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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-201 (2013)

56-12-201. Short title.

This part shall be known and may be cited as the "Tennessee Life and Health Insurance Guaranty Association Act."

HISTORY: Acts 1988, ch. 1032, § 1.

NOTES: Section to Section References.

This part is referred to in *§ 56-9-103*.

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Tenn. Code Ann. § 56-12-202 (2013)

56-12-202. Purpose.

(a) The purpose of this part is to protect, subject to certain limitations, the persons listed in *§ 56-12-204(a)* against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in *§ 56-12-204(b)*, because of the impairment or insolvency of the member insurer that issued the policies or contracts.

(b) To provide this protection, an association of insurers is hereby created to pay benefits and to continue coverages as limited herein.

(c) Members of the association are subject to assessment to provide funds to carry out the purpose of this part, and shall provide such services as are necessary to implement the protections accorded to policyholders by this part.

HISTORY: Acts 1988, ch. 1032, § 2.

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Annotations current through April 26, 2013 for the Tennessee Supreme Court

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Tenn. Code Ann. § 56-12-203 (2013)

56-12-203. Part definitions.

As used in this part:

(1) "Account" means any of the accounts created under *§ 56-12-205*;

(2) "Association" means the Tennessee life and health insurance guaranty association created under *§ 56-12-205*;

(3) "Commissioner" means the commissioner of commerce and insurance;

(4) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or a portion thereof, for which coverage is provided under *§ 56-12-204*;

(5) "Covered policy" means a policy or contract, or a portion of a policy or contract, for which coverage is provided under *§ 56-12-204*;

(6) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs;

(7) "Health insurance benefits" means benefits payable under any form of accident and health insurance policy;

(8) "Impaired insurer" means a member insurer which, after July 1, 1989, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(9) "Insolvent insurer" means a member insurer which after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

(10) "Member insurer" means an insurer or nonprofit hospital and medical service organization licensed or that

holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under *§ 56-12-204*, and includes an insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(A) A health maintenance organization;

(B) A fraternal benefit society;

(C) A mandatory state pooling plan;

(D) A mutual assessment company or other person that operates on an assessment basis;

(E) An insurance exchange;

(F) An organization that is authorized under the law of this state to issue charitable gift annuities; or

(G) An entity similar to any of the above;

(11) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto;

(12) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract;

(13) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization;

(14) "Premiums" means amounts or considerations, by whatever name called received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts, or for the portions of policies or contracts for which coverage is not provided under *§ 56-12-204(b)*, except that assessable premium shall not be reduced on account of *§ 56-12-204(b)(2)(C)* relating to interest limitations or *§ 56-12-204(c)(2)* relating to limitations with respect to one (1) individual, one (1) participant and one (1) contract owner. "Premiums" shall not include:

(A) Premiums on an unallocated annuity contract; or

(B) With respect to multiple non-group policies of life insurance owned by one (1) owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars ($5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

(15) "Principal place of business" of a person, other than a natural person, means the single state in which the natural person who establishes a policy for the direction, control and coordination of the operations of the entity, as a whole, primarily exercises that function as determined by the association in its reasonable judgment by considering the following factors:

(A) The state in which the primary executive and administrative headquarters of the entity is located;

(B) The state in which the principal office of the chief executive officer of the entity is located;

(C) The state in which the board of directors or similar governing person or persons of the entity conducts the majority of its meetings;

(D) The state in which the executive or management committee of the board of directors or similar governing person or persons of the entity conducts the majority of its meetings; and

(E) The state from which the management of the overall operations of the entity is directed;

(16) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer;

(17) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this part shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts;

(18) "State" means a state, the District of Columbia, Puerto Rico, and an United States possession, territory or protectorate;

(19) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for, or with respect to, personal injury suffered by the plaintiff or other claimant;

(20) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

(21) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

HISTORY: Acts 1988, ch. 1032, § 4; 1995, ch. 110, § 1; 2000, ch. 895, § 12; 2010, ch. 713, § 1.

NOTES: Compiler's Notes.

Acts 2000, ch. 895, § 13, provided that this chapter shall apply to charitable gift annuity agreements entered into on or after June 19, 2000.

Amendments.

The 2010 amendment deleted ", unless the context otherwise requires" from the end of the introductory paragraph; added the definitions for "extra-contractual claims", "health insurance benefits", "owner", "principal place of business", "receivership court", "state" and "structured settlement annuity"; in the definition of "account", deleted "four (4)" preceding "accounts" and substituted "under" for "by"; substituted "under" for "by" in the definition of "association"; in the definition of "contractual obligation", substituted "an" for "any", substituted "or a portion" for "or portion", and substituted "under" for "by"; rewrote the definition of "covered policy" which read: " 'Covered policy' means any policy or contract within the scope of this part as set forth by *§ 56-12-204*;"; rewrote the definition of "impaired insurer" which read: " 'Impaired insurer' means a member insurer that, after July 1, 1989, is not an insolvent insurer, and:
"(A) Is deemed by the commissioner to be potentially unable to fulfill its contractual obligations; or
"(B) Is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;"; in the definition of "member insurer", substituted "means an insurer" for "means any insurer", substituted "that holds" for "holding",

substituted "provided under" for "provided by" and substituted "includes an insurer" for "includes any insurer" in the introductory paragraph, substituted "other person" for "any entity" in (D), redesignated former (F) as present (G) and former (G) as present (F), and rewrote present (F) which read: "(G) An organization that has a certificate or license limited to the issuance of charitable gift annuities;"; rewrote the definition of "person" which read: " 'Person' means any individual, corporation, partnership, association or voluntary organization;"; rewrote the definition of "premiums" which read: " 'Premiums' means amounts received on covered policies or contracts, less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. 'Premiums' does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided by *§ 56-12-204(b)*, except that assessable premiums shall not be reduced on accounts for *§ 56-12-204(b)(2)(C)* relating to interest limitations, and *§ 56-12-204(c)(2)* relating to limitations with respect to any one (1) life and any one (1) contract holder;"; rewrote the definition of "resident" which read: " 'Resident' means any person who resides in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business;"; rewrote the definition of "supplemental contract" which read: " 'Supplemental contract' means any agreement entered into for the distribution of policy or contract proceeds;"; and substituted "means an annuity" for "means any annuity", substituted "which" for "that" and substituted "such" for "the" in the definition of "unallocated annuity contract".

Effective Dates.

Acts 2010, ch. 713, § 5. April 5, 2010.

Section to Section References.

This section is referred to in *§ 56-7-2203*.

Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

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Tenn. Code Ann. § 56-12-204 (2013)

56-12-204. Applicability -- Limitations on liability.

(a) This part shall provide coverage for the policies and contracts specified in subsection (b):

(1) To persons who, regardless of where they reside except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of persons covered under subdivision (a)(2);

(2) To persons who are owners of or certificate holders under the policies or contracts, other structured settlement annuities, and who:

(A) Are residents; or

(B) Are not residents, but only under all of the following conditions:

(i) The insurer that issued the policies or contracts is domiciled in this state;

(ii) The states in which the persons reside have associations similar to the association created by this part; and

(iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subsection (b), subdivisions (a)(1) and (a)(2) shall not apply, and this part shall, except as provided in subdivisions (a)(4) and (a)(5), provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

(B) Is not a resident, but only under both of the following conditions:

(i) **(a)** The contract owner of the structured settlement annuity is a resident; or

(b) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this part; and

(ii) Neither the payee, or the beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This part shall not provide coverage to a person who is a payee or the beneficiary of a contract owner resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; or

(5) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, such person shall not be provided coverage under this part. In determining the application of the provisions of this subdivision (a)(5) in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(b) **(1)** This part shall provide coverage to the persons specified in subsection (a) for direct, non-group life, accident and health, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by this part. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) This part shall not provide coverage for:

(A) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(B) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(i) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier; and

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(D) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

(i) A multiple employer welfare arrangement as defined in *29 U.S.C. § 1144;*

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(E) A portion of a policy or contract to the extent that it provides for:

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(F) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(G) A portion of a policy or contract to the extent that the assessments required by *§ 56-12-208* with respect to the policy or contract are preempted by federal or state law;

(H) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(I) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(J) An unallocated annuity contract;

(K) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision (b)(2)(K), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

(L) A policy or contract providing any hospital, medical, prescription drug or other healthcare benefits pursuant

to part C or part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare part C & D, or any regulations issued pursuant thereto.

(c) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) **(A)** With respect to one (1) life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars ($100,000) in health insurance benefits; provided, for policies or contracts issued by a member insurer that becomes insolvent after January 1, 2010, the limits for health insurance benefits shall be as follows:

(a) One hundred thousand dollars ($100,000) for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values;

(b) Three hundred thousand dollars ($300,000) for disability insurance and three hundred thousand dollars ($300,000) for long term care insurance;

(c) Five hundred thousand dollars ($500,000) for basic hospital, medical and surgical insurance or major medical insurance;

(iii) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(B) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(C) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under paragraphs (c)(2)(A) and (B) except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance under subdivision (c)(2)(A)(ii)*(c)*, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one (1) individual; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner;

(D) The limitations set forth in this subsection (c) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(3) As used in this subsection (c):

(A) "Disability insurance" means insurance that provides stated benefits upon the disability of the insured as defined in the policy;

(B) "Long term care insurance" has the same meaning as set forth in *§ 56-42-103(5)*; and

(C) "Basic hospital, medical and surgical insurance or major medical insurance" means insurance that provides coverage for medical expenses incurred because of injury or illness, but does not include disability insurance, long term care insurance, Medicare supplement insurance, hospital confinement indemnity insurance, accident only insurance, specified disease insurance, loss of limb or body function insurance, or other limited benefit or supplemental health insurance excluded from the definition of health insurance in *§ 56-1-105*.

(d) In performing its obligations to provide coverage under *§ 56-12-207*, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

HISTORY: Acts 1988, ch. 1032, § 3; 2001, ch. 91, § 2; 2009, ch. 178, § 1; 2010, ch. 713, § 2.

NOTES: Amendments.

The 2009 amendment substituted "Two hundred fifty thousand dollars ($250,000)" for "One hundred thousand dollars ($100,000)" at the beginning of (c)(2)(C).

The 2010 amendment rewrote the section which read: "(a) This part shall provide coverage, for the policies and contracts specified in subsection (b) to persons who:
"(1) Regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of the persons covered under subdivision (a)(2); and
"(2) Are owners of or certificate holders under such policies or contracts, and who:
"(A) Are residents; or
"(B) Are not residents, but only if all of the following conditions are met:
"(i) The insurers that issued such policies or contracts are domiciled in this state;
"(ii) Such insurers never held a license or certificate of authority in the states in which such persons reside;
"(iii) Such states have associations similar to the association created by this part; and
"(iv) Such persons are not eligible for coverage by such associations.
"(b)(1) This part shall provide coverage to the persons specified in subsection (a) for direct, nongroup life, health, annuity and supplemental policies or contracts issued by member insurers, and for certificates under direct group policies and contracts, except as limited by this part.
"(2) This part does not provide coverage for:
"(A) Any portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract holder;
"(B) Any policy or contract of reinsurance, unless assumption certificates have been issued;
"(C) Any portion of a policy or contract to the extent that the rate of interest on which it is based:
"(i) Averaged over the period of four (4) years prior to the date on which the association becomes obligated with respect to such policy or contract, exceeds a rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period, if the policy or contract was issued less than four (4) years before the association became obligated; and
"(ii) On and after the date on which the association becomes obligated with respect to such policy or contract, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;
"(D) Any plan or program of an employer, association or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to,

benefits payable by an employer, association or similar entity under:
"(i) A multiple employer welfare arrangement as defined in *29 U.S.C. § 514* (the Employee Retirement Income Security Act of 1974) as amended:
"(ii) A minimum premium group insurance plan;
"(iii) A stop-loss group insurance plan; or
"(iv) An administrative services only contract;
"(E) Any portion of a policy or contract to the extent that it provides dividends, premium refunds, or experience rating credits, or provides that any fees or allowances be paid to any person, including the policy or contract holder, in connection with the service to or administration of such policy or contract;
"(F) Any policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state; and
"(G) Any unallocated annuity contract, including, for purposes of this section only, guaranteed investment contracts and funding agreements, except unallocated annuity contracts and defined contribution government plans qualified under the *United States Internal Revenue Code, § 403(b)*, codified as *26 U.S.C. § 403*(b).
"(c) The benefits for which the association may become liable shall in no event exceed the lesser of:
"(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or
"(2) With respect to any one (1) life, regardless of the number of policies or contracts:
"(A) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;
"(B) One hundred thousand dollars ($100,000) in health insurance benefits, including any net cash surrender and net cash withdrawal values; and
"(C) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;
"provided, that in no event shall the association be liable to expend more than three hundred thousand dollars ($300,000) in the aggregate with respect to any one (1) life under subdivisions (c)(2)(A)-(C).
"(d) The liability of the association is strictly limited by the express terms of such covered policies and contracts and by the provisions of this part, and is not affected by the contents of any brochures, illustrations, advertisements, or oral statements by agents, brokers, or others used or made in connection with their sale. The association is not liable for any extracontractual, exemplary or punitive damages, attorney's fees or interest, other than as provided for in the terms of such policies or contracts, as limited by this part."

Effective Dates.

Acts 2009, ch. 178, § 2. July 1, 2009.

Acts 2010, ch. 713, § 5. April 5, 2010.

Section to Section References.

This section is referred to in *§§ 56-12-202*, *56-12-203*, *56-12-207*, *56-12-218*.

Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683*.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

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GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-205 (2013)

56-12-205. Creation of association -- Accounts.

(a) There is created a nonprofit legal entity to be known as the Tennessee life and health insurance guaranty association. Provisions of this part relative to the Tennessee life and health insurance guaranty association shall be read as supplemental to the provisions of part 1 of this chapter. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its function under the plan of operation established and approved pursuant to *§ 56-12-209*, and shall exercise its powers through a board of directors established by *§ 56-12-206*. For purposes of administration and assessment, the association shall maintain four (4) accounts:

(1) The life insurance account;

(2) The health insurance account;

(3) The annuity account excluding unallocated annuity contracts and defined contribution government plans qualified under *§ 403(b) of the Internal Revenue Code*, codified in *26 U.S.C. § 403*(b); and

(4) The defined contribution plan account, meaning defined contribution plans qualified under *§ 403(b) of the Internal Revenue Code*, codified in *26 U.S.C. § 403*(b).

(b) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened upon majority vote of the board of directors of the association.

(c) Effective January 1, 2011, the association shall maintain the following three (3) accounts:

(1) A life insurance account;

(2) An annuity account; and

(3) A health insurance account.

HISTORY: Acts 1988, ch. 1032, § 5; 2010, ch. 713, § 3.

NOTES: Compiler's Notes.

The Tennessee life and health insurance guaranty association, created by this section, terminates June 30, 2017. See *§§ 4-29-112*, *4-29-238*.

Amendments.

The 2010 amendment added (c).

Effective Dates.

Acts 2010, ch. 713, § 5. April 5, 2010.

Section to Section References.

This section is referred to in *§§ 4-29-238*, *56-12-203*.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-206 (2013)

56-12-206. Board of directors -- Reimbursement.

(a) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member insurer shall be entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors in accordance with the state's travel regulations. Members of the board shall not otherwise be compensated by the association for their services.

HISTORY: Acts 1988, ch. 1032, § 6.

NOTES: Section to Section References.

This section is referred to in *§§ 56-12-205*, *56-12-209*.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-207 (2013)

56-12-207. Impaired or insolvent insurers.

(a) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the commissioner:

(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer; or

(2) Provide such monies, pledges, loans, notes, guarantees or other means as are proper to effectuate subdivision (a)(1) and assure payment of the contractual obligations of the impaired insurer pending action under subdivision (a)(1).

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(1) (A) (i) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(ii) Assure payment of the contractual obligations of the insolvent insurer; and

(B) Provide monies, pledges, loans, notes, guarantees, or other means reasonably necessary to discharge the association's duties; or

(2) Provide benefits and coverage in accordance with the following provisions:

(A) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits except for terms of conversion and renewability that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, no later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(ii) With respect to non-group policies, contracts, and annuities no later than the earlier of the next renewal date if any under the policies or contracts or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to the policies or contracts;

(B) Make diligent efforts to provide all known insureds or annuitants for non-group policies and contracts, or group policy owners with respect to group policies and contracts, thirty (30) days notice of the termination pursuant to subdivision (b)(2)(A), of the benefits provided;

(C) With respect to non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (b)(2)(D), if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or annuity or had a right only to make changes in premium by class;

(D) **(i)** In providing the substitute coverage required under subdivision (b)(2)(C), the association may offer either to reissue the terminated coverage or to issue an alternative policy;

(ii) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy;

(iii) The association may reinsure any alternative or reissued policy;

(E) **(i)** Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(ii) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(iii) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association;

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the domiciliary insurance commissioner and the receivership court;

(G) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association; and

(H) When proceeding under this subdivision (b)(2), with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with §

56-12-204(b)(2)(C).

(c) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage under this part with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this part.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by this part shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) In carrying out its duties under subsection (b), the association may:

(1) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; or

(2) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state, pursuant to *§ 56-9-409* shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection (g). Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

(h) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b) of this section, the commissioner shall have the powers and duties of the association under this part with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of an impaired or insolvent insurer.

(j) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction

over an impaired or insolvent insurer concerning which the association is or may become obligated under this part or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k) **(1)** A person receiving benefits under this part shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this part upon the person.

(2) The subrogation rights of the association under this subsection (k) shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.

(3) In addition to subdivisions (k)(1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contracts including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this part, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under *26 U.S.C. § 130,* et seq.

(4) If the preceding provisions of this subsection (k) are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or portion thereof covered by the association.

(5) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding subdivisions of this subsection (k), the person shall pay to the association the portion of the recovery attributable to the policies or portion thereof covered by the association.

(l) In addition to the rights and powers elsewhere in this part, the association may:

(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under *§ 56-12-208* and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this part; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this part;

(5) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this part;

(7) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(8) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this part with respect to the person, and the person shall promptly comply with the request; and

(9) Take other necessary or appropriate action to discharge its duties and obligations under this part or to exercise its powers under this part.

(m) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(n) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that such contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(o) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this part in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits of this part to a covered person under a plan or arrangement that fulfills the association's obligations under this part, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) Venue in a suit against the association arising under this part shall be in chancery court of Davidson County. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this part.

(r) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under this section, the association may, subject to approval of the receivership court, issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(1) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for:

(A) A fixed interest rate;

(B) Payment of dividends with minimum guarantees; and

(C) A different method for calculating interest or changes in value;

(2) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(3) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

HISTORY: Acts 1988, ch. 1032, § 7; 2010, ch. 713, § 4.

NOTES: Amendments.

The 2010 amendment rewrote the section which read: "(a) If a member insurer is an impaired domestic insurer, the association may, in its discretion, subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, are approved by the commissioner, and are, except in cases of court ordered conservation or rehabilitation, also approved by the impaired insurer:
"(1) Guarantee, assume or reinsure, or cause to be guaranteed, assumed, or reinsured, any or all of the policies or contracts of the impaired insurer;
"(2) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate subdivision (a)(1) and assure payment of the contractual obligations of the impaired insurer pending action pursuant to subdivision (a)(1); or
"(3) Loan money to the impaired insurer.
"(b)(1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims timely, then subject to the preconditions specified by subdivision (b)(2), the association shall, in its discretion, either:
"(A) Take any of the actions specified in subsection (a), subject to the conditions in subsection (a); or
"(B) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals, for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.
"(2) The association shall be subject to the requirements of subdivision (b)(1) only if:
"(A) The laws of its state of domicile provide that until all payments of or on account of the impaired insurer's contractual obligations by all guaranty associations, together with all expenses thereof and interest on all such payments and expenses, have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations:
"(i) The delinquency proceeding shall not be dismissed;
"(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management;
"(iii) It shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and
"(B)(i) If the impaired insurer is a domestic insurer, it has been placed under an order of rehabilitation by a court of competent jurisdiction in this state; or
"(ii) If the impaired insurer is a foreign or alien insurer, it has been prohibited from soliciting or accepting new business in this state, its certificate of authority has been suspended or revoked in this state, and a petition for rehabilitation or liquidation has been filed in a court of competent jurisdiction in its state of domicile by the commissioner of the state.
"(c) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:
"(1)(A) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or
"(B) Assure payment of the contractual obligations of the insolvent insurer; and
"(C) Provide such moneys, pledges, guarantees, or other means as are reasonably necessary to discharge such duties; or
"(2) With respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection (d).
"(d)(1) When proceeding under subdivision (b)(1)(B) or (c)(2), the association shall, with respect to only life and health insurance policies:
"(A) Assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies of the insolvent insurer, for claims incurred:
"(i) With respect to group policies, not later than the earlier of the next renewal date under such policies or contracts of

forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to such policies; and
"(ii) With respect to individual policies, not later than the earlier of the next renewal date, if any, under such policies or one (1) year, but in no event less than thirty (30) days, from the date on which the association becomes obligated with respect to such policies;
"(B) Make every reasonable effort to provide all known insureds or group policyholders with respect to group policies thirty (30) days' notice of the termination of the benefits provided; and
"(C) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subdivision (d)(2), if the insured had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or had a right only to make changes in premium by class.
"(2)(A) In providing the substitute coverage required under subdivision (d)(1)(C), the association may offer either to reissue the terminated coverage or to issue an alternative policy.
"(B) Alternative or reissued policies shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.
"(C) The association may reinsure any alternative or reissued policy.
"(3)(A) Alternative policies adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.
"(B) Alternative policies shall contain at least the minimum statutory provisions required by chapter 7 of this title, and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.
"(C) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy issued by the impaired or insolvent insurer, as determined by the association.
"(4) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or by a court of competent jurisdiction.
"(5) The association's obligations with respect to coverage under any policy of the impaired or insolvent or under any reissued or alternative policy shall cease on the date such coverage or policy is replaced by another similar policy by the policyholder, the insured, or the association.
"(e) When proceeding under subdivision (b)(1)(B) or subsection (c) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with *§ 56-12-204(b)(2)(C)*.
"(f) Nonpayment of premiums within thirty-one (31) days after the date required by the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under such policy or coverage under this part with respect to such policy or coverage, except any claims incurred or any net cash surrender value which may be due in accordance with this part.
"(g) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association, and the association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.
"(h) The protection provided by this part does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.
"(i) In carrying out its duties under subsections (b) and (c), the association may, subject to approval by the court:
"(1) Impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts that can be assessed under this part are less than the amounts needed to assure full and prompt performance of the association's duties under this part, or that the economic or financial conditions as

they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and
"(2) Impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.
"(j) If the association fails to act within a reasonable period of time as provided in subdivision (b)(1)(B), and subsections (c) and (d), the commissioner shall have the powers and duties of the association under this part with respect to impaired or insolvent insurers.
"(k) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance of contractual obligations of any impaired or insolvent insurer.
"(*l*) The association has standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this part. Such standing shall extend to all matters relative to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association also has the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer, for which the association is or may become obligated, or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.
"(m)(1) Any person receiving benefits under this part shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received because of this part, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this part upon such person.
"(2) The subrogation rights of the association under this subsection (m) shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this part.
"(3) In addition to subdivisions (m)(1) and (2), the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to such policy or contract.
"(n) The association may:
"(1) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this part;
"(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments pursuant to *§ 56-12-208* and to settle claims or potential claims against it;
"(3) Borrow money to effect the purposes of this part; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;
"(4) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this part;
"(5) Take such legal action as may be necessary to avoid payment of improper claims; and
"(6) Exercise, for the purposes of this part and to the extent approved by the commissioner, the powers of a domestic life or health insurer, but in no case may the association issue insurance policies or annuity contracts other than those issued to perform its obligations under this part.
"(o) The association may join an organization of one (1) or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association."

Effective Dates.

Acts 2010, ch. 713, § 5. April 5, 2010.

Section to Section References.

This section is referred to in *§§ 56-12-204*, *56-12-208*, *56-12-209*, *56-12-213*.

Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-208 (2013)

56-12-208. Assessments.

(a) 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 thirty (30) days after prior written notice to the member insurers and shall accrue interest at ten percent (10%) per annum on and after the due date.

(b) There shall be two (2) assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other expenses and examinations conducted under the authority of *§ 56-12-211(e)*. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer; and

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association pursuant to *§ 56-12-207* with regard to an impaired or an insolvent insurer.

(c) **(1)** The amount of any Class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. A non-pro rata assessment shall not exceed one hundred fifty dollars ($150) per member insurer in any one (1) calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer or policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such

calendar years by all assessed member insurers.

(3) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this part. Classification of assessments by subsection (b) and computation of assessments by this subsection (c) shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

(e) **(1)** The total of all assessments upon a member insurer for each account shall not in any one (1) calendar year exceed two percent (2%) of such insurer's average premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this part.

(2) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investment. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(g) It is proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this part, to consider the amount reasonably necessary to meet its assessment obligations under this part.

(h) The association shall issue to each insurer paying an assessment under this part, other than Class A assessments, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

HISTORY: Acts 1988, ch. 1032, § 8.

NOTES: Section to Section References.

This section is referred to in *§§ 56-12-204*, *56-12-207*, *56-12-209*, *56-12-212*.

Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-209 (2013)

56-12-209. Plan of operation.

(a) **(1)** The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or within thirty (30) days if the commissioner has not disapproved it during such thirty-day period.

(2) If an association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this part. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(b) All member insurers shall comply with the plan of operation.

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this part:

(1) Establish procedures for handling the assets of the association;

(2) Establish the amount and method of reimbursing members of the board of directors under *§ 56-12-206*;

(3) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(4) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(6) Establish any additional procedures for assessments pursuant to *§ 56-12-208*; and

(7) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(d) The plan of operation may provide that any or all powers and duties of the association, except those set forth in *§§ 56-12-207(k)(3)* and *56-12-208*, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection (d) shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this part.

HISTORY: Acts 1988, ch. 1032, § 9.

NOTES: Section to Section References.

This section is referred to in *§ 56-12-205*.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-210 (2013)

56-12-210. Powers and duties of commissioner -- Judicial review.

(a) In addition to the duties and powers enumerated elsewhere in this part, the commissioner shall:

(1) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer;

(2) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this part; and

(3) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer who fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a forfeiture on any member insurer who fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100) per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer, if such appeal is taken within sixty (60) days of the final action which is being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and be available to meet association obligations during the pendancy of an appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of this part.

HISTORY: Acts 1988, ch. 1032, § 10.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-211 (2013)

56-12-211. Detection and prevention of insurer insolvencies and impairments.

(a) To aid in the detection and prevention of insurer insolvencies or impairments, it shall be the duty of the commissioner to:

(1) Notify the commissioner of insurance, or other appropriate official, of all the other states, territories of the United States and the District of Columbia, when the commissioner takes any of the following actions against a member insurer:

(A) Revocation of license;

(B) Suspension of license; or

(C) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

Such notice shall be mailed to all such commissioners or other appropriate officials within thirty (30) days following the action taken or the date on which such action occurs;

(2) Report to the board of directors when the commissioner has taken any of the actions set forth in subdivision (a)(1), or has received a report from any other commissioner indicating that any such action has been taken in another state. Such report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner or other appropriate official;

(3) Report to the board of directors when the commissioner has reasonable cause to believe from any examination, whether completed or in process, of any member company, that such company may be an impaired or insolvent insurer; and

(4) Furnish to the board of directors of the National Association of Insurance Commissioners, insurance regulatory information system ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners. The board may then use the information contained therein in carrying out its duties and responsibilities under this section. Such report and the information contained in the report shall be kept confidential by the board of directors, until such time as made public by the commissioner or other lawful authority.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(c) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter relative to the solvency, liquidation, rehabilitation or conservation of any member insurer or relative to the solvency of any company seeking to transact insurance business in this state. Such reports and recommendations shall not be considered public documents.

(d) It is the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) **(1)** The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (a).

(2) The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report to the commissioner containing such information as it may have in its possession relative to the history and causes of such insolvency. The board shall cooperate with the boards of directors of guaranty associations in other states in preparing a report on the history and causes of insolvency of a particular insurer, and may adopt by reference any report prepared by such other associations.

HISTORY: Acts 1988, ch. 1032, § 11.

NOTES: Cross-References.

Confidentiality of public records, *§ 10-7-504*.

Section to Section References.

This section is referred to in *§ 56-12-208*.

Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

TENNESSEE CODE ANNOTATED
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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-212 (2013)

56-12-212. Right of offset.

(a) (1) A member insurer may offset against any premium, franchise, excise or income tax liability or liabilities to this state an assessment described in *§ 56-12-208(h)* to the extent of the lesser of:

(A) Ten percent (10%) of the amount of such assessment for each of the ten (10) calendar years following the year in which such assessment was paid; or

(B) One tenth of one percent (0.10%) of all premiums written in this state by the member insurer for each calendar year until recovery of the assessment or assessments is made.

(2) In the event a member insurer ceases doing business in this state, all uncredited assessments may be credited against any premium, franchise, excise, or income tax due for the year it ceases doing business.

(b) A member insurer may transfer any offset right as described in this section to an affiliated member insurer. As used in this section:

(1) "Affiliated member insurer" means an insurance company licensed or holding a certificate of authority to do business in this state that controls, is controlled by, or is under common control with, another member insurer; and

(2) "Control" means holding, directly or indirectly, the ownership of, or power to vote, one hundred percent (100%) of the voting stock of another member insurer.

(c) Any sums that are acquired by refund, pursuant to *§ 56-12-208(f)*, from the association by member insurers, and that have theretofore been offset against premium, franchise, excise, or income taxes as provided in subsection (a), shall be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

HISTORY: Acts 1988, ch. 1032, § 12.

TENNESSEE CODE ANNOTATED
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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-213 (2013)

56-12-213. Liquidation, rehabilitation, and conservation proceedings.

(a) Nothing in this part shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all negotiations and meetings in which the association or its representatives discuss the activities of the association in carrying out its powers and duties as created by *§ 56-12-207*. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection (b) shall limit the duty of the association to render a report of its activities pursuant to *§ 56-12-214*.

(c) For the purpose of carrying out its obligations under this part, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, reduced by any amounts to which the association is entitled as subrogee pursuant to *§ 56-12-207(k)*. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this part. Assets attributable to covered policies, as used in this subsection (c), are that proportion of the assets that the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) **(1)** Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the

total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties as created by *§ 56-12-207* with respect to such insurer have been fully recovered by the association.

(e) **(1)** If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation, subject to the limitations of subdivisions (e)(2)-(4).

(2) No such distribution shall be recoverable, if the insurer shows that when paid the distribution was lawful and reasonable, and that the insurer did not know, and could not reasonably have known, that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection (e) shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(5) If any person liable under subdivision (e)(3) is insolvent, all its affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

HISTORY: Acts 1988, ch. 1032, § 13.

NOTES: Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-214 (2013)

56-12-214. Annual report.

(a) The association shall be subject to examination and regulation by the commissioner.

(b) The board of directors shall submit to the commissioner each year, not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

HISTORY: Acts 1988, ch. 1032, § 14.

NOTES: Section to Section References.

This section is referred to in *§ 56-12-213*.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-215 (2013)

56-12-215. Tax and fee exemption.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

HISTORY: Acts 1988, ch. 1032, § 15.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-216 (2013)

56-12-216. Immunity from liability.

(a) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or the commissioner's representatives, for any action or omission by them in the performance of their powers and duties under this part.

(b) This immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

HISTORY: Acts 1988, ch. 1032, § 16.

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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-217 (2013)

56-12-217. Stay of proceedings -- Default judgments.

(a) All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty (60) days from the date an order of liquidation, rehabilitation, or conservation is final to permit proper legal action by the association on any matters relative to its powers or duties.

(b) As to judgment under any decision, order, verdict, or finding based on default, the association may apply to have the judgment set aside by the same court that entered the judgment and shall be permitted to defend against the suit on the merits.

HISTORY: Acts 1988, ch. 1032, § 17.

NOTES: Collateral References.

Validity, construction, and application of Uniform Insurers Liquidation Act. *44 A.L.R.5th 683.*

TENNESSEE CODE ANNOTATED
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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-218 (2013)

56-12-218. Sales promotions listing association prohibited -- Disclaimer notice.

(a) No person, including an insurer, agent or affiliate of an insurer, shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the association for the purpose of sales solicitation, or inducement to purchase any form of insurance covered by this part.

(b) The association shall prepare a summary document describing the general purposes and current limitations of this part and complying with subsection (c). This document shall be submitted to the commissioner for approval. Sixty (60) days after receiving the approval, no insurer may deliver a policy or contract described in *§ 56-12-204(b)(1)* to a policy or contract holder, unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract, except if subsection (d) applies. The document shall also be available upon request by a policyholder. The distribution, delivery, or contents or interpretation of this document shall not mean that either the policy or the contract or the holder thereof would be covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to this part may require. Failure to receive this document does not give the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this part.

(c) The document prepared pursuant to subsection (b) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(1) State the name and address of the life and health insurance guaranty association and the department of commerce and insurance;

(2) Prominently warn the policy or contract holder that the life and health insurance guaranty association may not

cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and will be conditioned on continued residence in the state;

(3) State that the insurer and its agents are prohibited by law from using the existence of the life and health insurance guaranty association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the life and health insurance guaranty association when selecting an insurer; and

(5) Provide other information as directed by the commissioner.

(d) No insurer or agent may deliver a policy or contract described in *§ 56-12-204(b)(1)* and excluded by *§ 56-12-204(b)(2)(A)* from coverage under this part unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy or contract is not covered by the life and health insurance guaranty association. The commissioner shall by rule specify the form and content of the notice.

(e) This section does not apply to the association or any other entity that does not sell or solicit insurance.

HISTORY: Acts 1988, ch. 1032, § 18.

TENNESSEE CODE ANNOTATED
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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-219 (2013)

56-12-219. Insurers not covered.

This part does not apply to any insurer that is insolvent or unable to fulfill its contractual obligations on July 1, 1989.

HISTORY: Acts 1988, ch. 1032, § 21.

TENNESSEE CODE ANNOTATED
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*** Current through the 2013 Regular Session ***
Annotations current through April 26, 2013 for the Tennessee Supreme Court

Title 56 Insurance
Chapter 12 Insurance Guaranty Associations
Part 2 Life and Health Insurance Guaranty Association Act

GO TO THE TENNESSEE ANNOTATED STATUTES ARCHIVE DIRECTORY

Tenn. Code Ann. § 56-12-220 (2013)

56-12-220. Rules and regulations.

(a) The commissioner is authorized to promulgate rules and regulations to effectuate the purposes of this part.

(b) All such rules and regulations shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

HISTORY: Acts 1988, ch. 1032, § 19.

NOTES:

Cited:

Abdur'Rahman v. Bredesen, 181 S.W.3d 292, 2005 Tenn. LEXIS 828 (Tenn. 2005).