STATE OF CALIFORNIA
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

Senate Bill No. 1242

CHAPTER 424

An act to amend Sections 106, 396, 510, 676.2, 676.8, 677.2, 677.4, 678, 678.1, 785, 799.02, 1652, 1725.5, 1749, 1749.3, 1749.31, 1749.32, 1749.33, 1758.9, 1871.2, 1872.4, 10111.2, 10144.55, 10235.45, 11664, and 13902 of, to add Sections 1872.41 and 1872.51 to, and to repeal Section 1879.2 of, the Insurance Code, and to amend Section 5401.7 of the Labor Code, relating to insurance.

[Approved by Governor September 18, 2022. Filed with Secretary of State September 18, 2022.]

legislative counsel's digest

SB 1242, Committee on Insurance. Insurance.

(1) Existing law establishes a Fraud Division within the Department of Insurance to investigate fraudulent claims. Existing law requires an insurer that reasonably believes or knows that a fraudulent claim is being made to send a prescribed form and additional information about the fraudulent claim to the Fraud Division within 60 days after determination by the insurer that the claim appears to be a fraudulent claim.

This bill would instead require an insurer to send that form and information within 60 days after it that has determined, after the completion of an investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring. The bill would require an agent or broker to use the electronic form within Fraud Division's Consumer Fraud Reporting Portal before placing an insurance application with an insurer to report if they reasonably suspect or know that a fraudulent application is being made. If the agent or broker reasonably suspects or knows that a fraud has been perpetrated after an insurance application has been placed with an insurer, the bill would require the agent or broker to report that information directly to the insurer's special investigative unit. The bill would insulate an agent or broker who furnishes this information, or a governmental agency or its employees that furnishes or receives this information or assists in an insurance fraud investigation, from civil liability if they acted in good faith, as specified.

Existing law requires the Department of Justice to maintain state summary criminal history information, authorizes the Department of Justice to furnish that information to another agency, and makes it a crime to furnish that information to an unauthorized person. Existing law regulates the licensing and the renewal of licensing of insurance agents, adjusters, and brokers. Existing law requires an individual to apply with the Insurance Commissioner for a specified license using a form prescribed by the commissioner. Existing law requires specified licensees and applicants for

specified licenses to complete a course of study on ethics, which is 12 hours for new applicants and 3 hours before each license renewal for existing licensees. Existing law requires a person licensed to transact specified types of insurance to include their license number on business cards, written price quotations, and print advertisements in a specified type size.

This bill would require the commissioner to submit fingerprint images and related information regarding specified license applicants to the Department of Justice, and would require the Department of Justice to provide state or federal criminal history information for each applicant to the commissioner. Because the bill would expand the scope of a crime, the bill would impose a state-mandated local program. On and after March 1, 2023, the bill would require an ethics course for a specified licensee or applicant to include one hour of study on insurance fraud. This bill would require specified licensees to include their license number in the emails the person sends that involve an activity for which a license is required. The bill would set forth size and location requirements for including the license number in an email.

(2) Existing law requires an insurer to provide a long-term care insurance policyholder or certificate holder a statement with specified information, including that the policyholder or certificate holder may cancel the payment before the payment date, at least 30 days before the first payment of an accelerated death benefit for long-term care. Existing law also requires an insurer to provide a report to a policyholder or certificate holder no later than 30 days after every payment of an accelerated death benefit for long-term care. Under existing law, a loan or withdrawal from the cash value of a life insurance policy that accelerates benefits for long-term care is incomplete until the insurer provides specified information to the policyholder or certificate holder.

This bill would clarify the information that is to be provided in the statement at least 30 days before the expected first payment of an accelerated death benefit for long-term care, would alternatively authorize an insurer to provide the statement at the time of payment if the insurer allows cancellation for at least 30 days after the payment, and would specify the information to be included if the statement is provided at the time of payment. The bill would require an insurer to provide a policyholder or certificate holder with a statement summarizing the effect of the payment on the remaining policy values no later than 30 days after every payment, or 45 days after the first payment, of an accelerated death benefit for long-term care. The bill would authorize an insurer to immediately approve a loan from the cash value of a life insurance policy that accelerates benefits for long-term care if the loan is not treated as a taxable distribution for federal income tax purposes and the insurer permits cancellation of the loan for at least 30 days after the loan payment has been made.

(3) Existing law requires an insurer to include a written disclosure with contact information of the unit within the Department of Insurance that deals with consumer affairs when a specified policy of automobile, residential property, life, or disability insurance, or a certificate of coverage

for a group disability master policy, is first issued to or delivered to a new insured or a new policyholder.

This bill would additionally require that disclosure to be included when a bail bond is first executed or delivered.

Existing law requires an insurer to include a statement indicating that it is a crime to present false and fraudulent information to obtain or amend insurance coverage on a form it uses for an application, policy changes, or making a claim in connection with an insurance application, contract, or provision of contract for liability insurance, or on a rider attached to that form.

This bill would require that statement to appear on the form, exclusive of schedules attached to the form, or an endorsement separate from the form, if used in connection with an insurance application, contract, or provision of contract. The bill would also make conforming changes.

(4) Existing law requires an insurance pool to furnish a copy of the pool's annual audited financial statement and most recent actuarial review to specified committees of the Legislature within 180 days of the close of the pool's fiscal year.

This bill would also require an insurance pool to furnish a copy of that statement and review to the Insurance Commissioner within 180 days of the close of the pool's fiscal year.

(5) Existing law generally regulates classes of insurance, including disability income insurance. Existing law defines "disability income insurance" to mean insurance against loss of occupational earning capacity arising from injury, sickness, or disablement.

This bill would make technical, nonsubstantive changes to provisions cross-referencing that definition.

(6) Existing law provides that mailing a specified notice is complete when the notice is deposited in a facility regularly maintained by the United States Postal Service, in a sealed envelope, with postage paid, and addressed to the person at the last address that person provided to the person mailing the notice. Existing law extends the period of notice and any right or duty to respond to that mailed notice by 5 calendar days if the place of mailing or the recipient's address is within California, 10 calendar days if the place of mailing or the recipient's address is outside of California but within the United States, or 20 calendar days if the place of mailing or the recipient's address is outside of the United States. Existing law specifies that these time periods and procedures are applicable to various insurance-related notices.

This bill would make technical, nonsubstantive changes to provisions referencing those time periods and procedures.

(7) Beginning January 1, 2023, existing law prohibits an insurer from declining an application or enrollment request for coverage under a policy or certificate for life insurance or disability income insurance based solely on the results of a positive HIV test if the policy's operation is contingent on medical review for other diseases or medical conditions.

This bill would make technical, nonsubstantive changes to those provisions.

(8) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 106 of the Insurance Code is amended to read:

106. (a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision (c) of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

(c) In a statute that becomes effective on or after January 1, 2008, the term "specialized health insurance policy" as used in this code shall mean a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies.

SEC. 2. Section 396 of the Insurance Code is amended to read:

396. (a) An insurer shall do either of the following:

(1) Maintain a verifiable process that allows a policyholder to designate in writing or by electronic transmission pursuant to Section 38.6 one additional person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of a policy for nonpayment of premium. The insurer shall notify the policyholder in writing or by electronic transmission pursuant to Section 38.6 of this right at the time of the application or within 30 days after the inception date of an individual policy described in subdivision (f), and at least every two years thereafter. The notification described in this subdivision shall instruct the policyholder how to request the designation and how to replace or delete a designee. If a policyholder

initiates contact with the insurer after the insurer has provided notice and the insurer complies with the policyholder's request to establish or change the additional person to receive the notice described in this section, the insurer shall not be required to maintain additional verification.

(2) Comply with subdivision (b).

(b) An insurer that adopts the following procedure shall be deemed to have complied with subdivision (a).

(1) Unless an applicant for insurance has been provided notice of the right set forth in this section prior to inception of the policy, the insurer shall provide the policyholder, within 30 days after the inception date of an individual policy described in subdivision (f), with notice of the right to designate one person, in addition to the policyholder, to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of a policy for nonpayment of premium. The insurer shall provide each applicant or policyholder with notice in writing or by electronic transmission pursuant to Section 38.6 of the opportunity to make the designation. That notice shall instruct the applicant or policyholder on how the applicant or policyholder is to submit the name and address of one person, in addition to the applicant or policyholder, who is to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of the policy for nonpayment of premium.

(2) If after having been provided notice from the insurer of the right to designate an individual to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium, the applicant or policyholder fails to designate an individual within 30 days, the applicant or policyholder shall be conclusively presumed to have declined the opportunity to exercise their right at that time.

(3) Notwithstanding subparagraph (C) of paragraph (2) of subdivision (a) of Section 791.13 or any other law, the insurer shall retain and utilize as necessary the contact information provided in the written designation for the lifetime of the policy, and allow the policyholder to update the written designation if the policyholder so requests.

(c) (1) A policyholder retains the right to designate the one additional person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium at any time, at the initiative of the policyholder, regardless of whether the policyholder previously declined to exercise that right. At least every two years, the insurer shall notify the policyholder in writing or by electronic transmission pursuant to Section 38.6, of whichever of the following applies:

(A) If a policyholder has previously provided a designation pursuant to this subdivision, in writing or by electronic transmission pursuant to Section 38.6, the right to change the prior designation by replacing or deleting a person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium.

(B) If the policyholder has not previously designated a person to receive the notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium pursuant to this subdivision, the right to designate

a person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium.

(2) The notice requirements in subparagraphs (A) and (B) of paragraph (1) may be provided to a policyholder in a single notice and shall not require two separate notices.

(d) When a policyholder pays the premium for an insurance policy through a payroll or pension deduction plan, the requirements contained in paragraph (1) of subdivision (b) need not be met until 60 days after the policyholder is no longer on that deduction payment plan.

(e) An insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer, at least 10 days prior to the effective date of the lapse, termination, expiration, nonrenewal, or cancellation, gives notice to the individual designated pursuant to subdivision (a) or (b) at the address provided by the policyholder for purposes of receiving the notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium. Notwithstanding any other law, notice shall be given by first-class United States mail, postage prepaid, within 10 days after the premium is due and unpaid. This subdivision does not modify requirements for notice to the policyholder of lapse, termination, expiration, nonrenewal, or cancellation set forth in other sections of this code.

(f) This section applies only to policies of private passenger automobile insurance that provide coverage for six months or longer, policies of residential property insurance as described in subdivision (a) of Section 10087 that take effect or that are renewed after the effective date of this section, and policies of individual disability income insurance as described in subdivision (c) of Section 799.01, except if the premiums for the individual disability income policy are paid entirely by the employer.

(g) This section applies to policies that are issued and take effect or that are renewed on or after January 1, 2016.

(h) An individual designated by a policyholder pursuant to this section to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of the policy for nonpayment of premium does not have any rights, whether as an additional insured or otherwise, to any benefits under the policy, other than the right to receive notice as provided by this section.

SEC. 3. Section 510 of the Insurance Code is amended to read:

510. (a) Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, or when a bail bond as defined in Section 1800.4 is first executed or delivered, the insurer shall include a written disclosure containing the name, address, toll-free telephone number, and internet website of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

(b) The disclosure described in subdivision (a) shall also contain the address and customer service telephone number of the insurer, or the address and customer service telephone number of the agent or broker of record, or all of those addresses and telephone numbers. All addresses and telephone numbers for the insurer or the agent or broker of record shall be prominently displayed, in boldfaced type. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact their agent or broker for assistance.

SEC. 4. Section 676.2 of the Insurance Code is amended to read:

676.2. (a) This section applies only to policies of commercial insurance that are subject to Section 675.5.

(b) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it complies with Section 677.2 and it is based on the occurrence, after the effective date of the policy, of one or more of the following:

(1) Nonpayment of premium, including payment due on a prior policy issued by the insurer and due during the current policy term covering the same risks.

(2) A judgment by a court or an administrative tribunal that the named insured has violated any law of this state or of the United States having as one of its necessary elements an act that materially increases any of the risks insured against.

(3) Discovery of fraud or material misrepresentation by either of the following:

(A) The insured or the insured's representative in obtaining the insurance.

(B) The named insured or the named insured's representative in pursuing a claim under the policy.

(4) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards, by the named insured or the named insured's representative, which materially increase any of the risks insured against.

(5) Failure by the named insured or the named insured's representative to implement reasonable loss control requirements that were agreed to by the insured as a condition of policy issuance or that were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(6) A determination by the commissioner that the loss of, or changes in, an insurer's reinsurance covering all or part of the risk would threaten the financial integrity or solvency of the insurer. A certification made under penalty of perjury to the commissioner by an officer of the insurer of the loss of, or change in, reinsurance and that the loss or change will threaten the financial integrity or solvency of the insurer if the cancellation of the policy is not permitted shall constitute this determination unless disapproved

by the commissioner within 30 days of the filing. There shall be no extensions to this 30-day period.

(7) A determination by the commissioner that a continuation of the policy coverage would place the insurer in violation of the laws of this state or the state of its domicile or that the continuation of coverage would threaten the solvency of the insurer.

(8) A change by the named insured or the named insured's representative in the activities or property of the commercial or industrial enterprise that results in a material added risk, a materially increased risk, or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(c) (1) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately upon renewal, no increase in the rate upon which the premium is based, reduction in limits, or change in the conditions of coverage shall be effective during the policy period unless a written notice is mailed or delivered to the named insured and the producer of record at the mailing address shown on the policy, at least 30 days prior to the effective date of the increase, reduction, or change. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed. The notice shall state the effective date of, and the reasons for, the increase, reduction, or change.

(2) The increase, reduction, or change shall not be effective unless it is based upon one of the following reasons:

(A) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards by the named insured that materially increase any of the risks or hazards insured against.

(B) Failure by the named insured to implement reasonable loss control requirements that were agreed to by the insured as a condition of policy issuance or that were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(C) A determination by the commissioner that loss of or changes in an insurer's reinsurance covering all or part of the risk covered by the policy would threaten the financial integrity or solvency of the insurer unless the change in the terms or conditions or rate upon which the premium is based is permitted.

(D) A change by the named insured in the activities or property of the commercial or industrial enterprise that results in a materially added risk, a materially increased risk, or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(E) With respect to a change in the rate of a policy of professional liability insurance for a health care provider, the insurer's offer of renewal notifies the policyholder that the insurer has an application filed pursuant to Section 1861.05 pending with the commissioner for approval of a change in the rate upon which the premium is based, and the commissioner subsequently

approves the rate change, or some different amount for the policy period. The change shall not be retroactive.

(d) The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Title 2 of Division 3 of the Government Code) shall not apply to a determination pursuant to paragraph (6) or (7) of subdivision (b) or subparagraph (C) of paragraph (2) of subdivision (c). The commissioner shall charge an insurer who requests a determination pursuant to paragraph (6) or (7) of subdivision (b) a fee sufficient to recover the costs of making the determination. If the commissioner does not act upon a request by an insurer to cancel or change a policy pursuant to those provisions within 30 days, the request shall be deemed to be approved.

(e) This section shall not prohibit an insurer from increasing a premium during the policy period if the increase is calculated in accordance with the current rating manual of the insurer and is justified by a physical change in the insured property or by a change in the activities of the commercial or industrial enterprise that materially increases any of the risks insured against.

(f) This section shall not apply to a transfer of a policy without a change in its terms or conditions or the rate upon which the premium is based between insurers that are members of the same insurance group.

SEC. 5. Section 676.8 of the Insurance Code is amended to read:

676.8. (a) This section applies only to policies of workers' compensation insurance.

(b) After a policy is in effect, a notice of cancellation shall not be effective unless it complies with the notice requirements of this section and is based upon the occurrence, after the effective date of the policy, of one or more of the following:

(1) The policyholder's failure to make any workers' compensation insurance premium payment when due.

(2) The policyholder's failure to report payroll, to permit the insurer to audit payroll as required by the terms of the policy or of a previous policy issued by the insurer, or to pay any additional premium as a result of an audit of payroll as required by the terms of the policy or of a previous policy.

(3) The policyholder's material failure to comply with federal or state safety orders or written recommendations of the insurer's designated loss control representative.

(4) A material change in ownership or any change in the policyholder's business or operations that materially increases the hazard for frequency or severity of loss, requires additional or different classifications for premium calculations, or contemplates an activity excluded by the insurer's reinsurance treaties.

(5) Material misrepresentation by the policyholder or its agent.

(6) Failure to cooperate with the insurer in the insurer's investigation of a claim.

(c) A policy shall not be canceled for the conditions specified in paragraph (1), (2), (5), or (6) of subdivision (b) except upon 10 days' written notice

to the policyholder by the insurer. A policy shall not be canceled for the conditions specified in paragraph (3) or (4) of subdivision (b) except upon 30 days' written notice to the policyholder by the insurer, provided that notice is not required if an insured and insurer consent to the cancellation and reissuance of a policy effective upon a material change in ownership or operations of the insured. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed. If the policyholder remedies the condition to the insurer's satisfaction within the specified time period, the policy shall not be canceled by the insurer.

(d) Nothing in this section shall preclude, while policies are in force, changes in the premium rate required or authorized by law, regulation, or order of the commissioner, or otherwise agreed to between the policyholder and insurer.

(e) Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall be considered as if written for successive policy periods of one year.

SEC. 6. Section 677.2 of the Insurance Code is amended to read:

677.2. (a) This section applies only to policies covered by Section 675.5.

(b) A notice of cancellation shall be in writing and shall be delivered or mailed to the producer of record, provided that the producer of record is not an employee of the insurer, and to the named insured at the mailing address shown on the policy. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

The notice of cancellation shall include the effective date of the cancellation and the reasons for the cancellation.

(c) The notice of cancellation shall be given at least 30 days prior to the effective date of the cancellation, except that in the case of cancellation for nonpayment of premiums or for fraud the notice shall be given no less than 10 days prior to the effective date of the cancellation. Notice of a proposed cancellation pursuant to subdivision (d) of Section 676.2 given prior to a finding of the commissioner shall satisfy the requirements of this section if it is given no less than 30 days prior to the effective date of the cancellation and if it states that cancellation will be effective only upon the approval of the commissioner.

(d) This section applies only to cancellations pursuant to Section 676.2.

SEC. 7. Section 677.4 of the Insurance Code is amended to read:

677.4. A notice of cancellation with respect to a policy covered under Section 675 shall be delivered at least 20 calendar days prior to the effective date of the cancellation, except that in the case of a cancellation for nonpayment of premiums, or for fraud, the notice shall be given at least 10 calendar days prior to the effective date of the cancellation. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

SEC. 8. Section 678 of the Insurance Code is amended to read:

678. (a) (1) At least 45 days before the policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(A) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(i) Any reduction of limits or elimination of coverage. That reduction of limits or elimination of coverage shall identify the specific limits being reduced or coverage being eliminated by the offer of renewal. The elimination of coverage for the previously covered peril of fire shall be subject to subdivision (b) of Section 10103.6.

(ii) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(B) A notice of nonrenewal of the policy. That notice shall contain all of the following:

(i) The specific reason or reasons for the nonrenewal.

(ii) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(iii) Until July 1, 2020, a brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(iv) On or after July 1, 2020, a statement that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the department's internet website, www.insurance.ca.gov, the department's telephone number, (800) 927-HELP (4357), and the mailing address of the department's Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013.

(2) On and after July 1, 2022, the time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if an offer or notice is mailed.

(b) If an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Notwithstanding subdivisions (a) and (b), with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, the following timelines apply:

(1) At least 75 days before the policy expiration, the insurer shall deliver the notice of nonrenewal to the named insured or mail the notice of

nonrenewal to the named insured at the address shown in the policy. The notice shall include the information contained in subparagraph (B) of paragraph (1) of subdivision (a). On and after July 1, 2022, the time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if a notice is mailed.

(2) If an insurer fails to give the named insured a notice of nonrenewal at least 75 days before the policy expiration, as required by paragraph (1), the existing policy, with no change in its terms and conditions, shall remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the notice of nonrenewal.

(d) A policy written for a term of less than one year shall be considered as if written for a term of one year. A policy written for a term longer than one year, or a policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(e) A notice of nonrenewal for a residential property insurance policy expiring on or after July 1, 2021, shall be accompanied by the following notice:

The California Department of Insurance has developed the California Home Insurance Finder, an online tool that can assist you in obtaining insurance for your home. The Finder contains names, addresses, telephone numbers, and internet website links of licensed insurance agents, brokers, and insurance companies that may be able to sell insurance to you. The Finder is organized by ZIP Code and the languages in which the agent, broker, or insurance company sells insurance.

The California FAIR Plan (FAIR Plan) provides basic property insurance as the “insurer of last resort” if you cannot find insurance coverage for your property in the normal (voluntary) insurance market. The FAIR Plan provides basic property insurance coverage for residential structures, as well as personal property coverage for residential and business occupancies. However, FAIR Plan policies may not cover liability, theft, or water damage, among other things. There are also optional coverages available for both residential properties. Applications can be made directly with the FAIR Plan (cfpnet.com), although the FAIR Plan strongly encourages use of a licensed agent or broker for assistance in preparing and obtaining a quote. There is no additional cost for using an agent or broker for purchasing a FAIR Plan policy.

California law requires an agent or broker to assist a person seeking a FAIR Plan policy by (1) submitting a coverage application to the FAIR Plan on behalf of the consumer, (2) providing the consumer the FAIR Plan’s internet website address and toll-free telephone number, or (3) obtaining a policy for the consumer through an admitted or nonadmitted insurer.

To supplement a FAIR Plan policy, a Difference in Conditions (DIC) policy should be considered. A DIC policy is sold by some private insurers, and provides coverage for things not covered by the basic property insurance policy provided by the FAIR Plan. A consumer who wants broader coverage

than that provided by the FAIR Plan policy should contact an agent, broker, or insurance company that offers a DIC policy to obtain this additional coverage. The Department of Insurance maintains a list of insurance companies that sell DIC policies on its internet website (insurance.ca.gov). Additional assistance may be obtained by contacting an agent or broker listed with the department's online agent locator.

(f) An insurer may use a notice substantially similar to the notice set forth in subdivision (e) to the extent that the notice provides additional or more detailed information.

(g) This section applies only to policies of insurance specified in Section 675.

SEC. 9. Section 678.1 of the Insurance Code is amended to read:

678.1. (a) This section applies only to policies of insurance of commercial insurance that are subject to Sections 675.5 and 676.6.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 60 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy, or to condition renewal upon reduction of limits, elimination of coverages, increase in deductibles, or increase of more than 25 percent in the rate upon which the premium is based.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its terms or conditions, for a period of 60 days after the insurer gives the notice.

(e) With respect to policies defined in subdivision (b) of Section 676.6, in addition to the bases for conditional renewal set forth in subdivision (c), an insurer may also condition renewal upon requirements relating to the underlying policy or policies. If the requirements are not satisfied as of (1) the expiration date of the policy, or (2) 30 days after mailing or delivery of such notice, whichever is later, the conditional renewal notice shall be treated as an effective notice of nonrenewal, provided the insurer has sent written confirmation to the first named insured and the producer of record that the conditions were not met and that coverage ceased at the expiration date shown in the expiring policy.

(f) A notice of nonrenewal shall not be required in any of the following situations.

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured, within the time period specified in subdivision (c), to renew the policy under changed terms or conditions or at a changed premium rate. As used herein, "terms or conditions" includes, but is not limited to, a reduction in limits, elimination of coverages, or an increase in deductibles.

(g) This section shall become operative on January 1, 2019.

SEC. 10. Section 785 of the Insurance Code is amended to read:

785. (a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision (m) of Section 10192.4.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, 2002, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision (c) of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant to Section 1753.

SEC. 11. Section 799.02 of the Insurance Code, as added by Section 3 of Chapter 184 of the Statutes of 2020, is amended to read:

799.02. (a) A life or disability income insurer shall not decline an application or an enrollment request for coverage under a policy or certificate

for life insurance or disability income insurance based solely on the results of a positive HIV test, regardless of when or at whose direction the test was performed.

(b) Notwithstanding any other law, this article does not prevent or otherwise restrict a life or disability income insurer from refusing to insure an applicant that is HIV positive, limiting the amount, extent, or kind of coverage for an applicant that is HIV positive, or charging a different rate to an applicant that is HIV positive, if the refusal, limitation, or charge is based on sound actuarial principles and actual or reasonably anticipated experience.

(c) Transferring an applicant from a simplified, expedited, accelerated, or algorithmic underwriting process to a traditional medical underwriting process, based solely on the results of a positive HIV test, does not constitute a denial of the application or a violation of this section.

(d) This section applies if coverage is contingent upon medical review for other diseases or medical conditions.

SEC. 12. Section 1652 of the Insurance Code is amended to read:

1652. (a) The commissioner shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice pursuant to subdivision (u) of Section 11105 of the Penal Code, and the Department of Justice shall provide to the commissioner a state or federal response pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code, for all applicants of each of the following:

(1) A property licensee or a casualty licensee, as defined in Section 1625.

(2) A personal lines licensee, as defined in Sections 1625.5.

(3) A limited lines automobile insurance agent, as defined in Section 1625.55.

(4) A life and accident and health or sickness licensee, as defined in Section 1626.

(5) A life licensee limited to the payment of funeral and burial expenses, as defined in Section 1676.

(6) A special lines' surplus line broker, as defined in Section 1760.5.

(7) A surplus line broker, as defined in Section 47.

(8) A cargo owner's or shipper's agent, as defined in Section 1757.1.

(9) A portable electronics agent license, as defined in Section 1758.69.

(10) A car rental agent, as defined in Section 1758.89.

(11) A credit insurance agent license, as defined in Section 1758.992.

(12) An administrator, as defined in Section 1759.

(13) A reinsurance intermediary-broker, as defined in Section 1781.2.

(14) A bail agent license, as defined in Section 1802.

(15) A bail permittee license, as defined in Section 1802.5.

(16) A bail solicitor license, as defined in Section 1803.

(17) A bail fugitive recovery agent license, as defined in Section 1802.3.

(18) A life and disability analyst, as defined in Section 32.5.

(19) A stock agent who sells securities, as defined in Section 825.

(20) An insurance adjuster, as defined in Section 14021.

(21) A crop insurance adjuster as defined in Section 14085.

(22) A public insurance adjuster, as defined in Section 15007.

(23) A part-time fraternal licensee, as described in Sections 11102 and 11103.

(24) A life settlement broker, as defined in Section 10113.1.

(25) A motor club agent, as defined in Section 12143.

(26) A title marketing representative, as defined in Section 12418.

(b) A license shall be applied for, and renewed by the filing with the commissioner of a written application therefor. The application shall be on a form prescribed by the commissioner, which form shall prescribe the disclosure of information that will aid the commissioner in determining whether the prerequisites for the license sought have been met. The applicant shall declare, under penalty of perjury, that the contents of the application are true and correct.

(c) The forms prescribed by the commissioner other than for renewal applications may require authenticated fingerprints of any of the following:

(1) Individual applicants.

(2) Specified partners or officers of organization applicants.

(3) The individuals who are to transact insurance for an organization applicant.

(d) The forms may require the fingerprints to be affixed to the application or to an attachment to be affixed to the application. The commissioner, in the commissioner's discretion, may require the fingerprints on applications for any, some, or all of the licenses issued pursuant to this chapter or Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831), provided that as to any one such type of license the requirement is applied without discrimination to all applicants within specified classifications. The classifications may be made upon any or all of the following bases:

(1) Length of continuous residence in this state.

(2) Whether or not previously or currently licensed by the commissioner.

(3) Whether or not currently licensed by specified regulatory agencies of the State of California which require fingerprints on applications for licenses and routinely process the fingerprints for positive identification.

(4) Other reasonable criteria.

(e) The commissioner may decline to act on an incomplete or defective application until an amended application which completes the prescribed form is filed with the commissioner.

SEC. 13. Section 1725.5 of the Insurance Code is amended to read:

1725.5. (a) A person licensed under Section 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 1800, 14020, or 15006, or Chapter 8 (commencing with Section 1831), shall affix, type, or print on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products, its license number in a type size that is at least as large as any indicated telephone number, address, or fax number or in 12-point type, or in 8-point type for business cards, whichever is larger. If a licensee includes the names of multiple licensed organizations on a business card, written price quotation, or print

advertisement distributed exclusively in this state, affixing, typing, or printing the license number of any one of the organizations complies with the requirements of this section.

(b) A person licensed under Section 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 14020, or 15006, or Chapter 8 (commencing with Section 1831), shall affix, type, or print on business cards, written price quotations for insurance products, and print advertisements distributed in this state for insurance products, the word "Insurance" in a type size that is at least as large as the smallest telephone number or in 12-point type, or in 8-point type for business cards, whichever is larger.

(c) A person licensed under Section 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 14020, or 15006, or Chapter 8 (commencing with Section 1831), shall include the person's license number in the emails the person sends that involve an activity for which a license is required. A person's license number shall be in a type size that is no smaller than the largest of any telephone number, street address, or email address of the person included in the email. The license number of an individual licensee shall appear adjacent to or on the line below the individual's name or title. The license number of an organizational licensee shall appear adjacent to or on the line below the organization's name.

(d) A natural person who is a solicitor, as defined in Section 1624, working exclusively as an employee of a motor club agent, or working exclusively for a property broker-agent or casualty broker-agent on behalf of a motor club, shall use the organizational licensee number of that person's employer.

(e) A person in violation of this section shall be subject to a fine levied by the commissioner in the amount of two hundred dollars ($200) for the first offense, five hundred dollars ($500) for the second offense, and one thousand dollars ($1,000) for the third and subsequent offenses. The penalty shall not exceed one thousand dollars ($1,000) for any one offense. These fines shall be deposited into the Insurance Fund.

(f) A separate penalty shall not be imposed upon each piece of printed material that fails to conform to the requirements of this section.

(g) If the commissioner finds that the failure of a licensee to comply with the provisions of subdivision (a) or (b) is due to reasonable cause or circumstance beyond the licensee's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, the licensee may be relieved of the penalty in subdivision (e).

(h) A licensee seeking to be relieved of the penalty in subdivision (e) shall file with the department a statement with supporting documents setting forth the facts upon which the licensee bases its claims for relief.

(i) This section does not apply to a person or entity that is not currently required to be licensed by the department or that is exempted from licensure.

(j) This section does not apply to general advertisements of motor clubs that merely list insurance products as one of several services offered by the motor club, and do not provide any details of the insurance products.

(k) This section does not apply to life insurance policy illustrations required by Chapter 5.5 (commencing with Section 10509.950) of Part 2 of Division 2 or to life insurance cost indexes required by Chapter 5.6 (commencing with Section 10509.970) of Part 2 of Division 2.

SEC. 14. Section 1749 of the Insurance Code is amended to read:

1749. The department shall require all new applicants for license as a property broker-agent, casualty broker-agent, limited lines automobile insurance agent, personal lines broker-agent, life agent, or accident and health or sickness agent to meet prelicensing education standards as follows:

(a) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a property broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(b) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a casualty broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(c) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a personal lines broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(d) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a life agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(e) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a limited lines automobile insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(f) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for an accident and health or sickness insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and

certified by the department. This curriculum shall also include instruction in workers' compensation and general principles of employers' liability.

(g) In addition to the 20 hours of prelicensing education required to qualify for a license as a property broker-agent, casualty broker-agent, personal lines broker-agent, a life agent, or an accident and health or sickness agent, or the 20 hours of prelicensing education required to qualify for a license as a limited lines automobile insurance agent, the department shall require 12 hours of study on ethics and this code. On and after March 1, 2023, that 12-hour ethics course shall include one hour of study on insurance fraud. If an applicant seeks a license for more than one of the following license types: a property broker-agent license, a casualty broker-agent license, a personal lines broker-agent license, a life license, or an accident and health or sickness license, the applicant shall only be required to complete one 12-hour course on ethics and this code, which shall include one hour of study on insurance fraud on and after March 1, 2023. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval.

(h) An applicant for a life agent license, an accident and health or sickness license, a personal lines broker-agent license, or a limited lines automobile insurance agent license, who is currently licensed as a nonresident in this state shall be required to complete only the 12-hour course of study on ethics and this code, as required by this section. On and after March 1, 2023, the 12-hour ethics course shall include one hour of study on insurance fraud. Additionally, any applicant for that license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4 shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of the license.

(i) An applicant for a property broker-agent or casualty broker-agent license who is currently licensed as a nonresident in this state shall be required to complete only the 12-hour course of study on ethics and this code, as required by subdivision (g). On and after March 1, 2023, the 12-hour ethics course shall include one hour of study on insurance fraud. Additionally, any applicant for a license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4, shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of a license.

(j) An applicant for a property broker-agent or casualty broker-agent license or both who is licensed as a personal lines agent shall complete a minimum of 20 hours of prelicensing study as a prerequisite for each of these licenses. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. The applicant shall not be required to repeat any prelicensing requirements completed as a prerequisite to being licensed as a personal lines agent.

(k) Review and approval of prelicensing courses not conducted in a classroom, as referenced in subdivisions (a) to (j), inclusive, shall include an evaluation of the safeguards in place to ensure that the student completing

the course is the person enrolled in the course, methods used to monitor the student's attendance are adequate, methods for the student to interact with the entity providing the training exist, and methods used to record the times spent completing the course are adequate.

(l) Prelicensing certificates of completion expire three years from the completion date of the course, whether or not a license is issued.

SEC. 15. Section 1749.3 of the Insurance Code is amended to read:

1749.3. An individual licensed as a life agent or an accident and health or sickness agent and also licensed as a property or casualty broker-agent, or an individual only licensed as a property or casualty broker-agent, shall complete those courses, programs of instruction, or seminars approved by the commissioner for the type of license held. Completion of specified product training required in subdivision (d) of Section 1749.33, subdivision (b) of Section 1749.8, and paragraph (4) of subdivision (a) of Section 10234.93 may result in the completion of more than the minimum of required continuing education hours. The minimum number of hours required is as follows:

(a) A licensee, as specified in this section, shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An individual licensed as a property broker-agent or casualty broker-agent and as a life agent or an accident and health or sickness agent shall satisfy the requirements of this section by demonstrating completion of the courses, programs of instruction, or seminars approved by the commissioner for any of the license types listed in this section.

(c) A licensee is not required to comply with the requirements of this article if the licensee submits proof satisfactory to the commissioner that the licensee has been a licensee in good standing for 30 continuous years in this state and is 70 years of age or older. This exemption does not apply to those individuals licensed for the first time on or after January 1, 2010.

SEC. 16. Section 1749.31 of the Insurance Code is amended to read:

1749.31. (a) An individual licensed as a personal lines broker-agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The personal lines broker-agent shall complete 24 hours, of which three hours shall be in ethics, during each two-year license term as defined in subdivision (d) of Section 1625.5. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.

(b) An individual licensed as a personal lines broker-agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 17. Section 1749.32 of the Insurance Code is amended to read:

1749.32. (a) An individual licensed as a limited lines automobile insurance agent shall complete required continuing education courses,

programs of instruction, or seminars approved by the commissioner. The minimum number of hours required is 20 hours, of which three hours shall be in ethics, per license term prior to the renewal of the license. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.

(b) An individual licensed as a limited automobile insurance agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 18. Section 1749.33 of the Insurance Code is amended to read:

1749.33. (a) A life agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud. These hours of instruction may be completed at any time prior to renewal of the license.

(b) An accident and health or sickness agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud. These hours of instruction may be completed at any time prior to renewal of the license.

(c) An agent licensed as both a life agent and as an accident and health or sickness agent shall satisfactorily complete a total of 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud. These hours of instruction may be completed at any time prior to renewal of the license.

(d) Any accident and health or sickness agent who wishes to sell 24-hour care coverage, as defined in Section 1749.02, shall complete a course, program of instruction, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability, which shall be completed by examination approved by the commissioner as part of the continuing education course, program of instruction, or seminar prior to selling this coverage. The required number of instruction hours shall be equal to but no greater than that required by the curriculum board for the prelicensing requirements of a property broker-agent or a casualty broker-agent on these subjects. For resident licensees, this requirement shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section. This section does not authorize an accident and health or sickness agent to satisfy the obligations set forth in this section by other than a proctored examination administered or approved by the department.

SEC. 19. Section 1758.9 of the Insurance Code is amended to read:

1758.9. No person shall sell or solicit any form of credit insurance in this state unless that person is licensed as an insurance agent or broker

pursuant to Article 3 (commencing with Section 1631) or is licensed as a credit insurance agent or endorsee under this article.

SEC. 20. Section 1871.2 of the Insurance Code is amended to read:

1871.2. (a) An insurer who, in connection with any insurance application, contract, or provision of contract, prints, reproduces, or furnishes a form to any person upon which that person applies for a policy, seeks to make a change to an existing policy, or gives notice of a claim to the insurer or makes a claim against the insurer by reason of accident, injury, death, or other noticed or claimed loss, shall cause to be printed or displayed in comparative prominence with other content on the form, exclusive of schedules attached to the form, or an endorsement separate from the form, the statement: "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." This statement shall be preceded by the words: "For your protection California law requires the following to appear on this form" or other explanatory words of similar meaning.

(b) This section is not applicable to a contract of reinsurance as defined in Section 620.

SEC. 21. Section 1872.4 of the Insurance Code is amended to read:

1872.4. (a) Any company licensed to write insurance in this state that has determined, after the completion of the insurer's special investigative unit investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring shall, within 60 days after that determination by the insurer, send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances regarding the alleged insurance fraud and person or entity that may have committed or is committing insurance fraud, as specified in Section 2698.38 of Title 10 of the California Code of Regulations. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional misrepresentation of any kind has been committed in the submission of the claim, claims, application, or other insurance transaction, the commissioner shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, the commissioner shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the Fraud Division the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Fraud Division, when so requested, and shall otherwise assist and cooperate with the division.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Fraud Division information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

SEC. 22. Section 1872.41 is added to the Insurance Code, to read:

1872.41. (a) An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made shall, within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application. All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

(c) An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the department upon request, and shall otherwise assist and cooperate with the department.

(d) (1) For purposes of this section, an "agent or broker" is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5, 1625.55, 1626, or 1758.1 and is not the employee of an insurer.

(2) An agent or broker is not considered a "contracted entity" or "integral antifraud personnel" pursuant to Section 2689.30 of Title 10 of the California Code of Regulations.

SEC. 23. Section 1872.51 is added to the Insurance Code, to read:

1872.51. (a) An agent or broker who furnishes written or oral information pursuant to Section 1872.41, or an authorized governmental agency, or its employees, that furnishes or receives written or oral information pursuant to Section 1872.41 or assists in an investigation of a suspected insurance fraud violation conducted by an authorized governmental agency, shall not be subject to any civil liability in a cause or action if the insurer, authorized agent, agent or broker, or authorized governmental agency acted in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained by reasonable efforts.

(b) This chapter does not abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, agent or broker, licensed rating organization, or any authorized governmental agency or its employees.

SEC. 24. Section 1879.2 of the Insurance Code is repealed.

SEC. 25. Section 10111.2 of the Insurance Code is amended to read:

10111.2. (a) Under a policy of disability insurance other than health insurance, as defined in Section 106, including a policy of disability income insurance, as defined in subdivision (c) of Section 799.01, payment of benefits to the insured shall be made within 30 calendar days after the insurer has received all information needed to determine liability for a claim. However, the 30-calendar-day period shall not include any time during which the insurer is doing any of the following:

(1) Awaiting a response for relevant medical information from a health care provider.

(2) Awaiting a response from the claimant to a request for additional relevant information.

(3) Investigating possible fraud that has been reported to the department's Fraud Division in compliance with subdivision (a) of Section 1872.4.

(b) If the insurer has not received all information needed to determine liability for a claim within 30 calendar days after receipt of the claim, the insurer shall notify the insured in writing and include a written list of all information it reasonably needs to determine liability for the claim. In that event, the 30-calendar-day period set out in subdivision (a) shall commence when the insured has provided to the insurer all information in that notification. If no notice is sent by the insurer within 30 calendar days after the claim is filed by the insured, interest shall begin to accrue on the payment of benefits on the 31st calendar day after receipt of the claim, at the rate of 10 percent per year.

(c) When the insurer has received all information needed to determine liability for a claim, and the insurer determines that liability exists and fails to make payment of benefits to the insured within 30 calendar days after the insurer has received that information, any delayed payment shall bear

interest, beginning the 31st calendar day, at the rate of 10 percent per year. Liability shall, in all cases, be determined by the insurer within 30 calendar days of receiving all information set out in the insurer's written notification to the insured.

(d) Nothing in this section is intended to restrict any other remedies available to an insured by statute or any other law.

SEC. 26. Section 10144.55 of the Insurance Code is amended to read:

10144.55. (a) Every policy of disability income insurance, as defined in subdivision (c) of Section 799.01, that is of a short-term limited duration of two years or less, that is issued, amended, or renewed on or after July 1, 2014, and that provides disability income benefits shall provide coverage for disability caused by severe mental illnesses.

(b) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders, including postpartum depression.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.

SEC. 27. Section 10235.45 of the Insurance Code is amended to read:

10235.45. (a) If a life insurance policy contains long-term care benefits and permits policy loans or cash withdrawals, then access to those loans or withdrawals shall not be prohibited or limited due to the payment of long-term care benefits, except as provided in paragraphs (1) and (2).

(1) Payment of an accelerated death benefit for long-term care shall result in no more than a pro rata reduction in the cash value of the life insurance policy. A reduction in cash value shall be proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment. Future access to policy loans and cash withdrawals may be limited to the remaining cash value.

(2) Notwithstanding paragraph (1), payment of an accelerated death benefit for long-term care may be considered a lien against the death benefit of the life insurance policy, and access to the cash value of the life insurance policy may be restricted to the excess of the cash value over the sum of outstanding policy loans and the lien. Future access to policy loans and cash withdrawals may also be limited to the excess of the cash value over the sum of outstanding policy loans and the lien.

(3) This subdivision applies only to policies issued on or after January 1, 2021.

(b) If payment of an accelerated death benefit for long-term care results in a pro rata reduction in the cash value of the life insurance policy, the payment may be applied toward repayment of a pro rata portion of outstanding policy loans. The amount of the loan repayment shall be

proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment.

(c) At least 30 days before the expected first payment of an accelerated death benefit for long-term care, the insurer shall provide the policyholder or certificate holder with a statement that includes the information described in this subdivision. Alternatively, an insurer may provide the statement at the time of payment, but only if the insurer allows cancellation of the payment for at least 30 days after it is made.

(1) The statement shall be dated and shall include all of the following:

(A) An explanation of changes to the policy that have occurred as a result of the payment, or would occur as a result of the estimated payment, including, but not limited to, a prohibition or limitation of access to loans or cash withdrawals.

(B) A numerical demonstration of the estimated effect of the payment on any applicable remaining policy values. The demonstration shall include, if applicable, impact to the death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, premium payments or cost of insurance charges, and any other values impacted by the payment.

(C) A notice stating: "WARNING: Payment of an accelerated death benefit for long-term care will reduce and may potentially eliminate your death benefit. Receipt of an accelerated death benefit for long-term care may be taxable and may also adversely affect your eligibility for Medicaid or other government entitlements. Please consult a financial advisor."

(2) If the statement is provided before the payment date, it shall also include all of the following:

(A) The expected payment date.

(B) An explanation that the policyholder or certificate holder may request payment before the expected payment date.

(C) Notice that the policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer's address or telephone number at any time before the expected payment date.

(3) If the statement is provided at the time of payment, it shall also include notice that the policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer's address or telephone number within the cancellation period and returning the payment.

(d) The statement required by subdivision (c) is required only once per policyholder for an individual policy, or once per certificate holder for a group policy, and does not need to be provided for later accelerated death benefit claims by the same policyholder or certificate holder.

(e) No later than 30 days after every payment of an accelerated death benefit for long-term care, or 45 days after the first payment of an accelerated death benefit for long-term care, the insurer shall provide the policyholder or certificate holder with a statement summarizing the effect of the payment on the remaining policy values. The statement shall include all of the following:

(1) The accelerated death benefits paid out during the prior month.

(2) An explanation of changes, if applicable, to the remaining death benefit, cash value or accumulation account, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, premium payments or cost of insurance charges, and any other values impacted by the payment.

(3) The amount of the remaining benefits that can be accelerated.

(f) If a policyholder or certificate holder initiates a request to take a loan or withdrawal from the cash value of a life insurance policy that accelerates benefits for long-term care, the insurer shall provide the policyholder or certificate holder with a statement that includes the information described in paragraph (3).

(1) Except for a loan that is immediately approved pursuant to paragraph (2), a request to take a loan or withdrawal shall be deemed incomplete, and the insurer shall not approve the loan or withdrawal, until the information has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan or withdrawal.

(2) The insurer may immediately approve a loan and provide the statement at the time of payment, but only if the loan is not treated as a taxable distribution for federal income tax purposes and the insurer permits cancellation of the loan for at least 30 days after the loan payment has been made.

(A) The insurer shall provide notice that the policyholder or certificate holder may cancel the loan by contacting the insurer at the insurer's address or telephone number within the cancellation period and returning the loan payment.

(B) At the time the loan is requested, the insurer shall provide an option to receive the statement before the loan request is finalized. If the policyholder or certificate holder elects this option, the loan request shall be deemed incomplete, and the insurer shall not approve the loan, until the statement has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan.

(3) The statement shall be dated and shall include all of the following:

(A) An explanation of changes to the policy that would occur as a result of the loan or withdrawal.

(B) A numerical demonstration of the estimated effect of the payment on any applicable remaining policy values. The demonstration shall include, if applicable, impact to the death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, premium payments or cost of insurance charges, daily, monthly, or lifetime long-term care benefits, and any other values impacted by the payment.

(C) If a policyholder or certificate holder is initiating a request for a loan, a notice stating: "WARNING: Loans may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a loan may adversely affect your eligibility for Medicaid or other government entitlements, and loan proceeds may be taxable if the loan is not repaid and the policy is surrendered or lapses. Please consult a financial advisor."

(D) If a policyholder or certificate holder is initiating a request for a withdrawal, a notice stating: "WARNING: Cash withdrawals may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a cash withdrawal may be taxable and may also adversely affect your eligibility for Medicaid or other government benefits or entitlements. Please consult a financial advisor."

(E) A description of circumstances in which a loan or withdrawal may result in or contribute to the lapse of the policy.

(F) If applicable, a hypothetical demonstration of how loan repayment may be deducted from a future payment of an accelerated death benefit for long-term care.

(G) If applicable, a notice explaining the rate at which the loan will accrue interest and stating the projected outstanding loan amount after five years, assuming that the interest rate does not change, no loan repayments are made, and no additional loans are taken.

(g) The statements and notices required by this section shall be in at least 12-point type.

SEC. 28. Section 11664 of the Insurance Code is amended to read:

11664. (a) This section applies only to policies of workers' compensation insurance.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. The time periods and procedures in subdivision (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 30 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its premium rate, for a period of 60 days after the insurer gives the notice.

(e) A notice of nonrenewal shall not be required in any of the following situations.

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured to renew the policy at a premium rate increase of less than 25 percent.

(A) If the premium rate in the governing classification for the insured is to be increased 25 percent or greater and the insurer intends to renew the policy, the insurer shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with subdivision (c) of Section 11750.3.

(B) For purposes of this section, "premium rate" means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

SEC. 29. Section 13902 of the Insurance Code is amended to read:

13902. (a) Any insurance pool, established pursuant to this division, may be organized as a nonprofit corporation, limited liability company, partnership, or trust, whether organized under the laws of this state or another state or operating in another state.

(b) Any insurance pool established pursuant to this division shall have initial pooled resources of not less than two million five hundred thousand dollars ($2,500,000) in the form of cash or cash equivalents.

(c) Any insurance pool established pursuant to this division shall maintain adequate reinsurance to protect against its risks.

(d) Any insurance pool established pursuant to this division shall furnish a copy of the pool's annual audited financial statement and most recent actuarial review, by first-class mail or by any other method of delivery, including electronic transmission, to the Insurance Commissioner, the Assembly Committee on Housing and Community Development, the Assembly Committee on Insurance, the Senate Committee on Insurance, and the Senate Committee on Transportation and Housing within 180 days of the close of the pool's fiscal year. If, in the period of time since the last submittal required by this subdivision, any of the following has occurred, the transmittal letter accompanying the annual audited financial statement and most recent actuarial review shall so indicate and shall provide a brief description of each matter:

(1) There has been a change to the pool's plan of financing, management, or operation, including any material amendment to any of those plans.

(2) A claims audit report has been filed with any regulatory body with respect to the pool.

(3) A report of examination issued by any regulatory body with respect to the pool has been received.

(4) There has been a material change in the scope of the regulation of the pool by other states in which the pool operates.

SEC. 30. Section 5401.7 of the Labor Code is amended to read:

5401.7. The claim form shall contain, prominently stated, the following statement:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of

obtaining or denying workers' compensation benefits or payments is guilty of a felony."

The statements required to be printed or displayed pursuant to Section 1871.2 of the Insurance Code may, but are not required to, appear on the claim form.

SEC. 31. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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As Amends the Law Today

SECTION 1.

Section 106 of the Insurance Code is amended to read:

106.

(a) Disability insurance includes insurance appertaining to injury, disablement or death resulting to the insured from accidents, and appertaining to disablements resulting to the insured from sickness.

(b) In statutes that become effective on or after January 1, 2002, the term "health insurance" for purposes of this code shall mean an individual or group disability insurance policy that provides coverage for hospital, medical, or surgical benefits. The term "health insurance" shall not include any of the following kinds of insurance:

(1) Accidental death and accidental death and dismemberment.

(2) Disability insurance, including hospital indemnity, accident only, and specified disease insurance that pays benefits on a fixed benefit, cash payment only basis.

(3) Credit disability, as defined in subdivision (2) of Section 779.2.

(4) Coverage issued as a supplement to liability insurance.

(5) Disability income, as defined in subdivision ~~(i)~~ *(c)* of Section 799.01.

(6) Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) Insurance arising out of a workers' compensation or similar law.

(8) Long-term care.

(c) In a statute that becomes effective on or after January 1, 2008, the term "specialized health insurance policy" as used in this code shall mean a policy of health insurance for covered benefits in a single specialized area of health care, including dental-only, vision-only, and behavioral health-only policies.

SEC. 2.

Section 396 of the Insurance Code is amended to read:

396.

(a) An insurer shall do either of the following:

(1) Maintain a verifiable process that allows a policyholder to designate in writing or by electronic transmission pursuant to Section 38.6 one additional person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of a policy for nonpayment of premium. The insurer shall notify the policyholder in writing or by electronic transmission pursuant to Section 38.6 of this right at the time of the application or within 30 days after the inception date of an individual policy described in subdivision (f), and at least every two years thereafter. The notification described in this subdivision shall instruct the policyholder how to request the designation and how to replace or delete a designee. If a policyholder initiates contact with the insurer after the insurer has provided notice and the insurer complies with the policyholder's request to establish or change the

additional person to receive the notice described in this section, the insurer shall not be required to maintain additional verification.

(2) Comply with subdivision (b).

(b) An insurer that adopts the following procedure shall be deemed to have complied with subdivision (a).

(1) Unless an applicant for insurance has been provided notice of the right set forth in this section prior to inception of the policy, the insurer shall provide the policyholder, within 30 days after the inception date of an individual policy described in subdivision (f), with notice of the right to designate one person, in addition to the policyholder, to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of a policy for nonpayment of premium. The insurer shall provide each applicant or policyholder with notice in writing or by electronic transmission pursuant to Section 38.6 of the opportunity to make the designation. That notice shall instruct the applicant or policyholder on how ~~he~~ *the applicant* or ~~she~~ *policyholder* is to submit the name and address of one person, in addition to the applicant or policyholder, who is to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of the policy for nonpayment of premium.

(2) If after having been provided notice from the insurer of the right to designate an individual to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium, the applicant or policyholder fails to designate an individual within 30 days, the applicant or policyholder shall be conclusively presumed to have declined the opportunity to exercise ~~his or her~~ *their* right at that time.

(3) Notwithstanding subparagraph (C) of paragraph (2) of subdivision (a) of Section 791.13 or any other law, the insurer shall retain and utilize as necessary the contact information provided in the written designation for the lifetime of the policy, and allow the policyholder to update the written designation if the policyholder so requests.

(c) (1) A policyholder retains the right to designate the one additional person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium at any time, at the initiative of the policyholder, regardless of whether the policyholder previously declined to exercise that right. At least every two years, the insurer shall notify the policyholder in writing or by electronic transmission pursuant to Section 38.6, of whichever of the following applies:

(A) If a policyholder has previously provided a designation pursuant to this subdivision, in writing or by electronic transmission pursuant to Section 38.6, the right to change the prior designation by replacing or deleting a person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium.

(B) If the policyholder has not previously designated a person to receive the notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium pursuant to this subdivision, the right to designate a person to receive notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium.

(2) The notice requirements in subparagraphs (A) and (B) of paragraph (1) may be provided to a policyholder in a single notice and shall not require two separate notices.

(d) When a policyholder pays the premium for an insurance policy through a payroll or pension deduction plan, the requirements contained in paragraph (1) of subdivision (b) need not be met until 60 days after the policyholder is no longer on that deduction payment plan.

(e) An insurance policy shall not lapse or be terminated for nonpayment of premium unless the insurer, at least 10 days prior to the effective date of the lapse, termination, expiration, nonrenewal, or cancellation, gives notice to the individual designated pursuant to subdivision (a) or (b) at the address provided by the policyholder for purposes of receiving the notice of lapse, termination, expiration, nonrenewal, or cancellation for nonpayment of premium. Notwithstanding any other law, notice shall be given by first-class United States mail, postage prepaid, within 10 days after the premium is due and unpaid. This subdivision does not modify requirements for notice to the policyholder of lapse, termination, expiration, nonrenewal, or cancellation set forth in other sections of this code.

(f) This section applies only to policies of private passenger automobile insurance that provide coverage for six months or longer, policies of residential property insurance as described in subdivision (a) of Section 10087 that take effect or that are renewed after the effective date of this section, and policies of individual disability income insurance as described in subdivision ~~(i)~~ *(c)* of Section 799.01, except if the premiums for the individual disability income policy are paid entirely by the employer.

(g) This section applies to policies that are issued and take effect or that are renewed on or after January 1, 2016.

(h) An individual designated by a policyholder pursuant to this section to receive notice of lapse, termination, expiration, nonrenewal, or cancellation of the policy for nonpayment of premium does not have any rights, whether as an additional insured or otherwise, to any benefits under the policy, other than the right to receive notice as provided by this section.

SEC. 3.

Section 510 of the Insurance Code is amended to read:

510.

(a) Whenever a policy of insurance specified in Section 660 or 675, a policy of life insurance as defined in Section 101, a policy of disability insurance as defined in Section 106, or a certificate of coverage as defined in Section 10270.6, is first issued to or delivered to a new insured or a new policyholder in this state, *or when a bail bond as defined in Section 1800.4 is first executed or delivered,* the insurer shall include a written disclosure containing the name, address, toll-free telephone number, and ~~Internet Web site~~ *internet website* of the unit within the Department of Insurance that deals with consumer affairs. The telephone number shall be the same as that provided to consumers under Section 12921.1. The disclosure shall be printed in large, boldface type.

(b) The disclosure *described in subdivision (a)* shall also contain the address and customer service telephone number of the insurer, or the address and customer service telephone number of the agent or broker of record, or all of those addresses and telephone numbers. All addresses and telephone numbers for the insurer or the agent or broker of record shall be prominently displayed, in boldfaced type. The disclosure shall also contain a statement that the Department of Insurance should be contacted only after discussions with the insurer, or its agent or other representative, or both, have failed to produce a satisfactory resolution to the problem. If the policy or certificate was issued or delivered by an agent or broker, the disclosure shall specifically advise the insured to contact ~~his or her~~ *their* agent or broker for assistance.

~~(b) This section shall become operative on January 1, 2017.~~

SEC. 4.

Section 676.2 of the Insurance Code is amended to read:

676.2.

(a) This section applies only to policies of commercial insurance that are subject to Section 675.5.

(b) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it complies with Section 677.2 and it is based on the occurrence, after the effective date of the policy, of one or more of the following:

(1) Nonpayment of premium, including payment due on a prior policy issued by the insurer and due during the current policy term covering the same risks.

(2) A judgment by a court or an administrative tribunal that the named insured has violated any law of this state or of the United States having as one of its necessary elements an act that materially increases any of the risks insured against.

(3) Discovery of fraud or material misrepresentation by either of the following:

(A) The insured or ~~his or her~~ *the insured's* representative in obtaining the insurance.

(B) The named insured or ~~his or her~~ *the named insured's* representative in pursuing a claim under the policy.

(4) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards, by the named insured or ~~his or her~~ *the named insured's* representative, which materially increase any of the risks insured against.

(5) Failure by the named insured or ~~his or her~~ *the named insured's* representative to implement reasonable loss control requirements that were agreed to by the insured as a condition of policy issuance or that were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(6) A determination by the commissioner that the loss of, or changes in, an insurer's reinsurance covering all or part of the risk would threaten the financial integrity or solvency of the insurer. A certification made under penalty of perjury to the commissioner by an officer of the insurer of the loss of, or change in, reinsurance and that the loss or change will threaten the financial integrity or solvency of the insurer if the cancellation of the policy is not permitted shall constitute this determination unless disapproved by the commissioner within 30 days of the filing. There shall be no extensions to this 30-day period.

(7) A determination by the commissioner that a continuation of the policy coverage would place the insurer in violation of the laws of this state or the state of its domicile or that the continuation of coverage would threaten the solvency of the insurer.

(8) A change by the named insured or ~~his or her~~ *the named insured's* representative in the activities or property of the commercial or industrial enterprise that results in a material added risk, a materially increased risk, or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(c) (1) After a policy has been in effect for more than 60 days, or if the policy is a renewal, effective immediately upon renewal, no increase in the rate upon which the premium is based, reduction in limits, or change in the conditions of coverage shall be effective during the policy period unless a written notice is mailed or delivered to the named insured and the producer of record at the mailing address shown on the policy, at least 30 days prior to the effective date of the increase,

reduction, or change. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure ~~is~~ *shall be* applicable if the notice is mailed. The notice shall state the effective date of, and the reasons for, the increase, reduction, or change.

(2) The increase, reduction, or change shall not be effective unless it is based upon one of the following reasons:

(A) Discovery of willful or grossly negligent acts or omissions, or of any violations of state laws or regulations establishing safety standards by the named insured that materially increase any of the risks or hazards insured against.

(B) Failure by the named insured to implement reasonable loss control requirements that were agreed to by the insured as a condition of policy issuance or that were conditions precedent to the use by the insurer of a particular rate or rating plan, if the failure materially increases any of the risks insured against.

(C) A determination by the commissioner that loss of or changes in an insurer's reinsurance covering all or part of the risk covered by the policy would threaten the financial integrity or solvency of the insurer unless the change in the terms or conditions or rate upon which the premium is based is permitted.

(D) A change by the named insured in the activities or property of the commercial or industrial enterprise that results in a materially added risk, a materially increased risk, or a materially changed risk, unless the added, increased, or changed risk is included in the policy.

(E) With respect to a change in the rate of a policy of professional liability insurance for a health care provider, the insurer's offer of renewal notifies the policyholder that the insurer has an application filed pursuant to Section 1861.05 pending with the commissioner for approval of a change in the rate upon which the premium is based, and the commissioner subsequently approves the rate change, or some different amount for the policy period. The change shall not be retroactive.

(d) The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4 (commencing with Section 11370), and Chapter 5 (commencing with Section 11500) of Title 2 of Division 3 of the Government Code) shall not apply to a determination pursuant to paragraph (6) or (7) of subdivision (b) or subparagraph (C) of paragraph (2) of subdivision (c). The commissioner shall charge an insurer who requests a determination pursuant to paragraph (6) or (7) of subdivision (b) a fee sufficient to recover the costs of making the determination. If the commissioner does not act upon a request by an insurer to cancel or change a policy pursuant to those provisions within 30 days, the request shall be deemed to be approved.

(e) This section shall not prohibit an insurer from increasing a premium during the policy period if the increase is calculated in accordance with the current rating manual of the insurer and is justified by a physical change in the insured property or by a change in the activities of the commercial or industrial enterprise that materially increases any of the risks insured against.

(f) This section shall not apply to a transfer of a policy without a change in its terms or conditions or the rate upon which the premium is based between insurers that are members of the same insurance group.

SEC. 5.

Section 676.8 of the Insurance Code is amended to read:

676.8.

(a) This section applies only to policies of workers' compensation insurance.

(b) After a policy is in effect, a notice of cancellation shall not be effective unless it complies with the notice requirements of this section and is based upon the occurrence, after the effective date of the policy, of one or more of the following:

(1) The policyholder's failure to make any workers' compensation insurance premium payment when due.

(2) The policyholder's failure to report payroll, to permit the insurer to audit payroll as required by the terms of the policy or of a previous policy issued by the insurer, or to pay any additional premium as a result of ~~a~~ *an* audit of payroll as required by the terms of the policy or of a previous policy.

(3) The policyholder's material failure to comply with federal or state safety orders or written recommendations of the insurer's designated loss control representative.

(4) A material change in ownership or any change in the policyholder's business or operations that materially increases the hazard for frequency or severity of loss, requires additional or different classifications for premium calculations, or contemplates an activity excluded by the insurer's reinsurance treaties.

(5) Material misrepresentation by the policyholder or its agent.

(6) Failure to cooperate with the insurer in the insurer's investigation of a claim.

(c) A policy shall not be canceled for the conditions specified in paragraph (1), (2), (5), or (6) of subdivision (b) except upon 10 days' written notice to the policyholder by the insurer. A policy shall not be canceled for the conditions specified in paragraph (3) or (4) of subdivision (b) except upon 30 days' written notice to the policyholder by the insurer, provided that notice is not required if an insured and insurer consent to the cancellation and reissuance of a policy effective upon a material change in ownership or operations of the insured. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure ~~applies~~ *shall be applicable* if the notice is mailed. If the policyholder remedies the condition to the insurer's satisfaction within the specified time period, the policy shall not be canceled by the insurer.

(d) Nothing in this section shall preclude, while policies are in force, changes in the premium rate required or authorized by law, regulation, or order of the commissioner, or otherwise agreed to between the policyholder and insurer.

(e) Any policy written for a term longer than one year, or any policy with no fixed expiration date, shall be considered as if written for successive policy periods of one year.

SEC. 6.

Section 677.2 of the Insurance Code is amended to read:

677.2.

(a) This section applies only to policies covered by Section 675.5.

(b) A notice of cancellation shall be in writing and shall be delivered or mailed to the producer of record, provided that the producer of record is not an employee of the insurer, and to the named insured at the mailing address shown on the policy. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure ~~is~~ *shall be* applicable if the notice is mailed.

The notice of cancellation shall include the effective date of the cancellation and the reasons for the cancellation.

(c) The notice of cancellation shall be given at least 30 days prior to the effective date of the cancellation, except that in the case of cancellation for nonpayment of premiums or for fraud the notice shall be given no less than 10 days prior to the effective date of the cancellation. Notice of a proposed cancellation pursuant to subdivision (d) of Section 676.2 given prior to a finding of the commissioner shall satisfy the requirements of this section if it is given no less than 30 days prior to the effective date of the cancellation and if it states that cancellation will be effective only upon the approval of the commissioner.

(d) This section applies only to cancellations pursuant to Section 676.2.

SEC. 7.

Section 677.4 of the Insurance Code is amended to read:

677.4.

A notice of cancellation with respect to a policy covered under Section 675 shall be delivered at least 20 calendar days prior to the effective date of the cancellation, except that in the case of a cancellation for nonpayment of premiums, or for fraud, the notice shall be given at least 10 calendar days prior to the effective date of the cancellation. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure ~~is~~ *shall be* applicable if the notice is mailed.

SEC. 8.

Section 678 of the Insurance Code is amended to read:

678.

(a) (1) At least 45 days before the policy expiration, an insurer shall deliver to the named insured or mail to the named insured at the address shown in the policy, either of the following:

(A) An offer of renewal of the policy contingent upon payment of premium as stated in the offer, stating each of the following:

(i) Any reduction of limits or elimination of coverage. That reduction of limits or elimination of coverage shall identify the specific limits being reduced or coverage being eliminated by the offer of renewal. The elimination of coverage for the previously covered peril of fire shall be subject to subdivision (b) of Section 10103.6.

(ii) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the renewal offer.

(B) A notice of nonrenewal of the policy. That notice shall contain all of the following:

(i) The specific reason or reasons for the nonrenewal.

(ii) The telephone number of the insurer's representatives who handle consumer inquiries or complaints. The telephone number shall be displayed prominently in a font size consistent with the other text of the notice of nonrenewal.

(iii) Until July 1, 2020, a brief statement indicating that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by

the department. The statement shall include the telephone number of the unit within the department that responds to consumer inquiries and complaints.

(iv) On or after July 1, 2020, a statement that if the consumer has contacted the insurer to discuss the nonrenewal and remains unsatisfied, the consumer may have the matter reviewed by the department. The statement shall include the department's internet website, www.insurance.ca.gov, the department's telephone number, (800) 927-HELP (4357), and the mailing address of the department's Consumer Services Division, 300 S. Spring Street, Los Angeles, CA 90013.

(2) On and after July 1, 2022, *the time periods and procedures in* subdivision (a) of Section 1013 of the Code of Civil Procedure ~~applies~~ *shall be applicable* if an offer or notice is mailed.

(b) If an insurer fails to give the named insured either an offer of renewal or notice of nonrenewal as required by this section, the existing policy, with no change in its terms and conditions, shall remain in effect for 45 days from the date that either the offer to renew or the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the policy or the notice of renewal or nonrenewal.

(c) Notwithstanding subdivisions (a) and (b), with respect to a notice of nonrenewal for a policy that expires on or after July 1, 2020, the following timelines apply:

(1) At least 75 days before the policy expiration, the insurer shall deliver the notice of nonrenewal to the named insured or mail the notice of nonrenewal to the named insured at the address shown in the policy. The notice shall include the information contained in subparagraph (B) of paragraph (1) of subdivision (a). On and after July 1, 2022, *the time periods and procedures in* subdivision (a) of Section 1013 of the Code of Civil Procedure ~~applies~~ *shall be applicable* if a notice is mailed.

(2) If an insurer fails to give the named insured a notice of nonrenewal at least 75 days before the policy expiration, as required by paragraph (1), the existing policy, with no change in its terms and conditions, shall remain in effect for 75 days from the date that the notice of nonrenewal is delivered or mailed to the named insured. A notice to this effect shall be provided by the insurer to the named insured with the notice of nonrenewal.

(d) A policy written for a term of less than one year shall be considered as if written for a term of one year. A policy written for a term longer than one year, or a policy with no fixed expiration date, shall be considered as if written for successive policy periods or terms of one year.

(e) A notice of nonrenewal for a residential property insurance policy expiring on or after July 1, 2021, shall be accompanied by the following notice:

The California Department of Insurance has developed the California Home Insurance Finder, an online tool that can assist you in obtaining insurance for your home. The Finder contains names, addresses, telephone numbers, and internet website links of licensed insurance agents, brokers, and insurance companies that may be able to sell insurance to you. The Finder is organized by ZIP Code and the languages in which the agent, broker, or insurance company sells insurance.

The California FAIR Plan (FAIR Plan) provides basic property insurance as the "insurer of last resort" if you cannot find insurance coverage for your property in the normal (voluntary) insurance market. The FAIR Plan provides basic property insurance coverage for residential structures, as well as personal property coverage for residential and business occupancies. However, FAIR Plan policies may not cover liability, theft, or water damage, among other things. There are also optional coverages available for both residential properties. Applications can be made directly with the FAIR Plan (cfpnet.com), although the FAIR Plan strongly encourages use of a licensed agent or broker for

assistance in preparing and obtaining a quote. There is no additional cost for using an agent or broker for purchasing a FAIR Plan policy.

California law requires an agent or broker to assist a person seeking a FAIR Plan policy by (1) submitting a coverage application to the FAIR Plan on behalf of the consumer, (2) providing the consumer the FAIR Plan's internet website address and toll-free telephone number, or (3) obtaining a policy for the consumer through an admitted or nonadmitted insurer.

To supplement a FAIR Plan policy, a Difference in Conditions (DIC) policy should be considered. A DIC policy is sold by some private insurers, and provides coverage for things not covered by the basic property insurance policy provided by the FAIR Plan. A consumer who wants broader coverage than that provided by the FAIR Plan policy should contact an agent, broker, or insurance company that offers a DIC policy to obtain this additional coverage. The Department of Insurance maintains a list of insurance companies that sell DIC policies on its internet website (insurance.ca.gov). Additional assistance may be obtained by contacting an agent or broker listed with the department's online agent locator.

(f) An insurer may use a notice substantially similar to the notice set forth in subdivision (e) to the extent that the notice provides additional or more detailed information.

(g) This section applies only to policies of insurance specified in Section 675.

SEC. 9.

Section 678.1 of the Insurance Code is amended to read:

678.1.

(a) This section applies only to policies of insurance of commercial insurance that are subject to Sections 675.5 and 676.6.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 60 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy, or to condition renewal upon reduction of limits, elimination of coverages, increase in deductibles, or increase of more than 25 percent in the rate upon which the premium is based.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its terms or conditions, for a period of 60 days after the insurer gives the notice.

(e) With respect to policies defined in subdivision (b) of Section 676.6, in addition to the bases for conditional renewal set forth in subdivision (c), an insurer may also condition renewal upon requirements relating to the underlying policy or policies. If the requirements are not satisfied as of (1) the expiration date of the policy, or (2) 30 days after mailing or delivery of such notice, whichever is later, the conditional renewal notice shall be treated as an effective notice of nonrenewal, provided the insurer has sent written confirmation to the first named insured and the producer of record that the conditions were not met and that coverage ceased at the expiration date shown in the expiring policy.

(f) A notice of nonrenewal shall not be required in any of the following situations.

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured, within the time period specified in subdivision (c), to renew the policy under changed terms or conditions or at a changed premium rate. As used herein, "terms or conditions" includes, but is not limited to, a reduction in limits, elimination of coverages, or an increase in deductibles.

(g) This section shall become operative on January 1, 2019.

SEC. 10.

Section 785 of the Insurance Code is amended to read:

785.

(a) All insurers, brokers, agents, and others engaged in the transaction of insurance owe a prospective insured who is 65 years of age or older, a duty of honesty, good faith, and fair dealing. This duty is in addition to any other duty, whether express or implied, that may exist.

(b) Conduct of an insurer, broker, or agent, or other person engaged in the transaction of insurance, during the offer and sale of a policy or certificate previous to the purchase is relevant to any action alleging a breach of the duty of good faith and fair dealing.

(c) Except where explicitly provided to the contrary, this article shall not apply to any of the following:

(1) Medicare supplement insurance as defined in subdivision (m) of Section 10192.4.

(2) Long-term care insurance as defined in Section 10231.2.

(3) Disability coverage provided through the insured's employer or former employer.

(4) Disability insurance policies or certificates principally designed to provide coverage for accidents or expenses incurred while traveling if the premium for the policy or certificate is ten dollars ($10) or less.

(5) Blanket disability insurance as defined in Section 10270.3.

(6) Credit disability insurance as defined in Section 779.2.

(7) Accidental death insurance.

(8) Until January 1, 2002, disability policies or certificates that are sold through direct response methods of delivery.

(9) Disability income insurance as defined in subdivision ~~(i)~~ *(c)* of Section 799.01.

(d) Provided that the requirements of Section 10296 are met, this article shall not apply to transportation ticket policies and baggage insurance policy types allowable for sale by travel agents pursuant to Section 1753.

SEC. 11.

Section 799.02 of the Insurance Code, as added by Section 3 of Chapter 184 of the Statutes of 2020, is amended to read:

799.02.

(a) A life or disability income insurer shall not decline an application or *an* enrollment request for coverage under a policy or certificate for life insurance or disability income insurance based solely on the results of a positive HIV test, regardless of when or at whose direction the test was performed.

(b) Notwithstanding any other law, this article does not prevent or otherwise restrict a life or disability income insurer from refusing to insure an applicant that is HIV positive, limiting the amount, extent, or kind of coverage for an applicant that is HIV positive, or charging a different rate to an applicant that is HIV positive, if the refusal, limitation, or charge is based on sound actuarial principles and actual or reasonably anticipated experience.

(c) Transferring an applicant from a simplified, expedited, accelerated, or algorithmic underwriting process to a traditional medical underwriting process, based solely on the results of a positive HIV test, does not constitute a denial of the application or a violation of this section.

~~(d) This section applies to a policy, certificate, application, or enrollment request that meets both of the following requirements:~~

~~(1) It is issued, delivered, or received on or after January 1, 2023.~~

~~(2)~~ *(d)* ~~In order to be effective, its issuance, delivery, or granting~~ *This section applies if coverage* is contingent upon medical review for other diseases or medical conditions.

SEC. 12.

Section 1652 of the Insurance Code is amended to read:

1652.

(a) The commissioner shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice pursuant to subdivision (u) of Section 11105 of the Penal Code, and the Department of Justice shall provide to the commissioner a state or federal response pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code, for all applicants of each of the following:

(1) A property licensee or a casualty licensee, as defined in Section 1625.

(2) A personal lines licensee, as defined in Sections 1625.5.

(3) A limited lines automobile insurance agent, as defined in Section 1625.55.

(4) A life and accident and health or sickness licensee, as defined in Section 1626.

(5) A life licensee limited to the payment of funeral and burial expenses, as defined in Section 1676.

(6) A special lines' surplus line broker, as defined in Section 1760.5.

(7) A surplus line broker, as defined in Section 47.

(8) A cargo owner's or shipper's agent, as defined in Section 1757.1.

(9) A portable electronics agent license, as defined in Section 1758.69.

(10) A car rental agent, as defined in Section 1758.89.

(11) A credit insurance agent license, as defined in Section 1758.992.

(12) An administrator, as defined in Section 1759.

(13) A reinsurance intermediary-broker, as defined in Section 1781.2.

(14) A bail agent license, as defined in Section 1802.

(15) A bail permittee license, as defined in Section 1802.5.

(16) A bail solicitor license, as defined in Section 1803.

(17) A bail fugitive recovery agent license, as defined in Section 1802.3.

(18) A life and disability analyst, as defined in Section 32.5.

(19) A stock agent who sells securities, as defined in Section 825.

(20) An insurance adjuster, as defined in Section 14021.

(21) A crop insurance adjuster as defined in Section 14085.

(22) A public insurance adjuster, as defined in Section 15007.

(23) A part-time fraternal licensee, as described in Sections 11102 and 11103.

(24) A life settlement broker, as defined in Section 10113.1.

(25) A motor club agent, as defined in Section 12143.

(26) A title marketing representative, as defined in Section 12418.

~~(a)~~ *(b)* A license ~~under this chapter, Chapter 5A (commencing with Section 1759), Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), and Chapter 8 (commencing with Section 1831), of Part 2 of Division 1, and Chapter 1 (commencing with Section 14000) and Chapter 2 (commencing with Section 15000) of Division 5~~ shall be applied for, and renewed by the filing with the commissioner of a written application therefor. The application shall be on a form prescribed by the commissioner, which form shall prescribe the disclosure of information that will aid the commissioner in determining whether the prerequisites for the license sought have been met. The applicant shall declare, under penalty of perjury, that the contents of the application are true and correct.

~~(b)~~ *(c)* The forms prescribed by the commissioner other than for renewal applications may require authenticated fingerprints of any of the following:

(1) Individual applicants.

(2) Specified partners or officers of organization applicants.

(3) The individuals who are to transact insurance for an organization applicant.

~~(c)~~ *(d)* The forms may require the fingerprints to be affixed to the application or to an attachment to be affixed to the application. The commissioner, in the commissioner's discretion, may require the fingerprints on applications for any, some, or all of the licenses issued pursuant to this chapter or Chapter 6 (commencing with Section 1760), Chapter 7 (commencing with Section 1800), or Chapter 8 (commencing with Section 1831), provided that as to any one such type of license the requirement is applied without discrimination to all applicants within specified classifications. The classifications may be made upon any or all of the following bases:

(1) Length of continuous residence in this state.

(2) Whether or not previously or currently licensed by the commissioner.

(3) Whether or not currently licensed by specified regulatory agencies of the State of California which require fingerprints on applications for licenses and routinely process the fingerprints for positive identification.

(4) Other reasonable criteria.

~~(d)~~ *(e)* The commissioner may decline to act on an incomplete or defective application until an amended application which completes the prescribed form is filed with the commissioner.

SEC. 13.

Section 1725.5 of the Insurance Code is amended to read:

1725.5.

(a) A person licensed under ~~Sections~~ *Section* 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 1800, 14020, ~~and~~ *or* 15006, ~~and~~ *or* Chapter 8 (commencing with Section 1831), shall affix, type, or print on business cards, written price quotations for insurance products, and print advertisements distributed exclusively in this state for insurance products, its license number in a type size that is at least as large as any indicated telephone number, address, or fax number or in 12-point type, or in 8-point type for business cards, whichever is larger. If a licensee includes the names of multiple licensed organizations on a business card, written price quotation, or print advertisement distributed exclusively in this state, affixing, typing, or printing the license number of any one of the organizations complies with the requirements of this section.

(b) A person licensed under ~~Sections~~ *Section* 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 14020, ~~and~~ *or* 15006, ~~and~~ *or* Chapter 8 (commencing with Section 1831), shall affix, type, or print on business cards, written price quotations for insurance products, and print advertisements distributed in this state for insurance products, the word "Insurance" in a type size that is at least as large as the smallest telephone number or in 12-point type, or in 8-point type for business cards, whichever is larger.

(c) A person licensed under Section 1625, 1625.5, 1625.55, 1626, 1758.1, 1765, 14020, or 15006, or Chapter 8 (commencing with Section 1831), shall include the person's license number in the emails the person sends that involve an activity for which a license is required. A person's license number shall be in a type size that is no smaller than the largest of any telephone number, street address, or email address of the person included in the email. The license number of an individual licensee shall appear adjacent to or on the line below the individual's name or title. The license number of an organizational licensee shall appear adjacent to or on the line below the organization's name.

~~(c)~~ *(d)* A natural person who is a solicitor, as defined in Section 1624, working exclusively as an employee of a motor club agent, or working exclusively for a property broker-agent or casualty broker-agent on behalf of a motor club, shall use the organizational licensee number of that person's employer.

~~(d)~~ *(e)* A person in violation of this section shall be subject to a fine levied by the commissioner in the amount of two hundred dollars ($200) for the first offense, five hundred dollars ($500) for the second offense, and one thousand dollars ($1,000) for the third and subsequent offenses. The penalty shall not exceed one thousand dollars ($1,000) for any one offense. These fines shall be deposited into the Insurance Fund.

~~(e)~~ *(f)* A separate penalty shall not be imposed upon each piece of printed material that fails to conform to the requirements of this section.

~~(f)~~ *(g)* If the commissioner finds that the failure of a licensee to comply with the provisions of subdivision (a) or (b) is due to reasonable cause or circumstance beyond the licensee's control, and occurred notwithstanding the exercise of ordinary care and in the absence of willful neglect, the licensee may be relieved of the penalty in subdivision ~~(d).~~ *(e).*

~~(g)~~ *(h)* A licensee seeking to be relieved of the penalty in subdivision ~~(d)~~ *(e)* shall file with the department a statement with supporting documents setting forth the facts upon which the licensee bases its claims for relief.

~~(h)~~ *(i)* This section does not apply to a person or entity that is not currently required to be licensed by the department or that is exempted from licensure.

~~(i)~~ *(j)* This section does not apply to general advertisements of motor clubs that merely list insurance products as one of several services offered by the motor club, and do not provide any details of the insurance products.

~~(j)~~ *(k)* This section does not apply to life insurance policy illustrations required by Chapter 5.5 (commencing with Section 10509.950) of Part 2 of Division 2 or to life insurance cost indexes required by Chapter 5.6 (commencing with Section 10509.970) of Part 2 of Division 2.

~~(k) This section shall become operative on January 1, 2019.~~

SEC. 14.

Section 1749 of the Insurance Code is amended to read:

1749.

The department shall require all new applicants for license as a property broker-agent, casualty broker-agent, limited lines automobile insurance agent, personal lines broker-agent, life agent, or accident and health or sickness agent to meet prelicensing education standards as follows:

(a) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a property broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(b) Require a minimum of 20 hours of prelicensing study as a prerequisite to qualification for a casualty broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the

minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(c) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a personal lines broker-agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(d) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a life agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements provided by this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(e) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for a limited lines automobile insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department.

(f) Require a minimum of 20 hours of prelicensing study as a prerequisite for qualification for an accident and health or sickness insurance agent license. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. Any additions to the minimum requirements under this section shall be approved by the curriculum board pursuant to Section 1749.1 and certified by the department. This curriculum shall also include instruction in workers' compensation and general principles of employers' liability.

(g) In addition to the 20 hours of prelicensing education required to qualify for a license as a property broker-agent, casualty broker-agent, personal lines broker-agent, a life agent, or an accident and health or sickness agent, or the 20 hours of prelicensing education required to qualify for a license as a limited lines automobile insurance agent, the department shall require 12 hours of study on ethics and this code. ~~Where~~ *On and after March 1, 2023, that 12-hour ethics course shall include one hour of study on insurance fraud. If* an applicant seeks a license for more than one of the following license types: a property broker-agent license, a casualty broker-agent license, a personal lines broker-agent license, a life license, or an accident and health or sickness license, the applicant shall only be required to complete one 12-hour course on ethics and this ~~code.~~ *code, which shall include one hour of study on insurance fraud on and after March 1, 2023.* The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval.

(h) An applicant for a life agent license, an accident and health or sickness license, a personal lines broker-agent license, or a limited lines automobile insurance agent license, who is currently licensed as a nonresident in this state shall be required to complete only the *12-hour* course of study on ethics and this code, as required by this section. *On and after March 1, 2023, the 12-hour ethics course shall include one hour of study on insurance fraud.* Additionally, any applicant for that license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4 shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of the license.

(i) An applicant for a property broker-agent or casualty broker-agent license who is currently licensed as a nonresident in this state shall be required to complete only the *12-hour* course of study on ethics and this code, as required by subdivision (g). *On and after March 1, 2023, the 12-hour ethics course shall include one hour of study on insurance fraud.* Additionally, any applicant for a license holding one or more of the designations specified in subdivisions (a) to (p), inclusive, of Section 1749.4, shall be exempted from any requirement for courses in general insurance that would otherwise be a condition of issuance of a license.

(j) An applicant for a property broker-agent or casualty broker-agent license or both who is licensed as a personal lines agent shall complete a minimum of 20 hours of prelicensing study as a prerequisite for each of these licenses. The curriculum for satisfying this requirement shall be approved by the curriculum board and submitted to the commissioner for final approval. The applicant shall not be required to repeat any prelicensing requirements completed as a prerequisite to being licensed as a personal lines agent.

(k) Review and approval of prelicensing courses not conducted in a classroom, as referenced in subdivisions (a) to (j), inclusive, shall include an evaluation of the safeguards in place to ensure that the student completing the course is the person enrolled in the course, methods used to monitor the student's attendance are adequate, methods for the student to interact with the entity providing the training exist, and methods used to record the times spent completing the course are adequate.

(l) Prelicensing certificates of completion expire three years from the completion date of the course, whether or not a license is issued.

SEC. 15.

Section 1749.3 of the Insurance Code is amended to read:

1749.3.

An individual licensed as a life agent or an accident and health or sickness agent and also licensed as a property or casualty broker-agent, or an individual only licensed as a property or casualty broker-agent, shall complete those courses, programs of instruction, or seminars approved by the commissioner for the type of license held. Completion of specified product training required in subdivision (d) of Section 1749.33, subdivision (b) of Section 1749.8, and paragraph (4) of subdivision (a) of Section 10234.93 may result in the completion of more than the minimum of required continuing education hours. The minimum number of hours required is as follows:

(a) A licensee, as specified in this section, shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.* These hours of instruction may be completed at any time prior to renewal of the license.

(b) An individual licensed as a property broker-agent or casualty broker-agent and as a life agent or an accident and health or sickness agent shall satisfy the requirements of this section by demonstrating completion of the courses, programs of instruction, or seminars approved by the commissioner for any of the license types listed in this section.

(c) A licensee is not required to comply with the requirements of this article if the licensee submits proof satisfactory to the commissioner that the licensee has been a licensee in good standing for 30 continuous years in this state and is 70 years of age or older. This exemption does not apply to those individuals licensed for the first time on or after January 1, 2010.

SEC. 16.

Section 1749.31 of the Insurance Code is amended to read:

1749.31.

(a) An individual licensed as a personal lines broker-agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The personal lines broker-agent shall complete 24 hours, of which three hours shall be in ethics, during each two-year license term as defined in subdivision (d) of Section 1625.5. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.*

(b) An individual licensed as a personal lines broker-agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 17.

Section 1749.32 of the Insurance Code is amended to read:

1749.32.

(a) An individual licensed as a limited lines automobile insurance agent shall complete required continuing education courses, programs of instruction, or seminars approved by the commissioner. The minimum number of hours required is 20 hours, of which three hours shall be in ethics, per license term prior to the renewal of the license. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.*

(b) An individual licensed as a limited automobile insurance agent and as a life agent or accident and health or sickness agent shall satisfy the requirements of this section by satisfactorily completing 24 hours of instruction prior to renewal of the license.

SEC. 18.

Section 1749.33 of the Insurance Code is amended to read:

1749.33.

(a) A life agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.* These hours of instruction may be completed at any time prior to renewal of the license.

(b) An accident and health or sickness agent licensee shall satisfactorily complete 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.* These hours of instruction may be completed at any time prior to renewal of the license.

(c) An agent licensed as both a life agent and as an accident and health or sickness agent shall satisfactorily complete a total of 24 hours of instruction, of which three hours shall be in ethics, prior to renewal of the license. *On and after March 1, 2023, the three-hour ethics course shall include one hour of study on insurance fraud.* These hours of instruction may be completed at any time prior to renewal of the license.

(d) Any accident and health or sickness agent who wishes to sell 24-hour care coverage, as defined in Section 1749.02, shall complete a course, program of instruction, or seminar of an approved continuing education provider on workers' compensation and general principles of employer liability, which shall be completed by examination approved by the commissioner as part of the continuing education course, program of instruction, or seminar prior to selling this coverage. The required number of instruction hours shall be equal to but no greater than that required by the

curriculum board for the prelicensing requirements of a property broker-agent or a casualty broker-agent on these subjects. For resident licensees, this requirement shall count toward the licensee's continuing education requirement, but may still result in completing more than the minimum number of continuing education hours set forth in this section. This section does not authorize an accident and health or sickness agent to satisfy the obligations set forth in this section by other than a proctored examination administered or approved by the department.

SEC. 19.

Section 1758.9 of the Insurance Code is amended to read:

1758.9.

No person shall sell or solicit any form of credit insurance in this ~~state, and receive a commission for their efforts,~~ *state* unless that person is licensed as an insurance agent or broker pursuant to Article 3 (commencing with Section 1631) or is licensed as a credit insurance agent or endorsee under this article.

SEC. 20.

Section 1871.2 of the Insurance Code is amended to read:

1871.2.

(a) An insurer who, in connection with any insurance application, contract, or provision of ~~contract described in Section 108,~~ *contract,* prints, reproduces, or furnishes a form to any person upon which that person applies for a policy, seeks to make a change to an existing policy, or gives notice of a claim to the insurer or makes a claim against the insurer by reason of accident, injury, death, or other noticed or claimed loss, ~~or on a rider attached to the form,~~ shall cause to be printed or displayed in comparative prominence with other content ~~the~~ *on the form, exclusive of schedules attached to the form, or an endorsement separate from the form, the* statement: "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." This statement shall be preceded by the words: "For your protection California law requires the following to appear on this form" or other explanatory words of similar meaning.

(b) This section is not applicable to a contract of reinsurance as defined in Section 620.

SEC. 21.

Section 1872.4 of the Insurance Code is amended to read:

1872.4.

(a) Any company licensed to write insurance in this state that ~~reasonably believes or knows that a fraudulent claim is being made~~ *has determined, after the completion of the insurer's special investigative unit investigation, that it reasonably suspects or knows an act of insurance fraud may have occurred or might be occurring* shall, within 60 days after *that* determination by the ~~insurer that the claim appears to be a fraudulent claim,~~ *insurer,* send to the Fraud Division, on a form prescribed by the department, the information requested by the form and any additional information relative to the factual circumstances ~~of the claim and the parties claiming loss or damages that the commissioner may require.~~ *regarding the alleged insurance fraud and person or entity that may have committed or is committing insurance fraud, as specified in Section 2698.38 of Title 10 of the California Code of Regulations.* The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations. Whenever the commissioner is satisfied that fraud, deceit, or intentional

misrepresentation of any kind has been committed in the submission of the claim, ~~he or she~~ *claims, application, or other insurance transaction, the commissioner* shall report the violations of law to the insurer, to the appropriate licensing agency, and to the district attorney of the county in which the offenses were committed, as provided by Sections 12928 and 12930. If the commissioner is satisfied that fraud, deceit, or intentional misrepresentation has not been committed, ~~he or she~~ *the commissioner* shall report that determination to the insurer. If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations.

(b) This section shall not require an insurer to submit to the Fraud Division the information specified in subdivision (a) in either of the following instances:

(1) The insurer's initial investigation indicated a potentially fraudulent claim but further investigation revealed that it was not fraudulent.

(2) The insurer and the claimant have reached agreement as to the amount of the claim and the insurer does not have reasonable grounds to believe that claim to be fraudulent.

(c) Nothing contained in this article shall relieve an insurer of its existing obligations to also report suspected violations of law to appropriate local law enforcement agencies.

(d) Any police, sheriff, disciplinary body governed by the provisions of the Business and Professions Code, or other law enforcement agency shall furnish all papers, documents, reports, complaints, or other facts or evidence to the Fraud Division, when so requested, and shall otherwise assist and cooperate with the division.

(e) If an insurer, at the time the insurer, pursuant to subdivision (a) forwards to the Fraud Division information on a claim that appears to be fraudulent, has no evidence to believe the insured on that claim is involved with the fraud or the fraudulent collision, the insurer shall take all necessary steps to assure that no surcharge is added to the insured's premium because of the claim.

SEC. 22.

Section 1872.41 is added to the Insurance Code, to read:

1872.41.

(a) An agent or broker who, before placing an insurance application with an insurer, reasonably suspects or knows that a fraudulent application is being made shall, within 60 days after the determination by the agent or broker that the application appears to be fraudulent, submit to the Fraud Division, using the electronic form within Fraud Division's Consumer Fraud Reporting Portal, the information requested by the form and any additional information relative to the factual circumstances of the application and the alleged material misrepresentations contained in the application. All data fields within the Fraud Division's Consumer Fraud Reporting Portal electronic form shall be completed accurately, to the best of the agent or broker's ability. An agent or broker shall not submit a fraud referral anonymously. The Fraud Division shall review each report and undertake further investigation it deems necessary and proper to determine the validity of the allegations.

(b) An agent or broker who, after an insurance application has been placed with an insurer, reasonably suspects or knows that fraud has been perpetrated shall report that information directly to the insurer's special investigative unit. An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the insurer's special investigative unit upon request, and shall otherwise assist and cooperate with the insurer's special investigative unit.

(c) An agent or broker shall furnish all papers, documents, reports, or other facts or evidence to the department upon request, and shall otherwise assist and cooperate with the department.

(d) (1) For purposes of this section, an "agent or broker" is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5, 1625.55, 1626, or 1758.1 and is not the employee of an insurer.

(2) An agent or broker is not considered a "contracted entity" or "integral antifraud personnel" pursuant to Section 2689.30 of Title 10 of the California Code of Regulations.

SEC. 23.

Section 1872.51 is added to the Insurance Code, to read:

1872.51.

(a) An agent or broker who furnishes written or oral information pursuant to Section 1872.41, or an authorized governmental agency, or its employees, that furnishes or receives written or oral information pursuant to Section 1872.41 or assists in an investigation of a suspected insurance fraud violation conducted by an authorized governmental agency, shall not be subject to any civil liability in a cause or action if the insurer, authorized agent, agent or broker, or authorized governmental agency acted in good faith, without malice, and reasonably believes that the action taken was warranted by the then-known facts, obtained by reasonable efforts.

(b) This chapter does not abrogate or lessen the existing common law or statutory privileges and immunities of an insurer, agent authorized by that insurer to act on its behalf, agent or broker, licensed rating organization, or any authorized governmental agency or its employees.

SEC. 24.

Section 1879.2 of the Insurance Code is repealed.

~~**1879.2.**~~

~~(a) Any insurer that prints, reproduces, or furnishes a form to any person upon which that person gives notice to the insurer of a claim under any contract of insurance or makes a claim against the insurer for any loss, damage, liability, or other covered event shall cause to be printed or displayed, in comparative prominence compared to other contents, the following statement: "Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison." The statement shall be preceded by the words: "For your protection California law requires the following to appear on this form" or other explanatory words of similar meaning.~~

~~(b) Any insurer that has produced or caused to be printed forms containing the statement required by subdivision (a), as originally added by Chapter 1008 of the Statutes of 1994, may continue to use those forms until December 31, 1996. This subdivision is intended to prevent any unnecessary waste of resources that might result from insurers' efforts to comply with conflicting provisions of law.~~

SEC. 25.

Section 10111.2 of the Insurance Code is amended to read:

10111.2.

(a) Under a policy of disability insurance other than health insurance, as defined in Section 106, including a policy of disability income insurance, as defined in subdivision ~~(i)~~ *(c)* of Section 799.01, payment of benefits to the insured shall be made within 30 calendar days after the insurer has

received all information needed to determine liability for a claim. However, the 30-calendar-day period shall not include any time during which the insurer is doing any of the following:

(1) Awaiting a response for relevant medical information from a health care provider.

(2) Awaiting a response from the claimant to a request for additional relevant information.

(3) Investigating possible fraud that has been reported to the department's Fraud Division in compliance with subdivision (a) of Section 1872.4.

(b) If the insurer has not received all information needed to determine liability for a claim within 30 calendar days after receipt of the claim, the insurer shall notify the insured in writing and include a written list of all information it reasonably needs to determine liability for the claim. In that event, the 30-calendar-day period set out in subdivision (a) shall commence when the insured has provided to the insurer all information in that notification. If no notice is sent by the insurer within 30 calendar days after the claim is filed by the insured, interest shall begin to accrue on the payment of benefits on the 31st calendar day after receipt of the claim, at the rate of 10 percent per year.

(c) When the insurer has received all information needed to determine liability for a claim, and the insurer determines that liability exists and fails to make payment of benefits to the insured within 30 calendar days after the insurer has received that information, any delayed payment shall bear interest, beginning the 31st calendar day, at the rate of 10 percent per year. Liability shall, in all cases, be determined by the insurer within 30 calendar days of receiving all information set out in the insurer's written notification to the insured.

(d) Nothing in this section is intended to restrict any other remedies available to an insured by statute or any other law.

SEC. 26.

Section 10144.55 of the Insurance Code is amended to read:

10144.55.

(a) Every policy of disability income insurance, as defined in subdivision ~~(i)~~ *(c)* of Section 799.01, that is of a short-term limited duration of two years or less, that is issued, amended, or renewed on or after July 1, 2014, and that provides disability income benefits shall provide coverage for disability caused by severe mental illnesses.

(b) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders, including postpartum depression.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

SEC. 27.

Section 10235.45 of the Insurance Code is amended to read:

10235.45.

(a) If a life insurance policy ~~issued on or after January 1, 2021,~~ contains long-term care benefits and permits policy loans or cash withdrawals, then access to those loans or withdrawals shall not be prohibited or limited due to the payment of long-term care benefits, except as provided in paragraphs (1) and (2).

(1) Payment of an accelerated death benefit for long-term care shall result in no more than a pro rata reduction in the cash value of the life insurance policy. A reduction in cash value shall be proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment. Future access to policy loans and cash withdrawals may be limited to the remaining cash value.

(2) Notwithstanding paragraph (1), payment of an accelerated death benefit for long-term care may be considered a lien against the death benefit of the life insurance policy, and access to the cash value of the life insurance policy may be restricted to the excess of the cash value over the sum of outstanding policy loans and the lien. Future access to policy loans and cash withdrawals may also be limited to the excess of the cash value over the sum of outstanding policy loans and the lien.

(3) This subdivision applies only to policies issued on or after January 1, 2021.

(b) If payment of an accelerated death benefit for long-term care results in a pro rata reduction in the cash value of the life insurance policy, the payment may be applied toward repayment of a pro rata portion of outstanding policy loans. The amount of the loan repayment shall be proportionally equal to the percentage of death benefits accelerated to produce the accelerated death benefit payment.

(c) At least 30 days before the *expected* first payment of an accelerated death benefit for long-term care, the insurer shall ~~send~~ *provide* the policyholder or certificate holder *with* a statement that includes ~~all of the following:~~ *the information described in this subdivision. Alternatively, an insurer may provide the statement at the time of payment, but only if the insurer allows cancellation of the payment for at least 30 days after it is made.*

(1) The ~~scheduled payment date and an option to cancel the payment before the payment date. The policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer's address or telephone number at any time before the payment date.~~ *statement shall be dated and shall include all of the following:*

~~(2)~~ *(A)* An explanation of changes to the policy that *have occurred as a result of the payment, or* would occur as a result of the *estimated* payment, including, but not limited to, a prohibition or limitation of access to loans or cash withdrawals.

~~(3)~~ *(B)* A numerical demonstration of the *estimated* effect of the payment on ~~the remaining~~ *any applicable remaining policy values. The demonstration shall include, if applicable, impact to the* death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, ~~and~~ premium payments or cost of insurance ~~charges.~~ *charges, and any other values impacted by the payment.*

~~(4)~~ *(C)* A notice stating: "WARNING: Payment of an accelerated death benefit for long-term care will reduce and may potentially eliminate your death benefit. Receipt of an accelerated death benefit for long-term care may be taxable and may also adversely affect your eligibility for Medicaid or other government entitlements. Please consult a financial advisor."

(2) If the statement is provided before the payment date, it shall also include all of the following:

(A) The expected payment date.

(B) An explanation that the policyholder or certificate holder may request payment before the expected payment date.

(C) Notice that the policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer's address or telephone number at any time before the expected payment date.

(3) If the statement is provided at the time of payment, it shall also include notice that the policyholder or certificate holder may cancel the payment by contacting the insurer at the insurer's address or telephone number within the cancellation period and returning the payment.

(d) The statement required by subdivision (c) is required only once per *policyholder for an individual* policy, or once per ~~policyholder if a policy has multiple policyholders,~~ *certificate holder for a group policy,* and does not need to be provided for later accelerated death benefit claims by the same ~~policyholder.~~ *policyholder or certificate holder.*

(e) No later than 30 days after every payment of an accelerated death benefit for long-term care, ~~the~~ *or 45 days after the first payment of an accelerated death benefit for long-term care, the* insurer shall provide the policyholder or certificate holder with a ~~report that includes~~ *statement summarizing the effect of the payment on the remaining policy values. The statement shall include* all of the following:

(1) The accelerated death benefits paid out during the prior month.

(2) An explanation of ~~changes~~ *changes, if applicable,* to the remaining death benefit, cash value or accumulation account, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, ~~and~~ premium payments or cost of insurance ~~charges.~~ *charges, and any other values impacted by the payment.*

(3) The amount of the remaining benefits that can be accelerated.

(f) If a policyholder or certificate holder initiates a request to take a loan or withdrawal from the cash value of a life insurance policy that accelerates benefits for long-term care, the insurer shall provide the policyholder or certificate holder with *a statement that includes* the information described in ~~paragraphs (1) to (7), inclusive, of this subdivision. The request shall be deemed incomplete, and the insurer shall not approve the loan or withdrawal, until the information has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan or withdrawal. The insurer shall send the policyholder or certificate holder a dated statement that includes all of the following:~~ *paragraph (3).*

(1) Except for a loan that is immediately approved pursuant to paragraph (2), a request to take a loan or withdrawal shall be deemed incomplete, and the insurer shall not approve the loan or withdrawal, until the information has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan or withdrawal.

(2) The insurer may immediately approve a loan and provide the statement at the time of payment, but only if the loan is not treated as a taxable distribution for federal income tax purposes and the insurer permits cancellation of the loan for at least 30 days after the loan payment has been made.

(A) The insurer shall provide notice that the policyholder or certificate holder may cancel the loan by contacting the insurer at the insurer's address or telephone number within the cancellation period and returning the loan payment.

(B) At the time the loan is requested, the insurer shall provide an option to receive the statement before the loan request is finalized. If the policyholder or certificate holder elects this option, the loan request shall be deemed incomplete, and the insurer shall not approve the loan, until the statement has been provided and the policyholder or certificate holder submits a response that finalizes the request for the loan.

(3) The statement shall be dated and shall include all of the following:

~~(1)~~ *(A)* An explanation of changes to the policy that would occur as a result of the loan or withdrawal.

~~(2)~~ *(B)* A numerical demonstration of the *estimated* effect of the payment on ~~the remaining~~ *any applicable remaining policy values. The demonstration shall include, if applicable, impact to the* death benefit, cash value or accumulation amount, policy loan value, outstanding policy loan amount, no-lapse guarantee, policy lien, premium payments or cost of insurance charges, ~~and~~ daily, monthly, or lifetime long-term care ~~benefits.~~ *benefits, and any other values impacted by the payment.*

~~(3)~~ *(C)* If a policyholder or certificate holder is initiating a request for a loan, a notice stating: "WARNING: Loans may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a loan may adversely affect your eligibility for Medicaid or other government entitlements, and loan proceeds may be taxable ~~at your death~~ if the loan is not ~~repaid.~~ *repaid and the policy is surrendered or lapses.* Please consult a financial advisor."

~~(4)~~ *(D)* If a policyholder or certificate holder is initiating a request for a withdrawal, a notice stating: "WARNING: Cash withdrawals may reduce and potentially eliminate your death benefit and your long-term care benefits. Receipt of a cash withdrawal may be taxable and may also adversely affect your eligibility for Medicaid or other government benefits or entitlements. Please consult a financial advisor."

~~(5)~~ *(E)* A description of circumstances in which a loan or withdrawal may result in or contribute to the lapse of the policy.

~~(6)~~ *(F)* If applicable, a hypothetical demonstration of how loan repayment may be deducted from a future payment of an accelerated death benefit for long-term care.

~~(7)~~ *(G)* If applicable, a notice explaining the rate at which the loan will accrue interest and stating the projected outstanding loan amount after five years, assuming that the interest rate does not change, no loan repayments are made, and no additional loans are taken.

(g) The statements and notices required by this section shall be in at least 12-point type.

SEC. 28.

Section 11664 of the Insurance Code is amended to read:

11664.

(a) This section applies only to policies of workers' compensation insurance.

(b) A notice of nonrenewal shall be in writing and shall be delivered or mailed to the producer of record and to the named insured at the mailing address shown on the policy. ~~Subdivision~~ *The time periods and procedures in subdivision* (a) of Section 1013 of the Code of Civil Procedure shall be applicable if the notice is mailed.

(c) An insurer, at least 30 days, but not more than 120 days, in advance of the end of the policy period, shall give notice of nonrenewal, and the reasons for the nonrenewal, if the insurer intends not to renew the policy.

(d) If an insurer fails to give timely notice required by subdivision (c), the policy of insurance shall be continued, with no change in its premium rate, for a period of 60 days after the insurer gives the notice.

(e) A notice of nonrenewal shall not be required in any of the following situations.

(1) The transfer of, or renewal of, a policy without a change in its terms or conditions or the rate on which the premium is based between insurers that are members of the same insurance group.

(2) The policy has been extended for 90 days or less, if the notice required in subdivision (c) has been given prior to the extension.

(3) The named insured has obtained replacement coverage or has agreed, in writing, within 60 days of the termination of the policy, to obtain that coverage.

(4) The policy is for a period of no more than 60 days and the insured is notified at the time of issuance that it may not be renewed.

(5) The named insured requests a change in the terms or conditions or risks covered by the policy within 60 days prior to the end of the policy period.

(6) The insurer has made a written offer to the insured to renew the policy at a premium rate increase of less than 25 percent.

(A) If the premium rate in the governing classification for the insured is to be increased 25 percent or greater and the insurer intends to renew the policy, the insurer shall provide a written notice of a renewal offer not less than 30 days prior to the policy renewal date. The governing classification shall be determined by the rules and regulations established in accordance with subdivision (c) of Section 11750.3.

(B) For purposes of this section, “premium rate” means the cost of insurance per unit of exposure prior to the application of individual risk variations based on loss or expense considerations such as scheduled rating and experience rating.

SEC. 29.

Section 13902 of the Insurance Code is amended to read:

13902.

(a) Any insurance pool, established pursuant to this division, may be organized as a nonprofit corporation, limited liability company, partnership, or trust, whether organized under the laws of this state or another state or operating in another state.

(b) Any insurance pool established pursuant to this division shall have initial pooled resources of not less than two million five hundred thousand dollars ($2,500,000) in the form of cash or cash equivalents.

(c) Any insurance pool established pursuant to this division shall maintain adequate reinsurance to protect against its risks.

(d) Any insurance pool established pursuant to this division shall furnish a copy of the pool's annual audited financial statement and most recent actuarial review, by first-class mail or by any other method of delivery, including electronic transmission, to the *Insurance Commissioner, the* Assembly Committee on Housing and Community Development, the Assembly Committee on Insurance, the Senate Committee on ~~Banking, Finance, and~~ Insurance, and the Senate Committee on Transportation and Housing within 180 days of the close of the pool's fiscal year. If, in the period of time since the last submittal required by this subdivision, any of the following has occurred, the transmittal letter accompanying the annual audited financial statement and most recent actuarial review shall so indicate and shall provide a brief description of each matter:

(1) There has been a change to the pool's plan of financing, management, or operation, including any material amendment to any of those plans.

(2) A claims audit report has been filed with any regulatory body with respect to the pool.

(3) A report of examination issued by any regulatory body with respect to the pool has been received.

(4) There has been a material change in the scope of the regulation of the pool by other states in which the pool operates.

SEC. 30.

Section 5401.7 of the Labor Code is amended to read:

5401.7.

The claim form shall contain, prominently stated, the following statement:

"Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony."

The statements required to be printed or displayed pursuant to ~~Sections~~ *Section* 1871.2 ~~and 1879.2~~ of the Insurance Code may, but are not required to, appear on the claim form.

SEC. 31.

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.