

CHAPTER 146. UNFAIR INSURANCE PRACTICES

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UNFAIR CLAIMS SETTLEMENT PRACTICES	146.1
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Authority

The provisions of this Chapter 146 issued under The Insurance Company Law of 1921 (40 P. S. §§ 341—999); The Insurance Department Act of 1921 (40 P. S. §§ 1—321); sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and section 4 of the Unfair Insurance Practices Act (40 P. S. § 1171.4), unless otherwise noted.

Source

The provisions of this Chapter 146 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575, unless otherwise noted.

Notes of Decisions

Construction

While statutory provisions of Pennsylvania insurance law are deemed incorporated into insurance policies, regulations are not deemed incorporated into insurance policies. *Santos v. Insurance Placement Facility of Pennsylvania*, 626 A.2d 1177 (Pa. Super. 1993); appeal denied 642 A.2d 487 (Pa. 1994).

General Comments

There is no private cause of action under the Unfair Insurance Practices Act or these regulations. *Smith v. Nationwide Mutual Fire Insurance Co.*, 935 F.Supp. 616 (W. D. Pa. 1996).

Subchapter A. UNFAIR CLAIMS SETTLEMENT PRACTICES

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§ 146.1. Scope.

This chapter defines certain minimum standards which, if violated with a frequency that indicates a general business practice, will be deemed to constitute unfair claims settlement practices. This chapter applies to persons and to insurance policies and insurance contracts except policies of workers' compensation insurance and fidelity, surety and guaranty bonds. This chapter is not exclusive, and other acts, not herein specified, may also be deemed to be a violation of sections 4 and 5(10) of the Unfair Insurance Practices Act (40 P. S. §§ 1171.4 and 1171.5(10)).

Source

The provisions of this § 146.1 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

Notes of Decisions*Jurisdiction*

Plaintiff's Unfair Trade Practices and Consumer Protection Law (73 P. S. § 201 et seq.), claim was dismissed for lack of subject matter jurisdiction to the extent that it was founded upon purported violations of the Unfair Insurance Practices Act (40 P. S. § 1171.1 et seq.), and the Unfair Claims Settlement Practices Regulations. *Smith v. Nationwide Mutual Fire Insurance Co.*, 935 F. Supp. 616 (W. D. Pa. 1996).

§ 146.2. Definitions.

(a) The definitions of "person" and of "insurance policy or insurance contract" contained in section 2 of the Unfair Insurance Practices Act (40 P. S. § 1171.2) applies to this chapter.

(b) The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Agent—An individual, corporation, association, partnership or other legal entity authorized to represent an insurer with respect to a claim.

Claim—A demand for payment by a claimant and not an inquiry concerning coverage.

Claimant—Except as provided in § 146.10 (relating to written notice to claimants of payment of claim in third-party settlements), either a first-party claimant, a third-party claimant, or both, and including the claimant's attorney and a member of the claimant's immediate family designated by the claimant.

Commissioner—The Insurance Commissioner of the Commonwealth.

Department—The Insurance Department of the Commonwealth.

First-party claimant—An individual, corporation, association, partnership or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by such policy or contract.

Insured—A natural person, association, corporation, partnership or other legal entity who is insured under an insurance policy or insurance contract issued in this Commonwealth.

Insurer—A person licensed to issue or who issues an insurance policy or insurance contract in this Commonwealth.

Investigation—Activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract and settlement of claims or losses thereunder.

Notification of claim—A notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant or insured, which reasonably apprises the insurer of the facts pertinent to a claim.

Third-party claimant—An individual, corporation, association, partnership or other legal entity asserting a claim against an individual, corporation, associa-

tion, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

(c) The term “worker’s compensation,” in this chapter, includes but is not limited to Longshoremen’s and Harbor Worker’s Compensation.

Source

The provisions of this § 146.2 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575; amended February 21, 1992, effective February 22, 1992, 22 Pa.B. 762. Immediately preceding text appears at serial page (143784).

§ 146.3. File and record documentation.

The claim files of the insurer shall be subject to examination by the Commissioner or by his appointed designees. The files shall contain notes and work papers pertaining to the claim in the detail that pertinent events and the dates of the events can be reconstructed.

Source

The provisions of this § 146.3 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.4. Misrepresentation of policy provisions.

(a) An insurer or agent may not fail to fully disclose to first-party claimants pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) An insurer or agent may not fail to fully disclose to first-party claimants benefits, coverages or other provisions of an insurance policy or insurance contract when the benefits, coverages or other provisions are pertinent to a claim.

(c) An insurer may not deny a claim for failure to exhibit the property without proof of demand and refusal by a claimant to do so.

(d) An insurer may not, except where there is a time limit specified in the policy, make statements—written or otherwise—requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if a time limit is not complied with unless the failure to comply with the time limit prejudices the rights of the insurer.

(e) An insurer may not request a first-party claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(f) An insurer may not issue checks or drafts in partial settlement of a loss or claim under a specific coverage which checks or drafts contain language which expressly or impliedly releases the insurer or its insured from its total liability.

Source

The provisions of this § 146.4 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.5. Failure to acknowledge pertinent communications.

(a) Every insurer, upon receiving notification of a claim, shall, within 10 working days, acknowledge the receipt of the notice unless payment is made within the period of time. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated. Notification given to an agent of an insurer shall be notification to the insurer, dating from the time the insurer receives notice.

(b) Every insurer, upon receipt of an inquiry from the Department respecting a claim shall, within 15 working days of receipt of the inquiry, furnish the Department with an adequate response to the inquiry.

(c) An appropriate reply shall be made within 10 working days on other pertinent communications from a claimant which reasonably suggest that a response is expected.

(d) Every insurer, upon receiving notification of claim, shall provide within 10 working days necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and reasonable requirements of the insurer. Compliance with this subsection within 10 working days of notification of a claim shall constitute compliance with subsection (a).

Source

The provisions of this § 146.5 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.6. Standards for prompt investigation of claims.

Every insurer shall complete investigation of a claim within 30 days after notification of claim, unless the investigation cannot reasonably be completed within the time. If the investigation cannot be completed within 30 days, and every 45 days thereafter, the insurer shall provide the claimant with a reasonable written explanation for the delay and state when a decision on the claim may be expected.

Source

The provisions of this § 146.6 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.7. Standards for prompt, fair and equitable settlements applicable to insurers.

(a) Acceptance or denial of a claim shall comply with the following:

(1) Within 15 working days after receipt by the insurer of properly executed proofs of loss, the first-party claimant shall be advised of the acceptance or denial of the claim by the insurer. An insurer may not deny a claim on the grounds of a specific policy provision, condition or exclusion unless refer-

ence to the provision, condition or exclusion is included in the denial. The denial shall be given to the claimant in writing and the claim file of the insurer shall contain a copy of the denial.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(b) If a claim is denied for reasons other than those described in subsection (a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer.

(c) The following provisions govern acceptance or denial of a claim where additional time is needed to make a determination:

(1) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, it shall so notify the first-party claimant within 15 working days after receipt of the proofs of loss giving the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 30 days from the date of the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation and state when a decision on the claim may be expected.

(2) Where there is a reasonable basis supported by specific information available for review by the insurance regulatory authority for suspecting that the first-party claimant has fraudulently caused or contributed to the loss by arson or other illegal activity, the insurer is relieved from the requirements of this subsection; provided, however, that the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(d) Insurers may not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

(e) Insurers may not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney until the rights of the claimant may be affected by a statute of limitations or a policy or contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the rights of the claimant. The notice shall be given to first-party claimants 30 days, and to third-party claimants 60 days, before the date on which the time limit may expire.

(f) An insurer may not make statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within

a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

Authority

The provisions of this § 146.7 issued under the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

Source

The provisions of this § 146.7 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575; amended May 21, 1982, effective May 22, 1982, 12 Pa.B. 1639. Immediately preceding text appears at serial pages (39830) and (48154).

§ 146.8. Standards for prompt, fair and equitable settlements applicable to automobile insurance.

(a) Insurers may not recommend that third-party claimants make claim under their own policies solely to avoid paying claims under the insurer's insurance policy or insurance contract.

(b) Insurers may not require a claimant to travel unreasonably either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at specific repair shops.

(c) Insurers shall, upon the request of the claimant, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimant, unless the deductible amount has been otherwise recovered. A deduction for expenses can not be made from the deductible recovery unless an outside attorney is retained to collect the recovery. The deduction may then be for only a pro rata share of the allocated loss adjustment expense.

(d) If an insurer prepares an appraisal of the cost of automobile repairs, the appraisal shall be in an amount for which it may be reasonably expected the damage can be satisfactorily repaired. The insurer shall give a copy of the appraisal to the claimant and may furnish to the claimant, upon his unsolicited request, the names of two or more conveniently located repair shops.

(e) When the amount claimed is reduced because of betterment or depreciation information for the reduction shall be contained in the claim file. The deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

(f) When the insurer elects to repair in a first-party claim, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy and within a reasonable period of time.

(g) The insurer may not use as a basis for cash settlement with a first-party claimant an amount which is less than the amount which the insurer would pay

if repairs were made, other than in total loss situations, unless the amount is agreed to by the insured or provided by the insurance policy or insurance contract.

Source

The provisions of this § 146.8 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.9. Comparative negligence.

(a) Where comparative negligence is applied to a claim settlement offer or denial, insurers shall fully disclose to claimants the basis in fact or in applicable law for the offer or denial and settlement standards relating to the claims.

(b) Insurers may not use comparative negligence claim settlement standards which are inequitable and which result in compelling claimants to litigate by offering substantially less than the amount due and ultimately recovered in actions brought by the persons. Comparative negligence should not be applied to a claim settlement to reduce amounts claimants would otherwise be entitled to but for their negligence without reasonable evidence of the negligence and its relativity to the total negligence involved. A record of the evidence and the evaluation of its effect should be maintained in the claim file.

Source

The provisions of this § 146.9 adopted December 15, 1978, effective December 16, 1978, 8 Pa.B. 3575.

§ 146.10. Written notice to claimants of payment of claim in third-party settlements.

(a) Upon payment of \$1,000 or more in settlement of a third-party liability claim, if the claimant is a natural person, the insurer shall cause written notice to be mailed to the claimant at the same time payment is made, by the insurer or its representative, including the insurer's attorney, to the claimant's attorney or other representative of the claimant by draft, check or otherwise.

(b) Nothing in this subsection will constitute a violation of this chapter if an insurer makes a good faith effort to comply with this section.

(c) A violation of this section will be deemed to occur if an insurer fails to provide the notice to claimants with a frequency that indicates that it is a general business practice.

Authority

The provisions of this § 146.10 issued under sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412); and the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15).

Source

The provisions of this § 146.10 adopted February 21, 1992, effective February 22, 1992, 22 Pa.B. 762.

Cross References

This section cited in 31 Pa. Code § 146.2 (relating to definitions).

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