the percentage was 65 percent

(2) For a policy providing for scheduled amounts of consideration payments, the minimum nonforfeiture amount shall be calculated using the assumption that considerations are paid annually in advance and the same calculation method as for a policy with flexible considerations, except that

(a) The portion of the net considerations for the first policy year to be accumulated shall be 65 percent of such net considerations plus 22-1/2 percent of the excess of such net considerations over the lesser of the net considerations for the second and third policy years, and

(b) The policy charge for a given policy year shall be the lesser of \$30 and 10 percent of the gross considerations for the year

(3) For a policy providing for a single consideration, the minimum nonforfeiture amount shall be calculated using the same method as for a policy with flexible considerations, except that

(a) The net consideration shall be the gross consideration less a policy charge of \$75, and

(b) The percentage shall be 90 percent [1977 c 320 §4]

743.284 Computation of benefits. (1) Any paid-up annuity benefit available under an annuity policy shall be such that its present value

on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date. Such present value shall be computed using the mortality table, if any, and the interest rate specified in the policy for determining the minimum guaranteed paid-up annuity benefits

(2) For annuity policies that provide cash surrender benefits, such benefits available prior to maturity shall be an amount not less than the present value on the date of surrender of the portion of the policy maturity value of its paid-up annuity benefits that arises from considerations paid before the surrender, reduced by appropriate amounts reflecting any previous withdrawals from or partial surrenders of the policy. Such present value shall be calculated using an interest rate not more than one percent higher than the interest rate specified in the policy for accumulating the net considerations to determine such policy maturity value, shall be decreased by the amount of any indebtedness to the insurer on the policy, and shall be increased by any existing additional amounts credited by the insurer to the policy. In no event shall the cash surrender benefit be less than the minimum nonforfeiture amount on the date of surrender. The death benefit under an annuity policy that provides cash surrender benefits shall be at least equal to the cash surrender benefit

(3) For annuity policies that do not provide cash surrender benefits, the present value of the paid-up annuity benefit available as a nonforfeiture option at any time prior to maturity shall not be less than the present value of the portion of the policy maturity value of its paid-up annuity benefits that arises from considerations paid before the policy is surrendered in exchange for, or changed to, a deferred paid-up annuity. Such present value shall be calculated for the period prior to the maturity date on the basis of the interest rate specified in the policy for accumulating the net considerations to determine the policy maturity value, and shall be increased by any existing additional amounts credited by the insurer to the policy. For such annuity policies that also do not provide any death benefits before annuity payments start, such present value shall be calculated on the basis of such interest rate and the mortality table specified in the policy for determining the policy maturity value of its paid-up annuity benefit. In no event, however, shall the present value of a paid-up annuity benefit be less at any time than the minimum nonforfeiture amount [1977 c 320 §5]

743.287 Commencement of annuity payments at optional maturity dates; cal-

ulation of benefits. (1) For the purpose of ORS 743 284 (2) and (3) in the case of annuity policies under which an election may be made to have annuity payments commence at optional maturity dates, the maturity date shall be considered to be the latest date for which such election is permitted by the policy, but not later than the later of the policy anniversary next following the annuitant's 70th birthday and the 10th anniversary of the policy

(2) Paid-up annuity, cash surrender and death benefits available at any time other than on a policy anniversary of a policy with scheduled amounts of consideration payments shall be calculated with allowance for the lapse of time and the payment of scheduled considerations beyond the start of the policy year in which termination of consideration payments occurs [1977 c 320 §6]

743.290 Notice of nonpayment of certain benefits to be included in annuity policy. An annuity policy that does not provide cash surrender benefits, or that does not provide death benefits at least equal to the minimum nonforfeiture amount prior to the start of annuity payments, shall include a prominent statement to that effect [1977 c 320 §7]

743.295 Effect of certain life insurance and disability benefits on minimum nonforfeiture amounts. (1) For an annuity policy that includes, by rider or otherwise, life insurance benefits that exceed the greater of the cash surrender benefit and the return of the gross considerations with interest, the minimum nonforfeiture benefits shall equal the sum of the minimum nonforfeiture benefits for the annuity portion and the minimum nonforfeiture benefits, if any, for the life insurance portion, computed as if each portion were a separate policy

(2) Additional benefits payable in the event of total and permanent disability, as reversionary annuity or deferred reversionary annuity benefits, or as other policy benefits additional to life insurance, endowment and annuity benefits, and considerations for all such additional benefits, shall be disregarded in ascertaining the minimum nonforfeiture amounts and paid-up annuity, cash surrender and death benefits required by the Standard Nonforfeiture Law for Individual Deferred Annuities. The inclusion of such additional benefits shall not be required in any paid-up benefits unless the additional benefits would separately require minimum nonforfeiture amounts and paid-up annuity, cash surrender and death benefits. [1977 c 320 §8]

GROUP LIFE INSURANCE

743.303 Requirements for issuance of group life insurance policies. Policies of group life insurance are subject to the following requirements

(1) The policy shall be issued upon the lives of persons who are associated in a common group formed for purposes other than the obtaining of insurance, except that group policies of credit life insurance may be issued to persons other than those in a common group,

(2) Not less than 75 percent of the eligible members of the group or 10 lives, whichever is the greater, are insured at the date of issue of the policy,

(3) The amounts of insurance under the policy shall be based on some plan precluding individual selection, except that optional supplemental insurance may be available to persons insured under the policy, if the amounts of such supplemental insurance are based upon age, salary, rank or similar objective standards, and

(4) The person contracting for the group coverage shall be responsible for the payment of premiums [1967 c 359 §412, 1971 c 231 §44]

743.306 Required provisions in group life insurance policies. (1) Except as provided in subsection (2) of this section a group life insurance policy shall contain in substance the provisions described in ORS 743 309 to 743 342

(2) The provisions described in ORS 743 327 to 743 339 shall not apply to policies of group credit life insurance. [1967 c 359 §413]

743.309 Nonforfeiture provisions. If a group life insurance policy is on a plan of insurance other than the term plan, it shall contain nonforfeiture provision or provisions which in the opinion of the director are equitable to the insured persons and to the policyholder, but nothing in this section shall be construed to require that group life insurance policies contain the same nonforfeiture provisions as are required for individual life insurance policies [1967 c 359 §414]

743.312 Grace period. A group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage shall continue in force, unless the policyholder shall have given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may

provide that the policyholder shall be liable to the insurer for the payment of a pro rata premium for the time the policy was in force during such grace period [1967 c 359 §415]

743.315 Incontestability. A group life insurance policy shall contain a provision that the validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue, and that no statement made by any person insured under the policy relating to the insurability of the person shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written instrument signed by the person [1967 c 359 §416]

743.318 Application; representations by policyholders and insureds. A group life insurance policy shall contain a provision that a copy of the application, if any, of the policyholder shall be attached to the policy when issued, that all statements made by the policyholder or by the persons insured shall be deemed representations and not warranties, and that no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or the beneficiary of the person [1967 c 359 §417]

743.321 Evidence of insurability. A group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of the coverage [1967 c 359 §418]

743.324 Misstatement of age. A group life insurance policy shall contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated, such provision to contain a clear statement of the method of adjustment to be used [1967 c 359 §419]

743.327 Payments under policy; payment of interest upon failure to pay proceeds. (1) A group life insurance policy shall contain a provision that any sum becoming due by reason of the death of a person insured shall be payable to the beneficiary designated by the person insured, subject to the provisions of the policy in the event there is no designated beneficiary, as to all or any part of such sum, living at the death of the person insured, and subject to any right reserved by the insurer in the policy and

set forth in the certificate to pay at its option a part of such sum not exceeding \$500 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured

(2) If the insurer fails to pay the proceeds of or make payment under the policy within 30 days after receipt of due proof of death and of the interest of the claimant, and if the beneficiary elects to receive a lump sum settlement, the insurer shall pay interest on any money due and unpaid after expiration of the 30-day period. The insurer shall compute the interest from the date of the insured's death until the date of payment, at a rate not lower than that paid by the insurer on other withdrawable policy owner funds. At the end of the 30-day period, the insurer shall notify the designated beneficiary or beneficiaries at their last-known address that interest at the applicable rate will be paid on the lump sum proceeds from the date of death of the insured

(3) Nothing in this section shall be construed to allow an insurer to withhold payment of money payable under a group life insurance policy to any designated beneficiary for a period longer than reasonably necessary to transmit the payment [1967 c 359 §420, 1983 c 754 §3]

743.330 Issuance of certificates. A group life insurance policy shall contain a provision that the insurer will issue to the policyholder for delivery to each person insured an individual certificate setting forth a statement as to the insurance protection to which the person is entitled, to whom the insurance benefits are payable, and the rights and conditions set forth in ORS 743 333, 743 336 and 743 339 [1967 c 359 §421]

743.333 Termination of individual coverage. A group life insurance policy shall contain a provision that if the insurance, or any portion of it, on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the policy, such person shall be entitled to have issued by the insurer, without evidence of insurability, an individual policy of life insurance without disability or other supplementary benefits, provided application for the individual policy shall be made, and the first premium paid to the insurer, within 31 days after such termination, and provided further that

(1) The individual policy shall, at the option of such person, be on any one of the forms, except term insurance, then customarily issued by the insurer at the age and for the amount applied for,

(2) The individual policy shall be in an amount not in excess of the amount of life insur-

ance which ceases because of such termination, less the amount of any life insurance for which such person is or becomes eligible under the same or any other group policy within 31 days after such termination, provided that any amount of insurance which shall have matured on or before the date of such termination as an endowment payable to the person insured, whether in one sum or in instalments or in the form of an annuity, shall not, for the purposes of this provision, be included in the amount which is considered to cease because of such termination, and

(3) The premium on the individual policy shall be at the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk to which such person then belongs, and to the age attained on the effective date of the individual policy [1967 c 359 §422]

743.336 Termination of policy or class of insured persons. A group life insurance policy shall contain a provision that if the group policy terminates or is amended so as to terminate the insurance of any class of insured persons, every person insured thereunder at the date of such termination whose insurance terminates and who has been so insured for at least five years prior to such termination date shall be entitled to have issued by the insurer an individual policy of life insurance, subject to the same conditions and limitations as are provided by ORS 743 333, except that the group policy may provide that the amount of such individual policy shall not exceed the smaller of.

(1) The amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after such termination, and

(2) \$2,000 [1967 c 359 §423]

743.339 Death during period for conversion to individual policy. A group life insurance policy shall contain a provision that if a person insured under the group policy dies during the period within which the person would have been entitled to have an individual policy issued in accordance with ORS 743 333 or 743 336 and before such an individual policy shall have become effective, the amount of life insurance which the person would have been entitled to have issued under such individual policy shall be payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium therefor has been made [1967 c 359 §424]

743.342 Statement furnished to insured under credit life insurance policy. A group credit life insurance policy shall contain a provision that the insurer will furnish to the policyholder for delivery to each debtor insured under the policy a form which will contain a statement that the life of the debtor is insured under the policy and that any death benefit paid thereunder by reason of death shall be applied to reduce or extinguish the indebtedness [1967 c 359 §425]

743.345 Assignability of group life policies. Nothing in the Insurance Code or in any other law shall be construed to prohibit any person insured under a group life insurance policy from making an assignment of all or any part of the incidents of ownership under such policy, including but not limited to the privilege to have issued an individual policy of life insurance pursuant to the provisions of ORS 743 333 to 743 339 and the right to name a beneficiary Subject to the terms of the policy or an agreement between the insured, the group policyholder and the insurer relating to assignment of incidents of ownership under the policy, such an assignment by an insured, made either before or after September 9, 1971, is valid for the purpose of vesting in the assignee, in accordance with any provisions included in the assignment as to the time at which it is to be effective, all of such incidents of ownership so assigned, but without prejudice to the insurer on account of any payment it may make, or individual policy it may issue in accordance with ORS 743 333 to 743 339, prior to receipt of notice of the assignment [1971 c 231 §6]

POLICY LANGUAGE SIMPLIFICATION

743.350 Short title. ORS 743 350 to 743 370 may be cited as the Life and Health Insurance Policy Language Simplification Act [1979 c 708 §2]

743.353 Purpose. (1) The purpose of the Life and Health Insurance Policy Language Simplification Act is to establish minimum standards for language used in policies and certificates of life insurance and health insurance delivered or issued for delivery in this state in order to facilitate ease of reading

(2) ORS 743 350 to 743 370 is not intended to increase the risk assumed by insurers or to supersede their obligation to comply with the substance of other Insurance Code provisions applicable to insurance policies ORS 743 350 to 743 370 is not intended to impede flexibility and innovation in the development of policy forms or content or to lead to the standardization of policy forms or content [1979 c 708 §3]

743.357 Definitions for ORS 743.350 to 743.370. As used in ORS 743 350 to 743 370, "policy" has the meaning given in ORS 731 122 and, in addition, includes a certificate issued pursuant to a group insurance policy delivered or issued for delivery in this state [1979 c 708 §4]

743.362 Scope of ORS 743.350 to 743.370. (1) ORS 743 350 to 743 370 applies to all policies delivered or issued for delivery in this state, except

(a) Any policy that is a security subject to federal jurisdiction

(b) Any group policy covering a group of 1,000 or more lives at date of issue, other than a group credit life insurance policy or a group credit health insurance policy. However, this paragraph shall not exempt any certificate issued pursuant to a group policy

(c) Any group annuity contract that serves as a funding vehicle for a pension, profit-sharing or deferred compensation plan

(d) Any form used in connection with, as a conversion from, as an addition to, or, pursuant to a contractual provision, in exchange for, a policy delivered or issued for delivery on a form approved or permitted to be issued prior to the date the form must be approved under section 9, chapter 708, Oregon Laws 1979

(e) The renewal of a policy delivered or issued for delivery prior to the date the policy form must be approved under section 9, chapter 708, Oregon Laws 1979

(f) Any certificate issued pursuant to a group policy not delivered or issued for delivery in this state

(2) A non-English language policy will be deemed to comply with ORS 743 365 if the insurer certifies that the policy is translated from an English language policy that complies with ORS 743 365 [1979 c 708 §5]

743.365 Reading ease standards for life and health insurance policies; procedures for determining ease of reading; certificate of compliance with standards to accompany policy filing. (1) No policy form shall be delivered or issued for delivery in this state unless

(a) The policy text achieves a score of 40 or more on the Flesch reading ease test, or an equivalent score on any comparable test as provided in subsection (3) of this section,

(b) The policy, except for specification pages, schedules and tables is printed in not less than 10-point type, one point leaded,

(c) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, including the text of any indorsements or riders, and

(d) The policy contains a table of contents or an index of the principal sections of the policy, if the policy has more than 3,000 words of text printed on three or less pages, or regardless of the number of words if the policy has more than three pages

(2) For the purposes of this section, a Flesch reading ease test score shall be calculated as follows

(a) For policy forms containing 10,000 words or less of text, the entire form shall be analyzed. For policy forms containing more than 10,000 words, two 200-word samples per page may be analyzed instead of the entire form. The samples shall be separated by at least 20 printed lines

(b) The number of words and sentences in the text shall be counted and the total number of words divided by the total number of sentences. The figure obtained shall be multiplied by a factor of 1 015

(c) The total number of syllables in the text shall be counted and divided by the total number of words. The figure obtained shall be multiplied by a factor of 84 6

(d) The sum of the figures computed under paragraphs (b) and (c) of this subsection subtracted from 206 835 equals the Flesch reading ease test score for the policy form

(e) For purposes of paragraphs (b) and (c) of this subsection, the following procedures shall be used

(A) A contraction, hyphenated word or numbers and letters, when separated by spaces, shall be counted as one word

(B) A unit of words ending with a period, semicolon or colon shall be counted as a sentence

(C) A "syllable" means a unit of spoken language consisting of one or more letters of a word as divided by an accepted dictionary. If the dictionary shows two or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used

(f) As used in this section, "text" includes all written matter except the following

(A) The name and address of the insurer, the name, number or title of the policy, the table of contents or index, captions and subcaptions; specification pages, schedules or tables, and

(B) Policy language drafted to conform to the requirements of any state or federal law, regula-

tion or agency interpretation, policy language required by any collectively bargained agreement, medical terminology, and words that are defined in the policy. However, the insurer shall identify the language or terminology excepted by this subparagraph and shall certify in writing that the language or terminology is entitled to be excepted by this subparagraph.

(3) Any other reading test may be approved by the director as an alternative to the Flesch reading ease test if it is comparable in result to the Flesch reading ease test.

(4) Each policy filing shall be accompanied by a certificate signed by an officer of the insurer stating that the policy meets the minimum required reading ease score on the test used, or stating that the score is lower than the minimum required but should be authorized in accordance with ORS 743.368. To confirm the accuracy of a certification, the director may require the submission of further information.

(5) At the option of the insurer, riders, endorsements, applications and other forms made a part of the policy may be scored as separate forms or as part of the policy with which they may be used. [1979 c 708 §6]

743.368 Director may authorize lower reading ease standards; conditions. The director may authorize a lower score than the Flesch reading ease test score required by ORS 743.365 when, in the director's sole discretion, the director finds that a lower required score

(1) Will provide a more accurate reflection of the readability of a policy form,

(2) Is warranted by the nature of a particular policy form or type or class of policy forms, or

(3) Is caused by certain policy language drafted to conform to the requirements of any state law, regulation or agency interpretation. [1979 c 708 §7]

743.370 Approval of certain policy forms not containing specified provisions; conditions for approval. A policy form meeting the requirements of ORS 743.365 shall not be disapproved because of other provisions of the Insurance Code that specify the content of policies, if the policy form provides the policyholders and claimants protection not less favorable than they would be entitled to under such provisions. [1979 c 708 §8]

INDIVIDUAL HEALTH INSURANCE

743.402 Exceptions to individual health insurance policy requirements.

Nothing in ORS 743.405 to 743.498 shall apply to or affect

(1) Any workers' compensation insurance policy or any liability insurance policy with or without supplementary expense coverage therein,

(2) Any policy of reinsurance,

(3) Any blanket or group policy of insurance, or

(4) Any life insurance policy, or policy supplemental thereto which contains only such provisions relating to health insurance as

(a) Provide additional benefits in case of death or dismemberment or loss of sight by accident, or

(b) Operate to safeguard such policy against lapse, or to give a special surrender value or special benefit or an annuity in the event the insured shall become totally and permanently disabled, as defined by the policy or supplemental policy. [Formerly 741.022]

743.405 General requirements, individual health insurance policies. A health insurance policy shall meet the following requirements

(1) The entire money and other considerations therefor shall be expressed therein,

(2) The time at which the insurance takes effect and terminates shall be expressed therein,

(3) It shall purport to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder,

(4) Except as provided in ORS 743.498, the style, arrangement and overall appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10 point with a lower case unspaced alphabet length not less than 120 point. Captions shall be printed in not less than 12-point type. The "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions,

(5) The exceptions and reductions of indemnity shall be set forth in the policy and, except

those which are set forth in ORS 743 411 to 743 480, shall be printed at the insurer's option either included with the benefit provision to which they apply or under an appropriate caption such as EXCEPTIONS, or EXCEPTIONS AND REDUCTIONS, provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies,

(6) Each form constituting the policy, including riders and indorsements, shall be identified by a form number in the lower lefthand corner of the first page thereof, and

(7) It shall contain no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of or reference to a statement of rates or classification of risks, or short rate table filed with the director [Formerly 741 120]

743.408 Mandatory provisions, individual health insurance policies. Except as provided in ORS 743 051, a health insurance policy shall contain the provisions set forth in ORS 743 411 to 743 444. Such provisions shall be preceded individually by the caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the director may approve [1967 c 359 §428]

743.411 Entire contract; changes. A health insurance policy shall contain a provision as follows "ENTIRE CONTRACT, CHANGES. This policy, including the indorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be indorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions." [1967 c 359 §429]

743.412 Coverage for alcoholism treatment; conditions; limits. A health insurance policy providing coverage for hospital or medical expenses not limited to expenses from accidents or specified sicknesses shall provide, at the request of the applicant, coverage for expenses arising from treatment for alcoholism. The following conditions apply to the requirement for such coverage

(1) The applicant shall be informed of the applicant's option to request this coverage

(2) The inclusion of the coverage may be made subject to the insurer's usual underwriting requirements

(3) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and co-insurance

(4) The policy may limit hospital expense coverage to treatment provided by the following facilities.

(a) A health care facility licensed as required by ORS 441 015

(b) A health care facility accredited by the Joint Commission on Accreditation of Hospitals

(c) A rehabilitation clinic and agency established, maintained, contracted with or operated by the Mental Health Division under ORS 430 260

(5) Except as permitted by subsection (3) of this section, the policy shall not limit payments thereunder for alcoholism to an amount less than \$4,500 in any 24-consecutive month period and the policy shall provide coverage, within the limits of this subsection, of not less than 80 percent of the hospital and medical expenses for treatment for alcoholism. [1977 c 632 §2, 1981 c 319 §1]

743.414 Time limit on certain defenses; incontestability. (1) A health insurance policy shall contain a provision as follows "TIME LIMIT ON CERTAIN DEFENSES. After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, commencing after the expiration of that period"

(2) The policy provision set forth in subsection (1) of this section shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, or to limit the application of ORS 743 450 to 743 462 in the event of misstatement with respect to age or occupation or other insurance

(3) A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the provision set forth in subsection (1) of this section the following provision, from which the clause in parentheses may be omitted at the insurer's option "INCONTESTABLE. After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is

disabled), it shall become incontestable as to the statements contained in the application "

(4) The policy shall contain a provision as follows, which shall be a separate paragraph under the same caption as, and immediately following, the provision set forth in subsection (1) or (3) of this section "No claim for loss incurred or disability, as defined in the policy, commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy" [1967 c 359 §430, 1969 c 159 §1]

743.417 Grace period. (1) A health insurance policy shall contain a provision as follows "GRACE PERIOD A grace period of — (insert a number not less than '7' for weekly premium policies, '10' for monthly premium policies and '31' for all other policies) days will be granted for the payment of each premium falling due after the first premium during which grace period the policy shall continue in force "

(2) A policy which contains a cancellation provision may add the following clause at the end of the provision set forth in subsection (1) of this section "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof "

(3) A policy in which the insurer reserves the right to refuse any renewal shall have the following clause at the beginning of the provision set forth in subsection (1) of this section "Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the last address of the insured as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted" [1967 c 359 §431]

743.420 Reinstatement. (1) A health insurance policy shall contain a provision as follows "REINSTATEMENT If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy, provided, however, that if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the 45th day

following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement "

(2) The last sentence of the provision set forth in subsection (1) of this section may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue [1967 c 359 §432]

743.423 Notice of claim. (1) A health insurance policy shall contain a provision as follows "NOTICE OF CLAIM Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible Notice given by or on behalf of the insured or the beneficiary to the insurer at — (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer "

(2) In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert the following between the first and second sentences of the provision set forth in subsection (1) of this section "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, the insured shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of such disability, except in the event of legal incapacity The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision Delay in the giving of such

notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given " [1967 c 359 §433]

743.426 Claim forms. A health insurance policy shall contain a provision as follows "CLAIM FORMS The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made " [1967 c 359 §434]

743.429 Proofs of loss A health insurance policy shall contain a provision as follows "PROOFS OF LOSS Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required " [1967 c 359 §435]

743.432 Time of payment of claims. A health insurance policy shall contain a provision as follows "TIME OF PAYMENT OF CLAIMS Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ——— (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof " [1967 c 359 §436]

743 435 Payment of claims. (1) A health insurance policy shall contain a provision as follows "PAYMENT OF CLAIMS Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions

respecting such payment which may be prescribed herein and effective at the time of payment If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate All other indemnities will be payable to the insured "

(2) The following provisions, or either of them, may be included with the provision set forth in subsection (1) of this section at the option of the insurer

(a) "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding \$—— (insert an amount which shall not exceed \$1,000), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment "

(b) "Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person " [1967 c 359 §437]

743.438 Physical examinations and autopsy A health insurance policy shall contain a provision as follows "PHYSICAL EXAMINATIONS AND AUTOPSY The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law " [1967 c 359 §438]

743.441 Legal actions. A health insurance policy shall contain a provision as follows "LEGAL ACTIONS No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished " [1967 c 359 §439]

743.444 Change of beneficiary. (1) A health insurance policy shall contain a provision as follows "CHANGE OF BENEFICIARY Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries or to any other changes in this policy"

(2) The first clause of the provision set forth in subsection (1) of this section, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option [1967 c 359 §440]

743.447 Optional provisions, individual health insurance. Except as provided in ORS 743 051, provisions in a health insurance policy respecting the matters set forth in ORS 743 450 to 743 480 shall be in the words which appear in such sections Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in such sections or, at the option of the insurer, by such appropriate individual or group captions or sub-captions as the director may approve [1967 c 359 §441]

743.450 Change of occupation. A health insurance policy may contain a provision as follows "CHANGE OF OCCUPATION If the insured be injured or contract sickness after having changed occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation If the insured changes occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the more recent In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued, but if such filing was not required, then the classification of occupational risk and

the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation" [1967 c 359 §442]

743.453 Misstatement of age. A health insurance policy may contain a provision as follows "MISSTATEMENT OF AGE If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age" [1967 c 359 §443]

743.456 Other insurance in same insurer. (1) A health insurance policy may contain a provision as follows "OTHER INSURANCE IN THIS INSURER If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ——— (insert type of coverage or coverages) in excess of \$—— (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to the estate of the insured"

(2) In lieu of the provisions set forth in subsection (1) of this section, the policy may contain a provision as follows "OTHER INSURANCE IN THIS INSURER Insurance effective at any one time on the insured under a like policy or policies in this company is limited to the one such policy elected by the insured, the beneficiary or the estate of the insured, as the case may be, and the insurer will return all premiums paid for all other such policies" [1967 c 359 §444]

743.459 Insurance with other insurers, expense incurred benefits. (1) A health insurance policy may contain a provision as follows "INSURANCE WITH OTHER INSURERS If there be other valid coverage, not with this insurer, providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro rata portion for the amount so determined For the purpose of applying this provision when other coverage is on a provision of service basis, the

'like amount' of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage "

(2) If the policy provision set forth in subsection (1) of this section is included in a policy which also contains the policy provision set forth in ORS 743 462, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "EXPENSE INCURRED BENEFITS" The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the director, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director In the absence of such definition such term shall not include group insurance, automobile medical payments insurance or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employe benefit organizations For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage" [1967 c 359 §445]

743.462 Insurance with other insurers, other than expense incurred benefits. (1) A health insurance policy may contain a provision as follows "INSURANCE WITH OTHER INSURERS If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro rata portion for the indemnities thus determined "

(2) If the policy provision set forth in subsection (1) of this section is included in a policy

which also contains the policy provision set forth in ORS 743 459, there shall be added to the caption of the provision set forth in subsection (1) of this section the phrase "OTHER BENEFITS" The insurer may, at its option, include in this provision a definition of "other valid coverage," approved as to form by the director, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which may be approved by the director In the absence of such definition such term shall not include group insurance, or benefits provided by union welfare plans or by employer or employe benefit organizations For the purpose of applying the policy provision set forth in this section with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), whether provided by a governmental agency or otherwise, shall in all cases be deemed to be "other valid coverage" of which the insurer has had notice In applying the policy provision set forth in this section no third party liability coverage shall be included as "other valid coverage" [1967 c 359 §446]

743.465 Relation of earnings to insurance. (1) A health insurance policy may contain a provision as follows "RELATION OF EARNINGS TO INSURANCE If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or the average monthly earnings of the insured for the period of two years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder, but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of \$200 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time "

(2) The policy provision set forth in subsection (1) of this section may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age 50 or, in the case of a policy issued after age 44, for at least five years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the director, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the director or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations [1967 c 359 §447]

743.468 Unpaid premium. A health insurance policy may contain a provision as follows "UNPAID PREMIUM Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom" [1967 c 359 §448]

743.471 Cancellation. A health insurance policy may contain a provision as follows "CANCELLATION The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the last address of the insured as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective, and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation" [1967 c 359 §449]

743.474 Conformity with state statutes. A health insurance policy may contain a provision as follows "CONFORMITY WITH

STATE STATUTES Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date hereby is amended to conform to the minimum requirements of such statutes" [1967 c 359 §450]

743.477 Illegal occupation. A health insurance policy may contain a provision as follows "ILLEGAL OCCUPATION The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation" [1967 c 359 §451]

743.480 Intoxicants and controlled substances. A health insurance policy may contain a provision as follows "INTOXICANTS AND CONTROLLED SUBSTANCES The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician" [1967 c 359 §452, 1979 c 744 §64]

743.483 Arrangement of provisions. The provisions of a health insurance policy which are the subject of ORS 743 408 to 743 480, or any corresponding provisions which are used in lieu thereof in accordance with the Insurance Code, shall be printed in the consecutive order of such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued [1967 c 359 §453]

743.486 Construction of term "insured" in statutory policy provisions. As used in ORS 743 402 to 743 498, the word "insured" shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein [1967 c 359 §454]

743.489 Extension of coverage beyond policy period; effect of misstatement of age. If any health insurance policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the

policy shall continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy [Formerly 741 170]

743.492 Policy return and premium refund provision. Every health insurance policy except single premium nonrenewable policies shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser pursuant to such notice returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued [Formerly 741 180]

743.495 Use of unqualified terms "noncancelable" or "guaranteed renewable"; synonymous terms. (1) No health insurance policy shall contain the following unqualified terms except as provided in this subsection

(a) The unqualified terms "noncancelable" or "noncancelable and guaranteed renewable" may be used only in a policy which the insured has the right to continue in force for life by the timely payment of premiums set forth in the policy, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force

(b) The unqualified term "guaranteed renewable," except as provided in paragraph (a) of this subsection, may be used only in a policy which the insured has the right to continue in force for life by the timely payment of premiums, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes

(2) The limitations prescribed in subsection (1) of this section on the use of the term "noncancelable" shall also apply to any synonymous

term such as "not cancelable" and such limitations on the use of the term "guaranteed renewable" shall also apply to any synonymous term such as "guaranteed continuable" [Formerly 741 190]

743.498 Statement in policy of cancelability or renewability. (1) A health insurance policy which is noncancelable or guaranteed renewable as those terms are used in ORS 743 495, except that the insured's right is for a limited period of more than one year rather than for life, shall contain the applicable one of the following statements, or such other statement which, in the opinion of the director, is equally clear or more definite as to the subject matter

(a) "THIS POLICY IS NONCANCELABLE ————" (designating the applicable period such as, for example, "to age — (specify)," or "for the period of — (specify) years from date of issuance") if the policy is noncancelable for such period

(b) "THIS POLICY IS GUARANTEED RENEWABLE ————" (designating the applicable period such as, for example, "to age — (specify)," or "for the period of — (specify) years from date of issuance") if the policy is guaranteed renewable for such period

(2) Except for policies meeting the conditions specified in ORS 743 495 or subsection (1) of this section, and except as provided in subsection (3) of this section, a health insurance policy shall contain the applicable one of the following statements, or such other statement which, in the opinion of the director, is equally clear or more definite as to the subject matter

(a) "THIS POLICY MAY BE CANCELED BY THE INSURER" if the policy contains a provision for cancellation by the insurer

(b) "THIS POLICY IS NOT RENEWABLE WITHOUT THE CONSENT OF THE INSURER" if the policy may be renewed only with the consent of the insurer

(3) The limitations and requirements as to the use of terms contained in ORS 743 495 and this section shall not prohibit the use of other terms for policies having other guarantees of renewability, provided such terms, in the opinion of the director are accurate, clear and not likely to be confused with the terms contained in ORS 743 495 and this section, and are incorporated in a concise statement relating to the guarantees of renewability

(4) The statement required by this section shall be printed in a type not smaller than the type used for captions. It shall appear prominently on the first page of the policy and shall be a

part of the brief description if the policy has a brief description on its first page [Formerly 741 200]

FRANCHISE HEALTH INSURANCE

743.516 "Franchise health insurance" defined. (1) "Franchise health insurance" means that form of individual health insurance issued on a franchise plan to

(a) Four or more employes of a corporation, partnership, individual employer, or of a governmental corporation or agency or department thereof, or

(b) Ten or more members, employes or employes of members of any trade or professional association or of a labor union or of any other association that has an active existence for at least two years, has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance

(2) "Employes" as used in this section includes the officers, managers and employes and retired employes of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership [1967 c 359 §459]

743.519 Requirements for franchise health insurance. Franchise health insurance shall be sold only pursuant to a written agreement between the insurer and an employer, association or union. Franchise health insurance shall be issued only where the insureds, with or without their dependents, are each issued the same form of an individual health insurance policy varying only as to amounts and kinds of coverage applied for by such persons. Franchise health insurance may be issued under an arrangement whereby the premiums on such policies are paid to the insurer periodically by the employer, with or without payroll deductions, by the association or union for its members or by some designated person acting on behalf of such employer or association or union. Franchise health insurance premiums may be paid directly by the covered person if a periodic certification is made by the employer, association or union that the person is entitled to such coverage [1967 c 359 §460, 1971 c 231 §25]

743.520 Sale of union or association membership to qualify for franchise health insurance prohibited. No person soliciting or selling franchise health insurance may solicit or sell membership in any association or labor union for the purpose of qualifying an applicant for franchise health insurance [1971 c 231 §4]

GROUP AND BLANKET HEALTH INSURANCE

743.522 "Group health insurance" defined. "Group health insurance" means that form of health insurance covering groups of persons as defined in this section, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of such groups of persons, and issued upon one of the following bases

(1) Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employes of such employer for the benefit of persons other than the employer. The term "employes" as used in this subsection shall be deemed to include the officers, managers, and employes of the employer, the individual proprietor or partners if the employer is an individual proprietor or partnership, the officers, managers, and employes of subsidiary or affiliated corporations, the individual proprietors, partners and employes of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise. The term "employes" as used in this subsection may include retired employes. A policy issued to insure employes of a public body may provide that the term "employes" shall include elected or appointed officials. The policy may provide that the term "employes" shall include the trustees or their employes, or both, if their duties are principally connected with such trusteeship

(2) Under a policy issued to an association, including a labor union, which has an active existence for at least one year, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring members, employes, or employes of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employes" as used in this subsection may include retired employes

(3) Under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in subsection (2) of this section, which trustees shall be deemed the policyholder, insuring employes of the employers or members of the

unions or of such association, or employes of members of such association for the benefit of persons other than the employers or the unions or such association. The term "employes" as used in this subsection may include the officers, managers and employes of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employes" as used in this subsection may include retired employes. The policy may provide that the term "employes" shall include the trustees or their employes, or both, if their duties are principally connected with such trusteeship.

(4) Under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.

(5) Under a policy issued to cover any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group health insurance policy [1967 c 359 §461, 1975 c 229 §1]

743.525 [1967 c 359 §462, repealed by 1981 c 752 §17]

743.527 Certain group health insurance policies to continue in effect upon payment of premium by insured individual; conditions for continued coverage; required provisions in policies. (1) Every group health insurance policy delivered or issued for delivery in this state shall contain in substance the following provisions, applicable to the coverage for hospital or medical services or expenses provided under the policy.

(a) A provision that, when the premium for the policy or any part thereof is paid by an employer under the terms of a collective bargaining agreement, if there is a cessation of work by employes insured under the policy due to a strike or lockout, the policy, upon timely payment of the premium, will continue in effect with respect to those employes insured by the policy on the date of the cessation of work who continue to pay their individual contribution and who assume and pay the contribution due from the employer.

(b) A provision that, when an employe insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is not a trustee of a fund established or maintained in whole or in part by an employer, the employe's individual contribution shall be

(A) The rate in the policy, on the date cessation of work occurs, applicable to an individual in the class to which the employe belongs as set forth in the policy, or

(B) If the policy does not provide for a rate applicable to individuals, an amount equal to the amount determined by dividing the total monthly premium in effect under the policy at the date of cessation of work by the total number of persons insured under the policy on such date.

(c) A provision that, when an employe insured under the policy pays a contribution pursuant to paragraph (a) of this subsection, if the policyholder is a trustee of a fund established or maintained in whole or in part by an employer, the employe's individual contribution shall be the amount which the employe and employer would have been required to contribute if the cessation of work had not occurred.

(2) Every group health insurance policy delivered or issued for delivery in this state may contain in substance the following provisions applicable to the coverage for hospital or medical services or expenses provided under the policy.

(a) A provision that, when employes insured under the policy pay contributions pursuant to paragraph (a) of subsection (1) of this section, the continuation of insurance under the policy is contingent upon the collection of individual contributions by the union representing the employes when the policyholder is not a trustee and by the policyholder or the policyholder's agent when the policyholder is a trustee.

(b) A provision that, when employes insured under the policy pay contributions pursuant to paragraph (a) of subsection (1) of this section, the continuation of insurance under the policy on each employe is contingent upon timely payment of contributions by the employes and timely payment of the premium by the entity responsible for collecting the individual contributions.

(c) A provision that, when employes insured under the policy pay contributions pursuant to paragraph (a) of subsection (1) of this section, each individual premium rate under the policy may be increased by not more than 20 percent, or by any higher percentage approved by the director, during the period of cessation of work in order to provide sufficient compensation to the insurer for increased administrative costs and increased mortality and morbidity. If the policy contains the provision allowed under this paragraph, an employe's contribution paid under paragraph (a) of subsection (1) of this section shall be increased by the same percentage.

(d) A provision that, when the policy is a policy insuring employes and which may continue in effect as provided in paragraph (a) of subsection (1) of this section, if the premium is unpaid at the date of cessation of work and the

premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of the premium prior to the date the next premium becomes due under the terms of the policy

(e) Any provision with respect to the continuation of the policy as provided in paragraph (a) of subsection (1) of this section that the director may approve

(3) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of a policy to increase or decrease the premium rates before, during or after a cessation of work by employes insured under the policy when the insurer had the right to increase the premium rates even if the cessation of work did not occur. If such a premium rate change is made, it shall be effective on such date as the insurer shall determine in accordance with the terms of the policy

(4) Nothing in this section shall be deemed to require continuation of any coverage in a group health insurance policy insuring employes and which may continue in effect as provided in paragraph (a) of subsection (1) of this section for longer than

(a) The time that 75 percent of insured employes continue such coverage,

(b) For an individual employe, the time at which the employe takes full-time employment with another employer, or

(c) Six months after cessation of work by the insured employes [1979 c 797 §2, 1981 c 395 §1]

743.528 Required provisions in group health insurance policies. A group health insurance policy shall contain in substance the following provisions

(1) A provision that, in the absence of fraud, all statements made by applicants, the policyholder or an insured person shall be deemed representations and not warranties, and that no statement made for the purpose of effecting insurance shall avoid the insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to the policyholder or to the person or the beneficiary of the person

(2) A provision that the insurer will furnish to the policyholder for delivery to each employe or member of the insured group a statement in summary form of the essential features of the insurance coverage of the employe or member, to whom the insurance benefits are payable, and the applicable rights and conditions set forth in ORS

743 527, 743 529 and 743 850 to 743 890. If dependents are included in the coverage, only one statement need be issued for each family unit

(3) A provision that to the group originally insured may be added from time to time eligible new employes or members or dependents, as the case may be, in accordance with the terms of the policy [1967 c 359 §463 1981 c 752 §13]

743.529 Continuation of benefits after termination of group health insurance policy. Every group health insurance policy that provides coverage for hospital or medical services or expenses shall provide that the insurer shall continue its obligation for benefits under the policy for any person insured under the policy who is hospitalized on the date of termination if the policy is terminated and immediately replaced by a group health insurance policy issued by another insurer. Any payment required under this section is subject to all terms, limitations and conditions of the policy except those relating to termination of benefits. Any obligation by an insurer under this section continues until the hospital confinement ends or hospital benefits under the policy are exhausted, whichever is earlier [1977 c 402 §5]

743.530 Continuation of benefits after injury or illness covered by workers' compensation. Every policy of group health insurance delivered or issued for delivery in this state shall contain a provision applicable to the coverage for hospital or medical services or expenses provided under the policy that if an employe incurs an injury or illness for which a workers' compensation claim is filed, that policy will continue in effect with respect to that employe upon timely payment by the employe of the premium that includes the individual contribution and the contribution due from the employer under the applicable benefit plan. The employe may maintain such coverage until whichever of the following events first occurs

(1) The employe takes full-time employment with another employer, or

(2) Six months from the date that the employe first makes payment under this section [1985 c 634 §2]

743.531 Direct payment of hospital and medical services; rate limitations. (1) A group health insurance policy may on request by the group policyholder provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering such services. However, the amount of any such

payment shall not exceed the amount of benefit provided by the policy with respect to the service or billing of the provider of aid. The amount of such payments pursuant to one or more assignments shall not exceed the amount of expenses incurred on account of such hospitalization or medical or surgical aid.

(2) Nothing in this section is intended to authorize an insurer to

(a) Furnish or provide directly services of hospitals or physicians and surgeons, or

(b) In any manner direct, participate in or control the selection of the hospital or physician and surgeon from whom the insured secures services or who exercises medical or dental professional judgment

(3) Nothing in subsection (2) of this section prevents an insurer from negotiating and entering into contracts for alternative rates of payment with providers and offering the benefit of such alternative rates to insureds who select such providers

(4) Payment so made shall discharge the insurer's obligation with respect to the amount of insurance so paid

(5) Insurers shall provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates under their group policy and shall also make such lists available for public inspection during regular business hours at the insurer's principal office within this state [1967 c 359 §464, 1985 c 747 §71]

743.532 Continuation of group health policy coverage for permanent employe after injury or illness covered by workers' compensation. (1) In addition to any coverage under ORS 743 530, every policy of group health insurance delivered or issued for delivery in this state shall contain a provision applicable to the coverage for hospital or medical services or expenses provided under the policy that if a permanent employe who is covered under ORS chapter 656 (Workers' Compensation Law) incurs an injury or illness for which a workers' compensation claim is filed, that the employer will cause the policy to continue in effect with respect to that employe by timely payment of the premium that includes the contribution due from the employer under the applicable benefit plan, subject to timely employe contributions of the amount paid by the employe before the occurrence of the injury or illness. The employer shall continue the policy in effect until whichever of the following events first occurs

(a) The worker's attending physician has determined the worker to be medically stationary,

(b) An order is entered specifying the worker's extent of disability,

(c) The employe returns to work for the employer and satisfies any probationary or minimum work time requirement for group health insurance benefit eligibility,

(d) The employe takes full-time employment with another employer,

(e) Twelve months have elapsed since the date of the injury, or

(f) The claim is denied and the claimant fails to appeal within the time provided by ORS 656 319 or the Workers' Compensation Board or a workers' compensation hearings referee issues an order finding the claim not compensable

(2) If the workers' compensation claim of an employe for whom health insurance is provided pursuant to subsection (1) of this section is denied and the employe does not appeal or the employe appeals and does not prevail, the employer may recover from the employe the value of the premium paid [1987 c 782 §2]

743.534 "Blanket health insurance" defined. "Blanket health insurance" means that form of a health insurance covering groups of persons defined in this section and issued on one of the following bases

(1) Under a policy issued to a common carrier or to an operator, owner or lessee of a means of transportation, who shall be deemed the policyholder, insuring a group of persons who may become passengers and which group is defined by reference to their travel status on such common carrier or means of transportation

(2) Under a policy issued to an employer, who shall be deemed the policyholder, insuring any group of employes, dependents or guests, defined by reference to specified hazards incident to an activity or activities or operations of the policyholder

(3) Under a policy issued to a college, school or other institution of learning, a school district or districts, or school jurisdictional unit, or to the head, principal or governing board of any such educational unit, who or which shall be deemed the policyholder, insuring students, teachers or employes

(4) Under a policy issued to a religious, charitable, recreational, educational, or civic organization, or branch thereof, which shall be deemed the policyholder, insuring any group of members

or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder

(5) Under a policy issued to a sports team, camp or sponsor thereof, who shall be deemed the policyholder, insuring members, campers, employes, officials or supervisors

(6) Under a policy issued to a volunteer fire department, first aid, civil defense, or other such volunteer organization, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder

(7) Under a policy issued to a newspaper or other publisher, which shall be deemed the policyholder, insuring its carriers

(8) Under a policy issued to an association, including a labor union, which has a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, which shall be deemed the policyholder, insuring any group of members or participants defined by reference to specified hazards incident to an activity or activities or operations sponsored or supervised by such policyholder

(9) Under a policy issued to cover any other risk or class of risks which, in the discretion of the director, may be properly eligible for blanket health insurance. The discretion of the director may be exercised on an individual risk basis or class of risks basis, or both [1967 c 359 §465]

743.537 Required provisions, blanket health insurance policies. A blanket health insurance policy shall contain provisions which in the opinion of the director are not less favorable to the policyholder and the individual insureds than the provisions described in ORS 743 411, 743 423, 743 426, 743 429, 743 432, 743 438 and 743 441 [1967 c 359 §466]

743.540 Application and certificates not required, blanket health insurance policies. An individual application need not be required from a person insured under a blanket health insurance policy, nor shall it be necessary for the insurer to furnish each person a certificate [1967 c 359 §467]

743.543 Facility of payment, blanket health insurance policies. All benefits under a blanket health insurance policy shall be payable to the person insured, or to the designated beneficiary or beneficiaries of the person, or to the

estate of the person, except that if the person insured is a minor or otherwise not competent to give a valid release, such benefits may be made payable to the parent, guardian or other person actually supporting the person. However, the policy may provide that all or a portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the option of the insurer and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services, but the policy may not require that the services be rendered by a particular hospital or person. Payment so made shall discharge the obligation of the insurer with respect to the amount of insurance so paid [1967 c 359 §468]

743.546 Policy form approval, blanket health insurance. The director may exempt from the policy form filing and approval requirements of ORS 743 006, for so long as the director deems proper, any blanket health insurance policy to which in the opinion of the director such requirements may not practicably be applied, or may dispense with such filing and approval whenever, in the opinion of the director, it is not desirable or necessary for the protection of the public [1967 c 359 §469]

743.549 Restriction on reduction of benefits provisions in group and blanket health policies. No group or blanket health insurance policy providing hospital, medical or surgical expense benefits, and which contains a provision for the reduction of benefits otherwise payable thereunder on the basis of other existing coverages, shall provide that such reduction will operate to reduce total benefits payable below an amount equal to 100 percent of total allowable expenses [1973 c 143 §2]

743.552 Guidelines for application of ORS 743.549. The director shall by rule establish guidelines for the application of ORS 743 549, including

- (1) The procedures by which persons insured under such policies are to be made aware of the existence of such a provision,
- (2) The benefits which may be subject to such a provision,
- (3) The effect of such a provision on the benefits provided,
- (4) Establishment of the order of benefit determination; and
- (5) Reasonable claim administration procedures to expedite claim payments under such a provision which shall include a time limit of 14

days beyond which the insurer shall not delay payment of a claim by reason of the application of coordination of benefits provision [1973 c 143 §3]

743.555 Application of ORS 743.549 and 743.552. ORS 743 549 and 743 552 shall apply to any group or blanket health insurance policy containing a provision described in ORS 743 549 which is issued more than 90 days after June 26, 1973. Policies which are in existence 90 days after June 26, 1973, shall be brought into compliance on the next anniversary date, renewal date or the expiration date of the applicable collectively bargained contract, if any, whichever date is latest [1973 c 143 §4]

743.556 Group health insurance coverage for treatment of chemical dependency, including alcoholism, and for mental or nervous conditions. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism and for mental or nervous conditions. The following conditions apply to the requirement for such coverage

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness

(2) Treatment provided in health care facilities, residential programs or facilities, day or partial hospitalization programs or outpatient services shall be considered eligible for reimbursement if it is provided by

(a) Programs or providers described in ORS 430 010 or approved by the office of Alcohol and Drug Abuse Programs or by the Mental Health Division under subsection (3) of this section

(b) Programs accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities

(c) Inpatient programs provided by health care facilities as defined in ORS 442 015 (16). Residential, outpatient, or day or partial hospitalization programs offered by or through a health care facility must meet the requirements

of either paragraph (a) or (b) of this subsection in order to be eligible for reimbursement

(d) Residential programs or facilities described in subsection (3) of this section if the patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week

(e) Programs in which staff are directly supervised or in which individual client treatment plans are approved by a person described in ORS 430 010 (4)(d) and which meet the standards established under subsection (3) of this section

(3) The office of Alcohol and Drug Abuse Programs shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient chemical dependency programs that are not related to the division or any county mental health program. The Mental Health Division shall adopt rules relating to the approval, for insurance reimbursement purposes, of noninpatient programs for mental or nervous conditions that are not related to the division or any county mental health program. Standards proposed by the American Association of Partial Hospitalization should be considered as one possible source for such rules. In addition, an insurer or insurers and the office of Alcohol and Drug Abuse Programs, or an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures for programs that are approved by the office or the division and that provide alternative arrangements for supervision or for review of treatment plans to become qualified to receive payments for treatment

(4) A program that provides services for persons with both a chemical dependency diagnosis and a mental or nervous condition shall be considered to be a distinct and specialized type of program for both chemical dependency and mental or nervous conditions. The Mental Health Division and the office of Alcohol and Drug Abuse Programs jointly shall develop specific standards related to such programs for program approval purposes and shall adopt rules relating to the approval, for insurance reimbursement purposes, of such noninpatient programs that are not related to the office or the division and any county mental health program

(5) As used in this section

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the individual's social, psychological or physical adjustment to common problems on a recurring

basis For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods

(b) "Child or adolescent" means a person who is 17 years of age or younger

(c) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility

(6) Notwithstanding the limits for particular types of services specified in this section, a policy shall not limit the total of payments for all treatment of any kind under this section for chemical dependency, together with payments for all treatment of any kind for mental or nervous conditions, to less than \$10,500 for adults and \$12,500 for children or adolescents For persons requesting payments for treatment of any kind for chemical dependency, but not requesting payments for treatment of any kind of mental or nervous condition, a policy shall not limit the total of payments for all treatment to less than \$6,500 for adults and \$10,500 for children and adolescents

(7) The limits for mental or nervous conditions specified in this section shall apply to persons with diagnoses of both chemical dependency and mental or nervous conditions, who are being treated for both types of diagnosis, as well as persons with only a diagnosis of a mental or nervous condition

(8) The higher benefit levels in this section for children or adolescents are in recognition of the longer period of treatment and the greater levels of staffing that may be required for children or adolescents and are intended to permit more services to meet the needs of children and adolescents

(9) Payments shall not be made under this section for educational programs to which drivers are referred by the judicial system, nor for volunteer mutual support groups

(10) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for inpatient treatment in hospitals and other health care facilities thereunder

(a) For chemical dependency to an amount less than \$4,500 for adults and \$4,000 for children or adolescents, and

(b) For mental or nervous conditions to an amount less than \$4,000 for adults and \$6,000 for children or adolescents

(11) Except as permitted by subsections (1), (6) and (12) of this section, the policy shall not limit payments for treatment in residential programs or facilities or day or partial hospitalization programs

(a) For chemical dependency to an amount less than \$3,500 for adults and \$3,000 for children or adolescents, and

(b) For mental or nervous conditions to an amount less than \$1,000 for adults and \$2,500 for children or adolescents

(12) Notwithstanding the minimum benefits for particular types of services specified in subsections (10) and (11) of this section, and except as permitted by subsection (1) of this section, the policy shall not limit total payments for inpatient, residential and day or partial hospitalization program care or treatment

(a) For chemical dependency to an amount less than \$8,500 for children or adolescents, and

(b) For mental or nervous conditions to an amount less than \$8,500 for adults and \$10,500 for children or adolescents

(13) Except as permitted by subsections (1) and (6) of this section, in the case of benefits for outpatient services, the policy shall not limit payments

(a) For chemical dependency to an amount less than \$1,500 for adults and \$2,000 for children or adolescents, and

(b) For mental or nervous conditions to an amount less than \$2,000

(14) If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health care facility, residential, day or partial hospitalization or outpatient services The policy may limit coverage for in-home service to persons who have completed their initial health care facility, residential, day or partial hospitalization or outpatient treatment and did not terminate that initial treatment against advice The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made

(15) Under ORS 430.021 and 430.315, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(16) A group health insurance policy may provide, with respect to treatment for chemical

dependency or mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state

(a) Proportion of coinsurance required for treatment in residential programs or facilities, day or partial hospitalization programs or outpatient services less than the proportion of coinsurance required for treatment in health care facilities

(b) Subject to the patient or client confidentiality provisions of ORS 40 235 relating to physicians, ORS 40 240 relating to nurse practitioners, ORS 40 230 relating to psychologists and ORS 40 250 and 675 580 relating to social workers, review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either insurer staff or personnel under contract to the insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment

(A) This review shall be made according to criteria made available to providers in advance upon request

(B) To facilitate implementation of utilization review programs by insurers, the office of the Director of Human Resources shall draft an advisory or model set of criteria for appropriate utilization of inpatient, residential, day or partial hospitalization, and outpatient facilities, programs and services by adults, children and adolescents, and persons with both a chemical dependency diagnosis and a mental or nervous condition. These criteria shall be consistent with this section and shall not be binding on any insurer or other party. However, at the time of contract negotiation or amendment, with the agreement of the parties to the contract, any insurer may adopt the criteria or similar criteria with or without modification. The office of the director shall revise these criteria at least every two years. In developing and revising these criteria, the office of the director shall organize a technical advisory panel including representatives of the Department of Insurance and Finance, the office of Alcohol and Drug Abuse Programs, the Mental Health Division, the Health Division, the insurance industry, the business community and providers of each level of care. The office of the director shall place substantial weight on the advice of this panel

(C) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon, a psychologist licensed by the State Board of Psychologist Examiners, a nurse practitioner registered by the Oregon State Board of Nursing, or a clinical social worker registered by the State Board of Clinical Social Workers, with physician consultation readily available. The reviewer shall have expertise in the evaluation of mental or nervous condition services or chemical dependency services

(D) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to subsequent review. If prior approval is not required, insurers shall permit treatment providers, policy holders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Insurers shall provide a timely response to such inquiries. Approval of a particular admission does not represent a guarantee of future payment

(E) An appeals process shall be provided

(F) An insurer may choose to review all providers on a sampling or audit basis only, or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case in a timely fashion to the insurer

(17) For purposes of paragraph (b) of subsection (16) of this section, a utilization review contractor is a professional review organization or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services

(18) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of inpatient treatment requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in

(a) The current living situation,

(b) An alternative, nontreatment living situation;

(c) An alternative residential program or facility, or

(d) A day or partial hospitalization program

(19) For purposes of paragraph (b) of subsection (16) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential, day or partial hospitalization level of treatment shall require demonstration that outpatient services, if appropriate and less costly than residential, day or partial hospitalization services

(a) Are not presently appropriate and available,

(b) Cannot be readily and timely made available, and

(c) Cannot meet documented needs for non-medical supervision, protection, assistance and treatment, either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational, social and living situations, risks to self or others, and readiness to participate consistently in treatment

(20) For purposes of paragraph (b) of subsection (16) of this section, reimbursability of treatment at the level for outpatient facility, service or program shall require demonstration that treatment is justified, considering the individual's history, and the current medical, occupational, social and psychological situation, and the overall prognosis

(21) Discrete medical or neurologic diagnostic or treatment services including any professional component of that service, costing in excess of \$300, occurring concurrently with but not directly related to treatment of mental or nervous conditions shall not be charged against the inpatient benefit level

(22) The benefits described in this section shall renew in full either on the first day of the 25th month of coverage following the first use of services for the treatment of chemical dependency or mental or nervous conditions, or both, or on the first day following two consecutive contract years

(23) Health maintenance organizations, as defined in ORS 750 005 (3), shall be subject to the following conditions and requirements in their provision of benefits for chemical dependency or mental or nervous conditions to enrollees

(a) Notwithstanding the provisions of subsection (1) of this section, health maintenance organizations may establish reasonable provisions for enrollee cost-sharing, so long as the amount the enrollee is required to pay does not exceed the amount of coinsurance and deductible

customarily required by other insurance policies which are subject to the provisions of this chapter for that type and level of service

(b) Nothing in this section prevents health maintenance organizations from establishing durational limits which are actuarially equivalent to the benefits required by this section

(c) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers associated with the health maintenance organization

(d) The department shall make rules establishing objective and quantifiable criteria for determining when a health maintenance organization meets the conditions and requirements of this subsection

(24) Nothing in this section shall prevent an insurer or health care service contractor other than a health maintenance organization, except as provided in subsection (23) of this section, from contracting with providers of health care services to furnish services to policy holders or certificate holders according to ORS 743 531 or 750 005, subject to the following conditions

(a) An insurer or health care service contractor may establish limits for contracted services which are actuarially equivalent to the benefits required by this section, so long as the same range of treatment settings is made available

(b) An insurer or health care service contractor other than a health maintenance organization, may negotiate with contracting providers as to the cost of actuarially equivalent benefits, and such actuarially equivalent benefits for services of contracting providers shall be deemed to equal the minimum benefit levels specified in this section

(c) An insurer or health care service contractor is not required to contract with all eligible providers, and payment for covered services of contracting providers may be in alternative methods or amounts rather than as specified in this section

(d) Insurers and health care service contractors other than health maintenance organizations shall pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions at the same level of deductible or coinsurance as would apply to covered charges of noncontracting providers of other health services under the same group policy or contract. The insured shall have the right to use the services of a noncontracting provider of serv-

ices for the treatment of chemical dependency or mental or nervous conditions. Policies described in this subsection shall be subject to the provisions of subsection (1) of this section, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(e) The department shall make rules establishing objective and quantifiable criteria for determining that a contract meets the conditions and requirements of this subsection and that actuarially equivalent services of contracting providers equal or exceed services obtainable with the minimum benefits specified in this section.

(25) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to assure continuing access to levels of care most appropriate for the insured's condition and progress.

(26) The director, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions [1987 c 411 §2]

Note Sections 7 and 8, chapter 44, Oregon Laws 1987, provide

Sec 7 ORS 743 145 does not apply to section 2 of this Act [743 556] because section 2 of this Act constitutes a reenactment of ORS 743 557 and 743 558 or to ORS 750 055 because of its amendment by this Act [1987 c 411 §7]

Sec 8 Section 2 of this Act and the amendments to ORS 750 055 (1)(k) of this Act apply to contracts entered into, renewed or extended on or after July 1, 1988 [1987 c 411 §8]

Note Section 10, chapter 411, Oregon Laws 1987, provides

Sec 10 Paragraph (a) of subsection (23) of section 2 of this Act [743 550] is not operative after June 30, 1991 [1987 c 411 §10]

743 557 [1975 c 689 §2, 1977 c 632 §3, 1981 c 319 §2, 1983 c 601 §5, repealed by 1987 c 411 §9]

Note 743 557 is repealed June 30, 1988. See section 9, c 411, Oregon Laws 1987 743 557 (1985 Replacement Part) is set forth for the user's convenience.

743 557 A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency including alcoholism. The following conditions apply to the requirement for such coverage:

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness. Deductibles and coinsurance for

outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness.

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services, as defined in ORS 430 010, within the limits specified in this section. Notwithstanding the limits for particular types of services specified in subsections (6) to (8) of this section, a policy may limit the total of payments for all treatment of any kind under this section for chemical dependency including alcoholism, together with payments for all treatment of any kind under ORS 743 558 for mental or nervous conditions, to \$6,000 in any 24-consecutive month period, except as otherwise provided in ORS 743 558. For persons requesting, in any 24-consecutive month period, payments for treatment of any kind for chemical dependency including alcoholism, but not requesting payments for treatment of any kind of mental or nervous conditions, a policy may limit the total of payments for all treatment to \$6,000 in that 24-consecutive month period.

(3) Subject to the provisions of ORS 743 123, 743 128 and 743 135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450, a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150, a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410, or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675 510 to 675 600, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450, a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150, a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410, or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675 510 to 675 600, shall be eligible to receive payments for treatment. In addition, an insurer or insurers and the Mental Health Division may mutually develop agreements, standards and procedures through which Mental Health Division approved programs with alternative arrangements for supervision or for review of treatment plans may become qualified to receive payments for treatment.

(4) Chemical dependency, for purposes of this section, refers to the addictive relationship an individual may have with any drug or alcohol agent. This dependency may be characterized by either a physical or psychological relationship, or both, to the extent that it interferes with the individual's social, psychological or physical adjustment to common problems on a daily basis. For purposes of this section, chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(5) Payments shall not be made under this section for educational programs to which drinking drivers are referred by the judicial system, nor for volunteer mutual support groups.

(6) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities there-

under for chemical dependency including alcoholism to an amount less than \$4 500 in any 24-consecutive month period

(7) Except as permitted by subsections (1) and (2) of this section in the case of benefits for care and treatment in residential facilities for chemical dependency including alcoholism the policy shall not limit payments to an amount less than \$3 000 in any 24-consecutive month period Within this dollar limit payments shall be made for either full-day, supervised residential treatment and care or for part-day treatment on an organized formal regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments

(8) Except as permitted by subsections (1) and (2) of this section in the case of benefits for outpatient services the policy shall not limit payments to an amount less than \$1 500 in any 24-consecutive month period If so specified in the policy outpatient coverage may include follow-up in-home service associated with any health facility residential or outpatient services The policy may limit coverage for such service to persons who have properly completed their initial health facility, residential or outpatient treatment and did not terminate that initial treatment against advice The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made

(9) Under ORS 430 315 the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference

(10) A group health insurance policy may provide with respect to treatment for chemical dependency including alcoholism that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state

(a) Proportion of coinsurance required for treatment in residential facilities outpatient services, or both less than the proportion of coinsurance required for treatment in health facilities

(b) Subject to the patient or client confidentiality provisions of ORS 40 235 relating to physicians ORS 40 240 relating to nurse practitioners, ORS 40 230 relating to psychologists and ORS 40 250 and 675 580 relating to social workers, review for level of treatment of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff personnel under contract to the insurer or by a utilization review contractor who shall have the power to certify for or deny level of payment This review shall be made according to criteria made available to providers in advance Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450 a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150 a nurse practi-

tioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410 or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675 510 to 675 600, with physician consultation readily available Review shall be on a post-admission basis rather than by mandatory prior approval although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible An appeals process shall be provided An insurer may choose to review all providers on a sampling or audit basis only, or to review on a less frequent basis, those providers who consistently supply full documentation, consistent with confidentiality statutes on each case, in a timely fashion, to the insurer

(11) For purposes of paragraph (b) of subsection (10) of this section a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which, under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services

(12) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract reimbursability of treatment at the health facility level of treatment as defined in ORS 430 010, requires demonstration that medical circumstances require 24-hour nursing care, or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis, or in

(a) The current living situation,

(b) An alternative nontreatment living situation, or

(c) An alternative residential facility

(13) For purposes of paragraph (b) of subsection (10) of this section, when implemented through an insurance contract, reimbursability of treatment at the residential facility level of treatment, as defined in ORS 430 010 and under subsection (7) of this section shall require demonstration that outpatient services as defined in ORS 430 010 and under subsection (7) of this section if appropriate and less costly than residential facility services

(a) Are not presently appropriate and available

(b) Cannot be readily and timely made available, and

(c) Cannot meet documented needs for nonmedical supervision, protection, assistance and treatment either in the current living situation or in a readily and timely available alternative, nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational social and living situations, risks to self or others, and readiness to participate consistently in treatment

(14) For purposes of paragraph (b) of subsection (10) of this section, reimbursability of treatment at the level for outpatient facility, service or program as defined in ORS 430 010 and under subsections (7) and (8) of this section, shall require demonstration that treatment is justified, considering the individual's history and the current medical, occupational social and psychological situation and the overall prognosis

743 558 [1973 c 613 §2, 1983 c 601 §6 repealed by 1987 c 411 §9]

Note 743 558 is repealed June 30, 1988 See section 9 chapter 411 Oregon Laws 1987 743 558 (1985 Replacement Part) is set forth for the user's convenience

743 558 Every insurer offering group health insurance benefits shall provide benefits for expense arising from mental or nervous conditions that meet the following requirements

(1) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance Deductibles and coinsurance for treatment in health facilities or residential facilities shall be no greater than those under the policy for expenses of hospitalization in the treatment of illness Deductibles and coinsurance for outpatient treatment shall be no greater than those under the policy for expenses of outpatient treatment of illness

(2) Treatment shall include treatment provided in health facilities, residential facilities or outpatient services as defined in ORS 430 010 within the limits specified in this section Notwithstanding the limits for particular types of services specified in subsections (4) to (6) of this section, a policy may limit the total of payments for all treatment of any kind under ORS 743 557 for chemical dependency including alcoholism together with payments for all treatment of any kind under this section for mental or nervous conditions to \$6,000 in any 24-consecutive month period, except as otherwise provided in this section However, for person requesting, in any 24-consecutive month period, payments for treatment of any kind for mental or nervous conditions, but not requesting payments for treatment of any kind for chemical dependency including alcoholism, a policy may not limit the total of payments for all treatment to less than \$9,000 in that 24-consecutive month period

(3) Subject to the provisions of ORS 743 123 743 128 and 743 135, programs in which staff are directly supervised by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450, a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150, a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410, or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675 510 to 675 600, and programs in which individual client treatment plans are approved by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450, a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150, a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410, or a clinical social worker registered by the State Board of Clinical Social Workers as provided under ORS 675 510 to 675 600, shall be eligible to receive payments for treatment

(4) Except as permitted by subsections (1) and (2) of this section, the policy shall not limit payments for inpatient care and treatment in hospitals and other health facilities thereunder for mental or nervous conditions to an amount less than \$7,500 in any 24-consecutive month period, subject to the provisions of subsection (5) of this section

(5) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for treatment in residential

facilities, the policy shall not limit payments to an amount less than \$3 000 in any 24 consecutive month period A policy may specify that any payments made under this subsection shall directly reduce dollar for dollar amounts available for payments under subsection (4) of this section Within the dollar limit in this subsection, payments shall be made for either full-day, supervised residential treatment and care, or for part-day treatment on an organized formal, regularly scheduled basis consisting of at least four hours of structured treatment per day, for at least four days each week Payments for part-day treatment on a less intensive schedule shall be made within the dollar limit for outpatient payments

(6) Except as permitted by subsections (1) and (2) of this section, in the case of benefits for outpatient treatment, the policy shall not limit payments to an amount less than \$2,000 in any 24-consecutive month period If so specified in the policy, outpatient coverage may include follow-up in-home service associated with any health facility, residential or outpatient services The policy may limit coverage for in-home service to persons who have properly completed their initial health facility residential or outpatient treatment and did not terminate that initial treatment against advice The policy may also limit coverage for in-home service by defining the circumstances of need under which payment will or will not be made

(7) Under ORS 430 021, the Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by assuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference

(8) A group health insurance policy may provide, with respect to treatment for mental or nervous conditions, that any one or more of the following cost containment methods shall be in effect and the method or methods used by an insurer in one part of the state may be different from the method or methods used by that insurer in another part of the state

(a) Proportion of coinsurance required for treatment in residential facilities, outpatient services, or both, less than the proportion of coinsurance required for treatment in health facilities

(b) Subject to the patient or client confidentiality provisions of ORS 40 235 relating to physicians, ORS 40 230 relating to nurse practitioners, ORS 40 230 relating to psychologists and ORS 40 250 and 675 580 relating to social workers, review, for level of treatment, of admissions and continued stays for treatment in health facilities or in both health facilities and residential facilities or in health facilities, residential facilities and outpatient services by either insurer staff, personnel under contract to the insurer, or by a utilization review contractor, who shall have the power to certify for or deny level of payment This review shall be made according to criteria made available to providers in advance Review shall be performed by a medical or osteopathic physician licensed by the Board of Medical Examiners for the State of Oregon as provided under ORS 677 010 to 677 450, a psychologist licensed by the State Board of Psychologist Examiners as provided under ORS 675 010 to 675 150, a nurse practitioner registered by the Oregon State Board of Nursing as provided under ORS 678 010 to 678 410, or a clinical social worker registered by the State Board of Clinical Social Work-

ers as provided under ORS 675 510 to 675 600, with physician consultation readily available. Review shall be on a post-admission basis rather than by mandatory prior approval, although policy holders or persons acting on their behalf shall be encouraged to make advance inquiries when feasible. An appeals process shall be provided. An insurer may choose to review all providers on a sampling or audit basis only, or to review on a less frequent basis those providers who consistently supply full documentation, consistent with confidentiality statutes on each case, in a timely fashion, to the insurer.

(9) For purposes of paragraph (b) of subsection (8) of this section, a utilization review contractor is a professional standards review organization, foundation for medical care or similar entity which under contract with an insurance carrier, performs certification of reimbursability of level of treatment for admissions and maintained stays in treatment programs, facilities or services.

(10) For purposes of paragraph (b) of subsection (8) of this section when implemented through an insurance contract, reimbursability of treatment at the health facility level of treatment as defined in ORS 430 010 requires demonstration that medical circumstances require 24-hour nursing care or physician or nurse assessment, treatment or supervision that cannot be readily made available on an outpatient basis or in

- (a) The current living situation
- (b) An alternative, nontreatment living situation or
- (c) An alternative residential facility

(11) For purposes of paragraph (h) of subsection (8) of this section when implemented through an insurance contract reimbursability of treatment at the residential facility level of treatment as defined in ORS 430 010 and under subsection (5) of this section, shall require demonstration that outpatient services, as defined in ORS 430 010 and under subsection (5) of this section if appropriate, and less costly than residential facility services

- (a) Are not presently appropriate and available,
- (b) Cannot be readily and timely made available, and
- (c) Cannot meet documented needs for nonmedical supervision, protection assistance and treatment either in the current living situation or in a readily and timely available alternative nontreatment living situation, taking into account the extent of both the available positive support and existing negative influences in the occupational social and living situation risks to self or others, and readiness to participate consistently in treatment

(12) For purposes of paragraph (b) of subsection (8) of this section, reimbursability of treatment at the level for outpatient facility, service or program, as defined in ORS 430 010 and under subsections (5) and (6) of this section, shall require demonstration that treatment is justified, considering the individual's history and the current medical, occupational, social and psychological situation and the overall prognosis.

743.559 Applicability to disability policies of coverage requirements for treatment for chemical dependency including alcoholism, and for mental or nervous conditions. Nothing in ORS 430 010, 430 021,

430 315, 430 580, 743 557 (1985 Replacement Part), 743 558 (1985 Replacement Part) and 750 055 applies to disability policies [1983 c 601 §12]

Note 743 559 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 743 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

CREDIT LIFE AND CREDIT HEALTH INSURANCE

743.561 Definitions for credit life and credit health insurance provisions. (1) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

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

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

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

(5) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a loan or other credit transaction [Formerly 739 565]

743.564 Applicability of credit life and credit health insurance provisions. All life or health insurance in connection with loans or other credit transactions shall be subject to ORS 743 561 to 743 588, except

(1) Insurance in connection with a loan or other credit transaction of more than 10 years' duration, or

(2) Insurance, the issuance of which is an isolated transaction on the part of the insurer not related to an agreement or a plan for insuring debtors of the creditor [Formerly 739 570 1969 c 336 §13]

743.567 Forms of credit life and credit health insurance. Credit life and credit health insurance shall be issued only in the following forms

(1) Individual policies of life insurance issued to debtors on the term plan

(2) Individual policies of health insurance issued to debtors on a term plan, or disability benefit provisions in individual policies of credit life insurance

(3) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan

(4) Group policies of health insurance issued to creditors on a term plan insuring debtors, or disability benefit provisions in group credit life insurance policies [Formerly 739 575]

743 570 Limits on amount of credit life insurance. (1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and, where an indebtedness is repayable in substantially equal instalments, the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater

(2) Notwithstanding the provisions of subsection (1) of this section, insurance on agricultural credit transaction commitments not exceeding 18 months in duration may be written up to the amount of the loan commitment, on a nondecreasing or level term plan

(3) Notwithstanding the provisions of subsection (1) of this section, insurance on educational credit transaction commitments may include the portion of such commitment that has not been advanced by the creditor [1967 c 359 §473]

743 573 Limit on amount of credit health insurance. The total amount of periodic indemnity payable by credit health insurance in the event of disability, as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid instalments of the indebtedness, and the amount of each periodic indemnity payment shall not exceed the original indebtedness divided by the number of periodic instalments [Formerly 741 425]

743.576 Duration of credit life and credit health insurance. (1) The term of any credit life or credit health insurance shall, subject to acceptance by the insurer, commence on the date when the debtor becomes obligated to the creditor, except that, where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than 30 days after the date when the debtor

becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance

(2) The term of the insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without additional cost to the debtor

(3) If the indebtedness is discharged because of renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness

(4) In all cases of termination of the insurance prior to the scheduled maturity date of the indebtedness, a refund shall be paid or credited as provided in ORS 743 582 [Formerly 739 585]

743.579 Credit life and credit health insurance policy or group certificate; contents; delivery of policy, certificate or copy of application. (1) All credit life or credit health insurance shall be evidenced by an individual policy or, in the case of group insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor

(2) Each individual policy or group certificate of credit life or credit health insurance, or both shall, in addition to other requirements of law, set forth

(a) The name and home-office address of the insurer,

(b) The name or names of the debtor, or in the case of a certificate under a group policy, the identity by name or otherwise of the debtor,

(c) The premium or amount of payment by the debtor separately for credit life insurance and for credit health insurance,

(d) A description of the coverage including the amount and term thereof, and any exceptions, limitations and restrictions, and

(e) A statement that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, wherever the amount of insurance may exceed the unpaid indebtedness, that any such excess shall be payable to a beneficiary, other than the creditor, named by the debtor or to the estate of the debtor.

(3) Such individual policy or group certificate of insurance shall be delivered to the insured debtor at the time the indebtedness is incurred

except as provided in subsection (4) of this section

(4) If such individual policy or group certificate of insurance is not delivered to the debtor at the time the indebtedness is incurred, a copy of the application for insurance or a notice of proposed insurance, signed by the debtor and setting forth the name and home-office address of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and for credit health insurance and the amount, term and a brief description of the coverage provided, shall be delivered to the debtor at the time the indebtedness is incurred. The copy of the application for insurance or notice of proposed insurance shall also refer exclusively to insurance coverage, and shall be separate and apart from the loan, sale or other credit statement of account, instrument or agreement, unless the information required by this subsection is prominently set forth therein. Upon acceptance of the insurance by the insurer and within 30 days of the date upon which the indebtedness is incurred, the insurer shall cause the individual policy or group certificate of insurance to be delivered to the debtor. The application for insurance or notice of proposed insurance shall state that upon acceptance by the insurer, the insurance shall become effective as provided in ORS 743 576

(5) If an insurer other than the named insurer accepts the risk, then the debtor shall receive a policy or certificate of insurance setting forth the name and home-office address of the substituted insurer and the amount of the premium to be charged, and if the amount of premium is less than that set forth in the notice of proposed insurance an appropriate refund shall be made [Formerly 739 590]

743.582 Charges and refunds to debtor, credit life and credit health insurance. (1) Each individual policy or group certificate of credit life or credit health insurance, or both, shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled thereto. However, the director shall prescribe a minimum refund and no refund which would be less than such minimum need be made. The formula to be used in computing such refund shall be filed with and approved by the director

(2) If a creditor requires a debtor to make any payment for credit life insurance or credit health insurance and an individual policy or group cer-

tificate of insurance is not issued, the creditor shall immediately give written notice to such debtor and shall promptly make an appropriate credit to the account

(3) The amount charged to a debtor for credit life insurance and for credit health insurance shall not exceed the respective premiums charged by the insurer, as computed at the time the charge to the debtor is determined [Formerly 739 600]

743.585 Status of remuneration to creditor. Notwithstanding the provisions of any other law of this state which may expressly or by construction provide otherwise, any commission or service fee or other benefit or return to any creditor arising out of the sale or provision of credit life and credit health insurance shall not be deemed interest or charges in connection with loans or credit transactions [Formerly 739 603]

743.588 Claim report and payment, credit life and credit health insurance. (1) All claims under policies of credit life or credit health insurance, or both, shall be promptly reported to the insurer or its designated claim representative and the insurer shall maintain adequate claim files. All claims shall be settled as soon as possible and in accordance with the terms of the policy

(2) All claims shall be paid either by draft drawn upon the insurer or by check of the insurer to the order of the claimant to whom payment is due pursuant to the policy provisions or, upon direction of such claimant, to the one specified [Formerly 739 610]

FIRE INSURANCE

743.603 Fire insurance not to exceed value of property insured. (1) No insurer, agent or insured shall knowingly issue or procure any fire insurance policy upon property within this state for an amount which with any existing insurance exceeds the fair value of the risk insured or of the interest of the insured therein

(2) This section does not apply to insurance on stocks of merchandise or property of fluctuating values where the reduced rate percentage value clause is made a part of the policy [Formerly 744 070]

743 606 Standard fire insurance policy. Except as provided in ORS 743 607, no fire insurer, its officers or agents, shall use any fire insurance policy or renew any fire insurance policy on property in this state unless it contains the provisions set forth in ORS 743 609 to 743 663, which shall form a portion of the contract between the insurer and the insured [1967 c 359 §481, 1967 c 453 §3]

743.607 Exceptions to standard fire insurance policy requirements. Any insurance policy that includes, either on an unspecified basis as to coverage or for a single premium, coverage against the peril of fire and substantial coverage against other perils need not comply with the provisions of ORS 743 606, if such policy

(1) Affords coverage with respect to the peril of fire, not less than the substantial equivalent of the coverage afforded by the provisions of the standard fire insurance policy as required by ORS 743 606,

(2) Contains, without change, the provisions relating to mortgagee interests and obligations as required for the standard fire insurance policy by ORS 743 606, and

(3) Is complete as to all its terms without reference to the standard fire insurance policy or any other policy [1967 c 453 §2]

743.609 Insuring agreement. A fire insurance policy shall contain provisions as follows "In consideration of the provisions and stipulations herein or added hereto and of ----- dollars (\$---) premium this company, for the term of ----- from the --- day of -----, 19--, to the --- day of -----, 19--, at 12 01 a m, at location of property involved, to an amount not exceeding ----- dollars (\$---), does insure ----- and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all direct loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere

"Assignment of this policy shall not be valid except with the written consent of this company

"This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which hereby are made a

part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy

"In witness whereof, this company has executed and attested these presents

Secretary

President "

[1967 c 359 §482, 1971 c 231 §26]

743.612 Concealment; fraud; representations by insured. A fire insurance policy shall contain the following provisions

(1) Subject to subsections (2) and (3) of this section, this entire policy shall be void if, whether before or after a loss, the insured has wilfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto

(2) All statements made by or on behalf of the insured, in the absence of fraud, shall be deemed representations and not warranties No such statements that arise from an error in the application shall be used in defense of a claim under the policy unless

(a) The statements are contained in a written application, and

(b) A copy of the application is indorsed upon or attached to the policy when issued

(3) In order to use any representation by or on behalf of the insured in defense of a claim under the policy, the insurer must show that the representations are material and that the insurer relied on them [1967 c 359 §483 1985 c 465 §3]

743.615 Uninsurable and excepted property. A fire insurance policy shall contain a provision as follows "This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities, nor, unless specifically named hereon in writing, bullion or manuscripts." [1967 c 359 §484]

743.618 Perils not included. A fire insurance policy shall contain a provision as follows "This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by (a) Enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack, (b) invasion, (c) insurrection, (d)

rebellion, (e) revolution, (f) civil war, (g) usurped power, (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy, (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises, (j) nor shall this company be liable for loss by theft " [1967 c 359 §485]

743.621 Other insurance. A fire insurance policy shall contain a provision as follows "Other insurance may be prohibited or the amount of insurance may be limited by indorsement attached hereto " [1967 c 359 §486]

743.624 Conditions suspending insurance. A fire insurance policy shall contain a provision as follows "Unless otherwise provided in writing added hereto this company shall not be liable for loss occurring

"(1) While the hazard is increased by any means within the control or knowledge of the insured, or

"(2) While a described building, whether intended for occupancy by owner or tenant, is vacated or unoccupied beyond a period of 60 consecutive days, or

"(3) As a result of explosion or riot, unless fire ensues, and in that event for loss by fire only " [1967 c 359 §487]

743.627 Additional perils insured A fire insurance policy shall contain a provision as follows "Any other peril to be insured against or subject of insurance to be covered in this policy shall be by indorsement in writing hereon or added hereto " [1967 c 359 §488]

743.630 Added provisions A fire insurance policy shall contain a provision as follows "The extent of the application of insurance under this policy and of the contribution to be made by this company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change " [1967 c 359 §489]

743.633 Waiver provisions. A fire insurance policy shall contain a provision as follows "No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this company relating

to appraisal or to any examination provided for herein " [1967 c 359 §490]

743.636 Cancellation A fire insurance policy shall contain a provision as follows "This policy shall be canceled at any time at the request of the insured, in which case this company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time This policy may be canceled at any time by this company by giving to the insured a five days' written notice of cancellation with or without tender of the excess of paid premium above the pro rata premium for the expired time, which excess, if not tendered, shall be refunded on demand Notice of cancellation shall state that said excess premium, if not tendered, will be refunded on demand " [1967 c 359 §491]

743.639 Mortgagee interest and obligation of mortgagee. A fire insurance policy shall contain provisions as follows

(1) "If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be canceled by giving to such mortgagee a 10 days' written notice of cancellation "

(2) "If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within 60 days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit If this company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue, or it may pay off the mortgage debt and require an assignment thereof and of the mortgage Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing " [1967 c 359 §492]

743.642 Pro rata liability of insurer. A fire insurance policy shall contain a provision as follows "This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not " [1967 c 359 §493]

743.645 Requirements in case loss occurs. A fire insurance policy shall contain a provision as follows "The insured shall give immediate written notice to this company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible

order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed, and within 60 days after the loss, unless such time is extended in writing by this company, the insured shall render to this company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: The time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this company all that remains of any property herein described, and submit to examinations under oath by any person named by this company, and subscribe the same, and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices, and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this company or its representative, and shall permit extracts and copies thereof to be made." [1967 c 359 §494]

743.648 Appraisal. A fire insurance policy shall contain a provision as follows: "In case the insured and this company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days of such demand. The appraisers shall first select a competent and disinterested umpire, and failing for 15 days to agree upon such umpire, then, on request of the insured or this company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item, and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this company shall determine

the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting the appraiser and the expenses of appraisal and umpire shall be paid by the parties equally." [1967 c 359 §495]

743.651 Insurer's options. A fire insurance policy shall contain a provision as follows: "It shall be optional with this company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss herein required." [1967 c 359 §496]

743.654 Abandonment. A fire insurance policy shall contain a provision as follows: "There can be no abandonment to this company of any property." [1967 c 359 §497]

743.657 When loss payable. A fire insurance policy shall contain a provision as follows: "The amount of loss for which this company may be liable shall be payable 60 days after proof of loss, as herein provided, is received by this company and ascertainment of the loss is made either by agreement between the insured and this company expressed in writing or by the filing with this company of an award as herein provided." [1967 c 359 §498]

743.660 Suit on policy. A fire insurance policy shall contain a provision as follows: "No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within 12 months next after inception of the loss." [1967 c 359 §499]

743.663 Subrogation. A fire insurance policy shall contain a provision as follows: "This company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this company." [1967 c 359 §500]

743.666 Coverage for loss from nuclear reaction or radiation. Insurers issuing the standard fire insurance policy pursuant to ORS 743.606 are authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy. However, nothing contained in this section shall be construed to prohibit the attachment to any such policy of an indorsement or indorsements

specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination [Formerly 744 125]

743.669 Other fire insurance policy provisions permitted. (1) A fire insurer may add, to the provisions required by ORS 743 606, other conditions, provisions, and agreements not in conflict with law or contrary to public policy

(2) Any provision restricting or abridging the rights of the insured under the policy must be preceded by a sufficiently explanatory title printed or written in type not smaller than eight-point capital letters [Formerly 744 130]

743.672 Mutual insurers policyholders' liability; nonassessable policies. (1) Each person accepting a policy in a mutual fire insurer thereby becomes a member of the insurer and liable for a proportionate share of losses and operating expenses

(2) Any person or persons holding property in trust may insure the same in a mutual fire insurer, and as such trustee assume the liabilities and be entitled to the rights of a member, but shall not be personally liable upon such insurance policy

(3) A mutual fire insurer may fix the contingent and mutual liability of its members for payment of losses and expenses by a uniform rule set forth in its bylaws and policies. Such mutual liability shall not be less than twice the amount of the usual advance assessment written in the policy

(4) A mutual fire insurer that received a certificate of authority prior to September 2, 1963, and has accumulated in the regular course of business assets of not less than \$200,000, of which not less than \$100,000 is surplus determined as provided in the Insurance Code, may while in that condition and subject to the approval of the director adopt bylaws limiting the liability of its policyholders to the premium specified in its policies. The power to issue policies with such limitation of liability continues only during the time the insurer is in such financial condition

(5) A mutual fire insurer that received a certificate of authority after September 2, 1963, and has \$500,000 in surplus determined as provided in the Insurance Code, may while in that condition and subject to the approval of the director adopt bylaws limiting the liability of its policyholders to the premium specified in its policies. The power to issue policies with such limitation of liability continues only during the time the insurer is in such financial condition

(6) Every mutual fire insurer which has not limited the liability of its policyholders in accord-

ance with subsections (4) and (5) of this section must print upon its policies such bylaws as will define the liability of a policyholder in addition to the statement required by ORS 743 066 [Formerly 744 430]

743.675 Mutual insurer's action to recover assessment. An action may be brought against any member of a mutual fire insurer who neglects or refuses to pay any assessment levied by the insurer to recover the whole amount of contingent liability with costs of the action. Execution shall issue on a judgment recovered in such an action for assessments and costs only as they accrue [Formerly 744 440]

743.678 Mutual fire insurers, withdrawal of members Any member of a mutual fire insurer may withdraw at any time by surrendering the member's policy to the insurer, giving written notice to the secretary of intention to withdraw and paying the member's share of all losses which have accrued and all assessments then due, accrued or pending [Formerly 744 450]

743.681 Mutual fire insurance policy cancellation. (1) A mutual fire insurer may cancel or terminate any fire insurance policy by giving the insured five days' written notice and returning to the insured any unearned assessment computed pro rata

(2) A mutual fire insurer shall use and issue only the standard form of policy required by ORS 743 606, except that

(a) It is not required upon cancellation of the insurance policy or certificate of membership to return any part of any policy, certificate, membership or inspection fee that may have been charged

(b) Where a definite part of the amount charged has been collected for and designated as an expense assessment, it may by bylaw determine the amount of refund that shall be made from such expense assessment

(c) If it is on an assessment basis, levying assessments at such times and in such amounts as are necessary to defray its losses and expenses, it may provide by bylaw that no part of the assessments shall be returned

(d) If it is organized for the insurance of a single class of risks and the assessment charged in a flat sum, it may provide in the insurance policy that no return assessment shall be paid upon cancellation [Formerly 744 460]

HOME PROTECTION INSURANCE

743.690 Home protection insurance.

(1) A home protection policy shall specify

(a) The home, home components and personal property relating to the home or its components that are covered by the policy

(b) The exclusions to and limitations on the coverage

(c) The period during which the policy will be in effect and the renewal terms, if any

(d) The particulars regarding the performance of services, if any, by or on behalf of the insurer, including but not necessarily limited to the following

(A) The kinds of services to be performed by or on behalf of the insurer, and the terms and conditions of the performance

(B) The service fee or deductible amount, if any, to be charged for the services

(C) All limitations regarding the performance of services, including any restrictions on the time period during which, or geographical area within which, services may be requested or will be performed

(D) A statement that services will be performed upon the insured's telephoned request to the insurer, without any requirement that a claim form or service application be filed before service is performed

(E) A representation that services will be initiated by or under the direction of the insurer within 48 hours after request is made for services

(e) All other provisions which are required by the Insurance Code or by rules issued by the director

(2) A home protection policy shall be noncancellable during the term for which it is originally written, except for nonpayment of the premium charge for the policy or for fraud or misrepresentation of facts material to the issuance of the policy. However, a policy providing coverage while the subject home is being offered for sale is cancellable in accordance with the policy provisions if no sale is made. A home protection policy is not renewable unless its terms provide otherwise.

(3) The director may adopt rules regarding home protection policies in order to protect the interests of persons affected by the policy contract. The director may not adopt rules specifying the home components or related personal property which must be covered by a home protection policy, except to the extent necessary to

(a) Obtain fairness in the exclusions from coverage, or

(b) Avoid illusory coverage caused by the nature or extent of the exclusions from coverage
[1981 c 247 §17]

MORTGAGE INSURANCE

743.702 [Formerly 746.010 repealed by 1969 c 692 §11]

743.705 Limitations on issuance of mortgage insurance. (1) No mortgage insurer shall provide insurance with respect to an obligation which exceeds, solely or in combination with liens existing at the time the insured loan is made, 95 percent of the fair market value of the securing property at the time the loan is made, or such higher percentage as may be authorized by the director and permitted by the insurer's domicile

(2) A mortgage insurer at its option may limit its coverage net of reinsurance to a maximum of 25 percent of the amount of the obligation insured. In such event, it may, in lieu of acquiring title to the property securing the obligation and paying the entire obligation, elect to pay its coverage percent of the obligation. In computing the aggregate amount of insured obligations under ORS 731.516, only the percent of coverage net of reinsurance on the insured obligation shall be included in the aggregate amount.

(3) No mortgage insurer shall issue a policy of lease insurance with respect to real property not improved by a building or buildings designed to be occupied for industrial or commercial purposes [Formerly 746.030 1969 c 692 §9, 1973 c 179 §1 1982 s s 1 c 5 §1, 1987 c 846 §13]

743.708 Insured obligations as legal investments and securities for deposit. (1) Obligations insured by mortgage insurance policies issued in conformity with the Insurance Code shall be legal investments for all trust funds held by any executor, administrator, conservator, trustee or other person or corporation holding trust funds, and also for the funds of banks, banking institutions and trust companies, and shall be accepted by this state and its officers and officials as securities constituting any part of any fund or deposit required by law to be made with this state, or any officer or official thereof, by any trust company doing business in this state. All premiums required to be paid according to the terms of any such mortgage insurance policy may be charged to or paid out of the income from the obligations covered thereby. In the case of such fund or deposit required by law, such obligations must constitute a first lien on real property that is worth at least double the amount of such lien.

(2) The provisions of subsection (1) of this section with respect to legal investments for funds shall also apply to obligations not so insured if

(a) The obligation constitutes a first lien upon a marketable title to real property,

(b) There exists a lease insurance policy covering the property securing the obligation, issued in conformity with the Insurance Code,

(c) The aggregate lease payments so insured exceeds the amount of the obligation, and

(d) The insurer is legally bound to remit all lease insurance proceeds directly to the owner of the obligation [Formerly 746 080, 1969 c 692 §10, 1973 c 823 §150]

743.711 Mortgage insurance; who may write All policies and contracts of insurance covering liens or security interests in real property shall be written by authorized mortgage insurers. No other class of insurer may write any form of mortgage insurance [1987 c 846 §15]

PRODUCT LIABILITY INSURANCE

743.720 Definitions for ORS

743.723. As used in ORS 743 723

(1) "Claim" means

(a) A written request to an insurer by or on behalf of an injured person for payment for personal injury, death or property damage alleged to have been caused by a defect in a product insured under a product liability policy, or

(b) A written notification to an insurer by an insured that a person has requested payment from the insured for personal injury, death or property damage alleged to have been caused by a defect in a product insured under the insured's product liability policy

(2) "Product liability policy" means

(a) Any policy of insurance insuring only the insured's legal obligation arising from the product liability exposure of the insured,

(b) Any other policy of liability insurance in which the premium computation includes a specific premium charge for product liability exposures of the insured, and

(c) Any other insurance policy designated by the director as providing product liability insurance [1979 c 866 §4, 1987 c 774 §56]

743.723 Product liability insurers to submit annual reports to director; contents of reports; availability to public. (1) Every insurer authorized to transact business in this state and providing product liability insurance shall, on or before the first day of May of each year, file with the director a report containing the information specified in this section. Such report

shall be made upon forms prescribed by the director and shall contain the name of the insurance company and the name of all other companies associated with the company submitting the report, either as a holding company, parent company, wholly owned subsidiary, division or through interlocking directorates

(2) An insurer filing the report required under subsection (1) of this section shall provide, for the period January 1 to December 31 of the year next preceding the filing of the report, as much of the information required by subsection (3) of this section on claims under a product liability policy as is available at the time of the report. If a claim has not been adjudicated, settled or disposed of at the time of the report, information on adjudication, settlement or disposition of the claim shall be included in the next report following the adjudication, settlement or disposition of the claim. Every insurer authorized to transact business in this state shall be subject to the provisions of this subsection in regard to claims adjudicated, settled or disposed of pursuant to the laws of this state or against residents of this state

(3) When a claim has been made against an insurer, the report of that insurer required under subsection (1) of this section shall contain as much of the following as is available at the time of the report

(a) The name and address of the insured or the insurer's claim number or file number,

(b) The type of product,

(c) Rating classification code of product liability coverage,

(d) The date of occurrence which created the claim,

(e) A summary of the occurrence that created the claim, including the state or other jurisdiction under whose jurisdiction the claim was adjudicated, settled or disposed of,

(f) Date of civil action, if filed,

(g) Date and amount of judgment or settlement, if any, the number of parties involved in the distribution of such judgment or settlement and the amount received by each and the amount of any economic, noneconomic and punitive damages awarded, if known, stated separately,

(h) Date and reason for final disposition, if any, if no judgment or settlement, and

(i) Such other information as the director may require

(4) The report required under subsection (1) of this section shall also contain in summary form the following

- (a) Total number of claims,
- (b) Total claims closed without payment,
- (c) Total claims closed with payment and the total amount of such payments,
- (d) Total number of civil actions filed,
- (e) Total number of verdicts or judgments for defendants,
- (f) Total number of verdicts or judgments for plaintiffs,
- (g) Total amounts for plaintiffs, and

(h) Total reserves established at each calendar year end during the pendency of the claims separately by calendar year in which the claims were first reported to the insurer. However, claims first reported eight or more years previous to the end of the year being reported on may be aggregated

(5) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer reporting under ORS 30 115, 30 920, 30 925, 743 720 and this section, its agents or employees, the director or the director's employes for any action taken under ORS 30 115, 30 920, 30 925, 743 720 and this section

(6) The director shall make the reports required under ORS 30 115, 30 920, 30 925, 743 720 and this section available to the public in a manner which will not reveal the names of any person, manufacturer or seller involved

(7) The reports required by this section shall not be admissible in evidence in any trial of a product liability civil action

(8) Failure to file a report within the time required by this section subjects an insurer to a civil penalty as provided in ORS 731 988 [1979 c 866 §5 1981 c 525 §1, 1987 c 774 §57]

SURETY INSURANCE

743 732 Bonds, undertakings and other obligations required by law may be executed by surety insurers. (1) Whenever any bond, undertaking, recognizance, or other obligation is by law or the charter, ordinance, rules or regulations of any municipality, board, body, organization, court, judge or public officer required or permitted to be made, given, tendered or filed with surety or sureties, and whenever the performance of any act, duty or obligation, or the refraining from any act is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance or guaranty may be executed by an authorized surety insurer

(2) The execution by such an insurer of any such obligation is in all respects a full and com-

plete compliance with every requirement that it be executed by one surety, or by one or more sureties, or that such sureties be residents or householders, or freeholders, or either or both, or possess any other qualification

(3) A surety insurer may be required to justify as surety. It shall be sufficient justification for such surety insurer when examined as to its qualifications to exhibit the certificate of authority issued to it by the director or a certified copy thereof [Formerly 747 080]

743.735 Reimbursement of private persons required to give bond. Any receiver, assignee, guardian, conservator, trustee, executor, administrator or other fiduciary, required by law or the order of any court or judge to give a bond or other obligation as such, may include as a part of the lawful expense of executing the trust, such reasonable sum paid an insurer for becoming surety on the bond as may be allowed by the court in which, or judge before whom, the person is required to account. Such sum shall not exceed one percent per annum of the amount of the bond [Formerly 747 100 1973 c 823 §151]

743.738 Reimbursement of public officials required to give bond. Any state, county or municipal officer or officer of any school district, public board or public commission within this state, or any deputy employed in the office of any such official, who is required by law, ordinance, regulation or public policy to give a bond for the faithful performance of duties, shall be allowed a reasonable sum paid a surety insurer for becoming surety on the bond. Such sum shall not exceed one-half of one percent per annum of the amount of the bond. Such premium shall be paid out of the proper state, county, municipal, district, board or commission funds [Formerly 747 110]

743.741 Surety insurer may take measures to reduce risk of loss. (1) Any surety insurer may contract for and receive and hold on deposit and in trust property of any kind as collateral security on any policy of guaranty or suretyship executed by it. The insurer may manage, realize on and dispose of the property so received and held on deposit as may be agreed to between it and the person making the deposit

(2) Any receiver, assignee, guardian, conservator, trustee, executor, administrator or other fiduciary or party from whom a policy of guaranty or suretyship is by law required or permitted may agree and arrange with the surety insurer for the deposit for safekeeping of any or all moneys, assets and other property for which the person is or may be responsible in a bank, savings bank, safe deposit or trust company authorized by law

to do business as such, in such manner as to prevent the withdrawal or alienation of such money, assets or other property, or any part thereof, without the written consent of the surety insurer or an order of a court of competent jurisdiction or a judge thereof made on such notice to the surety insurer as the court or judge may direct

(3) Generally, it shall be lawful for a surety insurer to enter into any contract of indemnity or security with any person if such contract is not otherwise prohibited by law or against public policy [Formerly 747 130]

743.744 Release of surety on official bonds by action of obligee. (1) Any official whose duty it is to approve any bond or undertaking given in favor of the state or any county, city, school district, drainage or irrigation district, board or commission within the state may cancel the bond or undertaking by serving written notice of its election so to do upon the principal and surety or sureties on such bond or undertaking 10 days before it desires the cancellation of the obligation to take effect

(2) The official at the time of serving such notice shall also file with the officer or official occupying the position of secretary or clerk of the state, county, city, school district, drainage or irrigation district, board or commission, as the case may be, at the regular place of business of such secretary or clerk, a certified copy of such notice At the expiration of 10 days from the filing of such notice, the surety or sureties upon such bond or undertaking shall be discharged from further liability thereon [Formerly 747 140]

743.747 Release of surety on bond of public official by action of surety. (1) The surety or sureties on the bond of any public official in this state shall be released from any future liability thereon upon giving notice of election to be released as provided in this section

(2) A surety desiring to be released from liability on the bond of any state officer may file with the Governor or Secretary of State 30 days before the surety desires the release to take effect, a notice in writing, duly subscribed by the surety or someone in behalf of the surety, setting forth the name and office of the person for whom the surety is surety, the amount for which the surety is liable as such, and the desire of the surety to be released from further liability on account thereof A duplicate of such notice shall also be served personally on the officer unless the officer has left this state, in which case it may be served by publication for 20 days in some newspaper printed at the seat of government, or if none is

printed there, then in such newspaper as shall be designated by the Governor or Secretary of State

(3) A surety desiring to be released from liability on the bond of any county officer may file and serve a similar notice The notice, except when it concerns the county clerk personally, shall be filed with the county clerk When the county clerk is personally concerned the notice shall be filed with the county treasurer

(4) A surety desiring to be released from liability on the bond of any city officer may file and serve a similar notice with the city clerk or mayor

(5) A surety desiring to be released from any other official bond or undertaking shall file and serve a similar notice with the officer, person or authority whose duty it is to approve such bonds

(6) A notice which under this section may be served by publication may be published in a newspaper in the same county or, if no newspaper is published therein, then in an adjoining or other county, without any order from any court or other authority In all cases for which publication is provided, a printed or written notice posted in at least three conspicuous places in the county for the time specified shall be deemed legal notice thereof [Formerly 747 150]

743.750 Release of surety on depository bond; provision required in such bonds. (1) A surety wishing to terminate the liability undertaken upon any bank depository bond or undertaking given to guarantee the safekeeping and return of any public moneys deposited in the bank may do so by giving notice of election so to do to the principal and to the official whose duty it is to approve such bond or undertaking A surety is released from any future liability upon any such depository bond or undertaking at the expiration of 30 days after the giving of such notice

(2) Where the form of depository bond or undertaking given to protect any public moneys is prescribed by statute or regulation the right to cancel such bond or undertaking shall be expressed in such bonds or undertakings by adding a paragraph to the prescribed form in substantially the following form "The above-named surety shall have the right to terminate any future liability hereunder by serving written notice of election so to do upon the principal and (here insert the official title of the state or county treasurer, or other officials whose duty it is to approve such bond), and thereupon the said surety shall be discharged from any future liability hereunder for any default of the said principal occurring after the expiration of 30 days

from and after the service of such notice" The purpose of such cancellation privilege is to afford the surety a means of obtaining definite release from its liability

(3) Any official or officials whose duty it is to approve any bank depository bond given to protect the deposits of any official moneys, on the official's own motion or upon written request from any bank in whose behalf such a bond is issued, may terminate the future liability on the bond by giving notice to the surety of elections so to do Thereupon the surety shall be discharged from any future liability upon any such depository bond for any default of the principal occurring after the expiration of 30 days from and after the service of such notice [1967 c 359 §516]

743.753 Fixing amount of new bond after release from original. Whenever a notice is filed, or filed and served, as provided in ORS 743 744, 743 747 and 743 750, or received after mailed as provided in ORS 743 755, the proper authority shall prescribe the penalty or amount in which a new or additional bond or undertaking shall be filed If no such order is made the new or additional bond or undertaking shall be executed for the same amount as the original [Formerly 747 170, 1969 c 526 §2]

743.755 Cancellation of bond by surety. (1) As used in this section

(a) "Bond" means any undertaking, recognition or other obligation required by statute, ordinance or regulation to be executed by a surety and given to a public body by any person as a condition to the granting of a permit, license or franchise by a public body

(b) "Public body" means the state and any department, agency, board or commission of the state, any city, county, school district or other political subdivision or municipal or public corporation, any instrumentality thereof and any court

(2) The surety may cancel a bond by sending notice of cancellation by registered or certified mail to the public body with which the bond is filed and to the principal at the principal's address of record with the surety Such cancellation takes effect on the date specified in the notice but not earlier than the 30th day after the date of mailing The surety shall have no liability under the bond for an act or default occurring after the effective date of such cancellation

(3) Notwithstanding subsection (2) of this section, a statute, ordinance, regulation or the provisions of a bond may provide procedures for release of surety on a bond [1969 c 526 §1]

743.756 Surety insurer may not deny power to execute bond; construction of policies. A surety insurer executing any bond or undertaking under the provisions of the Insurance Code is estopped in any proceeding, to deny its corporate power to execute such bond or undertaking or to assume such liability, and all such bonds or undertakings shall in any action be construed by the rules applicable to insurance policies and indemnity contracts [Formerly 747 180]

743.759 Bond construed as including omitted statutory provisions. Whenever any person is required by the provisions of any statute to give a bond to this state or any of its political subdivisions and the statute requires to be included therein any specific provisions, the bond shall have the same legal effect as though such provisions were included therein, although such provisions were omitted [Formerly 747 190]

743.762 Guaranteed arrest bond certificate. As used in ORS 743 765 and 743 768, "guaranteed arrest bond certificate" means any printed certificate which

(1) Is issued by an automobile club or automobile association to any of its members,

(2) Is signed by the member to whom it is issued, and

(3) Contains a printed statement that the automobile club or automobile association and a named surety insurer guarantee the appearance of the member whose signature appears on the certificate and that, if the member does not make the appearance in court to guarantee which the certificate is posted, they will pay in an amount not to exceed \$200 any fine or forfeiture imposed against the individual [Formerly 747 082]

743.765 Surety may issue guaranteed arrest bond certificate not to exceed \$200. Upon compliance with ORS 743 768, any authorized domestic or foreign surety insurer may become surety in an amount not to exceed \$200 with respect to any unexpired guaranteed arrest bond certificate that is issued by an automobile club or association [Formerly 747 084]

743.768 Requirements to issue guaranteed arrest bond certificate. To become surety under ORS 743 765 with respect to an unexpired guaranteed arrest bond certificate that is accepted during any year under ORS 810 320, the surety insurer shall file with the director on a form prescribed by the director an undertaking so to become surety for that year The undertaking shall state

(1) The name and address of each automobile club or automobile association with respect to

any guaranteed arrest bond certificate of which the surety insurer undertakes to be surety, and

(2) The unqualified obligation of the surety insurer to pay the fine or forfeiture in an amount not to exceed \$200 with respect to any individual who

(a) Posts an unexpired guaranteed arrest bond certificate with respect to which under this section the surety insurer has undertaken to be surety, and

(b) Fails to make the appearance in court to guarantee which the guaranteed arrest bond certificate was posted [Formerly 747 086, 1983 c 338 §964]

CASUALTY AND PROPERTY INSURANCE

743.770 Insurers to report medical malpractice claims to licensing board (1) As used in this section, "claim" means

(a) A written request for payment for injury alleged to have been caused by professional negligence that is made by or on behalf of the injured person to an insurer or self-insurance association, or

(b) A written notification to an insurer or self-insurance association by an insured that a person has requested payment from the insured for injury alleged to have been caused by professional negligence

(2) Any insurer or self-insurance association approved by the director that issues or underwrites professional liability insurance in this state to any physician or podiatrist licensed by the Board of Medical Examiners for the State of Oregon, to any optometrist registered by the Oregon Board of Optometry, to any dentist or dental hygienist licensed by the Oregon Board of Dentistry or to any naturopath licensed by the Board of Naturopathic Examiners shall report any claim against the insured for alleged professional negligence to the appropriate licensing board within 30 days after receiving notice of the claim from the insured or any other person

(3) The report required by subsection (2) of this section shall be kept confidential by all persons who make or receive it until the case is settled or closed and shall include

(a) The name of the insured,

(b) The name of the person making the claim,

(c) The reason or reasons for which the claim is made, and

(d) Any additional information the director considers necessary

(4) Any insurer or approved self-insurance association required to report to a board under this section shall also be required to advise the appropriate licensing board of any settlements, awards or judgments against a physician, optometrist, dentist or dental hygienist or naturopath within 30 days after the date of the settlement, award or judgment

(5) The appropriate board shall provide copies of all reports required by subsections (2) and (4) of this section to

(a) The director, and

(b) Each health care facility licensed under ORS 441 015 to 441 087, 441 525 to 441 595, 441 815, 441 820, 441 990, 442 320, 442 340 to 442 350 and 442 400 to 442 450 which employs or grants staff privileges to the person against whom the claim was filed

(6) The director shall maintain a permanent record of reports provided to the director under this section and shall provide an index of such reports

(7) Failure of an insurer or self-insurance association to report a claim within the time required by subsection (2) of this section subjects the insurer or association to a civil penalty as provided in ORS 731 988 [Formerly 743 780, 1987 c 774 §60]

743.771 Conditions for issuance of medical malpractice by insurer. (1) No insurer may require membership in a professional association as a condition of issuance of medical malpractice insurance to a physician. However, nothing in this subsection prohibits an insurer from requiring as a condition of coverage of a nonmember that the nonmember agrees to be subject to reasonable risk management, loss control or other similar programs and conditions to which members are subject, whether imposed by the insurer or the association

(2) No insurer who issues medical malpractice insurance to a physician may assess any surcharge or offer any discount to the physician based on whether or not the physician is a member of a professional association

(3) For purposes of this section, joint underwriting associations and risk retention groups shall be considered insurers [1987 c 744 §151]

Note 743 771 was added to and made a part of the Insurance Code but was not added to any chapter or smaller series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation

743.772 Bankruptcy clause required in certain liability policies. A policy of insurance against loss or damage resulting from acci-

dent to or injury suffered by an employe or other person and for which the person insured is liable, or against loss or damage to property caused by horses or by any vehicle drawn, propelled or operated by any motive power, and for which loss or damage the person insured is liable, shall contain within such policy a provision substantially as follows "Bankruptcy or insolvency of the insured shall not relieve the insurer of any of its obligations hereunder. If any person or legal representative of the person shall obtain final judgment against the insured because of any such injuries, and execution thereon is returned unsatisfied by reason of bankruptcy, insolvency or any other cause, or if such judgment is not satisfied within 30 days after it is rendered, then such person or legal representatives of the person may proceed against the insurer to recover the amount of such judgment, either at law or in equity, but not exceeding the limit of this policy applicable thereto." [Formerly 743 783]

743 774 [Formerly 486 097, renumbered 806 190 in 1987]

MOTOR VEHICLE LIABILITY INSURANCE

743.776 Contents of motor vehicle liability policy. (1) Every motor vehicle liability insurance policy issued for delivery in this state shall state the name and address of the named insured, the coverage afforded by the policy, the premium charged therefor, the policy period, and the limits of liability, and shall contain an agreement or indorsement which provides that the insurance is provided thereunder in accordance with the coverage described under ORS 806 070, 806 080 and 806 270 as respects bodily injury and death or property damage, or both, and is subject to all the provisions of the Oregon Vehicle Code relating to financial responsibility requirements as defined in ORS 801 280 and future responsibility filings as defined under ORS 801 290

(2) Every motor vehicle liability insurance policy issued for delivery in this state shall provide liability coverage to at least the limits specified in ORS 806 070 [Formerly 486 541]

743.778 Liabilities which need not be covered. The motor vehicle liability insurance policy required by ORS 806 010, 806 060, 806 080, 806 240 or 806 270 need not insure any liability under any workers' compensation law, nor any liability on account of bodily injury to or death of an employe of the insured while engaged in the employment, other than domestic, of the insured, or while engaged in the operation, maintenance or repair of a vehicle, nor any liability for

damage to property owned by, rented to, in charge of, or transported by the insured [Formerly 486 546]

743.779 When insurer's liability accrues; nonforfeiture provisions. The liability of an insurance carrier with respect to the insurance policy required by ORS 806 060, 806 240 or 806 270 shall become absolute whenever injury or damage covered by the vehicle liability policy occurs. The policy may not be canceled or annulled as to such liability by any agreement between the insurance carrier and the insured after the occurrence of the injury or damage. No statement made by the insured or on behalf of the insured and in violation of the policy shall defeat or void the policy. The provisions of this section are not applicable to policies of vehicle liability insurance other than those required in connection with ORS 806 060, 806 240 or 806 270 [Formerly 486 551]

743 780 [1975 c 796 §10, 1977 c 448 §12, 1985 c 103 §14, 1985 c 323 §10, 1985 c 624 §17a, renumbered 743 770]

743.781 General provisions governing liability policies. Every vehicle liability policy shall be subject to the following provisions which need not be contained therein

(1) The policy, the written application therefor, if any, and any rider or indorsement which does not conflict with the laws relating to vehicle liability policies shall constitute the entire contract between the parties

(2) The satisfaction by the insured of a judgment for injury or damage shall not be a condition precedent to the right or duty of the insurance carrier to make payment on account of such injury or damage.

(3) Any binder issued pending the issuance of a vehicle liability policy shall be deemed to fulfill the requirements for such a policy [Formerly 486 556]

743.782 Insurer's right to provide for reimbursement and proration. Any vehicle liability policy may provide that the insured shall reimburse the insurance carrier for any payment the insurance carrier would not have been obligated to make under the terms of the policy except for the provisions of ORS 743 776 to 743 785, 806 080 and 806 270 and it may further provide for the prorating of the insurance thereunder with other valid and collectible insurance [Formerly 486 561]

743 783 [Formerly 736 320, renumbered 743 772]

743.784 Insurer's right to settle claims. The insurance carrier shall have the right to settle any claim covered by the policy, and if such

settlement is made in good faith, the amount thereof shall be deductible from the limits of liability specified in respect to a vehicle liability policy [Formerly 486 564]

743.785 Excess coverage permitted; combining policies to meet requirements. Any policy which grants the coverage required for a motor vehicle liability insurance policy under ORS 743 776, 806 080 and 806 270 may also grant any lawful coverage in excess of or in addition to the required coverage, and such excess or additional coverage shall not be subject to the provisions of ORS 743 776 to 743 785. With respect to a policy which grants such excess or additional coverage only that part of the coverage which is required by ORS 806 080 and 806 270 is subject to the requirements of those sections [Formerly 486 566]

743.786 Definitions for ORS 743.786 to 743.795. As used in ORS 743 786 to 743 795

(1) "Uninsured motorist coverage" means coverage within the terms and conditions specified in ORS 743 792 insuring the insured, the heirs or legal representative of the insured for all sums which the insured or they shall be legally entitled to recover as damages for bodily injury or death caused by accident and arising out of the ownership, maintenance or use of an uninsured motor vehicle in amounts or limits not less than the amounts or limits prescribed for bodily injury or death under ORS 806 070

(2) "Motor vehicle" means every self-propelled device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include

(a) Devices used exclusively upon stationary rails or tracks,

(b) Motor trucks as defined in ORS 801 355 that have a registration weight, as defined by ORS 803 430 of more than 8,000 pounds, when the insured has employees who operate such trucks and such employees are covered by any workers' compensation law, disability benefits law or any similar law, or

(c) Farm-type tractors or self-propelled equipment designed for use principally off public highways [1967 c 482 §1 1971 c 523 §11 1979 c 842 §7 1983 c 338 §965]

743.789 Motor vehicle liability policies to provide uninsured motorist coverage; underinsurance coverage. (1) Every motor vehicle liability policy insuring against loss suffered by any natural person resulting from liability imposed by law for bodily injury or death arising out of the ownership, maintenance or use

of a motor vehicle shall provide uninsured motorist coverage therein or by indorsement thereon when such policy is either

(a) Issued for delivery in this state, or

(b) Issued or delivered by an insurer doing business in this state with respect to any motor vehicle then principally used or principally garaged in this state

(2) The insurer issuing such policy shall offer one or more options of uninsured motorist coverage larger than the amounts prescribed to meet the requirements of ORS 806 070 up to the limits provided under the policy for motor vehicle bodily injury liability insurance. Offers of uninsured motorist coverage larger than the amounts required by ORS 806 070 shall include underinsurance coverage for damages or death caused by accident and arising out of the ownership, maintenance or use of a motor vehicle that is insured for an amount that is less than the insured's uninsured motorist coverage. Underinsurance benefits shall be equal to uninsured motorist coverage benefits less the amount recovered from other automobile liability insurance policies

(3) The insurer issuing such policy may offer one or more options of uninsured motorist coverage larger than the amounts prescribed to meet the requirements of ORS 806 070 and in excess of the limits provided under the policy for motor vehicle bodily injury liability insurance. Offers of uninsured motorist coverage larger than the amounts required by ORS 806 070 shall include underinsurance coverage for damages or death caused by accident and arising out of the ownership, maintenance or use of a motor vehicle that is insured for an amount that is less than the insured's uninsured motorist coverage. Underinsurance benefits shall be equal to uninsured motorist coverage benefits less the amount recovered from other automobile liability insurance policies.

(4) Underinsurance coverage shall be subject to ORS 743 792 [1967 c 482 §2 1975 c 390 §1, 1981 c 586 §1, 1983 c 338 §966, 1987 c 632 §1]

743.792 Requirements of uninsured motorist coverage. Every policy required to provide the coverage specified in ORS 743 789 shall provide uninsured motorist coverage which in each instance is no less favorable in any respect to the insured or the beneficiary than if the following provisions were set forth in the policy. However, nothing contained in this section shall require the insurer to reproduce in such policy the particular language of any of the following provisions

(1)(a) The insurer will pay all sums which the insured, the heirs or the legal representative of the insured shall be legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle because of bodily injury sustained by the insured caused by accident and arising out of the ownership, maintenance or use of such uninsured vehicle. Determination as to whether the insured, the insured's heirs or the insured's legal representative is legally entitled to recover such damages, and if so, the amount thereof, shall be made by agreement between the insured and the insurer, or, in the event of disagreement, by arbitration.

(b) No judgment against any person or organization alleged to be legally responsible for bodily injury, except for proceedings instituted against the insurer as provided in this policy, shall be conclusive, as between the insured and the insurer, on the issues of liability of such person or organization or of the amount of damages to which the insured is legally entitled.

(2) As used in this policy

(a) "Insured," when unqualified, means when applied to uninsured motorist coverage

(A) The named insured as stated in the policy and any person designated as named insured in the schedule and, while residents of the same household, the spouse of any such named insured and relatives of either, provided, neither such relative nor spouse is the owner of a vehicle not described in the policy, and provided further, if the named insured as stated in the policy is other than an individual or husband and wife who are residents of the same household, the named insured shall be only a person so designated in the schedule, and

(B) Any other person while occupying an insured vehicle provided the actual use thereof is with the permission of the named insured

(b) "Insured vehicle," except as provided in paragraph (c) of this provision, means

(A) The vehicle described in the policy or a newly acquired or substitute vehicle, as each of those terms is defined in the public liability coverage of the policy, insured under the public liability provisions of the policy, or

(B) A nonowned vehicle operated by the named insured or spouse if a resident of the same household, provided the actual use thereof is with the permission of the owner of such vehicle and such vehicle is not owned by nor furnished for the regular or frequent use of the insured or any member of the same household

(c) "Insured vehicle" does not include a trailer of any type unless such trailer is a described vehicle in the policy

(d) "Uninsured vehicle," except as provided in paragraph (e) of this provision, means

(A) A vehicle with respect to the ownership, maintenance or use of which there is no collectible automobile bodily injury liability insurance or bond, in at least the amounts or limits prescribed for bodily injury or death under ORS 806.070 applicable at the time of the accident with respect to any person or organization legally responsible for the use of such vehicle, or with respect to which there is such collectible bodily injury liability insurance or bond applicable at the time of the accident but the insurance company writing the same denies coverage thereunder or, within two years of the date of the accident, such company writing the same becomes voluntarily or involuntarily declared bankrupt or for which a receiver is appointed or becomes insolvent. It shall be a disputable presumption that a vehicle is uninsured in the event the insured and the insurer, after reasonable efforts, fail to discover within 90 days from the date of the accident, the existence of a valid and collectible automobile bodily injury liability insurance or bond applicable at the time of the accident, or

(B) A hit-and-run vehicle as defined in paragraph (f) of this provision

(C) A phantom vehicle as defined in paragraph (g) of this provision

(e) "Uninsured vehicle" does not include

(A) An insured vehicle,

(B) A vehicle which is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law,

(C) A vehicle which is owned by the United States of America, Canada, a state, a political subdivision of any such government or an agency of any of the foregoing,

(D) A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle,

(E) A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads, or

(F) A vehicle owned by or furnished for the regular or frequent use of the insured or any member of the household of the insured

(f) "Hit-and-run vehicle" means a vehicle which causes bodily injury to an insured arising out of physical contact of such vehicle with the insured or with a vehicle which the insured is occupying at the time of the accident, provided

(A) There cannot be ascertained the identity of either the operator or the owner of such hit-and-run vehicle,

(B) The insured or someone on behalf of the insured shall have reported the accident within 72 hours to a police, peace or judicial officer, to the Motor Vehicles Division of the Department of Transportation of the State of Oregon or to the equivalent department in the state where the accident occurred, and shall have filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof, and

(C) At the insurer's request, the insured or the legal representative of the insured makes available for inspection the vehicle which the insured was occupying at the time of the accident

(g) "Phantom vehicle" means a vehicle which causes bodily injury to an insured arising out of a motor vehicle accident which is caused by an automobile which has no physical contact with the insured or the vehicle which the insured is occupying at the time of the accident, provided

(A) There cannot be ascertained the identity of either the operator or the owner of such phantom vehicle,

(B) The facts of such accident can be corroborated by competent evidence other than the testimony of the insured or any person having an uninsured motorist claim resulting from the accident, and

(C) The insured or someone on behalf of the insured shall have reported the accident within 72 hours to a police, peace or judicial officer, to the Motor Vehicles Division of the Department of Transportation of the State of Oregon or to the equivalent department in the state where the accident occurred, and shall have filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof

(h) "Bodily injury" means bodily injury, sickness or disease, including death resulting therefrom

(i) "Occupying" means in or upon or entering into or alighting from

(j) "State" includes the District of Columbia, a territory or possession of the United States and a province of Canada

(k) "Vehicle" means every device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include devices moved by human power or used exclusively upon stationary rails or tracks

(3) This coverage applies only to accidents which occur on and after the effective date of the policy, during the policy period and within the United States of America, its territories or possessions, or Canada

(4)(a) This coverage does not apply to bodily injury of an insured with respect to which such insured or the legal representative of the insured shall, without the written consent of the insurer, make any settlement with or prosecute to judgment any action against any person or organization who may be legally liable therefor

(b) This coverage does not apply to bodily injury to an insured while occupying a vehicle (other than an insured vehicle) owned by, or furnished for the regular use of, the named insured or any relative resident in the same household, or through being struck by such a vehicle

(c) This coverage does not apply so as to insure directly or indirectly to the benefit of any workers' compensation carrier, any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or any similar law or the State Accident Insurance Fund Corporation

(5)(a) As soon as practicable, the insured or other person making claim shall give to the insurer written proof of claim, under oath if required, including full particulars of the nature and extent of the injuries, treatment and other details entering into the determination of the amount payable hereunder. The insured and every other person making claim hereunder shall submit to examinations under oath by any person named by the insurer and subscribe the same, as often as may reasonably be required. Proof of claim shall be made upon forms furnished by the insurer unless the insurer shall have failed to furnish such forms within 15 days after receiving notice of claim

(b) Upon reasonable request of and at the expense of the insurer, the injured person shall submit to physical examinations by physicians

selected by the insurer and shall, upon each request from the insurer, execute authorization to enable the insurer to obtain medical reports and copies of records

(6) If, before the insurer makes payment of loss hereunder, the insured or the legal representative of the insured shall institute any legal action for bodily injury against any person or organization legally responsible for the use of a vehicle involved in the accident, a copy of the summons and complaint or other process served in connection with such legal action shall be forwarded immediately to the insurer by the insured or the legal representative of the insured

(7)(a) The limit of liability stated in the declarations as applicable to "each person" is the limit of the insurer's liability for all damages because of bodily injury sustained by one person as the result of any one accident and, subject to the above provision respecting each person, the limit of liability stated in the declarations as applicable to "each accident" is the total limit of the company's liability for all damages because of bodily injury sustained by two or more persons as the result of any one accident

(b) Any payment made under this coverage to or for an insured shall be applied in reduction of any amount which the insured may be entitled to recover from any person who is an insured under the bodily injury liability coverage of this policy, and

(c) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by

(A) All sums paid on account of such bodily injury by or on behalf of the owner or operator of the uninsured vehicle and by or on behalf of any other person or organization jointly or severally liable together with such owner or operator for such bodily injury including all sums paid under the bodily injury liability coverage of the policy, and

(B) The amount paid and the present value of all amounts payable on account of such bodily injury under any workers' compensation law, disability benefits law or any similar law

(8) No action shall lie against the insurer unless, as a condition precedent thereto, the insured or the legal representative of the insured has fully complied with all the terms of this policy

(9)(a) Except as provided in paragraph (c) of this subsection, with respect to bodily injury to an insured while occupying a vehicle not owned

by a named insured under this coverage, the insurance under this coverage shall apply only as excess insurance over any other insurance available to such occupant which is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all such other insurance

(b) With respect to bodily injury to an insured while occupying or through being struck by an uninsured vehicle, if such insured is an insured under other insurance available to the insured which is similar to this coverage, then the damages shall be deemed not to exceed the higher of the applicable limits of liability of this insurance or such other insurance, and the insurer shall not be liable under this coverage for a greater proportion of the damages than the applicable limit of liability of this coverage bears to the sum of the applicable limits of liability of this insurance and such other insurance

(c) With respect to bodily injury to an insured while occupying any motor vehicle used as a public or livery conveyance, the insurance under this coverage shall apply only as excess insurance over any other insurance available to the insured which is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all such other insurance

(10) If any person making claim hereunder and the insurer do not agree that such person is legally entitled to recover damages from the owner or operator of an uninsured vehicle because of bodily injury to the insured, or do not agree as to the amount of payment which may be owing under this coverage, then, in the event the insured or the insurer elects to settle the matter by arbitration, the arbitration shall take place under the arbitration laws of the State of Oregon and any judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof provided, however, the costs to the insured of the arbitration proceeding shall not exceed \$100 and that all other costs of arbitration shall be borne by the insurer "Costs" as used in this provision shall not include attorney fees or expenses incurred in the production of evidence or witnesses or the making of transcripts of the arbitration proceedings. Such person and the insurer each agree to consider themselves bound and to be bound by any award made by the arbitrators pursuant to this coverage in the event of such election. At the election of the insured, such arbitration shall be held

(a) In the county and state of residence of the insured,

(b) In the county and state where the insured's cause of action against the uninsured motorist arose, or

(c) At any other place mutually agreed upon by the insured and the insurer

(11) In the event of payment to any person under this coverage

(a) The insurer shall be entitled to the extent of such payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of such person against any uninsured motorist legally responsible for the bodily injury because of which such payment is made,

(b) Such person shall hold in trust for the benefit of the insurer all rights of recovery which the person shall have against such other uninsured person or organization because of the damages which are the subject of claim made under this coverage, but only to the extent that such claim is made or paid herein,

(c) If the insured is injured by the joint or concurrent act or acts of two or more persons, one or more of whom is uninsured, the insured shall have the election to receive from the insurer any payment to which the insured would be entitled under this coverage by reason of the act or acts of the uninsured motorist, or the insured may, with the written consent of the insurer, proceed with legal action against any or all persons claimed to be liable to the insured for such injuries. If the insured elects to receive payment from the insurer under this coverage, then the insured shall hold in trust for the benefit of the insurer all rights of recovery the insured shall have against any other person, firm or organization because of the damages which are the subject of claim made under this coverage, but only to the extent of the actual payment made by the insurer,

(d) Such person shall do whatever is proper to secure and shall do nothing after loss to prejudice such rights,

(e) If requested in writing by the insurer, such person shall take, through any representative not in conflict in interest with such person, designated by the insurer, such action as may be necessary or appropriate to recover such payment as damages from such other uninsured person or organization, such action to be taken in the name of such person, but only to the extent of the payment made hereunder. In the event of a recovery, the insurer shall be reimbursed out of such recovery for expenses, costs and attorney fees incurred by it in connection therewith, and

(f) Such person shall execute and deliver to the insurer such instruments and papers as may be appropriate to secure the rights and obligations of such person and the insurer established by this provision

(12) The parties to this coverage agree that no cause of action shall accrue to the insured under this coverage unless within two years from the date of the accident

(a) Suit for bodily injury has been filed against the uninsured motorist, in a court of competent jurisdiction,

(b) Agreement as to the amount due under the policy has been concluded, or

(c) The insured or the insurer has formally instituted arbitration proceedings [1967 c 482 §3, 1977 c 600 §3, 1979 c 842 §8, 1983 c 338 §967]

743.795 Allocation of responsibility among insurers. Notwithstanding the contrary provisions of any policy, the provisions of ORS 743.792 (9)(a) to (c) shall control allocation of responsibility between insurers, except that if all policies potentially involved expressly allocate responsibility between insurers, or self-insurers, without repugnancy, then the terms of the policies shall control [1979 c 842 §10]

743.796 Definitions for ORS 743.796 and 743.797. As used in this section and ORS 743.797

(1) "Covered motor vehicle" means a private passenger motor vehicle or a self-propelled mobile home that is owned by the named insured for which a premium has been paid for coverage under this section and ORS 743.797

(2) "Insured vehicle" means a motor vehicle described in the declarations for which a specific premium charge indicates that underinsured motorists coverage is afforded but the term "insured vehicle" shall not include a vehicle while used as a public or livery conveyance

(3) "Private passenger motor vehicle" means a four-wheel passenger or station wagon type motor vehicle not more than 12 years old and not used as a public or livery conveyance, and includes any other four-wheel motor vehicle of the utility, pickup body, sedan delivery or panel truck type not used for wholesale or retail delivery

(4)(a) "Uninsured vehicle" means

(A) A vehicle with respect to the ownership, maintenance or use of which there is no collectible property damage insurance or bond, in at least the amounts or limits prescribed under ORS 806.070 (2)(c) applicable at the time of the acci-

dent with respect to any person or organization legally responsible for the use of such vehicle, or with respect to which there is such collectible insurance or bond applicable at the time of the accident but the insurance company writing the same denies coverage thereunder or, within two years of the date of the accident, such company writing the same becomes voluntarily or involuntarily declared bankrupt or for which a receiver is appointed or becomes insolvent. It shall be a disputable presumption that a vehicle is uninsured in the event the insured and the insurer, after reasonable efforts, fail to discover within 90 days from the date of the accident, the existence of valid and collectible property damage insurance or bond applicable at the time of the accident.

(B) A hit-and-run vehicle as defined in subsection (5) of this section.

(C) A phantom vehicle as defined in subsection (5) of this section.

(b) As used in this section and ORS 743 797, "uninsured vehicle" does not include

(A) An insured vehicle,

(B) A vehicle which is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law,

(C) A vehicle which is owned by the United States of America, Canada, a state, a political subdivision of any such government or an agency of any of the foregoing,

(D) A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle,

(E) A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads, or

(F) A vehicle owned by or furnished for the regular or frequent use of the insured or any member of the household of the insured.

(5) As used in this section.

(a) "Hit-and-run vehicle" means a vehicle that causes damage to the covered vehicle of an insured arising out of physical contact between the vehicles, provided

(A) There cannot be ascertained the identity of either the operator or the owner of such hit-and-run vehicle;

(B) The insured or someone on behalf of the insured reports the accident within 72 hours to a police, peace or judicial officer, to the Motor Vehicles Division of the Department of Trans-

portation or to the equivalent department in the state where the accident occurred, and files with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof, and

(C) At the insurer's request, the insured or the legal representative of the insured makes available for inspection the vehicle which was insured at the time of the accident.

(b) "Phantom vehicle" means a vehicle that causes damage to the covered vehicle of an insured, although there is no physical contact between the vehicles, provided

(A) There cannot be ascertained the identity of either the operator or the owner of such phantom vehicle,

(B) The facts of such accident can be corroborated by competent evidence other than the testimony of the insured or any passenger in the insured motor vehicle, and

(C) The insured or someone on behalf of the insured shall have reported the accident within 72 hours to a police, peace or judicial officer, to the Motor Vehicles Division of the Department of Transportation or to the equivalent department in the state where the accident occurred, and shall have filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof [1987 c 742 §3]

Note. 743 796 and 743 797 were enacted into law by the Legislative Assembly and were added to and made a part of ORS chapter 796 but not to any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.797 Property damage coverage for damage to vehicle caused by uninsured vehicle. (1) Every insurer issuing motor vehicle liability insurance policies on private passenger motor vehicles or on self-propelled mobile homes for delivery in this state shall have for sale coverage for property damage to a vehicle of the insured caused by an uninsured vehicle. Coverage offered under this section shall be at least the amount prescribed to meet the requirements of ORS 806 070 for insurance for injury to or destruction of the property of others in any one accident.

(2) A policy with the coverage described in this section does not cover the first \$300 of property damage to the covered motor vehicle as the result of an accident with a hit-and-run vehicle or phantom vehicle. In all other cases the first \$200 damage is not covered.

(3) Coverage for property damage described in this section applies only to the amount of damages the insured may be legally entitled to recover [1987 c 742 §2]

Note See note under 743 796

743.800 Personal injury protection benefits for motor vehicle liability policies; applicability; definitions for ORS 743.800 to 743.835. (1) Every motor vehicle liability policy issued for delivery in this state that covers any private passenger motor vehicle shall provide personal injury protection benefits to the person insured thereunder, members of that person's family residing in the same household, passengers occupying the insured motor vehicle and pedestrians struck by the insured motor vehicle. "Personal injury protection benefits" means the benefits described in this section and ORS 743 805 and 743 815

(2) Personal injury protection benefits apply to a person's injury or death resulting

(a) In the case of the person insured under the policy and members of that person's family residing in the same household, from the use or maintenance of any motor vehicle, except the following vehicles

(A) A motor vehicle, including a motorcycle or moped, which is owned by any of such persons and which is not covered by a motor vehicle liability insurance policy that provides personal injury protection benefits with respect to the use and maintenance of that vehicle,

(B) A motorcycle or moped which is not owned by any of such persons, but this exclusion applies only when the injury or death results from such person's operating or riding upon the motorcycle or moped, and

(C) A motor vehicle not included in subparagraph (A) or (B) of this paragraph and not a private passenger motor vehicle. However, this exclusion applies only when the injury or death results from such person's operating or occupying the motor vehicle

(b) In the case of a passenger occupying or a pedestrian struck by the insured motor vehicle, from the use or maintenance of the vehicle

(3) Personal injury protection benefits consist of payments for expenses, loss of income and

loss of essential services as provided in ORS 743 805

(4) An insurer shall pay all personal injury protection benefits promptly after proof of loss has been submitted to the insurer

(5) The potential existence of a cause of action in tort does not relieve an insurer from the duty to pay personal injury protection benefits

(6) Disputes between insurers and beneficiaries about the amount of personal injury protection benefits, or about the denial of personal injury protection benefits, shall be decided by arbitration

(7) As used in ORS 743 800 to 743 835

(a) "Motor vehicle" means a self-propelled land motor vehicle or trailer, other than

(A) A farm type tractor or other self-propelled equipment designed for use principally off public roads, while not upon public roads,

(B) A vehicle operated on rails or crawler-treads, or

(C) A vehicle located for use as a residence or premises

(b) "Motorcycle" and "moped" have the meanings given those terms in ORS 801 345 and 801 365

(c) "Occupying" means in, or upon, or entering into or alighting from

(d) "Pedestrian" means a person while not occupying a self-propelled vehicle

(e) "Private passenger motor vehicle" means a four-wheel passenger or station wagon type motor vehicle not used as a public or livery conveyance, and includes any other four-wheel motor vehicle of the utility, pickup body, sedan delivery or panel truck type not used for wholesale or retail delivery other than farming, a self-propelled mobile home, and a farm truck [1971 c 523 §2, 1973 c 551 §1, 1975 c 784 §1, 1979 c 871 §45, 1981 c 414 §1, 1983 c 338 §968, 1987 c 588 §1]

743.802 Binding arbitration under ORS 743.800; costs. (1) Arbitration under ORS 743 800 (6) is binding on the parties to the arbitration

(2) Costs to the insured of the arbitration proceeding shall not exceed \$100 and all other costs of arbitration shall be borne by the insurer. As used in this subsection, "costs" does not include attorney fees or expenses incurred in the production of evidence or witnesses or the making of transcripts of the arbitration proceedings. [1987 c 588 §5]

743.805 Contents of personal injury protection benefits; deductibles. (1) Personal injury protection benefits as required by ORS 743 800 shall consist of the following payments for the injury or death of each person

(a) All reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services incurred within one year after the date of the person's injury, but not more than \$5,000 in the aggregate for all such expenses of the person. Expenses of medical, hospital, dental, surgical, ambulance and prosthetic services shall be presumed to be reasonable and necessary unless the provider is given notice of denial of the charges not more than 60 business days after the insurer receives from the provider notice of the claim for the services. At any time during the first 50 days after the insurer receives notice of claim, the provider shall, within 10 business days, answer in writing questions from the insurer regarding the claim. For purposes of determining when the 60-day period provided by this paragraph has elapsed, counting of days shall be suspended if the provider does not supply written answers to the insurer within 10 days and shall not resume until the answers are supplied.

(b) If the injured person is usually engaged in a remunerative occupation and if disability continues for at least 14 days, 70 percent of the loss of income from work during the period of the injured person's disability until the date the person is able to return to the person's usual occupation. This benefit is subject to a maximum payment of \$750 per month and a maximum payment period in the aggregate of 52 weeks. As used in this paragraph, "income" includes but is not limited to salary, wages, tips, commissions, professional fees and profits from an individually owned business or farm.

(c) If the injured person is not usually engaged in a remunerative occupation and if disability continues for at least 14 days, the expenses reasonably incurred by the injured person for essential services in lieu of the services the person would have performed without income during the period of the person's disability until the date the person is reasonably able to perform such essential services. This benefit is subject to a maximum payment of \$18 per day and a maximum payment period in the aggregate of 52 weeks.

(d) All reasonable and necessary funeral expenses incurred within one year after the date of the person's injury, but not more than \$1,000.

(2) With respect to the insured person and members of that person's family residing in the

same household, an insurer may offer forms of coverage for the benefits required by paragraphs (a), (b) and (c) of subsection (1) of this section with deductibles of up to \$250 [1971 c 523 §3, 1973 c 551 §2, 1975 c 784 §2, 1981 c 414 §2, 1987 c 588 §2]

743.810 Primary nature of benefits.

(1) The personal injury protection benefits with respect to

(a) The insured and members of the family of the insured residing in the same household injured while occupying the insured motor vehicle shall be primary

(b) Passengers injured while occupying the insured motor vehicle shall be primary

(c) The insured and members of family residing in the same household injured as pedestrians shall be primary

(d) The insured and members of family residing in the same household injured while occupying a motor vehicle not insured under the policy shall be excess

(e) Pedestrians injured by the insured motor vehicle, other than the insured and members of family residing in the same household, shall be excess over any other collateral benefits to which the injured person is entitled, including but not limited to insurance benefits, governmental benefits or gratuitous benefits

(2) The personal injury protection benefits may be reduced or eliminated, if it is so provided in the policy, when the injured person is entitled to receive, under the laws of this state or any other state or the United States, workers' compensation benefits or any other similar medical or disability benefits [1971 c 523 §4, 1973 c 551 §4, 1975 c 784 §3]

743.812 Notice of denial of payment of benefits. An insurer who denies payment of personal injury protection benefits to or on behalf of an insured shall

(1) Provide written notice of the denial, within 60 calendar days of receiving a claim from the provider, to the insured, stating the reason for the denial and informing the insured of the method for contesting the denial,

(2) Provide a copy of the notice of the denial, within 60 calendar days of receiving a claim from the provider, to a provider of services under ORS 743 805 (1)(a), and

(3) Provide a copy of the notice required by this section to the director [1987 c 588 §4]

743.815 Exclusions from coverage. (1) The insurer may exclude from the coverage for

personal injury protection benefits any injured person who

(a) Intentionally causes self-injury, or

(b) Is participating in any prearranged or organized racing or speed contest or practice or preparation for any such contest

(2) The insurer may exclude from the coverage for the benefits required by ORS 743 805 (1)(b) and (c) any person injured as a pedestrian in an accident outside this state, other than the insured person or a member of that person's family residing in the same household [1971 c 523 §5, 1973 c 551 §3, 1975 c 784 §4 1981 c 414 §3]

743.820 Benefits may be more favorable than those required by ORS 743.800, 743.805 and 743.815. Nothing in ORS 743 800 to 743 835 is intended to prevent an insurer from providing more favorable benefits than the personal injury protection benefits described in ORS 743 800, 743 805 and 743 815 [1971 c 523 §6, 1975 c 784 §5 1981 c 414 §4]

743.825 Reimbursement of other insurers paying benefits; arbitrating issues of liability and amount of reimbursement.

(1) Every authorized motor vehicle liability insurer whose insured is or would be held legally liable for damages for injuries sustained in a motor vehicle accident by a person for whom personal injury protection benefits have been furnished by another such insurer, or for whom benefits have been furnished by an authorized health insurer, shall reimburse such other insurer for the benefits it has so furnished if it has requested such reimbursement, has not given notice as provided in ORS 743 828 that it elects recovery by lien in accordance with that section and is entitled to reimbursement under this section by the terms of its policy. Reimbursement under this subsection, together with the amount paid to injured persons by the liability insurer, shall not exceed the limits of the policy issued by the insurer

(2) In calculating such reimbursement, the amount of benefits so furnished shall be diminished in proportion to the amount of negligence attributable to the person for whom benefits have been so furnished, and the reimbursement shall not exceed the amount of damages legally recoverable by the person

(3) Disputes between insurers as to such issues of liability and the amount of reimbursement required by this section shall be decided by arbitration

(4) Findings and awards made in such an arbitration proceeding are not admissible in any

action at law or suit in equity [1971 c 523 §7, 1975 c 784 §6 1987 c 569 §4, 1987 c 632 §2]

743.828 Notice of claim or legal action to insurer; insurer to elect manner of recovery of benefits furnished; lien of insurer. (1) When an authorized motor vehicle liability insurer has furnished personal injury protection benefits, or an authorized health insurer has furnished benefits, for a person injured in a motor vehicle accident, if such injured person makes claim, or institutes legal action, for damages for such injuries against any person, such injured person shall give notice of such claim or legal action to the insurer by personal service or by registered or certified mail. Service of a copy of the summons and complaint or copy of other process served in connection with such a legal action shall be sufficient notice to the insurer, in which case a return showing service of such notice shall be filed with the clerk of the court but shall not be a part of the record except to give notice

(2) The insurer may elect to seek reimbursement as provided in this section for benefits it has so furnished, out of any recovery under such claim or legal action, if the insurer has not been a party to an interinsurer reimbursement proceeding with respect to such benefits under ORS 743 825 and is entitled by the terms of its policy to the benefit of this section. The insurer shall give written notice of such election within 30 days from the receipt of notice or knowledge of such claim or legal action to the person making claim or instituting legal action and to the person against whom claim is made or legal action instituted, by personal service or by registered or certified mail. In the case of a legal action, a return showing service of such notice of election shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the claimant and the defendant of the lien of the insurer

(3) If the insurer so serves such written notice of election and, where applicable, such return is so filed

(a) The insurer has a lien against such cause of action for benefits it has so furnished, less the proportion, not to exceed 100 percent, of expenses, costs and attorney fees incurred by the injured person in connection with the recovery that the amount of the lien before such reduction bears to the amount of the recovery

(b) The injured person shall include as damages in such claim or legal action the benefits so furnished by the insurer

(c) In the case of a legal action, the action shall be taken in the name of the injured person

(4) As used in this section, "makes claim" or "claim" refers to a written demand made and delivered for a specific amount of damages and which meets other requirements reasonably established by the director's rule [1975 c 784 §8]

743.830 Subrogation rights of insurers to certain amounts received by claimant, recovery actions against persons causing injury. If a motor vehicle liability insurer has furnished personal injury protection benefits, or a health insurer has furnished benefits, for a person injured in a motor vehicle accident, and the interinsurer reimbursement benefit of ORS 743 825 is not available under the terms of that section, and the insurer has not elected recovery by lien as provided in ORS 743 828, and is entitled by the terms of its policy to the benefit of this section

(1) The insurer is entitled to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the injured person against any person legally responsible for the accident, to the extent of such benefits furnished by the insurer less the insurer's share of expenses, costs and attorney fees incurred by the injured person in connection with such recovery

(2) The injured person shall hold in trust for the benefit of the insurer all such rights of recovery which the injured person has, but only to the extent of such benefits furnished

(3) The injured person shall do whatever is proper to secure, and shall do nothing after loss to prejudice, such rights

(4) If requested in writing by the insurer, the injured person shall take, through any representative not in conflict in interest with the injured person designated by the insurer, such action as may be necessary or appropriate to recover such benefits furnished as damages from such responsible person, such action to be taken in the name of the injured person, but only to the extent of the benefits furnished by the insurer. In the event of a recovery, the insurer shall also be reimbursed out of such recovery for the injured person's share of expenses, costs and attorney fees incurred by the insurer in connection with the recovery

(5) In calculating respective shares of expenses, costs and attorney fees under this section, the basis of allocation shall be the respective proportions borne to the total recovery by

(a) Such benefits furnished by the insurer, and

(b) The total recovery less (a)

(6) The injured person shall execute and deliver to the insurer such instruments and

papers as may be appropriate to secure the rights and obligations of the insurer and the injured person as established by this section

(7) Any provisions in a motor vehicle liability insurance policy or health insurance policy giving rights to the insurer relating to subrogation or the subject matter of this section shall be construed and applied in accordance with the provisions of this section [1971 c 523 §8, 1975 c 784 §9]

743 833 Rules. The director shall have authority to issue such rules as are reasonably necessary to carry out the purposes of ORS 743 800 to 743 835 [1975 c 784 §12]

743.835 Effect of personal injury protection benefits paid. Payment by a motor vehicle liability insurer of personal injury protection benefits for its own insured shall be applied in reduction of the amount of damages that the insured may be entitled to recover from the insurer under uninsured motorist coverage for the same accident but may not be applied in reduction of the uninsured motorist coverage policy limits [1971 c 523 §9, 1975 c 784 §10 1987 c 632 §3]

743.840 Disputes over coverage for physical damage; independent appraisal; rules. (1) In the event of a dispute between the insurer and insured under a motor vehicle liability policy concerning coverage for physical damage, if the policy contains a provision authorizing the insured to obtain an independent appraisal by a disinterested party of the physical damage, that provision shall apply

(2) If a motor vehicle liability policy does not contain a provision described in subsection (1) of this section, then notwithstanding any other provision of the policy, any resolution of the dispute shall be subject to rules adopted by the director [1985 c 527 §2]

CONTINUATION AND CONVERSION OF GROUP HEALTH COVERAGE

743.850 Continuation of coverage under group policy upon termination of employment or membership or dissolution of marriage; applicability of waiting period to rehired employe. (1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that certificate holders whose coverage under the policy otherwise would terminate because of termination of employment or membership may continue coverage under the policy for themselves and their eligible dependents as provided in this section

(2) Continuation of coverage shall be available only to a certificate holder who has been insured continuously under the policy or similar predecessor policy during the three-month period ending on the date of the termination of employment or membership

(3) Continuation of coverage shall not be available to a certificate holder who is eligible for

(a) Federal Medicare coverage, or

(b) Coverage for hospital or medical expenses under any other program which was not covering the certificate holder immediately before the certificate holder's termination of employment or membership

(4) The continued coverage need not include benefits for dental, vision care or prescription drug expense, or any other benefits under the policy additional to hospital and medical expense benefits

(5) A certificate holder who has terminated employment or membership and who wishes to continue coverage must request continuation in writing not later than 10 days after the later of the date on which employment or membership terminated and the date on which the employer or group policyholder gave the certificate holder notice of the right to continue coverage. However, a certificate holder may not make a request for continuation more than 31 days after the date of termination of employment or membership

(6) A certificate holder who requests continuation of coverage must pay the premium on a monthly basis and in advance, as provided in this subsection. The certificate holder shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment may not exceed the group premium rate, for the insurance being continued under the group policy, as of the date the premium payment is due. The certificate holder must pay the first premium not later than 31 days after the date on which the certificate holder's coverage under the policy otherwise would end

(7) Continuation of coverage as provided under this section shall end upon the earliest of the following dates

(a) Six months after the date on which the certificate holder's coverage under the policy otherwise would have ended because of termination of employment or membership

(b) The end of the period for which the certificate holder last made timely premium payment, if the certificate holder fails to make timely payment of a required premium payment

(c) The premium payment due date coinciding with or next following the date the certificate holder becomes eligible for federal Medicare coverage

(d) The date on which the policy is terminated or the certificate holder's employer terminates participation under the policy. However, if the employer replaces the coverage which is terminating for the certificate holder with similar coverage under another group policy

(A) The certificate holder may obtain coverage under the replacement group policy for the balance of the period that the certificate holder would have remained covered under the replaced group policy under this section,

(B) The minimum level of benefits to be provided the certificate holder by the replacement group policy shall be the applicable level of benefits of the replaced policy reduced by any benefits still payable under that policy, and

(C) The replaced policy shall continue to provide benefits to the certificate holder to the extent of that policy's accrued liabilities and extensions of benefits as if the replacement had not occurred

(8) The group health insurance policy also shall contain a provision that

(a) The surviving spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.851 may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death, in the same manner that a certificate holder may exercise the right under this section

(b) The spouse of a certificate holder, if any, who is not eligible for continuation of coverage under ORS 743.851 may continue coverage under the policy, upon dissolution of marriage with the certificate holder, with respect to the spouse and any children whose coverage under the policy otherwise would terminate because of the dissolution of marriage, in the same manner that a certificate holder may exercise the right under this section

(c) A spouse who requests continuation of coverage under this subsection must pay the premium for the spouse and any dependent children, on a monthly basis and in advance, as provided in this paragraph. The spouse shall pay the premium to the insurer or to the employer or policyholder, whichever the group policy provides. The required premium payment under this subsection may not exceed the group premium

rate, for the insurance being continued under the group policy, as of the date the premium payment is due

(9) A certificate holder who has terminated employment by reason of layoff shall not be subject upon any rehire that occurs within six months of the time of the layoff to any waiting period prerequisite to coverage under the employer's group health insurance policy if the certificate holder was eligible for coverage at the time of the termination and regardless of whether the certificate holder continued coverage during the layoff

(10) This section applies only to employers who are not required to make available continuation of health insurance benefits under Titles X and XXII of the Consolidated Omnibus Reconciliation Act of 1985, as amended, P L 99-272, April 7, 1986 [1981 c 752 §1, 1983 c 817 §1, 1987 c 505 §1]

743.851 Availability of continued coverage under group policy for surviving, divorced or separated spouse 55 or older.

(1) A group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that

(a) The surviving spouse of a certificate holder may continue coverage under the policy, at the death of the certificate holder, with respect to the spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death of the certificate holder if the surviving spouse is 55 years of age or older at the time of the death, and

(b) The divorced or legally separated spouse of a certificate holder may continue coverage under the policy, upon dissolution of marriage with, or legal separation from, the certificate holder, with respect to the divorced or legally separated spouse and any dependent children whose coverage under the policy otherwise would terminate because of the dissolution of marriage or legal separation, if the divorced or legally separated spouse is 55 years of age or older at the time of the dissolution or legal separation

(2) Continued coverage for dental, vision care or prescription drug expenses shall be offered to legally separated, divorced or surviving spouses and any dependent children eligible under subsection (1) of this section if such coverage is or was available to the certificate holder [1987 c 505 §3]

Note 743.851, 743.852 and 743.853 were added to and made a part of ORS chapter 743 but were not added to any smaller series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

743.852 Procedure for obtaining continuation of coverage under ORS 743.851.

(1) As used in subsections (1) to (6) of this section, "plan administrator" means

(a) The person designated as the plan administrator by the instrument under which the group health insurance plan is operated, or

(b) If no plan administrator is designated, the plan sponsor

(2) Within 60 days of legal separation or the entry of a decree of dissolution of marriage, a legally separated or divorced spouse eligible for continued coverage under ORS 743.851 who seeks such coverage shall give the plan administrator written notice of the legal separation or dissolution. The notice shall include the mailing address of the legally separated or divorced spouse

(3) Within 30 days of the death of a certificate holder whose surviving spouse is eligible for continued coverage under ORS 743.851, the group policy holder shall give the plan administrator written notice of the death and of the mailing address of the surviving spouse

(4) Within 14 days of receipt of notice under subsection (2) or (3) of this section, the plan administrator shall notify the legally separated, divorced or surviving spouse that the policy may be continued. The notice shall be mailed to the mailing address provided to the plan administrator and shall include

(a) A form for election to continue the coverage,

(b) A statement of the amount of periodic premiums to be charged for the continuation of coverage and of the method and place of payment, and

(c) Instructions for returning the election form by mail within 60 days after the date of mailing of the notice by the plan administrator

(5) Failure of the legally separated, divorced or surviving spouse to exercise the election in accordance with subsection (4) of this section shall terminate the right to continuation of benefits

(6) If a plan administrator fails to notify the legally separated, divorced or surviving spouse as required by subsection (4) of this section, premiums shall be waived from the date the notice was required until the date notice is received by the legally separated, divorced or surviving spouse

(7) The provisions of ORS 107.092 and 743.850 to 743.853 apply only to employers with

20 or more employes and group health insurance plans with 20 or more certificate holders [1987 c 505 §§3a 4]

Note See note under 743 851

743.853 Premium for continuation of coverage under ORS 743.851; termination of right to continuation. If a legally separated, divorced or surviving spouse elects continuation of coverage under ORS 743 852 (1) to (6)

(1) The monthly premium for the continuation shall not be greater than the amount that would be charged if the legally separated, divorced or surviving spouse were a current certificate holder of the group plan plus the amount that the group policy holder would contribute toward the premium if the legally separated, divorced or surviving spouse were a certificate holder of the group plan, plus an additional amount not to exceed two percent of the certificate holder and group plan holder contributions, for the costs of administration

(2) The first premium shall be paid by the legally separated, divorced or surviving spouse within 45 days of the date of the election

(3) The right to continuation of coverage shall terminate upon the earliest of any of the following

(a) The failure to pay premiums when due, including any grace period allowed by the policy,

(b) The date that the group policy is terminated as to all group members except that if a different group policy is made available to group members, the legally separated, divorced or surviving spouse shall be eligible for continuation of coverage as if the original policy had not been terminated,

(c) The date on which the legally separated, divorced or surviving spouse becomes insured under any other group health plan,

(d) The date on which the legally separated, divorced or surviving spouse remarries and becomes covered under another group health plan, or

(e) The date on which the legally separated, divorced or surviving spouse becomes eligible for federal Medicare coverage [1987 c 505 §5]

Note See note under 743 851

743.855 Conversion of coverage under group policy to individual policy. (1) Except as provided in subsection (10) of this section, a group health insurance policy providing coverage for hospital or medical expenses, other than coverage limited to expenses from accidents or specific diseases, shall contain a provision that a

certificate holder whose insurance under the policy terminates may obtain an individual health insurance policy from the insurer without furnishing evidence of insurability Coverage under the individual policy shall be provided according to ORS 743 860

(2) The individual health insurance policy need not be made available to a certificate holder if the certificate holder's coverage under the group policy terminates for any of the following reasons

(a) Because of termination of the certificate holder's employment or membership and the certificate holder either is not entitled to obtain, or fails to request, continued coverage under the group policy

(b) Because the certificate holder failed to make timely payment of a required contribution under the group policy

(c) Because the group policy terminated or the certificate holder's employer terminated participation under the policy and the insurance is replaced by similar coverage under another group policy not later than 31 days after the date of the termination

(3) To obtain the individual health insurance policy, the certificate holder must submit a written application and the first premium payment for the coverage not later than 31 days after the date on which the certificate holder's coverage terminated under the group policy The individual policy shall become effective on the day following the termination of coverage under the group policy

(4) The insurer shall determine the premium for the individual policy in accordance with the insurer's table of premium rates applicable to the age and class of risk of each individual to be covered under the policy and the type and amount of insurance provided

(5) The individual policy shall cover the certificate holder and the dependents of the certificate holder who were covered by the group policy immediately before the termination of insurance under that policy, except that an insurer may issue a separate individual policy to provide coverage for one or more dependents Coverage under the separate individual policy shall be the same as the individual policy coverage provided the certificate holder

(6) The insurer is not required to provide coverage for an individual under an individual policy issued pursuant to this section if

(a) The individual is eligible for federal Medicare coverage, or

(b) The individual is covered under another individual policy providing benefits similar to those under the group policy, or is eligible for similar benefits under any state or federal law or group coverage program whether insured or uninsured, and the benefits available from these sources together with the benefits available under the individual policy issued pursuant to this section would result in overinsurance according to the insurer's standards. An individual policy issued under this section may provide that the insurer at any time may request information of any individual covered under the policy in order to determine whether the individual is covered or is eligible for benefits described in this paragraph.

(7) An individual policy issued under this section may provide that the insurer may refuse to renew the policy or the coverage of any insured individual as of any premium due date, but only for one or more of the following reasons:

(a) That the benefits described in paragraph (b) of subsection (6) of this section for which the individual is covered or is eligible, together with benefits under the individual policy issued under this section, would result in overinsurance according to the insurer's standards.

(b) That the insured individual has failed to provide information requested under subsection (6) of this section.

(c) That the individual has committed fraud or made a material misrepresentation in applying for any benefits under the individual policy.

(d) That the individual is eligible for federal Medicare coverage.

(e) Any other reason that the director allows by rule.

(8) The insurer shall not be required under this section to issue an individual policy providing hospital and medical benefits in excess of the benefits provided under the group policy giving rise to the issuance of the individual policy.

(9) The individual policy shall not exclude as a preexisting condition any condition covered by the group policy. However, the individual policy may provide that hospital and medical expense benefits under the policy may be reduced by the amount of benefits payable for this expense under the group policy. The individual policy also may provide that, during the first policy year, the benefits payable under the individual policy and the benefits payable under the group policy shall not exceed in total the benefits that would have been payable had the individual's coverage under the group policy remained in force.

(10) Instead of issuing an individual policy as provided in this section, the insurer may provide

coverage under a group policy that is at least as favorable to each individual exercising the right to obtain coverage [1981 c 752 §2]

743.860 Individual policy plans. (1) The certificate holder may obtain an individual policy issued under ORS 743 855 under one of the following plans, as selected by the certificate holder:

(a) Plan A, covering

(A) Daily hospital room and board expenses, in a maximum daily amount approximating the average semiprivate room rate charged in the major metropolitan area of this state, for a maximum duration of 70 days,

(B) Miscellaneous hospital expenses up to a maximum amount of 10 times the daily hospital room and board expense benefit, and

(C) Surgical expenses according to a surgical procedures schedule consistent with those customarily offered by the insurer under group or individual health insurance policies and providing a maximum benefit of \$800.

(b) Plan B, providing the same coverage as Plan A under this subsection except that

(A) The maximum hospital room and board daily expense benefit is 75 percent of the corresponding maximum under Plan A, and

(B) The maximum surgical expense benefit is \$600.

(c) Plan C, providing the same coverage as Plan A under this subsection except that

(A) The maximum hospital room and board daily expense benefit is 50 percent of the corresponding maximum under Plan A, and

(B) The maximum surgical expense benefit is \$400.

(2) The director shall determine by rule the maximum hospital room and board daily expense benefit to be provided under Plan A in subsection (1) of this section. The director may redetermine by rule, from time to time, the amount of that maximum for individual policies issued under Plan A subsequent to the redetermination. The director shall not make a redetermination more often than once every three years. In determining the maximum hospital room and board daily expense benefit for Plans A, B and C, the director shall round the actual amounts to the nearer multiple of \$10 [1981 c 752 §3]

743.865 Alternative plans for conversion. An insurer may offer plans for conversion of group health insurance coverage to individual health insurance coverage in addition to the plans required by ORS 743 860. If an insurer custom-

arily offers individual policies on a service basis, the insurer may make available individual policies on a service basis rather than on an expense-incurred basis, upon approval of the individual policies for this purpose by the director. A health maintenance organization qualified pursuant to Title XIII of the Public Health Service Act (42 U S C 300e et seq) is required to make available only coverage under an individual policy which meets the requirements of that Act [1981 c 752 §4]

743.870 Availability of coverage under group or individual policy for retired certificate holder. If a group health insurance policy allows a certificate holder to continue coverage under the group policy after retirement and before the certificate holder is eligible for federal Medicare coverage, the certificate holder either may continue the group coverage or may exercise the right to convert the group coverage to individual coverage as if the group coverage had terminated at retirement [1981 c 752 §5]

743.875 Reduction or termination of coverage under individual policy upon eligibility for Medicare. The individual policy issued under ORS 743 860 may provide for reduction or termination of coverage of any individual upon eligibility for federal Medicare coverage or coverage under any other state or federal law providing for benefits similar to those provided by the individual policy [1981 c 752 §6]

743.880 Availability of coverage under individual policy to persons other than certificate holder As provided in this section and notwithstanding ORS 743 855 (2)(a), the following persons may exercise the right to obtain coverage under an individual health insurance policy in the same manner that a certificate holder may exercise that right under ORS 743 855 to 743 875

(1) The surviving spouse of the certificate holder, if any, may exercise the right within 31 days following the death of the certificate holder or at anytime thereafter during the period that coverage under the policy is continued under ORS 743 850 (8)

(2) If there is no surviving spouse, each surviving child may exercise the right within 31 days following the death of the certificate holder, or at anytime thereafter during the period that coverage under the policy is continued if the group policy provides for continuation of dependents' coverage following the certificate holder's death

(3) The spouse of the certificate holder may exercise the right if the coverage of the spouse under the group policy ends because the spouse is

no longer a qualified family member. The spouse may exercise the right, with respect to the spouse and any children whose coverage under the group policy terminates at the same time, within 31 days following the date on which coverage under the group policy would terminate because the spouse is no longer a qualified family member or at any time thereafter during the period that coverage under the group policy is continued under ORS 743 850 (8)

(4) A child of a certificate holder may exercise the right solely with respect to the child if coverage terminates because the child is no longer a qualified family member under the group policy and if the right to obtain individual coverage is not otherwise provided under this section. The child must exercise the right within 31 days following the date on which coverage under the group policy terminates because the child is no longer a qualified family member [1981 c 752 §7]

743.885 Individual policy benefits substantially similar to group policy. If the benefits required under ORS 743 860 exceed the benefits provided under the group policy, the individual policy may offer benefits substantially similar to those provided under the group policy instead of those required under ORS 743 860 [1981 c 752 §8]

743.890 Out-of-state individual policy form. An individual policy issued under ORS 743 855 and delivered outside this state may be on a form meeting the requirements of the jurisdiction of delivery for an individual policy issued as a conversion from a group policy delivered in that jurisdiction [1981 c 752 §9]

CANCELLATION OF AUTOMOBILE LIABILITY POLICIES

743.900 Definitions for ORS 743.900 to 743.930. As used in ORS 743 900 to 743 930

(1) "Policy" means any insurance policy which provides automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage or automobile physical damage coverage on individually owned private passenger vehicles including pickup and panel trucks and station wagons, which are not used as a public or livery conveyance for passengers, nor rented to others, provided, however, that ORS 743 900 to 743 930 shall not apply to any policy

(a) Issued under an automobile assigned risk plan,

(b) Insuring more than four automobiles,

(c) Covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards, or

(d) Issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of such insured or on the ways immediately adjoining such premises

(2) "Renewal" or "to renew" means to continue coverage for an additional policy period upon expiration of the current policy period of a policy. Any policy with a policy period or term of less than six months shall for the purpose of ORS 743 900 to 743 930 be considered as if written for a policy period or term of six months. Any policy written for a term longer than one year or any policy with no fixed expiration date shall for the purpose of ORS 743 900 to 743 930 be considered as if written for successive policy periods or terms of one year but not extending beyond the actual term for which the policy was written

(3) "Nonpayment of premium" means failure of the named insured to discharge when due any of the insured's obligations in connection with the payment of premiums on the policy, or any instalment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit

(4) "Cancellation" means termination of coverage by an insurer, other than termination at the request of the insured, during a policy period

(5) "Nonrenewal" means a notice by an insurer to the named insured that the insurer is unwilling to renew a policy

(6) "Expiration" means termination of coverage by reason of the policy having reached the end of the term for which it was issued or the end of the period for which a premium has been paid [1971 c 476 §2, 1975 c 570 §1]

743.905 Grounds for cancellation of policies; notice required; applicability. (1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons

(a) Nonpayment of premium,

(b) Fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder, or violation of any of the terms or conditions of the policy, or

(c) The named insured or any operator either resident in the same household or who customarily operates an automobile insured under the policy has had driver's license suspended or revoked pursuant to law during the policy period, or, if the policy is a renewal, during its policy

period or the 180 days immediately preceding its effective date

(2) This section shall not apply to any policy or coverage which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy

(3) This section shall not apply to non-renewal [1971 c 476 §3]

743.910 Manner of giving cancellation notice. (1) No notice of cancellation of a policy to which ORS 743 905 applies shall be effective unless mailed or delivered by the insurer to the named insured at least 20 days prior to the effective date of cancellation and accompanied by a statement of the reason or reasons for cancellation, provided, however, that where cancellation is for nonpayment of premium at least 10 days' notice of cancellation accompanied by the reason therefor shall be given

(2) This section shall not apply to non-renewal [1971 c 476 §4, 1977 c 600 §7]

743 915 [1971 c 476 §5, repealed by 1975 c 570 §2 (743 916 enacted in lieu of 743 915)]

743.916 Renewal of policies; requirements for refusal to renew. (1) An insurer shall offer renewal of a policy, contingent upon payment of premium as stated in the offer, to an insured unless the insurer mails or delivers to the named insured, at the address shown in the policy, at least 20 days' advance notice of non-renewal. Such notice shall contain or be accompanied by a statement of the reason or reasons for nonrenewal

(2) The insurer shall not be required to notify the named insured or any other insured of non-renewal of the policy if the insurer has mailed or delivered a notice of expiration or cancellation on or prior to the 20th day preceding expiration of the policy period

(3) Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any replacement or succeeding automobile insurance policy, with respect to any automobile designated in both policies [1975 c 570 §3 (enacted in lieu of 743 915), 1977 c 600 §8]

743.920 Proof of cancellation or non-renewal notice. Proof of mailing notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy, shall be sufficient proof of notice. [1971 c 476 §6]

743.925 Notifying insured under canceled or unrenewed policy of eligibility for

participation in insurance pool. When automobile bodily injury and property damage liability coverage is canceled, other than for nonpayment of premium, or in the event of failure to renew automobile bodily injury and property damage liability coverage to which ORS 743 916 applies, the insurer shall notify the named insured of possible eligibility for automobile liability insurance through any insurance pool or facility operating in this state, whether voluntarily or under statute or rule. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew [1971 c 476 §7]

743.930 Immunity from liability of persons furnishing information regarding cancellation or nonrenewal of policies. There shall be no liability on the part of and no cause of action of any nature shall arise against the director or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, for any statement made by any of them in any written notice of cancellation or nonrenewal, or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal, or providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith [1971 c 476 §8, 1977 c 600 §4]

CANCELLATION AND NONRENEWAL OF COMMERCIAL LIABILITY POLICIES

743.940 Definitions for ORS 743.940 to 743.950. As used in ORS 743 940 to 743 950

- (1) "Cancellation" means termination of a policy at a date other than its expiration date
- (2) "Expiration date" means the date upon which coverage under a policy ends. For a policy written for a term longer than one year or with no fixed expiration date, "expiration date" means the annual anniversary date of the policy
- (3) "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premium on a policy of insurance subject to ORS 743 940 to 743 950, whether the payments are payable directly to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit
- (4) "Nonrenewal" means the refusal of an insurer to renew a policy at its expiration date
- (5) "Renewal" or "renew" means the issuance of, or the offer to issue by an insurer, a policy

succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date [1987 c 774 §36]

743.942 Grounds for cancellation; notice. (1) Except as provided in ORS 743 950, a contract of commercial liability insurance may not be canceled by an insurer before the expiration of the policy, except on one or more of the following grounds

- (a) Nonpayment of premium
- (b) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy
- (c) Substantial increase in the risk of loss after insurance coverage has been issued or renewed, including but not limited to an increase in exposure due to rules, legislation or court decision
- (d) Failure to comply with reasonable loss control recommendations
- (e) Substantial breach of contractual duties, conditions or warranties
- (f) Determination by the director that the continuation of a line of insurance or class of business to which the policy belongs will jeopardize a company's solvency or will place the insurer in violation of the insurance laws of Oregon or any other state
- (g) Loss or decrease in reinsurance covering the risk

(h) Any other reason approved by the director by rule

(2) Cancellation of a commercial liability policy shall not be effective until at least 10 working days after the insured receives a written notice of cancellation. The notice shall state the effective date of and the reason for cancellation and shall inform the insured of the hearing rights established by ORS 743 944

(3) This section does not apply to policies canceled because of action by an insurer under ORS 731 482 [1987 c 774 §37]

743.944 Hearing. Within 30 days after receiving a notice of cancellation under ORS 743 942, an insured may request a hearing before the director. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its notice of cancellation. The burden of proving the reason for cancellation shall be upon the insurer [1987 c 774 §38]

743.946 Renewal; nonrenewal. (1) If an insurer offers or purports to renew a commercial liability policy, but on terms less favorable to the insured or at higher rates, the new terms or rates may take effect on the renewal date, if the insurer provides the insured 30 days' written notice. If the insurer does not so notify the insured, the insured may cancel the renewal policy within 30 days after receipt of the notice or delivery of the renewal policy. Earned premium for the period of time the renewal policy was in force shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, any premium increase or changes in terms shall be effective immediately following the prior policy's expiration date.

(2) Nonrenewal of a commercial liability policy shall not be effective until at least 30 days after the insured receives a written notice of nonrenewal. If, after an insurer provides a notice of nonrenewal as described in this subsection, the insurer extends the policy 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.

(3) Subsection (1) of this section does not apply.

(a) If the change is a rate, form or plan filed with the director and applicable to the entire line of insurance or class of business to which the policy belongs, or

(b) To a premium increase based on the altered nature or extent of the risk insured against

(4) If a commercial liability policy is issued for a term longer than one year, and for additional

consideration a premium is guaranteed, the insurer may not refuse to renew the policy or increase the premium for the term of that policy [1987 c 774 §§39, 40]

743.948 Proof of receipt of notice. A post office certificate of mailing to the named insured at the named insured's last-known address shall constitute conclusive proof that the named insured received the notice of cancellation or nonrenewal on the third calendar day after the date of the certificate of mailing [1987 c 774 §41]

743.950 Exemptions from provisions of ORS 743.940 to 743.948. (1) ORS 743.940 to 743.948 do not apply to

(a) Any commercial liability insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered

(b) Any policy subject to the provisions of ORS 743.900 to 743.930

(c) Workers' compensation insurance

(d) Any assigned risk program

(e) Any policy issued by a surplus lines insurer

(2) The director may suspend, in whole or in part, the applicability of ORS 743.940 to 743.948 to any insurer if, in the director's discretion, its application will endanger the ability of the insurer to fulfill its contractual obligations [1987 c 774 §42]

INSURANCE
