Assembly Bill No. 1511

CHAPTER 627

An act to amend Sections 676.8, 678, 1656.1, 1656.2, 1668, 1668.5, 1871.2, 10103.7, 10168.25, 10271, 10271.1, 10273.6, 10295, 11797, 12921.2, 12928.6, 14050, 14052, 14062, and 15040 of, to amend, repeal, and add Section 1210 of, and to add Section 1871.10 to, the Insurance Code, relating to insurance.

[Approved by Governor October 7, 2021. Filed with Secretary of State October 7, 2021.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1511, Committee on Insurance. Insurance: omnibus.

(1) Existing law generally regulates insurance and creates the Department of Insurance, headed by the Insurance Commissioner. Existing law requires all public records of the department and the commissioner that are subject to disclosure under the California Public Records Act to be available for inspection and copying, as specified, at the offices of the department in the San Francisco Bay area, in the City of Los Angeles, and in the City of Sacramento.

This bill would eliminate the reference to an office in the San Francisco Bay area and instead refer to the department's offices in the City of Oakland, the City of Los Angeles, and the City of Sacramento.

(2) Existing law requires an insurer to deliver or mail to the named insured an offer of renewal or a notice of nonrenewal of a residential property insurance policy at least 45 days before the policy expiration, or 75 days before the policy expiration for a notice of nonrenewal for a policy that expires on or after July 1, 2020.

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.

On and after July 1, 2022, this bill would provide that the above-described mailing requirements and extended response time periods apply to a timely offer of renewal or notice of nonrenewal of a residential property insurance.

Existing law prohibits a notice of cancellation of a policy of workers' compensation insurance from being effective unless the notice complies

with certain requirements, including that 10 days' or 30 days' prior written notice be given to the policyholder, depending on the reason for the cancellation.

Under this bill, if the notice is mailed, the above-described mailing requirements and extended notice periods would apply.

(3) Existing law regulates the types and amounts of investments that insurers may make. Existing law establishes the California Organized Investment Network (COIN) within the department to, among other things, pursue active measures to encourage insurers to make investments in California's underserved and low-to-moderate-income communities. Existing law authorizes a domestic incorporated insurer to make discretionary investments after investment of an amount equal to its required minimum paid-in capital in specified securities. Under existing law, those discretionary investments may include the purchase of, or loans upon, properties and securities, but are limited to the lesser of 5% of the insurer's admitted assets or 50% of the excess of admitted assets over the sum of capital paid up, liabilities, and a required surplus.

This bill, until January 1, 2027, would increase that limitation if the commissioner has approved the amount and terms of the investment in advance and COIN has identified the investment in an investment opportunity bulletin or otherwise deemed it to be a qualified investment. The bill would require the commissioner to submit a report to the committees of the Senate and Assembly having jurisdiction over insurance on or before December 31, 2025, regarding the investments made due to the increased limitation.

(4) Existing law requires an insurer, who, in connection with any insurance contract providing liability insurance, provides a form for the purpose of making a claim against the insurer to include a statement indicating that it is a crime to knowingly present false or fraudulent claims for the payment of a loss.

This bill would expand that provision to also apply to a form provided in connection with an application for liability insurance or for the purpose of making a change to an existing policy, and would require the form to also include a statement indicating that it is a crime to present false and fraudulent information to obtain or amend insurance coverage. The bill would make it a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or amending an insurance policy. Because the bill would create a new crime, the bill would impose a state-mandated local program.

(5) Existing law, with respect to certain annuity contracts, establishes a formula to determine the interest rate used in determining minimum nonforfeiture amounts.

This bill would revise the formula to determine the interest rate depending on whether the annuity contract was issued before January 1, 2022, or on or after that date.

(6) Existing law authorizes the commissioner to bring a superior court action to enjoin a person who is violating or about to violate the Insurance Code.

This bill would additionally authorize the commissioner to apply to the clerk of the superior court for a judgment to enforce an order requiring a person to pay a monetary penalty or reimburse the department for its prosecutorial costs.

(7) Existing law requires a production agency license application filed by a corporation or limited liability company to contain the names and addresses of all stockholders or members who own 10% or more of the stock or membership interests and the names and addresses of the managers, officers, and directors of the corporation or company, as applicable. Existing law requires a licensed corporation or limited liability company to file written notice with the commissioner of any changes, except for address changes, to this information. Existing law authorizes the commissioner to deny an application for a production agency license, or suspend or revoke an organization's permanent license, for specified reasons, including that the applicant or controlling person has been convicted of a specified crime.

This bill would require the above-described notice of changes to be sent to the commissioner within 30 days from the date that the licensed corporation or limited liability company learns of a change. The bill would authorize the commissioner to deny an application for a production agency license, or suspend or revoke an organization's permanent license, if the applicant or controlling person has been found liable by clear and convincing evidence in a civil action involving allegations of elder or dependent abuse, oppression, fraud, malice, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty.

(8) The Insurance Adjuster Act regulates the licensing of insurance adjusters. Existing law requires an applicant for an insurance adjuster license to file a $2,000 surety bond with the Insurance Commissioner. In lieu of a surety bond, an applicant may deposit $2,000 cash with the state or show evidence of a $2,000 deposit in a specified account. Under the act, an insurance adjuster's license is immediately suspended if they fail to maintain the bond. A person who violates these provisions of the act is guilty of a misdemeanor. Under the act, as well as the Public Insurance Adjusters Act, which regulates the licensing of public insurance adjusters, the commissioner may suspend or revoke an insurance adjuster license if the commissioner determines the licensee has committed a specified crime, and a plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction for these purposes.

This bill would exempt from the above-described surety bond requirements a licensed insurance adjuster, or an employee of a licensee, who adjusts claims on behalf and under the direction of a licensee who is qualified as a manager and has filed a surety bond or certificate of insurance. The bill would also exempt from these requirements a licensed insurance adjuster, an employee of a licensee, or a qualified manager who adjusts claims for an association, organization, partnership, limited liability company, or

corporation that has filed a surety bond or certificate of insurance. The bill would require a surety bond or certificate of insurance to provide the names of all licensed insurance adjusters, employees, or qualified managers who may perform duties under that surety bond or certificate of insurance on a form provided by the commissioner, and to make any changes within 30 days in the manner required by the commissioner. The bill would require a license to be immediately suspended for a failure to maintain the names related to a surety bond or certificate, as specified. By increasing the duties relating to surety bonds under the act, this bill would expand an existing crime, thereby imposing a state-mandated local program.

This bill would specify, for purposes of suspending or revoking a license under the Insurance Adjuster Act or the Public Insurance Adjusters Act, that a plea or verdict of guilty or a plea of nolo contendere is deemed to be a conviction.

(9) Existing law generally regulates disability insurance policy provisions and excludes from these requirements provisions in life insurance, endowment, or annuity contracts that provide specified additional benefits, including special surrender benefits and accelerated death benefits.

This bill would also exclude a life insurance contract provision providing a terminal illness benefit from disability insurance policy requirements. The bill would define a "terminal illness benefit" to mean a provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a terminal illness.

(10) Existing law establishes the State Compensation Insurance Fund to be administered by a board of directors for the purpose of transacting workers' compensation insurance and other public employment-related insurances. Existing law requires the board to invest and reinvest all moneys in the State Compensation Insurance Fund in excess of current requirements in the same manner as is authorized in certain provisions applicable to private insurance carriers. Existing law, until January 1, 2025, authorizes the board to invest or reinvest an aggregated maximum of 20% of the moneys that are in excess of the admitted assets over the liabilities and required reserves in specified investments, including the stock of certain corporations and specified mortgage-related investment instruments.

This bill would extend that investment authorization until January 1, 2027. The bill, until January 1, 2027, would also authorize the State Compensation Insurance Fund to make discretionary investments in properties and securities, and to invest in money market mutual funds, as specified.

(11) 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 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 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 (a) of Section 1013 of the Code of Civil Procedure applies 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. 2. 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, subdivision (a) of Section 1013 of the Code of Civil Procedure applies 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, subdivision (a) of Section 1013 of the Code of Civil Procedure applies 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. 3. Section 1210 of the Insurance Code is amended to read:

1210. (a) A domestic incorporated insurer, after investing an amount equal to its required minimum paid-in capital in securities specified in Article 3 (commencing with Section 1170), may make investments as it may see fit in the purchase of, or loans upon, properties and securities other than or in addition to or in excess of those set forth in Article 2 (commencing with Section 1152), Article 3 (commencing with Section 1170), and Article 4 (commencing with Section 1190). Investments under this section shall not exceed, in the aggregate, the lesser of either of the following:

(1) Five percent of the insurer's admitted assets.

(2) Fifty percent of the excess of admitted assets over the sum of capital paid up, liabilities, and the surplus required by Section 700.02. The percentage or dollar value of admitted assets and capital paid up and liabilities shall be determined by the insurer's last preceding annual statement of conditions and affairs made as of the preceding December 31 and that has been filed with the commissioner as required by law. The investments shall be subject to the provisions of Sections 1153.5, 1154, 1200, 1201, and 1202 as if they were excess funds investments. This section applies to an insurer other than a life insurer only if the insurer has aggregate capital and surplus of at least ten million dollars ($10,000,000).

(b) An investment originally made by an insurer pursuant to this section that subsequently meets the requirements of an investment contained in Article 2 (commencing with Section 1152), Article 3 (commencing with Section 1170), or Article 4 (commencing with Section 1190) may, at the election of the insurer, be considered to be held pursuant to any provision contained in those articles.

(c) Pursuant to the authority conferred by subdivision (a), notwithstanding Section 1100, an insurer may make discretionary investments in shares of an open-end diversified management investment company, as defined in the federal Investment Company Act of 1940, as amended. This subdivision does not prohibit any other discretionary investment, now or in the future, that might otherwise be made by an insurer, whether expressly identified in this section or not.

(d) (1) The limitation in subdivision (a) shall be increased for an insurer if both of the following apply:

(A) The commissioner has approved the amount and other terms of the investment for the insurer before the insurer makes the investment.

(B) The California Organized Investment Network (COIN) has identified the investment in an investment opportunity bulletin, or otherwise deemed the investment to be a qualified investment, pursuant to Article 10.1 (commencing with Section 926) of Chapter 1.

(2) On or before December 31, 2025, the commissioner shall submit a report to the committees of the Senate and Assembly having jurisdiction over insurance on investments made pursuant to paragraph (1), with a focus on impact investments, high-impact investments, and community development investments, as defined in Article 10.1 (commencing with Section 926) of Chapter 1.

(e) This section shall remain in effect only until January 1, 2027, and as of that date is repealed.

SEC. 4. Section 1210 is added to the Insurance Code, to read:

1210. (a) A domestic incorporated insurer, after investing an amount equal to its required minimum paid-in capital in securities specified in Article 3 (commencing with Section 1170), may make investments as it may see fit in the purchase of, or loans upon, properties and securities other than or in addition to or in excess of those set forth in Article 2 (commencing with Section 1152), Article 3 (commencing with Section 1170), and Article 4 (commencing with Section 1190). Investments under this section shall not exceed, in the aggregate, the lesser of either of the following:

(1) Five percent of the insurer's admitted assets.

(2) Fifty percent of the excess of admitted assets over the sum of capital paid up, liabilities, and the surplus required by Section 700.02. The percentage or dollar value of admitted assets and capital paid up and liabilities shall be determined by the insurer's last preceding annual statement of conditions and affairs made as of the preceding December 31 and that has been filed with the commissioner as required by law. The investments shall be subject to the provisions of Sections 1153.5, 1154, 1200, 1201, and 1202 as if they were excess funds investments. This section applies to an insurer other than a life insurer only if the insurer has aggregate capital and surplus of at least ten million dollars ($10,000,000).

(b) An investment originally made by an insurer pursuant to this section that subsequently meets the requirements of an investment contained in Article 2 (commencing with Section 1152), Article 3 (commencing with Section 1170), or Article 4 (commencing with Section 1190) may, at the election of the insurer, be considered to be held pursuant to any provision contained in those articles.

(c) Pursuant to the authority conferred by subdivision (a), notwithstanding Section 1100, an insurer may make discretionary investments in shares of an open-end diversified management investment company, as defined in the federal Investment Company Act of 1940, as amended. This subdivision does not prohibit any other discretionary investment, now or in the future, that might otherwise be made by an insurer, whether expressly identified in this section or not.

(d) This section shall become operative on January 1, 2027.

SEC. 5. Section 1656.1 of the Insurance Code is amended to read:

1656.1. (a) Every application for a license filed by a corporation shall contain the names and addresses of all stockholders owning 10 percent or more of the corporation's stock and of all officers and directors of the corporation.

(b) Every such licensed corporation shall file a written notice with the commissioner of all changes, except address changes, of its stockholders who own 10 percent or more of the corporation's stock and of all officers and directors of the corporation. Notification to the commissioner shall be sent within 30 days of the date that the licensed corporation learns of a change of its stockholders who own 10 percent or more of the corporation's stock and of all officers and directors of the corporation.

(c) The commissioner may require the application or notice or both to also disclose additional information necessary to determine whether the applicant or licensee is in compliance with Section 1668.5.

SEC. 6. Section 1656.2 of the Insurance Code is amended to read:

1656.2. (a) Every application for a license filed by a limited liability company shall contain the names and addresses of all members owning 10 percent or more of the membership interests of the limited liability company, and of all managers, officers, and directors, if any, of the limited liability company.

(b) Every licensed limited liability company shall file a written notice with the commissioner of all changes, except address changes, of its members owning 10 percent or more of the membership interests of the limited liability company and of all managers, officers, and directors, if any, of the limited liability company. Notification to the commissioner shall be sent within 30 days of the date that the licensed limited liability company learns of a change of its members who own 10 percent or more of the membership interests of the limited liability company and of the managers, officers, and directors, if any, of the limited liability company.

(c) The commissioner may require the application or notice or both to also disclose additional information to determine whether the applicant or licensee is in compliance with Section 1668.5.

SEC. 7. Section 1668 of the Insurance Code is amended to read:

1668. The commissioner may deny an application for a license issued pursuant to this chapter if any of the following are true:

(a) The applicant is not properly qualified to perform the duties of a person holding the license for which the applicant applied.

(b) The granting of the license will be against public interest.

(c) The applicant does not intend actively and in good faith to carry on as a business with the general public the transactions that would be permitted by the issuance of the license for which the applicant applied.

(d) The applicant is not of good business reputation.

(e) The applicant is lacking in integrity.

(f) The applicant has been refused a professional, occupational, or vocational license or had a professional, occupational, or vocational license suspended or revoked by a licensing authority for reasons that should preclude the granting of the license for which the applicant applied.

(g) The applicant seeks the license for the purpose of avoiding or preventing the operation or enforcement of the insurance laws of this state.

(h) The applicant has knowingly or willfully made a misstatement in an application to the commissioner for a license, or in a document filed in support of that application, or has made a false statement in testimony given under oath before the commissioner or another person acting in the commissioner's stead.

(i) The applicant has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner.

(j) The applicant has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with the applicant to the danger of loss.

(k) The applicant has knowingly misrepresented the terms or effect of an insurance policy or contract.

(*l*) The applicant has failed to perform a duty expressly enjoined upon them by this code or has committed an act expressly forbidden by this code.

(m) The applicant has been convicted of any of the following:

(1) A felony.

(2) A misdemeanor specified by this code or other laws regulating insurance.

(3) A public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in acceptance, custody, or payment of money or property.

(n) The applicant has aided or abetted a person in an act or omission that would constitute grounds for the suspension, revocation, or refusal of a license or certificate issued under this code to the person aided or abetted.

(o) The applicant has permitted a person in the applicant's employ to violate this code.

(p) The applicant has violated a law relating to conduct of business that could lawfully be done only under authority conferred by that license.

(q) The applicant has submitted to the commissioner a false or fraudulent certificate pursuant to subdivision (d) of Section 1749.5.

(r) The applicant has been found liable by clear and convincing evidence in a civil action involving allegations of elder or dependent abuse, oppression, fraud, malice, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty.

A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

SEC. 8. Section 1668.5 of the Insurance Code is amended to read:

1668.5. (a) The commissioner may deny an application for a license issued pursuant to this chapter, and may suspend or revoke the permanent license of an organization licensed pursuant to this chapter as authorized by Section 1738, if the applicant or holder of the permanent license is an organization and a controlling person of the organization is any of the following:

(1) The controlling person has previously engaged in a fraudulent practice or act or has conducted any business in a dishonest manner.

(2) The controlling person has shown incompetency or untrustworthiness in the conduct of any business, or has by commission of a wrongful act or practice in the course of any business exposed the public or those dealing with the controlling person to the danger of loss.

(3) The controlling person has knowingly misrepresented the terms or effect of an insurance policy or contract.

(4) The controlling person has failed to perform a duty expressly enjoined upon them by a provision of this code or has committed an act expressly forbidden by a provision of this code.

(5) The controlling person has been convicted of any of the following:

(A) A felony.

(B) A misdemeanor specified by this code or other laws regulating insurance.

(C) A public offense having as one of its necessary elements a fraudulent act or an act of dishonesty in acceptance, custody, or payment of money or property.

A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(6) The controlling person has aided or abetted a person in an act or omission that would constitute grounds for the suspension, revocation, or refusal of a license or certificate issued under this code to the person aided or abetted.

(7) The controlling person has permitted a person in the controlling person's employ to violate this code.

(8) The controlling person has violated a law relating to conduct of business that could lawfully be done only under authority conferred by a license under this chapter.

(9) The controlling person has been found liable by clear and convincing evidence in a civil action involving allegations of elder or dependent abuse, oppression, fraud, malice, misappropriation or conversion of funds, misrepresentation, or breach of fiduciary duty.

(b) As used in this section, "controlling person" means a person who possesses, directly or indirectly, the power to direct or cause the direction of the management and policies of the organization, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, including, but not limited to, power that is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, more than 10 percent of the voting securities of the organization. This presumption may be rebutted by a showing that control does not exist in fact. The commissioner may, after furnishing all persons in interest notice and opportunity to be heard, determine that control exists in fact, notwithstanding the absence of a presumption to that effect.

SEC. 9. 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, 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 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. 10. Section 1871.10 is added to the Insurance Code, immediately following Section 1871.9, to read:

1871.10. It is unlawful to make or cause to be made a knowingly false or fraudulent material statement or material representation for the purpose of obtaining or amending an insurance policy under any line of insurance regulated by the department. A violation of this section is a public offense, punishable by a fine not to exceed ten thousand dollars ($10,000), by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or in a county jail not to exceed one year, or by both that fine and imprisonment.

SEC. 11. Section 10103.7 of the Insurance Code is amended to read:

10103.7. (a) In the event of a covered loss relating to a state of emergency, as defined in Section 8558 of the Government Code, an insured under a residential property insurance policy shall be permitted to combine payments for claims for losses up to the policy limits for the primary dwelling and other structures, for any of the covered expenses reasonably necessary to rebuild or replace the damaged or destroyed dwelling, if the policy limits for coverage to rebuild or replace the primary dwelling are insufficient. Any claims payments for losses pursuant to this subdivision for which replacement cost coverage is applicable shall be for the full replacement value of the loss without requiring actual replacement of the other structures. Claims payments for other structures in excess of the amount applied towards the necessary cost to rebuild or replace the damaged or destroyed dwelling shall be paid according to the terms of the policy.

(b) (1) In the event of a covered total loss of a primary dwelling under a residential property insurance policy resulting from a state of emergency, as defined in Section 8558 of the Government Code, if the residence was furnished at the time of the loss, the insurer shall offer a payment under the contents (personal property) coverage in an amount no less than 30 percent of the policy limit applicable to the covered dwelling structure, up to a

maximum of two hundred fifty thousand dollars ($250,000), without requiring the insured to file an itemized claim.

(2) After receiving the payment described in paragraph (1), the insured may recover additional amounts up to the policy limit for contents coverage by filing a claim pursuant to the terms of the policy for the loss of contents that exceeds the value of the payment provided pursuant to paragraph (1).

(3) When an insured files a claim relating to a state of emergency, as defined in Section 8558 of the Government Code, the insurer shall notify the insured of the option to receive payment for loss of contents pursuant to paragraph (1) and of the insured's option to subsequently file a full itemized claim pursuant to paragraph (2).

(4) This subdivision does not affect payment under the policy for scheduled personal property.

(5) This section does not prohibit an insurer from restricting payment in cases of suspected fraud.

SEC. 12. Section 10168.25 of the Insurance Code is amended to read:

10168.25. (a) This section shall apply to contracts issued on and after January 1, 2006, and may be applied by a company, on a contract-form-by-contract-form basis, to any contract issued on or after January 1, 2004, and before January 1, 2006.

(b) The minimum values as specified in Sections 10168.3, 10168.4, 10168.5, 10168.6, and 10168.8 of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as defined in this section.

(c) (1) The minimum nonforfeiture amount at any time at or prior to the commencement of any annuity payments shall be equal to an accumulation up to that time, at the rates of interest indicated in subdivision (d), of the net considerations (as hereafter defined) paid prior to that time, decreased by the sum of all of the following:

(A) Any prior withdrawals from or partial surrenders of the contract, accumulated at the rates of interest indicated in subdivision (d).

(B) An annual contract charge of fifty dollars ($50), accumulated at the rates of interest indicated in subdivision (d).

(C) Any state premium tax paid by the company for the contract, accumulated at the rates of interest indicated in subdivision (d). However, the minimum nonforfeiture amount may not be decreased by this amount if the premium tax is subsequently credited back to the company.

(D) The amount of any indebtedness to the company on the contract, including interest due and accrued.

(2) The net considerations for a given contract year used to define the minimum nonforfeiture amount shall be an amount equal to 87.5 percent of the gross considerations credited to the contract during that contract year.

(d) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of 3 percent per annum and the following, which shall be specified in the contract if the interest rate will be reset:

(1) The five-year Constant Maturity Treasury Rate reported by the Federal Reserve as of a date, or averaged over a period, rounded to the nearest one-twentieth of 1 percent, specified in the contract no longer than 15 months prior to the contract issue date or redetermination date under paragraph (2), reduced by 125 basis points, if, for contracts issued before January 1, 2022, the resulting rate is not less than 1 percent or 100 basis points, and, for contracts issued on or after January 1, 2022, the resulting rate is not less than 0.15 percent or 15 basis points.

(2) The interest rate shall apply for an initial period and may be redetermined for additional periods. The redetermination date, basis, and period, if any, shall be stated in the contract. The basis is the date, or average over a specified period, that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(e) During the period or term that a contract provides substantive participation in an equity indexed benefit, it may increase the reduction described in paragraph (1) of subdivision (d) by up to an additional 100 basis points to reflect the value of the equity index benefit. The present value at the contract issue date, and at each redetermination date thereafter, of the additional reduction shall not exceed the market value of the benefit. The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit. Lacking a demonstration that is acceptable to the commissioner, the commissioner may disallow or limit the additional reduction.

(f) The commissioner may adopt regulations to implement the provisions of subdivision (e) and to provide for further adjustments to the calculation of minimum nonforfeiture amounts for contracts that provide substantive participation in an equity index benefit and for other contracts with respect to which the commissioner determines adjustments are justified.

SEC. 13. Section 10271 of the Insurance Code is amended to read:

10271. (a) Except as set forth in this section and in Sections 10271.1, 10292, and 10295 to 10295.19, inclusive, this chapter does not apply to, or in any way affect, provisions in life insurance, endowment, or annuity contracts, or contracts supplemental thereto, that provide additional benefits in case of death or dismemberment or loss of sight by accident, or that operate to safeguard those contracts against lapse, as described in subdivision (a) of Section 10271.1, or give a special surrender benefit, as defined in subdivision (b) of Section 10271.1, a terminal illness benefit, as defined in subdivision (d) of Section 10271.1, or an accelerated death benefit, as defined in Article 2.1 (commencing with Section 10295), in the event that the owner, insured, or annuitant, as applicable, meets the benefit triggers specified in the life insurance or annuity contract or supplemental contract.

(b) For the purposes of this section, “supplemental benefit” means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a).

(c) A supplemental benefit described in subdivision (a) shall contain all of the following provisions. However, an insurer, at its option, may substitute for one or more of the provisions a corresponding provision of different

wording approved by the commissioner that is not less favorable in any respect to the owner, insured, or annuitant, as applicable. The required provisions shall be preceded individually by the appropriate caption, or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A life insurance policy or annuity contract that contains a supplemental benefit shall provide that the contract, supplemental contract, and papers attached thereto by the insurer, including the application if attached, constitute the entire insurance or annuity contract and shall also provide that an agent does not have the authority to change the contract or to waive its provisions. This provision shall be preceded individually by a caption stating "ENTIRE CONTRACT; CHANGES:" or other appropriate caption as the commissioner may approve.

(2) The supplemental benefit shall provide that reinstatement of the supplemental benefit shall be on the same or more favorable terms as reinstatement of the underlying life insurance policy or annuity contract. Following reinstatement, the insured and insurer shall have the same rights under reinstatement as they had under the supplemental benefit immediately before the due date of the defaulted premium, subject to the provisions endorsed in the rider or endorsement or attached to the rider or endorsement in connection with the reinstatement. This reinstatement provision shall be preceded individually by a caption stating "REINSTATEMENT:" or other appropriate caption as the commissioner may approve.

(3) A supplemental benefit subject to underwriting shall include an incontestability statement that provides that the insurer shall not contest the supplemental benefit after it has been in force during the lifetime of the insured for two years from its date of issue, and that the supplemental benefit may only be contested based on a statement made in the application for the supplemental benefit, if the statement is attached to the contract and if the statement was material to the risk accepted or the hazard assumed by the insurer. This provision shall be preceded individually by a caption stating "INCONTESTABILITY:" or other appropriate caption as the commissioner may approve.

(4) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide either that the insurer may accept written notice of claim at any time or that the insurer may require that written notice of claim be submitted by a due date that is no less than 20 days after an occurrence covered by the supplemental benefit, or commencement of a loss covered by the supplemental benefit, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer's address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating

"NOTICE OF CLAIM:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide either that the insured may give notice of claim at any time or that the insured shall give notice of claim by a due date that is at least 20 days after the insured receives documentation that establishes the occurrence of a qualifying event, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer's address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating "NOTICE OF CLAIM:" or other appropriate caption as the commissioner may approve.

(5) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant those forms as are usually furnished by it for filing a proof of occurrence or a proof of loss. If the forms are not furnished within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of the supplemental benefit as to proof of occurrence or proof of loss upon submitting, within the time fixed by the supplemental benefit for filing proof of occurrence or proof of loss, written proof covering the character and the extent of the occurrence or loss. This provision shall be preceded individually by a caption stating "CLAIM FORMS:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant any forms required for filing proof of loss. If the forms are not furnished within 15 days after notice of claim is given to the insurer, the claimant shall be deemed to have provided proof of loss upon sending, within the time fixed by the supplemental benefit for filing proof of loss, documentation that establishes the occurrence of a qualifying event. This provision shall be preceded individually by a caption stating "CLAIM FORMS:" or other appropriate caption as the commissioner may approve.

(6) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer may require, in the case of a claim for which the supplemental benefit provides a periodic payment contingent upon continuing occurrence or loss, that the insured provide written proof of occurrence or proof of loss no less than 90 days after the termination of the period for which the insurer is liable, and, in the case of claim for any other occurrence or loss, that the insured provide

written proof of occurrence or proof of loss within 90 days after the date of the occurrence or loss. Failure to furnish proof within the time required shall not invalidate or reduce the claim if it was not reasonably possible to give proof within the time, provided proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating "PROOF OF LOSS:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insured shall send completed claim forms and documentation that establishes the occurrence of a qualifying event within 90 days of receiving that documentation. Failure to send proof within the time required shall not invalidate or reduce the claim as long as proof is sent as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating "PROOF OF LOSS:" or other appropriate caption as the commissioner may approve.

(7) The supplemental benefit shall provide that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as the insurer may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law. This provision shall be preceded individually by a caption stating "PHYSICAL EXAMINATIONS:" or other appropriate caption as the commissioner may approve.

(d) The commissioner shall not approve a contract or supplemental contract for issuance or delivery in this state if the commissioner finds that the contract or supplemental contract does any of the following:

(1) Contains a provision, label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the supplemental benefit is offered, delivered, or issued.

(2) Constitutes fraud, unfair trade practices, or insurance economically unsound to the owner, insured, or annuitant, as applicable.

(3) Contains actuarial information that is materially incomplete, incorrect, or inadequate.

(e) A supplemental benefit described in subdivision (a) shall not contain a title, description, or any other indication that would describe or imply that the supplemental benefit provides long-term care coverage.

(f) Commencing two years from the date of the issuance of the supplemental benefit, no claim for loss incurred or disability, as defined by the supplemental benefit, may be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed before the effective date on the coverage of the supplemental benefit.

(g) With regard to supplemental benefits set forth in subdivision (a), the supplemental benefit shall specify any applicable exclusions, which shall be limited to the following:

(1) Condition or loss caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane.

(2) Condition or loss caused or substantially contributed to by war or an act of war, as defined in the exclusion provisions of the contract.

(3) Condition or loss caused or substantially contributed to by active participation in a riot, insurrection, or terrorist activity.

(4) Condition or loss caused or substantially contributed to by committing or attempting to commit a felony.

(5) Condition or loss caused or substantially contributed to by voluntary intake of either:

(A) A drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions.

(B) Poison, gas, or fumes, unless they are the direct result of an occupational accident.

(6) Condition or loss in consequence of the insured being intoxicated, as defined by the jurisdiction where the condition or loss occurred.

(7) Condition or loss caused or substantially contributed to by engaging in an illegal occupation.

(8) Condition or loss caused or substantially contributed to by engaging in aviation, other than as a fare-paying passenger.

(h) If the commissioner notifies the insurer, in writing, that the filed form or actuarial information does not comply with the law and specifies the reasons for the commissioner's opinion, it is unlawful for an insurer to issue a policy in that form.

SEC. 14. Section 10271.1 of the Insurance Code is amended to read:

10271.1. (a) (1) Supplemental benefits that operate to safeguard life insurance contracts against lapse are defined as a waiver of premium benefit or a waiver of monthly deduction benefit, as applicable, in which the insurer waives the premium or monthly deduction for a life insurance contract when the insured becomes totally disabled, as defined by the supplemental benefit, and where the waiver continues until the end of the insured's disability, or for the period specified by the supplemental benefit, consistent with paragraph (5).

(2) For purposes of this subdivision, total disability shall not be less favorable to the insured than the following:

(A) During the first 24 months of total disability, the insured is unable to perform with reasonable continuity the substantial and material duties of their job due to sickness or bodily injury.

(B) After the first 24 months of total disability, the insured, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which they could reasonably be expected to perform satisfactorily in light of their age, education, training, experience, station in life, or physical and mental capacity.

(3) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(4) The insurer may require total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) The waiver of premium or monthly deduction benefit shall continue for the period specified by the supplemental benefit, but shall not be less favorable to the insured than the following:

(A) If the insured's total disability begins before the insured attains 60 years of age, the insurer shall waive all premiums or monthly deductions due for the period that the insured continues to be totally disabled, except as follows:

(i) For group life insurance policies, if the insured's total disability begins before the insured attains 60 years of age, the insurer shall waive all premiums or monthly deductions due for the period of total disability up to 65 years of age. This subdivision does not preclude the insurer from extending a supplemental benefit for longer periods.

(ii) When a renewal is offered for a group life insurance policy that was issued prior to January 1, 2017, and contains a supplemental benefit described in this subparagraph, the insurer shall offer to renew the policy with a continuation of the in-force supplemental benefit, and may concurrently offer the group policyholder the option to change the supplemental benefit as described in clause (i).

(B) If the insured's total disability begins after the age specified in subparagraph (A), the insurer shall waive all premiums or monthly deductions due for the period that the insured continues to be totally disabled up to 65 years of age, except as follows:

(i) For group life insurance policies, if the insured's total disability begins on or after the date the insured attains 60 years of age, the insurer is not required to waive premiums or monthly deductions. This subdivision does not preclude the insurer from extending a supplemental benefit for longer periods.

(ii) When a renewal is offered for a group life insurance policy that was issued prior to January 1, 2017, and contains a supplemental benefit described in this subparagraph, the insurer shall offer to renew the policy with a continuation of the in-force supplemental benefit, and may concurrently offer the group policyholder the option to change the supplemental benefit as described in clause (i).

(6) In addition to the permissible exclusions listed in subdivision (g) of Section 10271, the insurer may exclude a total disability occurring after the policy anniversary or supplemental contract anniversary, as applicable and as defined by the supplemental benefit, on which the insured attains a specified age of no less than 65 years.

(b) "Special surrender benefit" means a "waiver of surrender charge benefit" wherein the insurer waives the surrender charge usually charged for a withdrawal of funds from the cash value of a life insurance contract or the account value of an annuity contract if the owner, insured, or annuitant, as applicable, meets any of the following criteria:

(1) The individual develops a terminal illness, as defined in subdivision (d).

(2) The individual is receiving, as prescribed by a physician, registered nurse, or licensed social worker, home care or community-based services, as defined in subdivision (a) of Section 10232.9, or is confined in a skilled nursing facility, convalescent nursing home, or extended care facility, which shall not be defined more restrictively than as in the Medicare program, or is confined in a residential care facility or residential care facility for the elderly, as defined in the Health and Safety Code. Out-of-state providers of services shall be defined as comparable in licensure and staffing requirements to California providers.

(3) The individual has any medical condition that would, in the absence of treatment, result in death within a limited period of time, as defined by the supplemental benefit, but that shall not be restricted to a period of less than six months.

(4) (A) The individual is totally disabled, as follows:

(i) During the first 24 months of total disability, the owner, insured, or annuitant, as applicable, is unable to perform with reasonable continuity the substantial and material duties of their job due to sickness or bodily injury.

(ii) After the first 24 months of total disability, the owner, insured, or annuitant, as applicable, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which they could reasonably be expected to perform satisfactorily in light of their age, education, training, experience, station in life, or physical and mental capacity.

(B) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(C) The insurer may require the total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) The individual has a chronic illness as defined in either subparagraph (A) or (B):

(A) Either of the following:

(i) Impairment in performing two out of seven activities of daily living, as set forth in subdivisions (a) and (g) of Section 10232.8, meaning the insured needs human assistance, or needs continual substantial supervision.

(ii) The insured has an impairment of cognitive ability, meaning a deterioration or loss of intellectual capacity due to mental illness or disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(B) Either of the following:

(i) Impairment in performing two out of six activities of daily living as described in subdivisions (b), (d), (e), and (f) of Section 10232.8 due to a loss of functional capacity to perform the activity.

(ii) Impairment of cognitive ability, meaning the insured needs substantial supervision due to severe cognitive impairment, as described in subdivisions (b), (d), and (e) of Section 10232.8.

(6) The individual has become involuntarily or voluntarily unemployed.

(c) "Supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a) of Section 10271.

(d) "Terminal illness benefit" means a provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a terminal illness. For the purposes of this chapter, "terminal illness" means a medical condition in which the owner's, insured's, or annuitant's life expectancy is expected to be less than or equal to a limited period of time that shall not be restricted to a period of less than 12 months or greater than 24 months.

SEC. 15. Section 10273.6 of the Insurance Code is amended to read:

10273.6. All individual health benefit plans shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) (1) Except as otherwise specified in paragraph (3), for nonpayment of the required premiums by the individual if the individual has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(3) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 36B of the Internal Revenue Code or advanced premium assistance subsidy authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(A) During the first month of the three-month grace period described in paragraph (3), an insurer shall continue to do both of the following:

(i) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the insured.

(ii) Provide coverage as required by the individual's policy.

(B) If the individual exhausts the three-month grace period described in paragraph (3) without paying all outstanding premiums due, the insurer shall return both of the following:

(i) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(ii) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to subdivision (a) of Section 100805 of the Government Code.

(C) An insurer shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health insurance contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive premium assistance subsidy authorized by Section 100800 of the Government Code.

(b) The insurer demonstrates fraud or intentional misrepresentation of material fact under the terms of the policy by the individual.

(c) Movement of the individual contractholder outside the service area, but only if coverage is terminated uniformly without regard to a health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state, as long as the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days before discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, a disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market, as long as the disability insurer notifies all affected individuals and the commissioner at least 90 days before the discontinuation of these plans, and the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(f) If coverage is made available in the individual market through a bona fide association, and the membership of the individual in the association on

the basis of which the coverage is provided ceases, but only if that coverage is terminated under this subdivision uniformly without regard to a health status-related factor of covered individuals.

(g) For the purposes of this section, "health benefit plan" has the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.

SEC. 16. Section 10295 of the Insurance Code is amended to read:

10295. (a) An accelerated death benefit, as described in this section, shall not be offered, sold, issued, or marketed as health, accident, or long-term care insurance. An accelerated death benefit shall not reimburse or provide specific coverage for any health, accident, or long-term care insurance benefits.

(b) (1) For the purposes of this article, an "accelerated death benefit" means a provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a qualifying event in accordance with Section 10295.1.

(2) For the purposes of this article, "qualifying event" means that subparagraph (A) or (B) applies.

(A) The insured has a medical condition that would, in the absence of treatment, result in death within a limited period of time, as defined by the supplemental benefit, but that shall not be restricted to a period of less than six months.

(B) (i) The insured has a chronic illness as defined in subparagraph (B) of paragraph (5) of subdivision (b) of Section 10271.1.

(ii) For policies intended to be federally tax qualified, the insurer shall require that a licensed health care practitioner, independent of the insurer, certifies that the insured meets the definition of "chronically ill individual" as defined under the federal Health Insurance Portability and Accountability Act (Public Law 104-191). The accelerated death benefit shall explain subclauses (I) through (IV) and comply with all of the following:

(I) An insured has the option of submitting a certification to the insurer or submitting a notice of claim and requesting that the insurer conduct the assessment. If the insured requests that the insurer conduct the assessment, the insurer shall provide an independent licensed health care practitioner to conduct the assessment. If a health care practitioner makes a determination, pursuant to this clause, that an insured does not meet the definition of "chronically ill individual," the insurer shall notify the insured that the insured shall be entitled to a second assessment by a licensed health care practitioner, upon request, who shall personally examine the insured. The requirement for a second assessment shall not apply if the initial assessment was performed by a practitioner who otherwise meets the requirements of this clause and who personally examined the insured.

(II) The assessments conducted pursuant to this clause shall be performed promptly with the certification completed as quickly as possible to ensure that an insured's benefits are not delayed. The written certification shall be renewed every 12 months.

(III) The costs to have a licensed health care practitioner certify that an insured meets, or continues to meet, the definition of "chronically ill individual," shall not count against the lifetime maximum of the policy or certificate.

(IV) In order to be considered "independent of the insurer," a licensed health care practitioner shall not be an employee of the insurer and shall not be compensated in any manner that is linked to the outcome of the certification.

(V) It is the intent of the Legislature in enacting this clause that the practitioner's assessments be unhindered by financial considerations.

(VI) This clause shall apply only to a policy or certificate intended to be federally tax qualified.

(3) For the purposes of this article, "applicant" means any of the following:

(A) In the case of an individual life insurance policy with an accelerated death benefit, the person who seeks to contract for benefits.

(B) (i) In the case of a group life insurance policy with an accelerated death benefit, the proposed certificate holder.

(ii) "Certificate" means any certificate issued under a group life insurance policy that includes an accelerated death benefit.

(4) For the purposes of this article, "supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a) of Section 10271.

(c) A life insurance policy that accelerates death benefits if the insured is chronically ill and requires that the insured receives long-term care services described in Section 10231.2, shall not be considered an accelerated death benefit for the purposes of this article.

(d) This section does not prohibit an insurer from including other riders to a life insurance policy, such as a terminal illness rider, that are not subject to this article.

SEC. 17. Section 11797 of the Insurance Code, as amended by Section 12 of Chapter 396 of the Statutes of 2019, is amended to read:

11797. (a) The board of directors shall cause all moneys in the State Compensation Insurance Fund that are in excess of current requirements to be invested and reinvested, from time to time, in the same manner as provided for private insurance carriers pursuant to Article 3 (commencing with Section 1170) and Article 4 (commencing with Section 1190) of Chapter 2 of Part 2 of Division 1, but excluding Sections 1191, 1191.1, 1191.5, 1192.2, 1192.4, 1192.6, 1192.7, 1192.95, 1192.10, 1194.7, 1194.8, 1194.81, 1194.82, 1194.85, 1198, and 1199, and excluding Section 1192.9, except as provided in subdivision (d). Notwithstanding the foregoing, the State Compensation Insurance Fund may invest or reinvest an aggregated maximum of 20 percent of moneys that are in excess of the admitted assets over the liabilities and required reserves in the investments allowed pursuant to Sections 1191, 1192.4, 1192.6, 1192.10, 1194.7, and 1198.

(b) (1) (A) Notwithstanding any other law, the State Compensation Insurance Fund may purchase general obligation bonds or other evidence

of indebtedness issued by the state, including, but not limited to, warrants issued pursuant to Part 4 (commencing with Section 17000) of Division 4 of Title 2 of the Government Code or notes issued pursuant to Part 5 (commencing with Section 17300) of Division 4 of Title 2 of the Government Code, in any amount and to enter into purchase contracts with the state for this purpose.

(B) Notwithstanding any other law, the State Compensation Insurance Fund may purchase Property Assessed Clean Energy (PACE) bonds, as defined in Section 26054 of the Public Resources Code.

(2) The bonds or other evidence of indebtedness specified in paragraph (1), upon delivery to the State Compensation Insurance Fund, shall, for all purposes, be valid and binding obligations of the issuer thereof, be validly issued and outstanding in accordance with their stated terms, and not be deemed to be owned by or on behalf of the issuer thereof.

(c) Notwithstanding any other law, the State Compensation Insurance Fund may invest in the discretionary investments authorized pursuant to Section 1210, but those investments shall not exceed the lesser of 2.5 percent of its admitted assets or 10 percent of moneys that are in excess of the admitted assets over the liabilities and required reserves.

(d) Notwithstanding subdivision (a) or any other law, the State Compensation Insurance Fund may invest in money market mutual funds that comply with Section 1192.9, but shall not invest in a money market mutual fund that holds any assets in foreign investments, as defined in Section 1240. Investments in money market mutual funds made by the State Compensation Insurance Fund shall not exceed the lesser of 2.5 percent of its admitted assets or 10 percent of moneys that are in excess of the admitted assets over the liabilities and required reserves. The commissioner shall retain all remedies available, including the remedies in subdivision (d) of Section 1192.9, to enforce compliance by the State Compensation Insurance Fund with the money market mutual fund investment authority granted by this subdivision.

(e) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

SEC. 18. Section 11797 of the Insurance Code, as amended by Section 13 of Chapter 396 of the Statutes of 2019, is amended to read:

11797. (a) The board of directors shall cause all moneys in the State Compensation Insurance Fund that are in excess of current requirements to be invested and reinvested, from time to time, in the same manner as provided for private insurance carriers pursuant to Article 3 (commencing with Section 1170) and Article 4 (commencing with Section 1190) of Chapter 2 of Part 2 of Division 1, but excluding Sections 1191, 1191.1, 1191.5, 1192.2, 1192.4, 1192.6, 1192.7, 1192.9, 1192.95, 1192.10, 1194.7, 1194.8, 1194.81, 1194.82, 1194.85, 1198, and 1199.

(b) (1) (A) Notwithstanding any other law, the State Compensation Insurance Fund may purchase general obligation bonds or other evidence of indebtedness issued by the state, including, but not limited to, notes issued

pursuant to Part 5 (commencing with Section 17300) of Division 4 of Title 2 of the Government Code or warrants issued pursuant to Part 4 (commencing with Section 17000) of Division 4 of Title 2 of the Government Code, in any amount and to enter into purchase contracts with the state for this purpose.

(B) Notwithstanding any other law, the State Compensation Insurance Fund may purchase Property Assessed Clean Energy (PACE) bonds, as defined in Section 26054 of the Public Resources Code.

(2) The bonds or other evidence of indebtedness specified in paragraph (1), upon delivery to the State Compensation Insurance Fund, shall, for all purposes, be valid and binding obligations of the issuer thereof, be validly issued and outstanding in accordance with their stated terms, and not be deemed to be owned by or on behalf of the issuer thereof.

(c) This section shall become operative on January 1, 2027.

SEC. 19. Section 12921.2 of the Insurance Code is amended to read:

12921.2. All public records of the department and the commissioner subject to disclosure under Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code shall be available for inspection and copying pursuant to those provisions at the offices of the department in the City of Oakland, the City of Los Angeles, and the City of Sacramento. Adequate copy facilities for this purpose shall be made available. Notwithstanding any other law, a person requesting copies of these records shall receive the copies from employees of the department and the fee charged for the copies shall not exceed the actual cost of producing the copies.

SEC. 20. Section 12928.6 of the Insurance Code is amended to read:

12928.6. (a) Whenever the commissioner believes, from evidence satisfactory to the commissioner, that a person is violating or about to violate this code or an order or requirement of the commissioner issued or promulgated pursuant to authority expressly granted the commissioner by this code or by law, the commissioner may bring an action in the name of the people of the State of California in the superior court of the State of California against the person to enjoin that person from continuing the violation or engaging therein or doing any act in furtherance thereof. In such action an order or judgment may be entered awarding such preliminary or final injunction as is proper.

(b) (1) The commissioner may apply to the clerk of the superior court for a judgment to enforce an order requiring a person to pay a monetary penalty or reimburse the department for costs incurred by the department in prosecuting a matter. The commissioner's application shall include a certified copy of the order and any associated decision.

(2) Subject to the requirements of paragraph (3), the order and decision shall constitute a sufficient showing to warrant issuance of a judgment in the amount ordered by the commissioner, plus interest. The clerk of the court shall accordingly enter a judgment within five court days.

(3) For an order to qualify for a judgment pursuant to this section, the application shall be accompanied by a declaration given by the legal counsel

for the commissioner affirming on information and belief that a petition for mandamus or other legal action for relief from the order has either been denied, or the time for the filing of a petition or action has lapsed.

(4) A judgment entered under this section has the same force and effect as, and is subject to all the laws relating to, a judgment in a civil action, and may be enforced in the same manner as any other judgment of the court in which it is entered.

SEC. 21. Section 14050 of the Insurance Code is amended to read:

14050. (a) A license shall not be issued under this chapter unless the applicant files with the commissioner a surety bond executed by a surety company authorized to do business in the state in the sum of two thousand dollars ($2,000) conditioned for the faithful and honest conduct of business by the applicant. The bond's form, execution, and sufficiency of the sureties shall be approved by the commissioner.

(b) (1) Notwithstanding subdivision (a), a surety bond is not required for a licensed insurance adjuster, or an employee of a licensee, who adjusts claims on behalf of, and under the direction of, a licensee who is qualified as a manager, as described in Section 14029, and who has filed a surety bond or certificate of insurance. Notwithstanding subdivision (a), a licensed insurance adjuster, an employee of a licensee, or a qualified manager is not required to file a surety bond or certificate of insurance if that licensed insurance adjuster, employee of a licensee, or qualified manager adjusts claims for an association, organization, partnership, limited liability company, or corporation that has filed a surety bond or certificate of insurance.

(2) A surety bond or certificate of insurance filed for the purposes described in paragraph (1) shall provide the names of all licensed insurance adjusters, employees, or qualified managers who may perform duties under that surety bond or certificate of insurance on a form provided by the commissioner. Any changes, removals, or additions to the licensed insurance adjusters, employees, or qualified managers listed on the form shall be made within 30 days in the manner required by the commissioner.

SEC. 22. Section 14052 of the Insurance Code is amended to read:

14052. (a) Every licensee who is required by this article to file a surety bond or a certificate of insurance shall at all times maintain on file the surety bond or certificate required by this article in full force and effect and shall maintain the names of all licensed insurance adjusters, employees, or qualified managers who may perform duties under that surety bond or certificate of insurance. If the licensee fails to maintain the surety bond or certificate or the names thereon, their license shall be immediately suspended and shall not be reinstated until an application therefor, in the form prescribed by the commissioner, is filed together with a proper surety bond or certificate.

(b) The commissioner may deny the application notwithstanding the applicant's compliance with this section:

(1) For any reason that would justify a refusal to issue, or a suspension or revocation of, a license.

(2) For the performance by applicant of any practice while under suspension for failure to keep the bond or certificate in force, for which a license under this article is required.

SEC. 23. Section 14062 of the Insurance Code is amended to read:

14062. The record of conviction, or a certified copy thereof, shall be conclusive evidence of the conviction, as that term is used in this article or in Section 14028 or 14028.5.

A plea or verdict of guilty or a plea of nolo contendere is deemed to be a conviction within the meaning of this article or of Section 14028 or 14028.5. The commissioner may order the license suspended or revoked, or may decline to issue a license, when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing that person to withdraw their plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

SEC. 24. Section 15040 of the Insurance Code is amended to read:

15040. The record or conviction, or a certified copy thereof, shall be conclusive evidence of the conviction as that term is used in this article or in Section 15018 or 15018.5.

A plea or verdict of guilty or a plea of nolo contendere is deemed to be a conviction within the meaning of this article or of Section 15018 or 15018.5. The commissioner may order the license suspended or revoked, or may decline to issue a license, when the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence, irrespective of a subsequent order under Section 1203.4 of the Penal Code allowing that person to withdraw their plea of guilty and enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment.

SEC. 25. 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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