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Life and Health Insurance

HAWAII | Law Supplement



LIFE AND HEALTH INSURANCE HAWAII LAW SUPPLEMENT,
EFFECTIVE FEBRUARY 13, 2008
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INTRODUCTION

This supplement focuses on statutes regarding Hawaii insurance law. Key aspects of each statute are discussed to help the student pass the state law portion of the licensing examination. In order to understand the content of this supplement, the student should first study the national insurance License Exam Manual. Thorough preparation for the exam requires the complete study of both the national License Exam Manual and the supplement.

I. HAWAII LAWS, RULES, AND REGULATIONS PERTINENT TO LIFE, ACCIDENT, AND HEALTH INSURANCE

A. INSURANCE COMMISSIONER

1. General powers and duties [Secs. 431:2-201 through 216; 2-301 through 306, 308; 9A-112, 126, 127, 129; 13-106, 201 through 204]

The Hawaii Insurance Commissioner has numerous powers and duties. According to Hawaii State law, he shall administer and enforce all laws pertaining to the business of insurance. The Commissioner will also have the power to revoke licenses of insurers, producers, and adjusters for just cause. The Commissioner may also make reasonable rules and regulations for effectuating any provision of Hawaii law, conduct examinations and investigations to determine whether any person has violated any provision of Hawaii law, and require, upon reasonable notice, that insurers report such claims information as he deems necessary to protect the public interest.

- a. The Director of Commerce and Consumer Affairs shall, with the approval of the Governor, appoint the Insurance Commissioner. Any illegalities committed by insurers, producers, or adjusters must be reported to the Attorney General for the assessment of further penalties. The Attorney General and other county attorneys throughout the state shall prosecute or defend all proceedings brought pursuant to Hawaii law when requested by the Commissioner.

1.) Sales to members of the armed forces [Sec. 431:2-201.8]

The Commissioner can adopt rules to protect members of the armed forces from dishonest and predatory life insurance sales practices that are false, misleading, or unfair.

- b. For the purpose of ascertaining its condition, or compliance with Hawaii law, the Insurance Commissioner may as often as he deems advisable, examine the insurance accounts, records, documents, and transactions of any insurance producer or adjuster; or any person engaged in or proposing to be engaged in or assisting in the promotion (promoters) or formation of a domestic insurer.

- 1.) **Hearings [Sec. 431:9A-112(b)]** The Insurance Commissioner shall also hold a hearing if required by Hawaii law. He may hold other

hearings as he deems necessary for such purposes as are within the scope of state law.

- a.) The hearing shall be held at a place designated by the Commissioner and at his discretion it may be open to the public.
- b.) Application for a hearing made to the Commissioner pursuant to Hawaii law shall be in writing within 10 days of receiving notice of the Commissioner's proposed action against the licensee. It shall specify in what respects the person so applying was aggrieved and the grounds to be relied upon as a basis for the relief to be demanded at the hearing.
- c.) The Commissioner shall hold the hearing applied for within 30 days after his receipt of the application unless postponed by mutual consent. The Insurance Commissioner shall, not less than 10 days in advance, give notice to each person to be affected by the hearing. If the persons to be given notice are not specified in the provision pursuant to which the hearing is held, the Commissioner shall give notice to all persons directly affected by the hearing.
- d.) The Commissioner may also subpoena witnesses or documentary evidence and take depositions in connection with a hearing. He may also administer oaths and examine statements made under oath.
- e.) **Immunity from liability [Sec. 431:2-301.8]** Any examiner appointed by the Commissioner will not be held liable for any statements made or conduct committed in good faith during the course of an examination.

c. Appointment of Commissioner as agent for service of process

[Sec. 431:2-205] All foreign and alien insurers shall appoint the Commissioner as its attorney to receive service of process. Records of examinations conducted by the Commissioner concerning an insurer must be maintained for five years. The Commissioner shall also file an annual report reviewing the (financial) condition of all insurers in the state.

d. Commissioner's Education and Training Fund [Sec. 431:2-214]

The Commissioner may establish a separate fund known as the **Commissioner's Education and Training Fund**. The fund is used to compensate or reimburse staff and personnel of the insurance division for education and training. Staff and other personnel may be reimbursed for:

- actual and reasonable travel expenses;
- a reasonable living expense allowance at a rate customary for these expenses;
- per diem compensation at a rate customary for this compensation; and

- any fees necessary to attend education and training conferences, workshops, and seminars.
 - Anyone receiving reimbursements must provide the Commissioner with a detailed account to justify those expenses.

e. Penalties for code violations [Sec. 431:2-203] Violation of any provision of Hawaiian insurance law is punishable by a fine of not less than \$100 nor more than \$10,000, or by imprisonment for up to one year, or both fine and imprisonment, in addition to any other penalty or forfeiture provided by the law. The order levying the fine shall specify the period within which the fine shall be fully paid, and which shall be not less than 30 nor more than 45 days from the date of the order. Failure to pay a fine when due, will cause the Commissioner to revoke the license of the licensee if not already revoked, and the fine shall be recovered in a civil action brought on behalf of the Commissioner by the attorney general. Any fine collected shall be paid by the Commissioner to the Director of Finance for the account of the Insurance Regulation Fund.

- 1.)** Intentionally or knowingly violating of any provision of insurance code is punishable by a fine of not less than \$100 nor more than \$10,000, or by imprisonment for not more than one year, or both, in addition to any other penalty or forfeiture provided by the law.
 - a.)** If the Commissioner believes that any person is violating any provision of the Insurance Code, the Commissioner may issue a cease and desist order to enforce compliance, or bring an action in court to enjoin the person from continuing the violation.
- 2.)** The order levying the fine shall specify the period within which the fine shall be fully paid, and that period shall be not less than 30 nor more than 45 days from the date of the order. Upon the licensee's failure to pay any fine when due, the Commissioner shall revoke the license of the licensee if not already revoked, and the fine may be recovered in a civil action brought on behalf of the Commissioner by the attorney general.
 - a.)** Any fine collected shall be paid by the Commissioner to the Director of Finance for the account of the Insurance Regulation Fund.
- 3.) Hearings on appeals [Sec. 431:9A-127]** Upon the hearing of an appeal from an order imposing any sanction upon a licensee, the courts may impose a fine of not more than \$10,000 in lieu of the Commissioner's action, and payment of that fine within 10 days of the court's order shall result in the acceptance of the licensee's application or the reinstatement, restoration, or extension of that license if:
 - the court finds that the licensee violated the law; and
 - the court deems the sanction imposed too severe a penalty under the facts as found.

4.) If the licensee has previously been sanctioned for a similar offense, the court shall not have jurisdiction to impose a fine in lieu of the Commissioner's action.

5.) **Suspension or revocation of certificate of authority [Sec. 431:3-217]** The Commissioner may suspend, revoke, or refuse to renew an insurer's certificate of authority if the insurer:

- knowingly fails to comply with or violates the code and suspension, denial, or nonrenewal of a certificate of authority is not otherwise mandated;
- knowingly fails to comply with an order of the Commissioner;
- is found to be in an unsound condition or in a condition that makes its continued operation in the state dangerous to the public or its policyholders;
- refuses to discharge a director or officer who has been convicted of a crime involving fraud or dishonesty;
- has a practice of forcing claimants to accept less than the amount due to them or to sue the insurer to collect the full amount due;
- is illegally owned, managed, or affiliated with an insurer not authorized to do business in the state;
- refuses to allow the Commissioner to examine its affairs;
- fails to pay a judgment against it within 60 days of a final order; or
- fails to file an annual statement when due.

f. **Other general duties** The Insurance Commissioner shall also regulate insurers for solvency and most insurance premium rates. Other general duties include:

- issuing licenses and collecting the appropriate fees;
- appointing examiners (deputies) who are delegated the duty of examining insurers;
- issuing cease and desist orders to insurers, producers, or adjusters for just cause; and
- conducting hearings in connection with wrongdoing of an insurer or licensee.

1.) **Examination of insurers [Sec. 431:2-302]** The Commissioner may examine the financial records of insurers to determine their solvency as often as the Commissioner deems necessary, but at least once every five years. The costs of these examinations are paid by the insurer being examined.

g. **Insurance Regulation Fund [Sec. 431:2-216]** A special fund has been established called the **Insurance Regulation Fund**. All assessments, fees, fines, penalties, and reimbursements collected by or on behalf of the Insurance Division, with a few exceptions, shall be deposited into this fund. The Insurance Regulation Fund shall be used to defray any administrative costs,

including personnel costs, associated with the programs of the division, and costs incurred by supporting offices and divisions.

- 1.)** Each mutual benefit society, health maintenance organization, and any other entity offering or providing health benefits or services under the regulation of the Commissioner shall deposit with the Commissioner, by July 1 of each year, an assessment of \$10,000 for the first 70,000 private, nongovernment members the entity covers and an additional assessment on a prorata basis to be determined and imposed by the Commissioner for covered members exceeding 70,000; provided that in the third year and each year thereafter, assessments shall be borne on a prorata basis. The aggregate annual assessment shall not exceed \$1,000,000. The assessment shall be credited to the Insurance Regulation Fund.

2.) Points to remember

- a.)** The Commissioner has the power to revoke licenses of companies, producers, and adjusters for just cause.
- b.)** The Commissioner has the obligation to report illegalities in the insurance business to the Attorney General. The Commissioner has the power to revoke and suspend licenses, but the Attorney General prosecutes when insurance laws are broken.
- c.)** The Commissioner regulates companies for solvency and regulates most insurance rates.
- d.)** The Commissioner collects fees, issues insurance licenses, and may subpoena witnesses.
- e.)** The Commissioner delegates examining duties to deputies.
- f.)** The Commissioner conducts hearings due to the complaints it receives.
- g.)** The Commissioner issues cease and desist orders for just cause. When the Commissioner finds that a person has engaged in any unfair trade practice, he will issue such an order which requires that person to stop conducting insurance business.
He may also be assessed a fine of not more than \$1,000 for each act (up to an aggregate of \$10,000) unless the act was done knowingly which will result in a fine of not more than \$5,000 for every act and not to exceed \$50,000 in any six-month period.

■ Any violation of a cease and desist order may subject a person to a fine of not more than \$10,000 for each and every act in violation of the order, or suspension and/or revocation of the person's license.

h.) The Insurance Regulation Fund shall be used to defray any administrative costs, including personnel costs, associated with the programs of the division, and costs incurred by supporting offices and divisions.

B. DEFINITIONS

1. Authorized and unauthorized insurers [Secs. 431:8-102 through 201]

a. An **authorized insurer** is one which is licensed and authorized to conduct insurance business in this state. No person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority granted to it by the Insurance Commissioner.

1.) Every certificate of authority shall specify the name of insurer, the location of its principal office, the name of and location of the principal office of its attorney-in-fact if a reciprocal insurer, and the classes of insurance it is authorized to transact in this state.

2.) An authorized insurance company is also known as an **admitted company**.

b. An **unauthorized insurer** is a company which has not received a certificate of authority from the state of Hawaii and is not licensed nor authorized to transact insurance business in this state.

1.) No person is permitted to represent or assist an unauthorized insurer in procuring, placing, or maintaining any insurance upon or with relation to any subject of insurance resident, located or to be performed in this state.

2.) No person may inspect or examine any risk or investigate or adjust any loss or collect or receive any premium on behalf of an unauthorized insurer.

3.) This section of Hawaii law does not apply to lawfully procured surplus lines insurance, reinsurance placed or procured, any transaction with respect to insurance delivered in a state where the insurer was legally qualified to transact insurance, or any transaction with respect to insurance delivered in this state at a time when the insurer was authorized to transact insurance in this state.

2. Domestic, foreign, and alien insurers [Secs. 431:3-101, 104, 105]

- a. A **domestic insurance company** is a company incorporated and organized under the laws of Hawaii and usually has its home or principal office located in this state. In other words, it is an insurer formed under the laws of Hawaii.
 - 1.) For instance, the Hanover Insurance Company of Worcester, Massachusetts is a domestic company in the state of Massachusetts since it is incorporated and has its principal office in that state.
 - 2.) The Commissioner shall examine a domestic insurer as often as necessary, but at least once every five years. [Sec. 431:2-302]
- b. A **foreign insurance company** is a company incorporated or organized under the laws of another state, but is licensed and permitted to conduct the business of insurance in this state.
 - 1.) For instance, assume that the Hanover Insurance Company of Worcester, Massachusetts is also licensed to solicit the business of insurance in the state of Hawaii. Therefore, in the state of Hawaii, the Hanover Insurance Company is viewed as a foreign company.
- c. An **alien insurance company** is a company incorporated or organized outside the United States but licensed in the state of Hawaii.
 - 1.) For example, The Continental Reinsurance Company of London, England is incorporated in another country (England), but is licensed to conduct the business of insurance in this state.

3. Stock and mutual insurers [Secs. 431:3-106, 110]

- a. An insurer owned by the holders of the company's capital stock is known as a **stock insurance company**. Such a company is mostly concerned with achieving profits. Policyholders of a stock company are not entitled to dividends nor liable for any assessments which may be necessary.
 - 1.) No domestic stock insurer shall pay any cash dividend to stockholders except out of that part of its available surplus funds which is derived from any realized net profits. In addition, no dividends shall be declared or paid which would reduce the insurer's surplus to an amount less than the minimum required for the classes of insurance thereafter to be transacted.
 - 2.) The Insurance Commissioner may revoke the certificate of authority of any stock insurer violating this section of Hawaii law.
- b. A **mutual insurance company** is an insurer owned by its policyholders. Such policyholders may share in the company's profits in the form of dividends.

Some mutual companies issue assessable policies and others issue nonassessable policies.

- 1.) The Insurance Commissioner shall not issue a certificate of authority to a domestic mutual insurer unless it has fully qualified under Hawaii law and unless it has met the minimum requirements for the classes of insurance it proposes to transact in this state.

4. Reciprocal insurers [Sec. 431:3-108] Like mutual insurers, reciprocal insurers are organized on the basis of ownership by their policyholders. However, with reciprocal insurers, the policyholders themselves insure the risks of the other policyholders. Each policyholder assumes a share of the risk brought to the company by others. The insurer is a risk-sharing mechanism. Reciprocals are managed by an attorney-in-fact.

As a member of the group of reciprocal insurers, each policyholder is both an insured and an insurer. Each policyholder's premium is paid into a separate account and his share of any loss is paid from this account.

5. Certificate of authority [Secs. 431:3-201 through 206] No person shall act as an insurer and no insurer shall transact insurance in this state other than as authorized by a certificate of authority granted to it by the Insurance Commissioner. Every insurer shall conduct its business in its own legal business name. Every certificate of authority shall specify the name of the insurer, the location of its principal office, the name and location of the principal office of its attorney-in-fact if a reciprocal insurer, and the classes of insurance it is authorized to transact in the state of Hawaii.

- a. To qualify for a certificate of authority, an insurer must:
 - be a stock, mutual, or reciprocal insurer of the same general type as may be formed as a domestic insurer under Hawaii law;
 - have capital funds as required by law; and
 - fully comply with state law.
 - 1.) Foreign and alien insurers must have appointed a general agent who is qualified under Hawaii law and who has continuously and successfully transacted insurance for at least five years.
 - 2.) **Change of name of foreign or alien insurer [Sec. 431:3-202]** If a foreign or alien insurer wants to change its name, it must file a request to do so with the Commissioner at least 30 days before the name is to change. If the Commissioner finds that the name change is improper, he will notify the insurer in writing of this fact and deny the request.
- b. A reciprocal insurer shall not transact life or disability insurance.

- c.** All new insurers must maintain minimum paid-in capital and surplus requirements of:
- \$750,000 for property;
 - \$1,500,000 for general casualty;
 - \$600,000 for life insurance;
 - \$450,000 for accident and health or sickness;
 - \$1,000,000 for surety;
 - \$400,000 for title insurance;
 - \$1,000,000 for vehicles; and
 - \$1,000,000 for marine and transportation.
- 1.)** Additional surplus of not less than 50% of the capital stock may be required of domestic insurers or new foreign and alien insurers that entered the business after July 1, 1988 (domestic insurers) or within the last five years (foreign and alien insurers).
- d.** After a hearing the Commissioner may suspend, revoke, or refuse to extend an insurer's Certificate of Authority, grounds in this code, if the insurer:
- knowingly fails to comply with or violates any provision of the insurance code;
 - knowingly fails to comply with any proper order of the Commissioner;
 - is found to be in an unsound financial condition;
 - refuses to remove or discharge a director or officer who has been convicted of any crime involving fraud or dishonesty;
 - commits, or performs with a frequency as to indicate a general business practice, any act which compels claimants under policies either to accept less than the amount due them or to bring suit against it to secure full payment of the amount due;
 - is affiliated with, and under the same general management, as another insurer which transacts insurance in this state without having a Certificate of Authority, except as is permitted by the insurance code;
 - refuses to be examined, or if its directors, officers, employees, or representatives refuse to submit to examination or give testimony concerning its affairs, or to produce its accounts, records, and files for examination by the Commissioner when required by the insurance code, or refuses to perform any legal obligation relative to the examination;
 - fails to pay any final judgment rendered against it upon any policy, bond, recognizance, or undertaking issued or guaranteed by it, within 60 days of final judgment; or
 - fails to file its annual statement when due or within any extension of time which the Commissioner may have granted.

6. Definition of insurance [Secs. 431:1-201 through 216] Insurance is a contract whereby one undertakes to indemnify another upon determinable contingencies. The following contracts are not considered to be insurance:

- a bond where no premium is charged;

- prepaid legal service plan; or
 - an unincorporated interindemnity plan or reciprocal contract (whose members consist only of licensed physicians or surgeons and purchased to indemnify solely for medical malpractice claims).
- a.** All of the following are lines of insurance under the Hawaii code:
- life (including industrial and group);
 - disability income (including group);
 - property;
 - marine and transportation;
 - vehicle (auto);
 - surety;
 - general casualty; and
 - any other approved by law.
- b.** Transacting insurance includes directing marketing by sales person or by direct mail. It also includes:
- the making or proposing of an insurance contract;
 - the taking or receiving of an application;
 - receiving of commissions for placing insurance;
 - the issuance or delivery of any insurance contract; or
 - the receiving of any premium.

C. LICENSING

- 1. General qualifications for licensing [Secs. 431:9A-101 to 130]** A person applying for a resident insurance producer license shall make application to the Commissioner on the uniform application and declare under penalty of denial, suspension, or revocation of the license that the statements made in the application are true, accurate, and complete to the best of the applicant's knowledge and belief. Before approving the application, the Commissioner shall find that the applicant:
- is at least 18 years of age;
 - has not committed any act that is a ground for a licensure sanction;
 - has paid the applicable fee; and
 - has successfully passed the applicable examination for each line of authority for which the applicant has applied, within the two years preceding the application. [Sec. 431:9A-106]
- a. Duration of exam scores [Sec. 431:9A-105]** A license examination score is valid for two years after the exam or renewal, whichever is later.
- 2.** A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform business entity application. Before approving the application, the Commissioner shall find that:
- the business entity has paid the applicable fee; and

- the business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws and rules of this state:
 - the Commissioner may require any documents reasonably necessary to verify the information contained in an application.

- 3. Producer [Secs. 431:9A-101 to 109, 111, 113]** A person shall not sell, solicit, or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority.
- a. An insurance producer may receive a license in one or more of the following lines of authority:
 - 1.) Life insurance coverage on human lives, including benefits of endowment and annuities, benefits in the event of death or dismemberment by accident, and benefits for disability income
 - 2.) Accident and health or sickness insurance coverage for sickness, bodily injury, or accidental death and benefits for disability income
 - 3.) Property insurance coverage for the direct or consequential loss or damage to property of every kind
 - 4.) Casualty insurance coverage against legal liability, including that for death, injury, or disability or damage to real or personal property
 - 5.) Variable life and variable annuity products insurance coverage provided under variable life insurance contracts and variable annuities
 - 6.) Credit limited line credit insurance
 - 7.) Any other line of insurance permitted under state law or rule
 - b. An insurance producer license shall remain in effect so long as the license fee is paid and the continuing education requirements for resident individual producers are timely met.
 - c. An insurance producer who allows the producer's license to lapse may, within 12 months from the due date of the renewal fee, reinstate that license without the necessity of passing a written examination.
 - 1.) However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.
 - d. A licensed insurance producer who is unable to comply with license renewal procedures due to military service or an extenuating circumstance as determined by the Commissioner may request a waiver of those procedures.

- 1.) The producer also may request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.
- e. Name of licensee [Sec. 431:9A-110]** The license shall contain the licensee's name, address, personal identification number, and the date of issuance, the lines of authority, the expiration date, and any other information the Commissioner deems necessary.
- 1.) Every insurance producer must report his legal name and trade name, if applicable, to the Commissioner.
 - 2.) **Place of business [Sec. 431:9A-122]** Every licensed producer and nonresident producer must maintain a place of business with an address that is accessible to the public.
- f. Change of address [Sec. 431:9A-107]** Licensees shall inform the Commissioner by any means acceptable to the Commissioner of a change of address within 30 days of the change.
- 1.) **Penalty [Sec. 431:9A-107]** Failure to inform the Commissioner of a change of address or business status within the time allowed can result in a penalty of at least \$100 but no more than \$10,000, license suspension, revocation, or nonrenewal, or a combination of these.
- g.** A license as an insurance producer shall not be required of the following.
- 1.) An officer or employee of an insurer or of an insurance producer provided that:
 - the officer, director, or employee does not receive any commission or remuneration on policies written or sold to insure risks residing, located, or to be performed in this state and their activities are executive, administrative, managerial, clerical, or a combination of these and are only indirectly related to the sale, solicitation, or negotiation of insurance;
 - their functions relate to underwriting, loss control, inspection, or the processing, adjusting, investigating, or settling of a claim on a contract of insurance; or
 - they act in the capacity of a special agent or agency supervisor, assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation, or negotiation of insurance.
 - 2.) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance, for the purpose of enrolling individuals under such plans, issuing certificates under plans,

or otherwise assists in administering the plans, performs administrative services related to mass marketed property and casualty insurance, or where no commission is paid to the person for the service.

- 3.)** An employer or association or its officers, directors, employees, or the trustee of any employee trust plan, to the extent that the employers, officers, employees, directors, or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, so long as the employers, associations, officers, directors, employees, or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts.
 - 4.)** Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating, or classification of risks, or in the supervision or the training of insurance producers, and who are not individually engaged in the sale, solicitation, or negotiation of insurance.
 - 5.)** A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media, whose distribution is not limited to residents of this state, provided that the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state.
 - 6.)** A person who is not a resident of this state who sells, solicits, or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract, provided that the person is otherwise licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state.
 - 7.)** A salaried, full-time employee who counsels or advises the person's employer relative to the insurance interests of the employer (such as a risk manager) or of the subsidiaries or business affiliates of the employer, provided that the employee does not sell or solicit insurance or receive commissions.
- h.** A resident applicant applying for an insurance producer license shall pass a written examination. The examination shall test the knowledge of the applicant concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer, and the insurance laws and rules of this state.
- 1.)** The Commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting fees. The fees collected shall be nonrefundable.

- 2.) Failure to pass license examination [Sec. 431:9A-120]** An applicant who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination. An applicant who has failed to pass two similar examinations may be required to wait up to six months before taking another examination.
- 4. Temporary license [Sec. 431:9A-111]** The Commissioner may issue a temporary insurance producer license for a period not to exceed 180 days without requiring an examination if the Commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases.
- To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned or controlled by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business.
 - To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license.
 - To the designee of a licensed insurance producer entering active service in the armed forces of the United States.
 - The Commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The Commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee.
- 5. Nonresident [Sec. 431:9A-108]** A nonresident applicant shall receive a nonresident producer license if:
- the applicant is currently licensed as a resident and is in good standing in the applicant's home state;
 - the applicant has submitted the proper request for licensure and has paid the applicable fees;
 - the applicant has submitted or transmitted to the Commissioner the application for licensure that the applicant submitted to the applicant's home state, or in lieu of the same, a completed uniform application; and
 - The applicant's home state awards a nonresident producer license to a resident of this state on the same basis.
- a.** A nonresident producer who moves from one state to another state or a resident producer who moves from this state to another state shall file a change of address with the Commissioner and shall provide certification from the new resident state within 30 days of the change of legal residence.

- b. An applicant licensed as a surplus lines producer in the applicant's home state shall receive a nonresident surplus lines producer license.
- c. An applicant licensed as a limited line credit insurance producer or other type of limited lines producer in the person's home state shall receive a nonresident limited lines producer license.

6. Exemptions [Secs. 431:9A-107, 109, 116] An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was licensed in good standing in that state, or the state's producer database records, maintained by the NAIC, its affiliates, or its subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

- a. A person licensed as an insurance producer in another state who moves to this state shall make application within 90 days of establishing legal residence to become a resident licensee. No prelicensing educational component or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the Commissioner determines otherwise by rule.
- b. The Commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state so long as the applicant's home state awards nonresident licenses to residents of this state on the same basis.
- c. A nonresident producer's satisfaction of the producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements so long as the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

7. Denial, suspension, revocation of licenses [Secs. 431:9A-112, 126, 127, 129] The Commissioner may deny, place on probation, suspend, revoke, or refuse to issue or renew an insurance producer's license and may levy a civil penalty or any combination of these actions, for:

- providing incorrect, misleading, incomplete, or materially untrue information in the license application;
- violating any law, or violating any rule, subpoena, or order of the Commissioner or of another state's Commissioner;
- obtaining or attempting to obtain a license through misrepresentation or fraud;
- improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing business;

- intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;
- having been convicted of a felony;
- having admitted to or been found to have committed any insurance unfair trade practice or fraud;
- using fraudulent, coercive, or dishonest practice or demonstrating incompetence, untrustworthiness, or financial irresponsibility in the conduct of business in this State or elsewhere;
- having an insurance producer license or its equivalent denied, placed on probation, suspended, or revoked in any other state, province, district, or territory;
- forging another's name to an application or to any document related to a transaction;
- improperly using notes or any other reference material while taking an examination for an insurance license;
- accepting insurance business from a person who is not licensed;
- failing to comply with an administrative or court order imposing a child support obligation; or
- failing to pay federal or state income taxes or failing to comply with any administrative or court order directing payment of federal or state income taxes.

- a. In the event that the Commissioner takes action the applicant or licensee shall be notified in writing of the reason for that action. The applicant or licensee may make written demand upon the Commissioner within 10 days of the date of receipt of the notice for a hearing before the Commissioner to determine the reasonableness of the Commissioner's action. The hearing shall be held within 20 days of receipt of the written demand.

8. Renewal of license (continuing education requirements) [Sec.

431:9A-124; HAR 16-171-306] In addition to payment of fees, to qualify for a license renewal a licensee shall, during the 24 months preceding a license renewal, complete the required number of credit hours in approved continuing education courses and pay the fees as required.

- a. The required number of continuing education credit hours shall be as follows.

- 1.) For a licensee authorized to sell classes of insurance in only one of the following groups:

- Life or disability
- Property, marine, and transportation, vehicle general casualty, or surety

... the requisite number of credit hours shall be 20 hours relating to the class of insurance for which the license is held, including three credit hours relating to the insurance laws and the insurance rules of Hawaii.

- 2.)** For a licensee with a license to sell classes of insurance in both groups listed above, the total requisite number of credit hours shall be 30 hours, of which:
- 12 hours shall relate to life or disability of which two hours shall relate to the insurance laws and the rules relating to the class of insurance for which the license is held; and
 - 18 hours shall relate to property, marine and transportation, vehicle general casualty, or surety, of which two hours shall relate to the insurance laws and the rules relating to the class of insurance for which the license is held.
- b.** Continuing education equivalents, as determined and approved by the Commissioner, may include the teaching of continuing education courses and holding certain professional designations, but shall not include the use of carryover credit hours earned in excess of the required hours in any two-year renewal cycle.
- c.** Unless an extension of time has been granted in advance by the Commissioner, a licensee's failure to satisfy all of the continuing education requirements one month prior to the renewal date shall result in that licensee's license being automatically placed on an inactive status. To reactivate a license, the licensee shall submit proof to the insurance division that the requisite number of credit hours have been completed and the licensee shall pay any required fees and penalties.
- 1.) Extension of time for military service** The Commissioner may extend the time in which to fulfill the continuing education requirements if a producer is on extended military duty. The extension will be for a period of time equal to the number of days the licensee was on active military duty.
- d.** After a licensee completes an approved continuing education course, the approved course provider shall issue to the licensee a certificate of completion in a form approved by the Commissioner that certifies that the licensee has successfully completed the course. Both the licensee and a person authorized to sign on behalf of the approved course provider shall sign the certificate of completion. The course provider shall submit the certificate of completion to the insurance division within 15 days of course completion.
- 1.) Duration of credit [Reg. 16-171-306]** Credits earned from a continuing education course are valid for 24 months after the course is successfully completed.
- e.** The Commissioner shall suspend, revoke, or refuse to extend the license of any licensee who has submitted an invalid, false, or fraudulent certificate of completion, subject to the right of a licensee to have a hearing.

- f. The Commissioner shall revoke the approval of an approved course provider who has issued a certificate of completion to a licensee who has not attended the continuing education course or who has not met the course requirements, subject to the right of an approved course provider to have a hearing.

D. MARKETING PRACTICES

1. Unfair practices and frauds [Secs. 431:13-101 through 108] The purpose of Hawaii law with regard to unfair practices and fraud is to regulate trade practice in the business of insurance in accordance with the intent of United States law, by defining, or providing for the determination of, all acts, methods, and practices which constitute unfair methods of competition or unfair or deceptive acts or practices in this state, and by prohibiting the trade practices so defined or determined. No person shall engage in this state in any act or practice which is defined under Hawaii law as or determined to be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance. The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance.

- a. Misrepresentation of insurance policies** This includes:
- misrepresenting the benefits, advantages, conditions, or terms of any insurance policy;
 - misrepresenting the dividends or share of surplus to be received on any insurance policy;
 - making any false or misleading statement as to the dividends or share of surplus previously paid on any insurance policy;
 - misleading or misrepresenting the financial condition of any insurer;
 - using any name or title of any insurance policy or class of insurance policy for the purpose of misrepresenting the true nature thereof;
 - misrepresenting for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of any insurance policy (twisting);
 - misrepresenting for the purpose of getting a pledge or assignment of or loan against any insurance policy; or
 - misrepresenting any insurance policy as being shares of stock.
- b. False information and advertising generally** This involves making, publishing, disseminating, or circulating in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion or statement with respect to the business of insurance or with respect to any person in the conduct of the person's insurance business, which is untrue, deceptive, or misleading.
- c. Defamation** This involves the making or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or mali-

ciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

- d. Boycott, coercion, and intimidation** This involves entering into any agreement to commit boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.
- 1.) It also may involve entering into any agreement on the condition, agreement, or understanding that a policy will not be issued or renewed unless the prospective insured contracts for another class or additional policy of the same class of insurance with the same insurer.
- e. False financial statements** Knowingly filing with any supervisory or other public official or placing before the public any false statement of a material fact as to the financial condition of an insurer.
- 1.) It also may involve knowingly making any false entry of a material fact in any book, report, or statement of any insurer with the intent to deceive any producer or examiner lawfully appointed to examine into its condition or into any of its affairs.
- f. Stock operations and advisory board contracts** This involves issuing or delivering agency company stock or other capital stock or securities of any kind promising returns and profits as an inducement to purchase insurance.
- g. Unfair discrimination** This involves making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.
- 1.) It may also involve making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to issue, refusing to renew, cancelling, or limiting the amount of insurance coverage on a risk because of the geographical location of the risk, the age of the applicants, the sex or marital status or occupation of the applicants, the applicant's having taken a HIV test before applying for insurance, or due to any mental or physical impairment.
- h. Rebating** No company, officer, producer, shall pay or allow, or offer to pay or allow, in connection with placing or negotiating any policy of insurance, any valuable consideration or inducement not specified in the policy or contract, or any special favor or advantage in the dividends accrued on such policies.
- 1.) Insurance personnel shall not give, sell, or purchase, or offer to give, sell, or purchase, anything of value whatsoever not specified in the policy. The giving, or selling, or purchasing, or offering to give, sell, or purchase

as an inducement to purchasing insurance or in connection therewith, any stocks, bonds, or other security of any insurance company or other corporation, association, or partnership or any dividends or profits accrued thereon, or anything of value not specified in the contract will be deemed as rebating.

- 2.) Knowingly offering or accepting any such rebates is illegal under Hawaii law.
 - 3.) The individual offering a rebate is the **offeror**. The person accepting a rebate is the **offeree**.
 - 4.) **Exemptions** The following acts shall not be considered to be rebating: in the case of life insurance, paying bonuses to policyholders or otherwise abating their premiums out of surplus accumulated from non-participating insurance provided that all such abatements shall be fair and equitable to all policyholders; readjustment of the rate of premium for a group insurance policy based on the loss or expense experience thereunder; in the case of any contract of insurance, the distribution of savings, earnings, or surplus equitably among a class of policyholders, all in accordance with Hawaii law.
- i. **Third party claims** An insurer cannot refuse to provide or limit coverage because the person may have a claim against a third party for recovery of damages.
 - j. **Unfair claim settlement practices** Committing or performing with such frequency as to indicate a general business practice of:
 - misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
 - failing to respond with reasonable promptness, in no case more than 15 working days, to communications with respect to claims arising under its policies;
 - failing to adopt and implement reasonable standards for the prompt investigation of claims;
 - refusing to pay claims without conducting a reasonable investigation;
 - failing to affirm or deny coverage of claims within a reasonable time after proof of loss has been provided;
 - not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims;
 - failing to offer payment within 30 calendar days of establishing liability, if the amount of the claim has been determined and is undisputed;
 - failing to give the insured or beneficiary a reasonable written explanation for the reason why a claim has not been resolved within 30 days from the date it was reported;
 - paying a claim without identifying the coverage under which the claim is paid;

- making known to insureds or claimants the insurer has a policy of appealing arbitration awards in favor of insureds or claimants in order to compel them to accept settlement amounts less than the amount awarded in arbitration;
- delaying investigation or payment of claims by requiring an insured, claimant, or physician to submit a preliminary claim report and then later requiring a formal proof of loss form when both documents contain the same information;
- compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;
- attempting to settle a claim for less than the amount to which a reasonable person would have believed the person was entitled by reference to written or printed advertising material accompanying or made part of an application;
- attempting to settle claims on the basis of an application which was altered without notice, or knowledge or consent of the insured;
- indicating to an insured that a payment for a claim is final or a release of any further liability if additional benefits related to the claim are probable under the policy's coverages, unless the policy limit has been paid or there is a genuine dispute over the coverage or the amount to be paid; and
- failing to promptly settle claims, where liability has become reasonably clear.

1.) Contested claims [Sec. 431:13-108] This section applies to accident and sickness insurance providers, mutual benefit societies, dental service corporations, and health maintenance organizations:

- a.) Unless shorter payment timeframes are otherwise specified in a contract, an insurer shall reimburse a claim that is not contested or denied not more than thirty calendar days after receiving the claim filed in writing, or 15 calendar days after receiving the claim filed electronically.
- b.) If a claim is contested or denied or requires more time for review, the insurer shall notify the health care provider in writing or electronically not more than 15 calendar days after receiving a claim filed in writing, or not more than seven calendar days after receiving a claim filed electronically, as appropriate. The notice shall identify the contested portion of the claim and the specific reason for contesting or denying the claim, and may request additional information.

k. Failure to maintain complaint handling procedures Failure of any insured to maintain a complete record of all the complaints which it has received since the date of its last examination is an unfair trade practice under Hawaii law.

l. Misrepresentation in insurance applications Making false or fraudulent statements or representations on or relative to an application for an insurance policy, with the purpose of obtaining a fee, commission, money, or other benefit from any insurer, producer, or individual is also an unfair trade practice.

m. Penalties If an act or practice by a licensee is a violation of Hawaii law, the Commissioner may, at his discretion, order any one or more of the following: payment of a monetary penalty of not more than \$1,000 for each and every act or violation but not to exceed an aggregate penalty of \$10,000, unless the person knew or reasonably should have known that the person was in violation of Hawaii law, in which case the penalty shall be not more than \$5,000 for each and every act or violation but not to exceed an aggregate penalty of \$50,000 in any six-month period; or suspension or revocation of the person's license, if the person knew or reasonably should have known that the person was in violation of Hawaii law.

2. Fiduciary responsibilities: reporting and accounting for premiums

[Sec. 431: 9A-230] Every licensed producer and adjuster is a fiduciary (and shall have the responsibilities of a trustee) for all premium and return premium funds received or collected under Hawaii law.

- a.** The licensee shall, upon receipt of funds, remit premiums to the insurer. He or she must also return premiums to persons entitled to them. Such funds may also be maintained in a federally insured account with a bank situated in Hawaii.
- b.** The licensee shall not be required to maintain a separate bank account for the funds of each insurer or person entitled to such funds, if and so long as the funds held for the insurer or person entitled thereto are reasonably ascertainable from the books of account and records of the licensee.
- c.** In the event the bank or savings and loan association account is an interest earning account, such licensee may not retain the interest earned on such funds for the licensee's own use or benefit without the prior written consent of the insurers or persons entitled to such funds.
- d.** Any such licensee who, not being lawfully entitled thereto, diverts or appropriates such funds or any portion thereof to his own use, shall be guilty of embezzlement, and shall be punished as provided by the criminal statutes of this state.

3. Sharing commissions [Sec. 431:9A-113] An insurance company or insurance producer shall not pay a commission, service fee, brokerage fee, or other valuable consideration to a person for selling, soliciting, or negotiating insurance in this state if that person is required to be licensed under this article and is not so licensed.

- a.** A person shall not accept a commission, service fee, brokerage fee, or other valuable consideration for selling, soliciting, or negotiating insurance in this

state if that person is required to be licensed under this article and is not so licensed.

- b.** Renewal or other deferred commissions may be paid to a person for selling, soliciting, or negotiating insurance in this state if that person was required to be licensed under this article at the time of the sale, solicitation, or negotiation and was so licensed.
- c.** An insurer or insurance producer may pay or assign commissions, service fees, brokerage fees, or other valuable consideration to an insurance agency or to persons who do not sell, solicit, or negotiate insurance in this state.

4. Required record and record retention [Secs. 431:9-229; 431:9A-123, 125] Every producer shall keep a record of all transactions consummated under his license for up to five years.

- a.** This record shall be in organized form according to class of insurance and shall include, if an adjuster, a record of each investigation or adjustment undertaken or consummated, and a statement of any fee, commission or other compensation received or to be received by the adjuster on account of such investigation or adjustment.
- b.** This section of Hawaii law shall not apply to life or disability insurance if the records required of such insurance are customarily maintained in the offices of the insurer.
- c.** Licensees shall maintain their own continuing education records and shall keep these records for four years after completion of an approved continuing education course.
- d.** Approved course providers shall maintain attendance records for five years to permit the Commissioner to verify the attendance and course completion of all licensees enrolled in an approved course. These course providers shall make the records available at all times to the Commissioner.

5. Controlled business [Sec. 431:9A-202] The purpose of a license issued in the state of Hawaii to a producer is to authorize and enable the licensee to engage in the insurance business with respect to the general public, and to facilitate the public supervision of such activities in the public interest and not for the purpose of enabling the licensee to receive a rebate of premium in the form of a commission or other compensation upon insurance solicited or procured by or through him upon his own interests or upon those of other persons with whom he is closely associated.

- a.** The Commissioner of Insurance shall not grant, renew, continue, or permit to exist any license as a producer as to any applicant or licensee if he finds that the license is being or will probably be used by the applicant or licensee materially for the purpose of writing controlled business.

- b.** Such a license shall be deemed to have been or intended to be, used materially for the purpose of writing controlled business if the Commissioner of Insurance finds that during either of the two calendar years immediately preceding the extension date of any such license the aggregate amount of premiums on insurance represented by controlled business exceeded the aggregate amount of premiums on all other insurance business of the licensee.
 - c.** The circumstances of the applicant for such license or of any such license are such as to cause the Commissioner reasonably to believe that during the 12-month period immediately following the issuance or extension of the license, the aggregate amount of premiums on controlled business would exceed the aggregate amount of premiums on all other insurance business of the applicant or licensee.
 - d.** **Controlled business** is insurance procured or to be procured by or through such person upon his own life, person, property, or risks, or those of his spouse, or the life, person, property, or risks of his employer or his partnership.
- 6. Premiums [Sec. 431:10-218]** The premium stated in the policy shall be inclusive of all fees, charges, premiums, or other considerations charged for the insurance or for the procurement thereof. This section of Hawaii state law shall not apply to surety or group insurance contracts.
- a.** No insurer or its officer, employee, producer, or other representative shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium specified in the policy.

E. INSURANCE COMPANY INSOLVENCY [SECS. 431:16-201 THROUGH 219]

- 1. Hawaii Life and Disability Insurance Guaranty Association Act** The Hawaii Life and Disability Insurance Guaranty Association evolved from the Hawaii Life and Disability Insurance Guaranty Association Act. The purpose of this act was to protect policyowners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, disability insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment of insolvency of the insurer issuing such policies or contracts.
- a.** An association of insurers was created to enable the guarantee of payments of benefits and of continuation of coverages.
 - b.** Members of the Association are subject to assessments to provide funds to carry out the purpose of this law.
 - c.** The Association is authorized to assist the Commissioner in the detection and prevention of insurer impairments or insolvencies.

- d. This law shall apply to direct life insurance policies, disability insurance policies, annuity contracts, and contracts supplemental to life and disability insurance policies, issued by persons licensed to transact business in this state at any time.
- e. An **insolvent insurer** is a member insurer which after April 23, 1979 becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court of competent jurisdiction.
- f. **Establishment of Association** All insurers licensed to solicit life and disability insurance in this state are required to be members of the Association. This requirement is a condition of the members authority to transact insurance in this state. The Association shall maintain three accounts: the life insurance account, the disability insurance account, and the annuity account.
- g. The contractual obligations of the insolvent insurer for which the Association becomes liable shall be as great as, but no greater than, the contractual obligations of the insolvent insurer.
 - 1.) The aggregate liability of the Association shall not exceed \$100,000 in cash values, or \$300,000 for all benefits, including cash values with respect to any one life.
- h. The Association may enter into such contracts as are necessary or proper to carry out the provisions and purpose of this law; sue or be sued; borrow money to effect the purpose of this law; employ or retain such persons as are necessary to handle the financial transactions of the Association and more.
- i. **Assessments** For the purpose of providing the funds necessary to carry out the powers and duties of the Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at 18% per year on and after the due date. There are three classes of assessments.
 - 1.) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses and examinations conducted under the authority of Hawaii law not related to a particular impaired or insolvent insurer.
 - 2.) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the Association under Hawaii law with regard to an impaired or insolvent domestic insurer.
 - 3.) Class C assessments shall be made to the extent to carry out the powers and duties of the Association under Hawaii law with regard to an insolvent foreign or alien insurer.

- 4.) The total of all assessments upon a member insurer for each account shall not, in any calendar year, exceed 2% of such insurer's premiums received in this state during the calendar year preceding the assessment on the policies covered by the account.

II. HAWAII LAWS, RULES, AND REGULATIONS PERTINENT TO LIFE INSURANCE ONLY

A. MARKETING METHODS AND PRACTICES

1. **Replacement [Secs. 431:10D-501 through 509]** The purpose of Hawaii laws regarding life insurance replacement is to implement the insurance laws of Hawaii by regulating the acts and practices of insurers with respect to life insurance replacing life insurance. These laws also protect the interest of the life insurance buying public by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of life insurance policies by making available full and clear information on which an applicant for life insurance can make a decision in the applicant's best interest. These laws also reduce the opportunity for misrepresentation and incomplete comparison in replacement situations.
 - a. **Replacement defined [Sec. 431:10D-502]** The replacement of life insurance is defined as any transaction wherein:
 - new life insurance is to be purchased and it is known or should be known to the producer that it is part of the transaction or in consequence of it;
 - any previously existing life insurance has been or is to be lapsed or surrendered; converted into paid-up insurance, continued as extended term insurance, or under another form of nonforfeiture benefit;
 - converted otherwise so as to effect a reduction either in the amount of the existing life insurance or in the period of time the existing life insurance will continue in force; or
 - reissued with a reduction in an amount such that substantial cash values are released.
 - b. **Exempt transactions [Sec. 431:10D-501(b)]** The regulations concerning the replacement of existing life insurance or annuities do not apply to:
 - credit life insurance;
 - group life insurance in which there has been no direct solicitation by a producer;
 - group life insurance used to fund prearranged funeral contracts;
 - an application to an existing insurer that issued the existing policy, or when a contractual change or conversion privilege is being exercised;
 - proposed life insurance that will replace a policy under a binding or conditional receipt issued by the same insurer;

- policies that fund employee pension or welfare benefit plans subject to ERISA;
- policies that fund a government or church welfare benefit plan;
- policies that fund nonqualified deferred compensation arrangements maintained by an employer;
- when new coverage under a life insurance policy is wholly provided by an employer or association to which the insured belongs;
- existing life insurance that is a non-convertible, nonrenewable term life policy that expires in fewer than five years;
- immediate annuities bought with proceeds from an existing policy; and
- structured settlements.

2. Duties of producers [Sec. 431:10D-503] Life insurance producers have specific responsibilities when a replacement is involved.

- a. Signed statement of existing policies** The producer must submit to the insurer a statement, signed by both the applicant and the producer, indicating whether the applicant has existing life insurance policies or contracts.
- 1.) If not, the producer does not have any other duties with respect to replacement.
 - 2.) If so, the producer will, when the application is taken, present and read to the applicant a notice approved by the Commissioner. This notice must be signed by the applicant and the producer. It states that the producer has read the notice aloud or that the applicant does not want the notice to be read aloud, and that it has been left with the applicant.
- b. Signed notice** The notice will list all life insurance policies or annuities that may be replaced, identifying the insurers and insured or annuitant, and the policy or contract number, if available. The notice will also state whether the policy or contract will be replaced or whether a policy will be used to finance the new policy or contract.
- c. Sales materials** When taking the application, the producer will leave with the applicant the originals or copies of all sales materials used in the transaction. Sales materials presented electronically will be given to the insured in printed form by the time the policy or contract is delivered.
- d. Submittals to insurer** When submitting the application to the insurer, the producer must tender the statement concerning existing life insurance policies and a copy of the required notice. The producer must also submit a statement that identifies any printed or electronically presented sales materials used in the transaction and copies of any customer-specific sales materials, including illustrations concerning the specific contract or policy that was sold.

3. General duties of insurers using producers [Sec. 431:10D-504] All insurers have the following duties.

- a. Supervision of producers** Insurers must maintain a system of supervision and control that ensures compliance with the requirements described below by:
- informing producers of the disclosure and notice requirements involved with replacements;
 - giving each producer a written statement of the insurer's position on the acceptability of replacements and giving guidance on when replacement is suitable;
 - reviewing the appropriateness of each replacement that does not comply with the insurer's position on replacement policies;
 - establishing procedures to confirm that these requirements have been met; and
 - establishing procedures to identify replacement transactions that the producer or applicant has not identified as such.
- b. Monitoring producer contracts** Insurers are to monitor their producers' sales of policies and annuities to identify replacement transactions. Records of these transactions are to be made available to the Commissioner upon request. The following transactions are subject to monitoring, as a percentage of the producer's total annual sales for the product in question:
- Life insurance replacements
 - The number of lapsed policies
 - Annuity contract replacements
 - The number of transactions that are unreported replacements of existing policies or contracts by the existing insurer
 - Replacements, as indexed by the replacing producer and the existing insurer
- c. Signed statement** Insurers are to accept applications for life insurance or annuities only when they are accompanied by a statement signed by the applicant and producer indicating whether the applicant has a life insurance policy or contract in force.
- d. Required notice** Insurers are to accept applications for life insurance or annuities only when they are accompanied by the required notice regarding replacements.
- e. Sales materials** Insurers must be able to show copies of any sales material used to sell a policy or annuity, and the statements signed by the applicant and producer with respect to financing and replacement, for at least five years after the policy or contract ends.
- f. Accuracy of sales materials** Insurers are to ensure that sales materials and illustrations are complete and accurate for the proposed policy or contract.

g. Incomplete applications If an application does not comply with these requirements, the insurer must notify the producer and applicant and ensure compliance.

h. Records Insurers must preserve records in such a way that they can reproduce the actual paper documents.

4. Duties of replacing insurers using producers [Sec. 431:10D-505]

Insurers have certain responsibilities when they replace a life insurance policy.

a. Forms Insurers must verify that all required forms are properly filed by producers.

b. Notice Within five days of receiving an application, an insurer must notify other existing insurers that they may be affected by the proposed replacement. The insurer must also mail a copy of a policy summary or illustration within five business days of receiving an existing insurer's request.

c. Documentation An insurer must be able to show copies of the notification regarding replacement, indexed by producer, for at least five years or until the next regular examination by the Insurance Department.

d. Free-look Insurers must give policyowners notice of the right to return the policy or annuity within 30 days of delivery and receive a full, unconditional refund of the premium.

e. Replacement with same insurer If the existing insurer is the same as the replacing insurer, the replacing insurer must give credit for the time that has passed under the replaced policy's incontestability or suicide period up to the face amount of the existing policy.

f. Prohibited sales materials If an insurer prohibits its producers from using sales materials that the insurer has not approved, the insurer may:

- require producers to include with every application submitted a signed statement attesting that the producers used only company-approved sales materials and affirming that copies of all sales materials were left with the applicant;
- within 10 days of issuing the policy or contract, notify the applicant that the producer has stated that copies of all sales materials have been left with the applicant, give the applicant a toll-free number to contact the insurer if this was not done, and stress the importance of keeping copies for future reference; and
- be able to show documentation of compliance with these requirements for at least five years after the policy or contract expires.

5. Duties of existing insurers [Sec. 431:10D-506] Existing insurers also have certain responsibilities when their policies are replaced.

- a. Documentation** Insurers must document all replacement notifications received, indexed by replacing insurer, for at least five years or until the next regular examination by the Commissioner, whichever is later.
- b. Notice to policyowner** Within five business days of learning that its policy is being replaced, an insurer must notify the policyowner of the right to receive information about existing policy values within five days of the policyowner's request.
- c. Policyowner request to borrow, surrender, or withdraw policy value** If a policyowner wants to borrow, surrender, or withdraw funds from a policy's cash value, the insurer must send a notice advising the policyowner that doing so may affect the guaranteed elements, nonguaranteed elements, face amount, or surrender value of the policy.

B. VARIABLE CONTRACTS [SEC. 431:10D-118] A domestic life insurance company may establish one or more separate accounts, to provide for life insurance or annuities payable in fixed or variable amounts or both. Amounts allocated to a separate account in the exercise of the power granted by Hawaii law shall be owned by the company. The income, gains and losses realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses of the company. Assets allocated to a separate account shall be valued at their market value on the date of valuation.

- 1.** Any variable contract providing benefits payable in variable amounts, delivered or issued for delivery in this state, shall contain a statement of the essential features of the procedures to be followed by the insurance company in determining the dollar amount of such variable benefits.
 - a.** Any such contract shall state that such dollar amounts will vary to reflect investment experience and shall contain on its first page a statement to the effect that the benefits thereunder are on a variable basis.
- 2.** No insurer shall deliver or issue for delivery contracts within this state unless it is licensed or organized to do a life insurance or annuity business in this state. In addition, the Commissioner must be satisfied that the insurer's condition and method of operation is not hazardous to the public or its policyholders.
- 3.** The Commissioner shall have sole and exclusive authority to regulate the issuance and the sale of variable contracts and to provide for the licensing of persons selling such contracts, and to issue reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of Hawaii law regarding variable contracts.

C. POLICY CLAUSES AND PROVISIONS

- 1. Protection of beneficiaries from creditors [Sec. 431:10-232]** All proceeds payable because of the death of the insured payable to a wife or husband of the insured, or to a child, parent, or other person dependent upon the insured, shall be exempt from execution, attachment, garnishment, or other process, for the debts or liabilities of the insured incurred subsequent to May 19, 1939, except as to premiums paid in fraud of creditors within the period limited by law for the recovery thereof.

 - a.** In other words, if a policy of life insurance is effected by any person on his own life, the named beneficiary shall be entitled to its proceeds. The creditors of the deceased may not attach any lien or claim to the policy proceeds. However, if it appears that a life insurance policy was purchased with the intent of defrauding creditors of the person purchasing such insurance, the party receiving the money secured by the policy shall be liable to such creditors for the amount of all premiums paid for such insurance.
 - b.** When the terms of any life or endowment policy or annuity contract require that the proceeds be retained by the insurer upon the death of the insured, the beneficiary shall be exempt from execution, attachment, garnishment, or other process for his debts or liabilities incurred. In other words, when life insurance proceeds are left at interest with the insurer, the creditors of the beneficiary may not attach such proceeds because of the debts or liabilities of the beneficiary.
- 2. Policy loan interest rate [Sec. 431:10D-103]** The policyholder may not borrow against the cash value of a life insurance policy until such policy has been in effect and the policyholder has paid premiums for three full years. The maximum loan value is an amount equal to the cash surrender value.

 - a.** The maximum rate of interest charged to a policyholder when borrowing from the policy's cash value is 8% per year. A provision permitting an adjustable or variable maximum interest rate may be established from time to time by a life insurer as permitted by Hawaii law. Such adjustable or variable interest rate will be based upon Moody's Corporate Bond Yield Average. The maximum rate for each policy shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any three-month period.
 - b.** If an insured dies while there is an outstanding loan on the policy, the beneficiary receives the face amount less the amount of the loan.
 - c.** An insurer shall reserve the right to defer the granting of a loan, other than for the payment of any premium to the insurer, for up to six months after the insured applies for such loan (**delay clause**).

- 3. Spouses' rights [Sec. 431:10D-212]** In general, insurance under a group life insurance policy can cover employees or members of a group for the loss of their spouses and dependent children.
- a. The insured's spouse and dependents may have an amount of coverage that is equivalent to the insured's.
 - b. Premiums for the insurance of the spouse or dependent will be paid either by the employer or group sponsor, by the insured individual, or by both.
 - c. An insurer may exclude or limit coverage for a spouse or dependent child if the insurer is not satisfied that he or she is insurable.
 - d. A "dependent" for purposes of these rules is a child of the insured individual when that child is
 - younger than 18 years of age;
 - younger than 23 years of age and attending an educational institution while relying upon the insured individual for financial support; or
 - incapable of self-sustaining employment, regardless of age, due to mental retardation or physical disability and relying upon the insured individual for primary support.

D. GROUP LIFE

- 1. Group requirements [Sec. 431:10D-201]** No contract of life insurance shall hereafter be delivered or issued for delivery in this state insuring the lives of more than one individual unless such contract is issued to:
- employee groups;
 - debtor groups;
 - labor union groups;
 - trustee groups;
 - agent groups;
 - public employee groups;
 - mutual benefit societies;
 - professional association groups;
 - trade association groups; and
 - credit union groups.
- 2. Assignment of proceeds [Sec. 431:10D-215]** Subject to the terms of the policy, any person insured under a group life insurance policy may make to any person, other than the policyholder, an assignment of all or any part of the incidents of ownership conferred on him by the policy or by law, including specifically, but not limited to the right to exercise the conversion privilege and the right to name a beneficiary.

3. Minimum number [Secs. 431:10D-202(4); 10A-117] The lives of a group of individuals may be insured under a policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustee is deemed a policyholder, insuring employees of the employer for the benefit of persons other than the employer. A group policy of this nature must cover at least 10 employees at the date of issue.

a. Group life insurance policies are subject to the following requirements:

- 1.)** all employees are eligible for insurance under the group policy, or all employees of a class as determined by conditions of the employment;
- 2.)** the policy premiums can be paid by the employer, the employees, or by both;
- 3.)** the insurer may exclude or limit coverage on a person if the insurer is not satisfied of the person's insurability; and
- 4.)** the amounts of insurance provided by the policy must be based on some plan that precludes individual selection by the employees, employer, or trustee.

4. Conversion [Secs. 431:10D-213 (8, 9, 10); 10D-214] Any individual insured under a group life insurance policy delivered in this state becomes entitled under the terms of the policy to have an individual policy of life insurance issued to him without evidence of insurability, subject to the making of an application and payment of the first premium within the specified period in the policy.

- a.** If the individual is not given notice of the existence of such right at least 15 days prior to the expiration date of such period, the individual shall have an additional period in which to exercise the right, but nothing herein shall be construed to continue any insurance beyond the period provided in the policy.
- b.** This additional period shall expire 15 days next after the individual is given such notice but in no event shall the additional period extend beyond 60 days next after the expiration date of the period provided in the policy.
- c.** The insured's right of conversion must usually be exercised within 31 days of termination under the group contract (the normal specified period under the policy).

E. PARTICIPATION IN SURPLUS [SEC. 431:10D-102 (6)] A provision in participating policies that, beginning not later than the end of the third policy year, the insurer shall annually ascertain and apportion the divisible surplus, if any, accruing on the policy dividends which shall be payable in cash or applied to any one of other such dividend options as may be provided by the policy.

1. If any such other dividend options are provided, the policy shall further state which option shall be automatically effective if the party shall not have elected some other option before the expiration of a period not less than 30 days following the date on which the dividend is due and payable.
2. If a policy provides that the benefit under any paid-up nonforfeiture provision is to be participating, it may provide that any divisible surplus apportioned while the insurance is in force under the nonforfeiture provision shall be applied in the manner set forth in the policy.

F. CREDIT LIFE [SECS. 431:10B-101 THROUGH 114] Credit life insurance means life insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transaction.

1. Credit life insurance shall be issued only in the following forms.
 - a. Individual policies of life insurance issued to debtors (borrowers) on a term plan.
 - b. Group policies of life insurance issued to creditors providing life insurance upon the lives of debtors on a term plan.
2. **Coverage amounts** The initial coverage amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness and the amount of insurance shall at no time exceed the scheduled or actual amount of unpaid indebtedness.
3. **Term of coverage** The term of coverage under a credit life policy shall commence on the date when the debtor becomes obligated to the creditor (except under group life when coverage commences on the effective date of the policy).
 - a. Where evidence of insurability is required and the evidence is furnished more than thirty days after the date when the debtor becomes obligated to the creditor, the term of insurance may commence on the date on which the insurer determines the evidence to be satisfactory, and in such event there shall be an appropriate refund or adjustment of any charge to the debtor for insurance.
 - b. The term of such insurance shall not extend more than 15 days beyond the scheduled maturity date of the indebtedness except when extended without the additional cost of the debtor.
4. **Policy provisions** All credit life insurance shall be evidenced by an individual policy (or in the case of a group policy, a certificate) which is delivered to the debtor.
 - a. The policy or certificate shall also include the benefits provided, a description of coverage, and the exceptions, limitations, and restrictions included.
5. **Policy filing** All policies must be filed and approved by the insurance department.

- 6. Penalties** Anyone who violates Hawaii law with respect to credit life insurance shall be fined \$250 unless the violation is willful which would result in a fine not to exceed \$1,000.

III. HAWAII LAWS, RULES, AND REGULATIONS PERTINENT TO ACCIDENT AND HEALTH INSURANCE ONLY

A. MARKETING METHODS AND PRACTICES

- 1. Prepaid health care [Ch. 393]** The cost of medical care in the case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of the Prepaid Health Care Act, in view of the spiraling costs of comprehensive medical care, to provide such protection for the employees in this state.

- a. Prepaid health care plans** A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under Hawaii law if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type which have the largest numbers of subscribers in the state. This applies to the types and quantity of benefits as well as to limitations or reimbursability, including deductibles, and to acquired amounts of coinsurance.

- 1.)** The Director of Labor and Industrial Relations shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the state, comply with the standards specified under Hawaii law.

- b.** Prepaid health care plans qualifying under Hawaii law shall include at least the following benefit types:

- hospital benefits including inpatient care (at least 120 days of confinement) covering room costs, general nursing services, operating room and anesthesia expenses, drugs, and drug transfusions as well as outpatient care covering outpatient use of the hospital and facilities for surgical procedures or medical care of an emergency or urgent nature;
- surgical benefits (including those performed by a licensed physician), after-care visits for a reasonable period, and anesthesiologists services;
- medical benefits (including necessary, home, office, and hospital visits by a licensed physician), intensive medical care while hospitalized, and medical or surgical consultations while confined;
- diagnostic laboratory services including x-ray films and radio therapeutic services;
- maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery; and
- substance abuse benefits including treatment for alcoholism and drug addiction.

c. Commencement of coverage An employer shall provide the coverage required under Hawaii law for any regular employee, who has been in his employ for four consecutive weeks.

d. Penalties If an employer fails to comply with Hawaii law, he shall pay a penalty of not less than \$25 or \$1 for each employee for every day during which such failure continues, whichever sum is greater. Any employer, employee, or prepaid health care plan contractor who willfully fails to comply with any other provisions of Hawaii law may be fined not more than \$200 for each violation.

2. Temporary disability insurance [Ch. 392] A large portion of the labor force of this state annually is disabled from pursuing gainful employment for reason of nonoccupational sickness or accident and as a result suffers serious loss of income. In approximately 10% of the cases, such sickness or accident can be expected to cause disability of more than one week's duration. More than two-fifths of the employees in private employment have either no fixed legal protection against wage loss from disabling nonoccupational sickness or accident, or only protection for a period of one work week or less.

a. Any individual in current employment who suffers disability resulting from accident, sickness, pregnancy, or termination of pregnancy, except accident or disease connected with or resulting from employment or any other applicable workers' compensation law, shall be entitled to receive temporary disability benefits.

b. The computation and distribution of benefit payments shall correspond to the greatest extent feasible, to the employee's wage loss due to his disability. An employee shall not be entitled to temporary disability benefits for periods of disability during which he would not have earned wages from employment according to the schedule of operation of his employer.

c. Temporary disability benefits shall be payable for any period of disability following the expiration of the waiting period required by Hawaii law. No temporary disability benefits shall be payable during the first seven consecutive days of any period of disability. The duration of benefit payments shall not exceed 26 weeks for any period of disability or during any benefit year.

d. Eligibility An individual is eligible to receive temporary disability benefits if he has been in employment for at least 14 weeks during each of which he has received remuneration in any form for 20 or more hours and earned wages of at least \$400, during the four completed calendar quarters immediately preceding the first day of disability.

1.) An individual shall be ineligible to receive temporary disability benefits with respect to any period during which he or she is not under the care of a person duly licensed to practice medicine. This section shall not apply to an individual who, pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

- 2.)** Other individuals who are ineligible to receive temporary disability benefits include:
- those who would be disqualified from receiving benefits under the Hawaii Employment Security Law by reason of unemployment due to a stoppage of work existing because of a labor dispute;
 - those who have knowingly made a false statement or representation of a fact in order to receive benefits; or
 - those persons who have suffered disability due to willfully and intentionally self-inflicted injury or to injury sustained in the commission of a criminal offense.
- e.** No assignment, pledge, or encumbrance of any right to benefits which are or may become due or payable under Hawaii law shall be valid. In addition, the rights to such benefits shall be exempt from execution, attachment, garnishment, or any other remedy whatsoever provided for the collection of debts.
- f. Payment of disability benefits** Benefits provided under Hawaii law shall be paid periodically and promptly and, except as to a contested period of disability, without any decision by the director. The first payment of benefits shall be paid within ten days exclusive of Saturday, Sundays, and holidays, after the filing of the required proof of claim. Thereafter, benefits shall be due and payable every two weeks.
- g. Notice of denial** No employer or insurer shall deny disability benefits to an employee without first submitting a copy of the notice of denial to the Department. The Department shall review the denial within ten days of the receipt of the notice. If the Department finds the denial erroneous, without proper legal basis, or without sufficient evidence to support it, the Department shall request the employer or insurer to reconsider its action in denying disability benefits. In any case where denial is present, the employee always has the right to appeal the denial of such benefits.
- 1.)** The claimant must file an appeal at the office of the Department (Department of Labor and Industrial Relations) in the county in which the claimant resides or the county in which the claimant was employed prior to his disability within 20 days after the date of payment of such disputed benefits or the denial thereof.

B. MANDATED BENEFITS, POLICY CLAUSES, AND PROVISIONS

- 1. Coverage of handicapped and retarded persons [Sec. 431:10-212]** An individual accident and health policy delivered or issued for delivery in this state which provides that coverage of a dependent child shall terminate upon the attainment of a limiting age (e.g., age 19; age 23 if a full-time student) for dependent children specified in the policy shall also provide that the attainment of such a limiting age shall not cause the coverage of such child to be terminated while the child is and continues to be both incapable of self-sustaining employment by reason of mental retardation or physically handicapped and chiefly dependent upon the policyholder for support and maintenance.

- a. However, proof of such incapacity and dependency must be furnished to the insurer by the policyholder within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

2. Coverage of newborns [Sec. 431:10A-115] All individual and group health insurance policies providing coverage on an expense incurred basis which provide coverage for a family member or the insured shall also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth. The coverage for such newly born children include the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

- a. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within 31 days after the date of birth in order to have the coverage continued beyond such 31-day period.

3. Child health supervision services [Secs. 431:10A-115.5; 431:10A-206.5] All health insurance policies issued in this State which provide coverage for the children of the insured shall provide coverage for child health supervision services from the moment of birth through age five years. These services shall be exempt from any deductible provisions, and immunizations shall be exempt from any copayment provisions, which may be in force in these policies or contracts.

- a. Child health supervision services shall include 12 visits at approximately the following intervals: birth, two months, four months, six months, nine months, 12 months, 15 months, 18 months, two years, three years, four years, and five years.
 - 1.) Services to be covered at each visit shall include a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests, in keeping with prevailing medical standards.
- b. Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section, except that the limitations authorized by this subsection shall not apply to immunizations.
- c. This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.
- d. **Child health supervision services** means physician-delivered, physician-supervised, or nurse-delivered services which shall include as the minimum benefit coverage for services delivered at intervals and scope stated.

4. Coverage for specific services [Secs. 431:10A-116; 431:10A-207]

Every person insured under a policy of accident and sickness insurance delivered or issued for delivery in this state shall be entitled to the reimbursements and coverages specified below.

- a.** Whenever a policy, contract, plan, or agreement provides for reimbursement for any visual or optometric service, these services shall include eye or visual examination, or both, or a correction of any visual or muscular anomaly, and the supplying of ophthalmic materials, lenses, contact lenses, spectacles, eye-glasses, and appurtenances thereto.
 - b.** Whenever provision is made for reimbursement or indemnity for any service related to surgical or emergency procedures, reimbursement or indemnification under the policy, contract, plan, or agreement shall not be denied when such services are performed by a dentist acting within the lawful scope of the dentist's license.
 - c.** Whenever the policy provides reimbursement or payment for any service, which is within the lawful scope of practice of a psychologist licensed in this state, the person entitled to benefits or performing the service shall be entitled to reimbursement or payment, whether the service is performed by a licensed physician or licensed psychologist.
 - d.** Notwithstanding any provision to the contrary, each policy, contract, plan, or agreement, except for policies that only provide coverage for specified diseases or other limited benefit coverage, shall provide coverage for screening by low-dose mammography for occult breast cancer as follows:
 - for women 40 years of age and older, an annual mammogram; and
 - for a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer, a mammogram upon the recommendation of the woman's physician.
- 1.)** Whenever a policy, contract, plan, or agreement provides coverage for the children of the insured, that coverage shall also extend to the date of birth of any newborn child to be adopted by the insured; provided that the insured gives written notice to the insurer of the insured's intent to adopt the child prior to the child's date of birth or within 30 days after the child's birth or within the time period required for enrollment of a natural born child under the policy, whichever period is longer.
 - a.)** In addition, if the adoption proceedings are not successful, the insured shall reimburse the insurer for any expenses paid for the child and where notification has not been received, insurance coverage shall be effective from the first day following the insurer's receipt of legal notification of the insured's ability to consent for treatment of the infant for whom coverage is sought.

- 2.) Notwithstanding any provision to the contrary, any policy issued or renewed in this state shall provide reimbursement for services provided by advanced practice registered nurses. Services rendered by advanced practice registered nurses are subject to the same policy limitations generally applicable to health care providers within the policy.

5. Coverage for telehealth [Sec. 431:10A-116.3] Telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

- a. Telehealth means the use of telecommunications services. These include real-time video conferencing, secure online web-based communication, and secure asynchronous information exchange to convey medical information about a patient. This information includes diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis to deliver health care services and information to distant parties. The use of standard telephones, facsimile transmissions, or email is not a telehealth service.
- b. There will be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers in the consultation.
 - 1.) A health care provider is a provider of medical or other health services and any person or organization who bills or is paid for health care in the usual course of business.
 - 2.) If a health care provider-patient relationship does not exist between the patient and the health care provider involved in the telehealth consultation, a telehealth mechanism can be used to establish a health care provider-patient relationship.
- c. No accident and sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided.

6. In vitro fertilization procedure coverage [Sec. 431:10A-116.5] All individual and group health insurance policies which provide pregnancy-related benefits shall include in addition to any other benefits for treating infertility, a one-time only benefit for all outpatient expenses arising from in vitro fertilization procedures performed on the insured or the insured's dependent spouse; provided that:

- benefits under this section shall be provided to the same extent as the benefits provided for other pregnancy-related benefits;
- the patient is the insured or covered dependent of the insured;
- the patient's oocytes are fertilized with the patient's spouse's sperm;

- the patient and the patient's spouse have a history of infertility of at least five years' duration; or infertility is associated with an approved medical condition;
- the patient has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available under the insurance contract; and
- the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetric and Gynecology guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

7. Contraceptive services [Sec. 431:10A-106.6] Each employer group health policy, shall cease to exclude contraceptive services or supplies for the subscriber or any dependent of the subscriber who is covered by the policy. All policies, contracts, plans, or agreements that provide contraceptive services or supplies, or prescription drug coverage, shall not exclude any prescription contraceptive supplies or impose any unusual copayment, charge, or waiting requirement for such supplies.

- a. **Contraceptive services** means physician-delivered, physician-supervised, physician assistant-delivered, nurse practitioner-delivered, certified nurse midwife-delivered, or nurse-delivered medical services intended to promote the effective use of contraceptive supplies or devices to prevent unwanted pregnancy.
- b. **Contraceptive supplies** means all Food and Drug Administration-approved contraceptive drugs or devices used to prevent unwanted pregnancy.

8. Contraceptive services and religious employers [Sec. 431:10A-106.7] Any religious employer may request a health insurance plan without coverage for contraceptive services and supplies that are contrary to the religious employer's religious tenets. If so requested, the health insurer, mutual benefit society, or health maintenance organization shall provide a health insurance plan without coverage for contraceptive services and supplies.

- a. Health insurers shall allow enrollees in a health plan exempted under this section to directly purchase coverage of contraceptive supplies and outpatient contraceptive services. The enrollee's cost of purchasing such coverage shall not exceed the enrollee's pro rata share of the price the group purchaser would have paid for such coverage had the group plan not invoked a religious exemption.

9. Franchise plan [Sec. 431:10A-117] The term **employees** shall include the officers, managers, and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. Insurance may be issued on a franchise plan under the terms of which accident and sickness insurance is issued to:

- five or more employees of any corporation, co-partnership, or individual employer, or any governmental corporation, agency, or department thereof; or

- 10 or more members, employees, or employees of members of any trade or professional association, of a labor union, or of any other association having had an active existence for at least two years.

10. Genetic information nondiscrimination in health insurance coverage [Sec. 431:10A-118] No insurer may:

- use an individual's or a family member's genetic information, or request for genetic services, to deny or limit any coverage or establish eligibility, continuation, enrollment, or premium payments;
- request or require collection or disclosure of an individual's or a family member's genetic information; or
- disclose an individual's or a family member's genetic information without the written consent of the person affected, the person's legal guardian, or a person with power of attorney for health care for the person affected.

This section shall not apply to any action taken in connection with policies of life insurance, disability income insurance, and long-term care insurance delivered or issued for delivery in this state.

11. Hospice care coverage [Sec. 431:10A-119] All authorized insurers that provide for payment of or reimbursement for hospice care, shall reimburse hospice care services for each insured policyholder covered for hospice care according to:

- a minimum daily rate as set by the Health Care Financing Administration for hospice care;
- reimbursement for residential hospice room and board expenses directly related to the hospice care being provided; and
- reimbursement for each hospice referral visit during which a patient is advised of hospice care options, regardless of whether the referred patient is eventually admitted to hospice care.

12. Medical foods and low-protein modified food products; treatment of inborn error of metabolism [Sec. 431:10A-120] Each policy of accident and sickness insurance, other than life insurance, disability income insurance, and long-term care insurance, issued or renewed in this state, shall contain a provision for coverage for medical foods and low-protein modified food products for the treatment of an inborn error of metabolism for its policyholders or dependents of the policyholder in this state. This is provided that the medical food or low protein modified food product is:

- prescribed as medically necessary for the therapeutic treatment of an inborn error of metabolism; and
 - consumed or administered enterally (through the intestine) under the supervision of a physician licensed.
- a.** Coverage shall be for at least 80% of the cost of the medical food or low-protein modified food product prescribed and administered.
- b.** **Inborn error of metabolism** means a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient

metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

- c. Low-protein modified food product** means a food product that:
 - is specially formulated to have less than one gram of protein per serving;
 - is prescribed or ordered by a physician as medically necessary for the dietary treatment of an inborn error of metabolism; and
 - does not include a food that is naturally low in protein.
- d. Medical food** means a food that is formulated to be consumed or administered enterally under the supervision of a physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

13. Coverage for diabetes [Sec. 431:10A-121] Each policy of accident and sickness insurance providing coverage for health care, other than an accident-only, specified disease, hospital indemnity, medicare supplement, long-term care, or other limited benefit health insurance policy, that is issued or renewed in this state, shall provide coverage for outpatient diabetes self-management training, education, equipment, and supplies, if:

- the equipment, supplies, training, and education are medically necessary; and
- the equipment, supplies, training, and education are prescribed by a health care professional.

14. Cancellation [Sec. 431:10A-106 (7)] The insurer may cancel accident and health policies at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than 5 days thereafter, such cancellation shall be effective.

- a.** After the policy has been continued beyond its original term, the insured may cancel his policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice.
- b.** In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short rate table. If the insurer cancels, the earned premium shall be computed pro rata.
- c.** Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

15. Discrimination against victims of domestic abuse [Sec. 431:10-217.5] No insurer shall deny or refuse to accept an application for insurance, refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of insurance, or charge a different rate for the same coverage, on the basis that the applicant or insured person is, has been, or may be a victim of domestic abuse.

- 16. Premium rate reduction [Sec. 431:115]** Any contract of group disability insurance or group life insurance may provide for the readjustment of the rate of premium based on experience at the end of the first year or of any subsequent year of insurance, and the readjustment may be made retroactive only for the policy year.
- 17. Premium inclusions [Sec. 431:10-218]** The premium stated in the policy shall be inclusive of all fees, charges, premiums, or other consideration charged for the insurance or for its procurement. No insurer or its officers, employees, producers, or other representatives shall charge or receive any fee, compensation, or consideration for insurance which is not included in the premium specified in the policy.
- 18. Multi-peril policies [Sec. 431:10-219]** Each insurer issuing a multi-peril policy shall provide the policyholder with a written statement separately stating the premiums and the amounts of insurance or limits of liability for fire and allied lines, inland marine, general liability, crime and each optional coverage, and shall state all pertinent rating factors including classifications, premium basis and rates used in the computation of the final premium. This section shall not apply to homeowners policies.
- 19. Recognition of dependent's eligibility in a qualified medical child support order [Sec. 431:10A-208]** An employer, who provides health coverage to dependent children of an employee, shall recognize a child identified in a qualified medical child support order as an eligible dependent without regard to any enrollment season restrictions.

C. LONG-TERM CARE

- 1. Basic standards [Sec. 431:10H-107]** No long-term care insurance policy may:
 - be cancelled, nonrenewed, or otherwise terminated on the grounds of the age or deterioration of the mental or physical health of the insured individual or certificate holder;
 - establish a new waiting period if existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
 - provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.
- 2. Outline of coverage [Sec. 431:10H-112]** An outline of coverage must be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation in a manner that prominently directs the attention of the recipient to the document and its purpose.
 - a.** In the case of producer solicitations, a producer will deliver the outline of coverage before the presentation of an application or enrollment form.

- b.** In the case of direct response solicitation, the outline of coverage must be presented with any application or enrollment form.
 - c.** In the case of a policy issued to a group, an outline of coverage need not be delivered to the group's members, provided that the information is contained in other enrollment materials. Upon request, these other materials must be made available to the Commissioner.
 - d.** The outline of coverage will include:

 - a description of the principal benefits and coverage provided in the policy;
 - a statement of the principal exclusions, reductions, and limitations contained in the policy;
 - a statement of the terms under which the policy, certificate, or both may be continued in force or discontinued, including any reservation in the policy of a right to change premium (continuation or conversion provisions of group coverage must be specifically described);
 - a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;
 - a description of the terms under which the policy or certificate may be returned and premium refunded;
 - a brief description of the relationship of costs of care and benefits ; and
 - a statement that discloses whether the policy is intended to be a federally tax-qualified long-term care insurance policy.
- 3. Policy definitions [Sec. 431:10H-201]** No long-term care insurance policy delivered or issued for delivery in Hawaii may use the terms listed below, unless the terms are defined in the policy and meet the following requirements.
- a. Activities of daily living** include at least bathing, continence, dressing, eating, toileting, and transferring.
 - b. Acute condition** means that the affected individual is medically unstable. Such an individual requires frequent monitoring by medical professionals to maintain the individual's health status.
 - c. Adult day care** is a program, for six or more individuals, of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.
 - d. Bathing** is washing oneself by sponge bath, in either a tub or shower, including the task of getting into or out of the tub or shower.

- e. Cognitive impairment** is a deficiency in a person's short- or long-term memory, orientation as to person, place, and time, deductive or abstract reasoning, or judgment as it relates to safety awareness.
- f. Continence** is the ability to maintain control of bowel and bladder function, or when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
- g. Dressing** is putting on and removing all items of clothing and any necessary braces, fasteners, or artificial limbs.
- h. Eating** is feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table), through a feeding tube, or intravenously.
- i. Hands-on assistance** is physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the activity of daily living.
- j. Home health care services** are medical and nonmedical services provided to ill, disabled, or infirm persons in their residences. These services may include homemaker services, assistance with activities of daily living, and respite care services.
- k. Medicare** will be defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and Popularly Known as the Health Insurance for the Aged Act, as Then Constituted and any Later Amendments or Substitutes Thereof," or words of similar import.
- l. Mental or nervous disorder** means neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder, and may not be defined beyond these terms.
- m. Personal care** is the provision of hands-on services to assist an individual with activities of daily living.
- n. Skilled nursing care, intermediate care, personal care, home care,** and other services will be defined in relation to the level of skill required, the nature of the care, and the setting in which care must be delivered.
- o. Toileting** is getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
- p. Transferring** is moving into or out of a bed, chair, or wheelchair.

- q.** All **providers of services**, including but not limited to skilled nursing facility, extended care facility, intermediate care facility, convalescent nursing home, personal care facility, and home care agency, will be defined in relation to the services and facilities required to be available and the licensure or degree status of those providing or supervising the services. The definition may require that the provider be appropriately licensed or certified, provided that when the definition so requires, it will also specify the requirements a provider must meet in place of licensure or certification when the state in which the service is to be rendered does not require a provider of such services to be licensed or certified, or when that state licenses or certifies providers of these services under another name.

4. Suitability [Sec. 431:10H-231]

- a.** Every insurer, health care service plan, or other entity marketing long-term care insurance must:
- develop and use suitability standards to determine whether the purchase or replacement of long-term care insurance is appropriate for the needs of the applicant;
 - train its producers in the use of its suitability standards; and
 - maintain a copy of its suitability standards and make them available for inspection upon request by the Commissioner.
- b.** To determine whether the applicant meets the standards developed by the issuer, the producer and insurer must develop procedures that take into consideration:
- the ability to pay for the proposed coverage and other pertinent financial information related to the purchase of the coverage;
 - the applicant's goals or needs with respect to long-term care and the advantages and disadvantages of insurance to meet these goals or needs; and
 - the values, benefits, and costs of the applicant's existing insurance, if any, when compared to the values, benefits, and costs of the recommended purchase or replacement.
- c.** The insurer and producer must make reasonable efforts to obtain the information described above.
- d.** The insurer and producer must present to the applicant, at or before application, the long-term care insurance personal worksheet.
- 1.)** The personal worksheet is to contain information in the format contained in NAIC long-term care insurance model regulation.
 - 2.)** The insurer may ask the applicant to provide additional information to comply with its suitability standards.

- 3.)** A copy of the insurer's personal worksheet will be filed with the Commissioner.
- 4.)** A completed worksheet will be returned to the insurer before the insurer considers the applicant for coverage, but need not be returned for sales of employer group long-term care insurance to employees and their spouses.
- 5.)** The sale or dissemination outside the company or agency by the insurer or producer of information obtained through the personal worksheet is prohibited.
- 6.)** The insurer will use the suitability standards it has developed in determining whether issuing long-term care insurance coverage to a particular applicant is appropriate. The producers will use the suitability standards developed by the insurer in marketing long-term care insurance.
- 7.)** The personal worksheet must be given to the applicant with the disclosure form titled "Things You Should Know Before You Buy Long-Term Care Insurance."
- 8.)** If the insurer determines that the applicant does not meet its financial suitability standards, or if the applicant has declined to provide the information, the insurer may reject the application.
 - a.)** However, if the applicant has declined to provide financial information, the insurer may use some other method to verify the applicant's intent.
 - b.)** Either the applicant's returned letter or a record of the alternate method of verification will be made part of the applicant's file.
- 9.)** The insurer will report annually to the Commissioner the total number of applications received from residents of Hawaii, the number of those who declined to provide information on a personal worksheet, the number of applicants who did not meet the suitability standards, and the number of those who chose to confirm after receiving a suitability letter.

HAWAII LAW SUPPLEMENT PRACTICE FINAL

Student instructions: Following your thorough study of this supplement, take this 50-question sample examination. Grade your performance using the answer key provided. Carefully review the topics pertaining to those questions answered incorrectly.

I. General Insurance

1. How long must a policyowner wait, once a life contract goes into effect, to borrow from his cash savings value?
 - A. 1 year
 - B. 2 years
 - C. 3 years
 - D. 5 years
2. The interest rate charged on a loan from a life insurance contract's cash value in the state of Hawaii is
 - A. 2%
 - B. 4%
 - C. 6%
 - D. 8%
3. In situations where a variable interest rate is charged to a policyowner who borrows from his cash savings value, the variable rate is based upon the
 - A. Consumer Price Index
 - B. Dow Jones Industrial Average
 - C. Moody's Bond Index
 - D. Prime Lending Rate
4. Which of the following must the producer give to an applicant for a life insurance policy when replacement is involved?
 - A. *Notice of Cancelability*
 - B. *Notice of Disclosure*
 - C. *Policy Summary*
 - D. *Notice to Applicant Regarding the Replacement of Life Insurance*
5. Which of the following statements regarding the protection of beneficiaries from creditors is(are) CORRECT?
 - A. All proceeds payable because of the death of an insured shall be exempt from attachment, garnishment, or other process, for the debts or liabilities of the insured.
 - B. If life insurance policy proceeds are retained by an insurer, such proceeds shall be exempt from attachment by creditors of the beneficiary.
 - C. Both A and B.
 - D. Neither A nor B.
6. Replacement regulations under Hawaii law apply when
 - A. new life insurance is provided under a group life insurance policy
 - B. application for new life insurance is made to the same insurer that issued the existing policy
 - C. a contractual policy change or conversion privilege is being exercised
 - D. the total cash value of all existing policies affected by the replacement is less than \$500 and the sum of the face amounts is less than \$5,000
7. All of the following are duties of a producer with regard to replacement of life insurance EXCEPT
 - A. obtaining the applicant's signed statement concerning whether other life insurance exists
 - B. reading the notice of policies to be replaced to the applicant, unless waived
 - C. leaving copies of all sales materials with the applicant
 - D. signing a statement that gives the producer's opinion as to whether replacement is involved

8. When the sale of a life insurance policy will replace an existing one, the producer must read the notice of existing life insurance policies and annuities to an applicant EXCEPT
- when the applicant is aware of the existing policies
 - when the applicant waives the reading of the notice
 - when the producer leaves a printed copy of the notice with the applicant
 - when the insurer provides the applicant with the notice within 5 days of the application
9. An insurer that is replacing a life insurance policy must notify existing insurers that they may be affected by the proposed replacement within how many days of receiving the application?
- 5
 - 7
 - 10
 - 14
10. Each of the following statements regarding a variable contract's separate account is true EXCEPT
- amounts allocated to any separate account and accumulations involved may be invested and reinvested without regard to any requirements or limitations governing the investments of life insurance companies
 - assets allocated to a separate account shall be valued at their market value on the date of purchase
 - amounts allocated to a separate account shall be owned by the company
 - the income, gains, and losses from assets allocated to a separate account shall be credited to or charged against the account, without regard to other income, gains, or losses to the company
11. A life insurance contract covering a group of employees must cover at least how many employees on the date of issue?
- 2
 - 5
 - 10
 - There is no minimum
12. No contract of life insurance shall be delivered or issued for delivery in the State of Hawaii insuring the lives of more than one individual unless issued to all of the following groups EXCEPT
- employee group
 - debtor group
 - professional Association group
 - insurer group
13. Any person insured under a group life insurance policy may make to any person an assignment of all or any part of the incidents of ownership including
- the right to exercise the conversion privilege
 - the right to name a beneficiary
 - both A and B
 - neither A nor B
14. Any individual insured under a group life insurance contract is entitled under the terms of the policy to have an individual policy of life insurance issued to him without evidence of insurability. Which of the following statements regarding a group life policyholder's conversion right is(are) CORRECT?
- The policyholder is required to pay the first premium within a specified period in order for coverage to be effective.
 - Evidence of insurability is not needed in order to convert to an individual plan.
 - Both A and B.
 - Neither A nor B.
15. The coverage amount of a credit life policy shall NOT exceed the
- premium paid for coverage
 - amount of the indebtedness
 - nonforfeiture values contained in the policy
 - net worth of the creditor

II. Life, Accident, and Health Insurance

16. An individual who knowingly receives a rebate is referred to as which of the following?
- Assignor
 - Offeror
 - Offeree
 - Assignee

17. Which of the following persons is permitted to prosecute producers who violate Hawaii insurance law?
- A. The Governor
 - B. The Insurance Commissioner
 - C. The Hawaii Attorney General
 - D. The Transportation Secretary
18. A producer must maintain records of all insurance transactions for what period of time?
- A. 1 year
 - B. 3 years
 - C. 5 years
 - D. 10 years
19. Which of the following statements regarding assessments under the Hawaii Life and Disability Insurance Guaranty Association Act is TRUE?
- A. There are 4 classes of assessments.
 - B. The total of all assessments upon a member insurer for each account may not exceed 2% of an insurer's premiums received in any calendar year.
 - C. Assessments are due not fewer than 20 days after prior written notice to the member insurers.
 - D. Past due assessments accrue interest at the rate of 19.45% per year.
20. Which of the following parties would be notified regarding the revocation or suspension of a producer's license?
- A. Producer
 - B. State Attorney General
 - C. Governor
 - D. Public Safety Commissioner
21. An illegal or unfair comparison of contracts in order to persuade an applicant to lapse or surrender his or her current policy best describes
- A. misrepresentation
 - B. rebating
 - C. coercion
 - D. collusion
22. Each of the following is a power and duty of the Commissioner of Insurance in this state EXCEPT
- A. issue cease and desist orders
 - B. supervise examiners
 - C. revoke or suspend licenses for just cause
 - D. prosecute producers for violated state laws
23. Which of the following best describes the process of rebating?
- A. The unfair comparison of policies in order to induce a lapse
 - B. The offer of a valuable consideration not specified in the policy
 - C. Withholding premiums from an insurer in order to pay commissions to brokers
 - D. Printing false material concerning the financial condition of any person or company
24. Commissions paid to a life insurance producer may be shared with which of the following persons?
- A. A person licensed to transact the same line of insurance
 - B. A person appointed by a property insurer
 - C. A person who is licensed as a resident producer
 - D. A person who is appointed by the same insurer
25. The purpose of the Hawaii Life and Disability Insurance Guaranty Association Act is to
- A. protect insurers and assignees of life insurance policies against the failure of reinsurers to meet their contractual obligations
 - B. create an association which may assess all licensed insurers in this state
 - C. authorize the Commissioner to begin legal proceedings against insurers which violate Hawaii law
 - D. protect policyowners, annuitants, and beneficiaries against the failure of impaired or insolvent companies to pay claims

26. An insurer that has its principal office in a state where it is authorized to transact insurance business best describes a
- A. stock company
 - B. domestic company
 - C. mutual company
 - D. foreign company
27. All of the following are powers and duties of the Commissioner of Insurance EXCEPT
- A. collects fees and issues insurance licenses
 - B. regulate companies for solvency and most insurance rates
 - C. prosecutes producers who have broken state insurance laws
 - D. delegates examining duties to deputies
28. Which of the following statements regarding cease and desist orders is TRUE?
- A. The Commissioner must always hold a hearing before issuing a cease and desist order.
 - B. Violations of cease and desist orders may result in suspension or revocation of a producer's license.
 - C. Violation of a cease and desist order may subject a producer to a fine of not more than \$1,000 for each violation.
 - D. The Commissioner may not revoke a producer's license for violation of a cease and desist order.
29. An unauthorized insurance company is an insurer that
- A. has not received a certificate of authority from Hawaii
 - B. is also known as an admitted insurer
 - C. is not incorporated in Hawaii
 - D. does not have its headquarters in Hawaii
30. An insurer incorporated or organized outside the United States but licensed in the state of Hawaii best describes a(n)
- A. domestic company
 - B. foreign company
 - C. mutual company
 - D. alien company
31. A mutual insurance company is an insurer owned by its policyholders. Such policyholders may share in the company's profits in the form of
- A. dividends
 - B. paid-up additions
 - C. settlement options
 - D. nonforfeiture values
32. Which of the following is NOT a qualification for licensure in Hawaii?
- A. The applicable licensing fee must be paid.
 - B. The applicant must be at least 18 years old.
 - C. The applicant must have a good business reputation in the community.
 - D. The applicant must receive a passing grade on a written examination.
33. Which of the following parties would be issued a limited license?
- A. A general agent soliciting on behalf of an authorized company
 - B. A sub-agent who collects premiums
 - C. A partnership licensed as a general agent
 - D. An individual selling baggage insurance on personal effects
34. A prospective insured who knowingly accepts a portion of a producer's commission in return for buying a policy best describes
- A. twisting
 - B. rebating
 - C. coercion
 - D. misrepresentation
35. An insurance producer who lets his license lapse may, within 12 months,
- A. reinstate the license without taking an exam
 - B. reinstate the license following the successful completion of an exam
 - C. not reinstate the license until 12 months have elapsed
 - D. not reinstate the license until 6 months have elapsed

36. A temporary license may be issued in the state of Hawaii for a period not to exceed how many months?
- A. 3
 - B. 6
 - C. 9
 - D. 12
37. A producer who changes his address must notify the Commissioner within
- A. 15 days
 - B. 30 days
 - C. 45 days
 - D. as soon as possible
38. An insurer that charges varying premium rates for individuals of the same class and equal expectation of life is engaged in
- A. discriminatory coercion
 - B. false financial statements
 - C. defamation
 - D. unfair discrimination
39. An insurer that fails to respond with reasonable promptness or who fails to implement reasonable standards for the prompt investigation of losses is engaged in
- A. rebating
 - B. unfair claim practices
 - C. defamation
 - D. false advertising
40. A prospective insured who accepts a share of a producer's commission in return for purchasing a policy of insurance has engaged in
- A. larceny
 - B. fraud
 - C. rebating
 - D. assignment

III. Accident and Health Insurance

41. Which of the following shall determine whether benefits provided in a prepaid health care plan complies with the standards specified under Hawaii law?
- A. Commissioner of Insurance
 - B. Governor
 - C. Director of Labor and Industrial Relations
 - D. Director of Health and Human Services
42. Prepaid health care plans qualifying under Hawaii law must include all of the following benefits EXCEPT
- A. hospital benefits
 - B. surgical benefits
 - C. long-term care benefits
 - D. substance abuse benefits
43. No temporary disability benefits may be payable for how many consecutive days after a period of disability begins?
- A. 3
 - B. 4
 - C. 5
 - D. 7
44. Temporary disability insurance provided by the state of Hawaii provides coverage for individuals who become disabled as a result of
- A. occupational accidents
 - B. occupational sickness
 - C. injuries or illness arising out of a person's employment
 - D. nonoccupational sickness or accidents

45. Which of the following statements regarding the denial of temporary disability insurance benefits is NOT correct?
- A. Employers or insurers denying disability benefits to an employee must submit a notice of denial to the Department of Labor and Industrial Relations.
 - B. If benefits are denied, the employee has the right to appeal the decision.
 - C. Appeals must be filed with the Commissioner.
 - D. Appeals must be filed within 20 days of the date of the denial.
46. Coverage for handicapped and retarded dependents may be provided under accident and health contracts in Hawaii following the attainment of a limiting age if proof of such incapacity and dependency is given to the insurer by the policyholder within how many days of the dependents' attainment of the limiting age?
- A. 30
 - B. 31
 - C. 60
 - D. 90
47. Which of the following statements regarding the coverage of newborns under accident and health insurance contracts issued in Hawaii is NOT correct?
- A. Newborn children are covered from the moment of birth.
 - B. Coverage is provided for all causes of loss except for the treatment of medically diagnosed congenital defects and birth abnormalities.
 - C. Any required premium must be paid to the insurer within 31 days of the birth date.
 - D. Notice of birth must be given to the insurer within 31 days of the birth date.
48. An insurer may cancel an accident and health insurance policy issued in Hawaii at any time by giving written notice to an insured within how many day of the effective date of cancellation?
- A. 5
 - B. 10
 - C. 20
 - D. 30
49. Which of the following types of refunds will be paid to an insured if an insurer cancels an accident and health contract?
- A. Pro rata
 - B. Short rate
 - C. Premium computation
 - D. Earned rate
50. The duration of benefit payments made under temporary disability insurance in Hawaii may not exceed
- A. 4 weeks
 - B. 13 weeks
 - C. 20 weeks
 - D. 26 weeks

ANSWERS TO HAWAII LAW PRACTICE FINAL

- | | | | | |
|--------------|--------------|--------------|--------------|--------------|
| 1. C | 11. D | 21. A | 31. A | 41. C |
| 2. D | 12. D | 22. D | 32. C | 42. C |
| 3. C | 13. C | 23. B | 33. D | 43. D |
| 4. D | 14. C | 24. A | 34. B | 44. D |
| 5. C | 15. B | 25. D | 35. A | 45. C |
| 6. A | 16. C | 26. B | 36. B | 46. B |
| 7. D | 17. C | 27. C | 37. B | 47. B |
| 8. B | 18. C | 28. B | 38. D | 48. A |
| 9. A | 19. B | 29. A | 39. B | 49. A |
| 10. B | 20. A | 30. D | 40. C | 50. D |

