Chapter 746

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Trade Practices

GENERAL PROVISIONS

746.005 Trade practices exempted from prohibitions

746.015 Discrimination; noncompliance; hearing

746.018 Discrimination in issuance of burglary, theft, robbery or casualty policies prohibited

746.025 Securities or other contracts as inducement to insurance

746.035 Inducements not specified in policy

746.045 Rebates

746.055 Title insurance commissions, rebates and discounts

746.065 Personal or controlled insurance

746.075 Misrepresentation generally

746.085 Regulating replacement of life insurance; compensation of agents

746.100 Misrepresentation in insurance applications or transactions

746.110 False, deceptive or misleading statements

746.115 Advertisements in languages other than English

746.120 Illegal dealing in premiums

746.130 “Free” insurance as inducement to sale or rental of property prohibited; exceptions; charges in accordance with filed rates

746.135 Use of genetic tests

746.140 Sale of life insurance with securities; written proposal; application of securities law

746.145 Workers' compensation insurance; combination of group of employers; purpose; conditions

746.147 Workers' compensation insurance; quoting premiums

746.150 Other insurance; combination of experience of group of persons or risks; purpose; conditions

746.155 Applicability of ORS 746.145 and 746.150

746.160 Practices injurious to free competition

746.180 Designation of property insurer by lender prohibited

746.182 Notice by certain financial institutions prior to sale of insurance policy

746.185 Definition of “lending institution” for ORS 746.185 to 746.211

746.191 Right of borrower to select property insurer; notice to borrower

746.195 Insurance on property securing loan or credit; certain practices by lending institutions prohibited

746.201 Lending institution to obtain required property insurance when borrower does not; notice required

746.205 ORS 746.185 to 746.205 not applicable to certain policies of insurance

746.211 ORS 746.185 to 746.195 not applicable to bank holding companies

746.220 Debtor's option in furnishing credit life or credit health insurance

746.222 Prohibition on referral of individual to Medical Insurance Pool

746.230 Unfair claim settlement practices

746.240 Undefined trade practices injurious to public prohibited

746.260 Driving record not to be considered in issuance of motor vehicle insurance

746.265 Purposes for which abstract of nonemployment driving record may be considered

746.270 Use of past investment or predicted future investment experience in sale of variable life insurance policies

746.275 Definitions for ORS 746.275 to 746.300

746.280 Designation of particular motor vehicle repair shop by insurer prohibited

746.285 Notice of prohibition in motor vehicle repair shops; size; location

746.287 Insurer requirement of installation of aftermarket crash part in vehicle

746.289 Insurer offer of crash part warranty

746.290 Notice of prohibition in policies and by adjusters

746.292 Motor vehicle repair shops; invoices; estimates; warranties; prohibited practices

746.295 Proof and amount of loss under motor vehicle liability policies; determination by insurer

746.300 Liability of insurers and motor vehicle repair shops for damages; attorney fees

746.305 Rules

746.308 Violation of provisions regarding totaled vehicles as violation of Insurance Code

UNAUTHORIZED INSURANCE

746.310 Representing or aiding unauthorized insurer prohibited; agent liable to insured

746.320 Service of process equivalent to personal service on unauthorized foreign or alien insurer

746.330 Judgment by default after service of process under ORS 746.320

746.340 Conditions to be met by defendant unauthorized insurer before filing motions or pleadings

746.350 Attorney fee allowable to prevailing party

746.360 Exceptions to application of unauthorized insurer service of process law

746.370 Records of insureds

PREMIUM FINANCING

746.405 Definitions for ORS 746.405 to 746.530

746.422 Inquiries from director to premium finance company

746.425 Applicability of ORS 746.405 to 746.530

746.465 Records required of premium finance companies; form; inspection

746.470 Prohibition against interfering with premium financing recommendation

746.475 Premium finance agreements; contents; form; delivery; notice to insurer

746.485 Regulation of service charge for premium financing; method of computation; prepayment

746.495 Delinquency charges regulated

746.505 Cancellation of policy by premium finance company; notice required; effective date of cancellation

746.515 Return of unearned premiums on cancellation

746.525 Agreement effective as security interest

746.530 Attorney fees

USE AND DISCLOSURE OF INSURANCE INFORMATION

746.600 Definitions for ORS 746.600 to 746.690 and 750.055

746.605 Purpose

746.610 Application of ORS 746.600 to 746.690 and 750.055

746.615 Pretext interviews prohibited

746.620 Notice of insurance information practices

746.625 Marketing and research surveys

746.630 Content of disclosure authorization forms

746.635 Investigative consumer reports

746.640 Access to recorded personal information

746.645 Correction, amendment or deletion of recorded personal information

746.650 Reasons for adverse underwriting decisions

746.655 Information concerning previous adverse underwriting decisions

746.660 Basing adverse underwriting decision on previous adverse decision

746.665 Limitations and conditions on disclosure of certain information

746.670 Investigatory powers

746.675 Service of process on out-of-state insurance-support organizations

746.680 Remedies

746.685 Liability for disclosure of information

746.690 Obtaining information under false pretenses prohibited

PENALTIES

746.991 Penalties

CROSS-REFERENCES

Definitions and general provisions applicable to chapter, 731.004 to 731.194

Home solicitation sales, insurance excepted, 83.710

Insurance Code defined, 731.004

Unfair and deceptive trade practices generally, Ch. 646

Workers' compensation insurers, manner of operation, Ch. 656

746.308

Violation as violation of Insurance Code, 819.014

746.665

Reporting criminal conduct involving insurance, 731.592

GENERAL PROVISIONS

746.005 Trade practices exempted from prohibitions. Nothing in this chapter shall apply to wet marine and

transportation insurance or prohibit any of the following practices:

(1) In the case of life insurance policies, paying bonuses to policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the insurer and its policyholders;

(2) In the case of industrial life insurance policies, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer, in an amount which fairly represents the saving in collection expense;

(3) Readjustment of the rate of premium for a group life or health insurance policy based on the loss or expense experience thereunder, at the end of the first or any subsequent policy year, which may be made retroactive only for such policy year;

(4) Extension of credit for payment of premiums without any service charge or interest by the insurer or agent for a period of not more than 90 days after the end of the month in which the policy becomes effective;

(5) Practices authorized pursuant to ORS 733.220 and 733.230;

(6) The issuing of life or health insurance policies on a salary savings, bank draft, preauthorized check or payroll deduction plan or similar plan at a reduced rate reasonably related to the savings made by use of such plan; or

(7) The issuing of life or health insurance policies at rates less than the usual premium rates for such policies, or using modifications of premium rates based on amount of insurance, if such issuance or modification does not result in reduction in premium rates in excess of savings in administration and issuance expenses reasonably attributable to such policies. [Formerly 736.825; 1983 c.740 s.254]

746.010 [Amended by 1961 c.256 s.1; 1967 c.359 s.507; renumbered 743.702]

746.015 Discrimination; noncompliance; hearing. (1) No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.

(2) Discrimination by an insurer in the application of its underwriting standards or rates based solely on an individual's physical handicap is prohibited, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. For purposes of this subsection, “physical handicap” shall include, but not be limited to, blindness, deafness, hearing or speaking impairment or loss, or partial loss, of function of one or more of the upper or lower extremities.

(3) Discrimination by an insurer in the application of its underwriting standards or rates based solely upon an insured's or applicant's attaining or exceeding 65 years of age is prohibited, unless such discrimination is clearly based on sound actuarial principles or is related to actual or reasonably anticipated experience.

(4)(a) No insurer, on the basis of the status of an insured or prospective insured as a victim of domestic violence, shall do any of the following:

(A) Deny, cancel or refuse to issue or renew an insurance policy;

(B) Demand or require a greater premium or payment;

(C) Designate domestic violence as a preexisting condition for which coverage will be denied or reduced;

(D) Exclude or limit coverage for losses or deny a claim; or

(E) Fix any lower rate for or discriminate in the fees or commissions of an agent for writing or renewing a policy.

(b) The fact that an insured or prospective insured is or has been a victim of domestic violence shall not be considered a permitted underwriting or rating criterion.

(c) Nothing in this subsection prohibits an insurer from taking an action described in paragraph (a) of this subsection if the action is otherwise permissible by law and is taken in the same manner and to the same extent with respect to all insureds and prospective insureds without regard to whether the insured or prospective insured is a victim of domestic violence.

(d) An insurer that complies in good faith with the requirements of this subsection shall not be subject to civil liability due to such compliance.

(e) For purposes of this subsection, “domestic violence” means the occurrence of one or more of the following acts between family or household members:

(A) Attempting to cause or intentionally or knowingly causing physical injury;

(B) Intentionally or knowingly placing another in fear of imminent serious physical injury; or

(C) Committing sexual abuse in any degree as defined in ORS 163.415, 163.425 and 163.427.

(5) If the Director of the Department of Consumer and Business Services has reason to believe that an insurer in the application of its underwriting standards or rates is not complying with the requirements of this section, the director shall, unless the director has reason to believe the noncompliance is willful, give notice in writing to the insurer stating in what manner such noncompliance is alleged to exist and specifying a reasonable time, not less than 10 days after the date of mailing, in which the noncompliance may be corrected.

(6)(a) If the director has reason to believe that noncompliance by an insurer with the requirements of this section is willful, or if, within the period prescribed by the director in the notice required by subsection (5) of this section, the insurer does not make the changes necessary to correct the noncompliance specified by the director or establish to the satisfaction of the director that such specified noncompliance does not exist, the director may hold a hearing in connection therewith. Not less than 10 days before the date of such hearing the director shall mail to the insurer written notice of the hearing, specifying the matters to be considered.

(b) If, after the hearing, the director finds that the insurer's application of its underwriting standards or rates violates the requirements of this section, the director may issue an order specifying in what respects such violation exists and stating when, within a reasonable period of time, further such application shall be prohibited. If the director finds that the violation was willful, the director may suspend or revoke the certificate of authority of the insurer.

(7) Affiliated workers' compensation insurers having reinsurance agreements which result in one carrier ceding 80 percent or more of its workers' compensation premium to the other, while utilizing different workers' compensation rate levels without objective evidence to support such differences, shall be presumed to be engaging in unfair discrimination. [1967 c.359 s.568; 1977 c.331 s.1; 1979 c.140 s.1; 1987 c.676 s.2; 1987 c.884 s.53; 1997 c.564 s.1; 1999 c.59 s.229]

746.018 Discrimination in issuance of burglary, theft, robbery or casualty policies prohibited. (1) In cities of 300,000 or more, and except as provided in subsection (3) of this section, no insurer shall make or permit any unfair discrimination between risks of essentially the same degree of hazard in the issuance of burglary and theft or robbery insurance policies or casualty insurance policies which insure against liability to persons arising out of the use or control of real or personal property other than motor vehicles.

(2) Property insured or persons insured against liability arising out of use or control of real or personal property other than motor vehicles, if comparable in other respects in exposures to the peril insured against, shall not be deemed to be of different hazard solely because of the geographic location of the property or the place of residence or business of the person to be insured.

(3) Notwithstanding subsection (1) of this section an insurer may make or permit discrimination between risks of essentially the same degree of hazard in the issuance of insurance policies described in subsection (1) of this section if the insurer, at the time of the discrimination, insures a percentage of the similar risks at least equal to the ratio that its premiums for the respective line of business as reported in the annual statement required by ORS 731.574 for the second preceding calendar year bears to the total premium for the same line of business as reported by all insurers in the annual statements required by ORS 731.574 for the second preceding calendar year, within a square one mile on each side centered upon the location of the property, insurance in regard to which the insurer declines to issue. [1971 c.522 s.2; 1973 c.9 s.1]

746.020 [Amended by 1965 c.610 s.13; repealed by 1967 c.359 s.704]

746.025 Securities or other contracts as inducement to insurance. No person shall sell, agree or offer to sell, or give or offer to give, directly or indirectly in any manner whatsoever, shares of stock, securities, bonds, special or advisory board contracts or agreements of any form or nature promising returns and profits as an inducement to insurance. No insurer engaging in or permitting its representatives to engage in such practices in this or any other state may be authorized to do business in this state. [Formerly 739.535]

746.030 [Amended by 1961 c.256 s.2; 1967 c.359 s.508; renumbered 743.705]

746.035 Inducements not specified in policy. Except as otherwise expressly provided by the Insurance Code, no person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon. [1967 c.359 s.570]

746.040 [Amended by 1961 c.256 s.3; repealed by 1967 c.359 s.704]

746.045 Rebates. No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the agent's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy. [1967 c.359 s.571]

746.050 [Amended by 1961 c.256 s.4; repealed by 1967 c.359 s.704]

746.055 Title insurance commissions, rebates and discounts. With respect to title insurance, no commissions, rebates or discounts shall be paid, allowed or permitted to any person having an interest in or lien upon real property which is the subject of the title insurance involved, or to any person acting for or on behalf of a person with such an interest or lien. [Formerly 748.086]

746.060 [Repealed by 1961 c.256 s.5]

746.065 Personal or controlled insurance. (1) As used in this section, “personal or controlled insurance” means insurance covering an insurance agent or:

(a) The spouse of the insurance agent, the employer of the insurance agent or the employer's spouse, or any group of employees under a group policy issued to the employer of the insurance agent;

(b) Any person related to the insurance agent, to the spouse of the insurance agent, to the employer of the insurance agent or to the employer's spouse within the second degree by blood or marriage;

(c) If the employer of the insurance agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation;

(d) If the employer of the insurance agent is a partnership or association, any person owning any interest in such partnership or association;

(e) If the agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent, and any corporation which is likewise directly or indirectly controlled by the person who so directly or indirectly controls the agent; or

(f) If the agent is a corporation, any corporation making consolidated returns for United States income tax purposes with any corporation described in paragraph (e) of this subsection.

(2) If premiums on personal or controlled insurance transacted by an agent payable in one calendar year exceed the premiums or with respect to life and health insurance twice the premiums, on other insurance transacted by the agent payable in the same year, the receipt of commissions upon the excess is an unlawful rebate.

(3) This section shall not apply to an individual licensee who:

(a) Is licensed during all of such calendar year individually as an agent;

(b) During such calendar year conducts an individual agency business, not being designated to exercise the powers conferred by an agent's license issued to any firm or corporation nor owning any interest in any firm or corporation transacting an insurance agency or brokerage business;

(c) Has been continuously licensed in some manner as an insurance agent, broker or solicitor, and has been active as such, for at least 25 years; and

(d) Is at least 65 years of age at the beginning of such calendar year.

(4) This section does not apply to the writing, issuing or soliciting by a seller of personal property of insurance covering the personal property sold by the seller on an installment contract whereunder the title to the property is reserved by the seller.

(5) This section shall not apply to an agent, whether an individual, firm or corporation, if:

(a) The agent is controlled or owned by a nonprofit professional association and offers professional liability and related business and personal umbrella or excess liability insurance exclusively to members of the association; and

(b) The primary function of the association is other than marketing insurance. [1967 c.359 s.573; 1987 c.774 s.147; 1989 c.701 s.73]

746.070 [Repealed by 1961 c.256 s.5]

746.075 Misrepresentation generally. In the offer or sale of any insurance, directly or indirectly, or in connection with any inducement or attempted inducement, directly or indirectly, of any insured or person with ownership rights under an issued life insurance policy to lapse, forfeit, surrender, assign, effect a loan against, retain, exchange or convert the policy, no person shall:

(1) Make, issue, circulate or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages therein or the dividends or share of surplus to be received thereon;

(2) Make any false or misleading representation as to the dividends or share of surplus previously paid on similar policies;

(3) Make any false or misleading representation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

(4) Use any name or title of any policy or class of policies misrepresenting the true nature thereof;

(5) Employ any device, scheme, or artifice to defraud;

(6) Obtain money or property by means of any untrue statement of a material fact or any omission to state a material fact necessary in order to make the statement made, in light of the circumstances under which it was made, not misleading; or

(7) Engage in any other transaction, practice or course of business which operates as a fraud or deceit upon the purchaser, insured or person with policy ownership rights. [1967 c.359 s.574]

746.080 [Amended by 1967 c.359 s.509; renumbered 743.708]

746.085 Regulating replacement of life insurance; compensation of agents. In addition to all other powers of the Director of the Department of Consumer and Business Services with respect thereto, the director may issue rules:

(1) Requiring persons who replace, or offer or propose to replace, existing life insurance, to leave with the policyholder written, signed and dated statements which fully and correctly compare the terms, conditions and benefits of an existing policy with the proposed policy; and

(2) Limiting the commission or compensation payable to an agent on account of a life insurance policy that provides a nonforfeiture value sold to replace an existing life insurance policy that provides a nonforfeiture value to the commission or compensation the agent would have received if both the replaced and the replacement insurance policies had been carried by the insurer which issues the replacement policy. [1967 c.359 s.575; 1971 c.231 s.35]

746.090 [Repealed by 1967 c.359 s.704]

746.100 Misrepresentation in insurance applications or transactions. No person shall make a false or fraudulent statement or representation on or relative to an application for insurance, or for the purpose of obtaining a fee, commission, money or benefit from an insurer or agent. [Formerly 736.460]

746.110 False, deceptive or misleading statements. No person 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 a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which is untrue, deceptive or misleading. [Formerly 736.608]

746.115 Advertisements in languages other than English. An insurer or licensee who advertises in a language other than English need not provide an insurance policy in any language other than English so long as the advertisement states clearly that the policy that is purchased is available only in English. [1997 c.809 s.2]

Note: 746.115 was added to and made a part of ORS chapter 746 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

746.120 Illegal dealing in premiums. No person shall willfully collect any sum as premium or charge for insurance which is not then provided, or is not in due course to be provided subject to acceptance of the risk by the

insurer, under an insurance policy issued by an insurer in conformity to the Insurance Code. [1967 c.359 s.579]

746.130 "Free" insurance as inducement to sale or rental of property prohibited; exceptions; charges in accordance with filed rates. (1) No insurer shall participate in any plan to offer or effect in this state, as an inducement to the purchase or rental by the public of any property or services, any insurance for which there is no separate charge to the insured. No person shall arrange the sale of any such insurance.

(2) Subsection (1) of this section does not apply to:

(a) Home protection insurance or other insurance offered as a guarantee of the performance of property and designed to protect the purchasers or users of such property;

(b) Title insurance; or

(c) Credit life or credit health insurance as defined in ORS 743.371.

(3) The charge for any insurance incidental to the purchase or rental by the public of any property or services shall be in accordance with rates on file with the Director of the Department of Consumer and Business Services. [1967 c.359 s.580; 1969 c.336 s.16; 1981 c.247 s.20; 1993 c.265 s.9]

746.135 Use of genetic tests. (1) If an insurance provider asks an applicant for insurance to take a genetic test in connection with an application for insurance, the use of the test shall be revealed to the applicant and the provider shall obtain the specific authorization of the applicant using a form prescribed by rules of the Health Division.

(2) An insurance provider may not use a favorable genetic test as an inducement to purchase insurance.

(3) An insurance provider may not use genetic information to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms and conditions of or otherwise affect any policy for hospital or medical expenses.

(4) For purposes of this section, "genetic information," "genetic test" and "insurance provider" have those meanings given in ORS 659.700. [1995 c.680 s.8]

746.140 Sale of life insurance with securities; written proposal; application of securities law. (1) Every insurer or agent soliciting an offer to buy or selling life insurance in correlation with the sale of securities shall furnish the prospect with a clear and unambiguous written proposal prior to the signing of the application by the applicant.

(2) The written proposal shall be dated and signed by the insurance agent, or by the insurer if no agent is involved, and left with the prospect. The written proposal shall be on a form which has been filed with the Director of the Department of Consumer and Business Services. If a sale is made of both life insurance and securities, a duplicate copy of the written proposal left with the buyer shall be retained by the insurer for a period of not less than three years.

(3) Each such proposal shall:

(a) State the name of the insurer in which the life insurance is to be written;

(b) State that the prospect has the right to purchase the life insurance only, the securities only or both the life insurance and the securities;

(c) Contain no misrepresentations or false, deceptive or misleading words, figures or statements;

(d) State all material facts without which the proposal would have the capacity or tendency to mislead or deceive; and

(e) Set forth all matters pertaining to life insurance, including premium charges, separately from matters not pertaining to life insurance.

(4) This section shall not be construed to affect the application of any other provision of law concerning or regulating securities. [Formerly 739.562]

746.145 Workers' compensation insurance; combination of group of employers; purpose; conditions. (1) Notwithstanding ORS 737.600, but subject to all other rate filing requirements of ORS chapter 737, an insurer may combine for dividend purposes the experience of a group of employers covered for workers' compensation insurance by the insurer, subject to applicable rules adopted by the Director of the Department of Consumer and Business Services, if:

(a) All the employers in the group are members of an organization.

(b) The employers in the group constitute at least 50 percent of the employers in the organization, unless the number of covered workers in the group exceeds 500, in which case the employers in the group must constitute at least 25 percent of the employers in the organization.

(c) The grouping of employers is likely to substantially improve accident prevention, claims handling for the employers and reduce expenses.

(2) This section does not apply to an organization of employers for which organization a workers' compensation policy was lawfully issued before October 4, 1977. The guaranty contract required by ORS 656.419 shall contain for each employer covered thereby the information required by ORS 656.419 (2). When an employer becomes an insured member of the organization the insurer shall, within 30 days after the date insured membership commenced, file a notice thereof with the Workers' Compensation Board. [1977 c.405 s.3; 1983 c.706 s.3; 1990 c.1 s.5]

746.147 Workers' compensation insurance; quoting premiums. An insurer or agent offering workers' compensation insurance in Oregon shall not quote projected net insurance premiums based upon figures that are discretionary or terms that are not guaranteed in the workers' compensation insurance policy. [1999 c.868 s.3]

Note: 746.147 was added to and made a part of ORS chapter 746 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

746.150 Other insurance; combination of experience of group of persons or risks; purpose; conditions. (1) For property, inland marine, casualty or surety insurance, an insurer may combine for dividend purposes the experience of a group of persons or risks any of which are within this state, except for workers' compensation insurance done in compliance with ORS 746.145 and subject to rules adopted by the Director of the Department of Consumer and Business Services.

(2) The director shall make reasonable rules regarding such dividend groupings as an aid to the effectuation and enforcement of the Insurance Code. Such rules shall have as their purpose the prevention of misrepresentation, unfair discrimination and other unfair trade practices, and may among other things require that:

(a) Such a grouping comprises substantially homogeneous risks.

(b) The organization under the auspices of which such a grouping is made has been in existence for at least two years and was formed for purposes other than that of obtaining insurance.

(c) A substantial improvement in loss prevention or claims handling will be a likely result of such a grouping.

(d) Information regarding eligibility for participation in the grouping and the system for allocation of dividends among the participants be filed with the director.

(3) An insurer shall not unfairly discriminate in the allocation of dividends among the participants in such a dividend grouping.

(4) The system for allocation of dividends among the participants may provide for allocation at a fixed percentage of premiums, or may provide for variations in the percentage of premiums paid as dividends, or may provide for other variations in determining the amounts of dividends allocated to participants. The variations may be based on loss or expense factors or on other reasonable considerations, such as risk size, risk location or industry or trade hazard classification, that have a probable effect on losses or expenses.

(5) Failure to apply in a consistent manner the dividend allocation system specified in an insurer's dividend declaration shall be prima facie evidence of unfair discrimination. [1977 c.405 s.4; 1983 c.706 s.4; 1999 c.59 s.230]

746.155 Applicability of ORS 746.145 and 746.150. ORS 746.145 and 746.150 do not apply to groupings or combinations of persons or risks by way of common ownership or common use and control as permitted under ORS 737.600. [1977 c.405 s.2]

746.160 Practices injurious to free competition. Except as otherwise expressly provided by law, no person, either within or outside of this state, directly or indirectly, shall enter into any contract, understanding or combination with any insurer or manager, agent or representative thereof for the purpose of, nor shall any such persons or insurers, jointly or severally do any act or engage in any practice for the purpose of:

(1) Controlling the rates to be charged, or the commissions or other compensations to be paid, for insuring any risk or class of risks in this state;

(2) Discriminating against or differentiating from any insurer, manager or agent, by reason of the plan or method of transacting business or the affiliation or nonaffiliation with any board or association of insurers, managers, agents or representatives; or

(3) Doing anything which is detrimental to free competition in the business or injurious to the insuring public. [Formerly 736.615]

746.170 [Formerly 736.705; repealed by 1977 c.742 s.9]

746.180 Designation of property insurer by lender prohibited. It is the policy of this state that its citizens have the right of free choice in the procurement of insurance and that, accordingly, no lender shall designate an insurer or insurance agent from which a borrower may procure the insurance required by the loan or sales agreement on the property securing the indebtedness. [Formerly 736.715]

746.182 Notice by certain financial institutions prior to sale of insurance policy. (1) Prior to selling any policy of insurance, other than a policy for a class of insurance referred to in subsection (2) of this section:

(a) Any agent that is an institution as defined in ORS 706.008, shall give the purchaser the notice required under ORS 708A.005 (2)(e);

(b) Any agent that is a corporation, all or part of the stock of which is held by an institution, shall give the purchaser the notice required under ORS 708A.120 (7)(f);

(c) Any agent that is a corporation, all or part of the stock of which is held by a bank holding company as defined in ORS 706.008, shall give the purchaser the notice required under ORS 715.075 (6);

(d) Any agent that is a corporation, all or part of the stock of which is held by a savings bank, as defined by ORS 706.008, shall give the purchaser the notice required under ORS 716.594 (6); and

(e) Any agent that is a savings bank, as defined in ORS 706.008, shall give the purchaser the notice required under ORS 716.610 (10)(e).

(2) The requirement under subsection (1) of this section does not apply to any policy for livestock insurance, mortgage insurance, motor vehicle physical damage insurance, credit life insurance, credit health insurance, credit involuntary unemployment insurance, credit insurance or lender's property insurance, as these classes of insurance are described in ORS 744.115. [1987 c.846 s.18; 1989 c.701 s.74; 1995 c.334 s.5; 1997 c.831 ss.6,6a]

746.185 Definition of “lending institution” for ORS 746.185 to 746.211. As used in ORS 746.185 to 746.211, “lending institution” means a financial institution or bank holding company as those terms are defined in ORS 706.008. [1977 c.742 s.2; 1985 c.762 s.189; 1997 c.631 s.551]

746.190 [Formerly 736.725; repealed by 1977 c.742 s.9]

746.191 Right of borrower to select property insurer; notice to borrower. A lending institution which solicits insurance on real or personal property must explain to the borrower in prominently displayed writing that insurance related to a loan or credit extension may be purchased from an insurer or agent of the borrower's choice, subject only to the lending institution's right to reject a given insurance policy or insurer as provided in ORS 746.195 (2). Compliance with the notice provided for in section 106 of the Truth in Lending Act (15 U.S.C.) shall be considered compliance with this section. [1977 c.742 s.3]

746.195 Insurance on property securing loan or credit; certain practices by lending institutions prohibited. A lending institution shall not:

(1) Solicit the sale of insurance for the protection of real or personal property after a person indicates interest in securing a loan or credit extension, until the lending institution has agreed to make the loan or credit extension;

(2) Unreasonably reject an insurance policy furnished by the borrower for the protection of the property securing the loan or credit. A rejection shall not be considered unreasonable when it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. The standards shall not discriminate against any particular type of insurer, nor shall the standards call for rejection of an insurance policy because the policy contains coverage in addition to that required in the credit transaction;

(3) Require that any borrower, mortgagor, purchaser, insurer or agent pay a separate charge in connection with the handling of any insurance policy required as security for a loan or credit extension, or pay a separate charge to substitute the insurance policy of one insurer for that of another. This subsection does not apply to the interest that may be charged on premium loans or premium advancements under the terms of the loan or credit document;

(4) Require any procedures or conditions of an insurer or agent not customarily required of insurers or agents that are affiliated or in any other way connected with the lending institution;

(5) Refuse to accept a written binder issued by an agent as proof that temporary insurance exists covering the real or personal property that is the subject matter of, or security for, a loan or extension of credit, and that a policy of insurance will be issued covering that property. A written binder issued by an agent or insurer covering real or personal

property that is the subject matter of, or security for, a loan or extension of credit shall be effective until a policy of insurance is issued in lieu thereof, including within its terms the identical insurance bound under the binder and the premium therefor, or until notice of the cancellation of the binder is received by the borrower and the lending institution extending credit or offering the loan. When a lending institution closes on a binder under ORS 742.043, the agent or insurer issuing the binder shall be bound to provide a policy of insurance, equivalent in coverage to the coverage set forth in the binder, within 60 days from the date of the binder. The provisions of this subsection do not apply when prohibited by federal or state statute or regulations; or

(6) Use or disclose to any other insurance agent, other than the original agent, the information relating to a policy of insurance furnished by a borrower unless the original agent fails to deliver a policy of insurance within 60 days prior to expiration to the lending institution without first procuring the written consent of the borrower. [1977 c.742 s.4; 1987 c.916 s.10]

746.200 [Formerly 736.735; repealed by 1977 c.742 s.9]

746.201 Lending institution to obtain required property insurance when borrower does not; notice required. (1) Nothing contained in ORS 746.185 to 746.205 shall prevent a lending institution or other lender or seller from placing insurance on real or personal property in which the financial institution or other lender or seller has a security interest when the mortgagor, borrower or purchaser fails to provide required insurance under the terms of the loan or credit document.

(2) In a contract or loan agreement, or in a separate document accompanying the contract or loan agreement and signed by the mortgagor, borrower or purchaser, that provides for a loan or other financing secured by the mortgagor's, borrower's or purchaser's real or personal property and that authorizes the secured party to place insurance on the property when the mortgagor, borrower or purchaser fails to maintain the insurance as required by the contract or loan agreement or the separate document, a warning in substantially the following form shall be set forth in 10-point type:

WARNING

Unless you provide us with evidence of the insurance coverage as required by our contract or loan agreement, we may purchase insurance at your expense to protect our interest. This insurance may, but need not, also protect your interest. If the collateral becomes damaged, the coverage we purchase may not pay any claim you make or any claim made against you. You may later cancel this coverage by providing evidence that you have obtained property coverage elsewhere.

You are responsible for the cost of any insurance purchased by us. The cost of this insurance may be added to your contract or loan balance. If the cost is added to your contract or loan balance, the interest rate on the underlying contract or loan will apply to this added amount. The effective date of coverage may be the date your prior coverage lapsed or the date you failed to provide proof of coverage.

The coverage we purchase may be considerably more expensive than insurance you can obtain on your own and may not satisfy any need for property damage coverage or any mandatory liability insurance requirements imposed by applicable law.

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(3) Substantial compliance by a secured party with subsection (2) of this section constitutes a complete defense to any claim arising under the laws of this state challenging the secured party's placement of insurance on the real or personal property in which the secured party has a security interest, for the protection of the secured party's interest in the property.

(4) Nothing contained in this section shall be construed to require any secured party to place or maintain insurance on real or personal property in which the secured party has a security interest, and the secured party shall not be liable to the mortgagor, borrower or purchaser or to any other party as a result of the failure of the secured party to place or maintain such insurance.

(5) The failure of a secured party prior to January 1, 1996, to include in a contract or loan agreement, or in a separate document accompanying the contract or loan agreement, the notice set forth in subsection (2) of this section shall not be admissible in any court or arbitration proceeding or otherwise used to prove that a secured party's actions with respect to the placement or maintenance of insurance on real or personal property in which the secured party has a security interest are or were unlawful or otherwise improper. A secured party shall not be liable to the mortgagor,

borrower or purchaser or to any other party for placing such insurance in accordance with the terms of an otherwise legal contract or loan agreement with the mortgagor, borrower or purchaser entered into prior to January 1, 1996. [1977 c.742 s.5; 1995 c.313 s.3]

Note: Section 4, chapter 313, Oregon Laws 1995, provides:

Sec. 4. (1) The amendments to ORS 746.201 by section 3 of this Act apply only to contracts and loan agreements entered into on or after January 1, 1996.

(2) Notwithstanding subsection (1) of this section, if a secured party has placed insurance prior to the effective date of this Act [January 1, 1996] and in doing so has substantially complied with ORS 746.201 (2), then ORS 746.201 (3) applies to any action pending on January 1, 1996, that challenges the placement of the insurance. [1995 c.313 s.4]

746.205 ORS 746.185 to 746.205 not applicable to certain policies of insurance. Nothing contained in ORS 746.185 to 746.205 applies to credit life, credit health or accidental death and disability insurance. [1977 c.742 s.6]

746.210 [Formerly 736.745; repealed by 1977 c.742 s.9]

746.211 ORS 746.185 to 746.195 not applicable to bank holding companies. ORS 746.185 to 746.195 do not apply to a bank holding company which, on or before January 1, 1977, owned, controlled or had power to vote not more than 20 percent of any class of voting securities of another lending institution. [1977 c.742 s.7; 1987 c.916 s.11]

746.220 Debtor's option in furnishing credit life or credit health insurance. When credit life insurance or credit health insurance, as defined in ORS 743.371, is required as additional security for any indebtedness, the debtor shall, upon request to the creditor, have the option of furnishing the required amount of insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through any authorized insurer. [Formerly 739.615]

746.222 Prohibition on referral of individual to Medical Insurance Pool. No insurer or licensee under the Insurance Code shall refer an individual to the Oregon Medical Insurance Pool, established under ORS 735.600 to 735.650, for coverage offered by the pool or arrange for the individual to apply to the pool for the purpose of separating the individual from health insurance benefits offered or provided in connection with a group health benefit plan. [1993 c.130 s.5; 1999 c.987 s.20]

746.225 [1975 c.469 s.2; repealed by 1979 c.140 s.3]

746.230 Unfair claim settlement practices. (1) No insurer or other person shall commit or perform any of the following unfair claim settlement practices:

(a) Misrepresenting facts or policy provisions in settling claims;

(b) Failing to acknowledge and act promptly upon communications relating to claims;

(c) Failing to adopt and implement reasonable standards for the prompt investigation of claims;

(d) Refusing to pay claims without conducting a reasonable investigation based on all available information;

(e) Failing to affirm or deny coverage of claims within a reasonable time after completed proof of loss statements have been submitted;

(f) Not attempting, in good faith, to promptly and equitably settle claims in which liability has become reasonably clear;

(g) Compelling claimants to initiate litigation to recover amounts due by offering substantially less than amounts ultimately recovered in actions brought by such claimants;

(h) Attempting to settle claims for less than the amount to which a reasonable person would believe a reasonable person was entitled after referring to written or printed advertising material accompanying or made part of an application;

(i) Attempting to settle claims on the basis of an application altered without notice to or consent of the applicant;

(j) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage under which payment has been made;

(k) Delaying investigation or payment of claims by requiring a claimant or the physician of the claimant to submit

a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

(L) Failing to promptly settle claims under one coverage of a policy where liability has become reasonably clear in order to influence settlements under other coverages of the policy; or

(m) Failing to promptly provide the proper explanation of the basis relied on in the insurance policy in relation to the facts or applicable law for the denial of a claim.

(2) No insurer shall refuse, without just cause, to pay or settle claims arising under coverages provided by its policies with such frequency as to indicate a general business practice in this state, which general business practice is evidenced by:

(a) A substantial increase in the number of complaints against the insurer received by the Department of Consumer and Business Services;

(b) A substantial increase in the number of lawsuits filed against the insurer or its insureds by claimants; or

(c) Other relevant evidence.

(3)(a) No health maintenance organization, as defined in ORS 750.005, shall unreasonably withhold the granting of participating provider status from a class of statutorily authorized health care providers for services rendered within the lawful scope of practice if the health care providers are licensed as such and reimbursement is for services mandated by statute.

(b) Any health maintenance organization that fails to comply with paragraph (a) of this subsection shall be subject to discipline under ORS 746.015.

(c) This subsection does not apply to group practice health maintenance organizations that are federally qualified pursuant to Title XIII of the Health Maintenance Organization Act. [1967 c.359 s.588a; 1973 c.281 s.1; 1989 c.594 s.1]

746.240 Undefined trade practices injurious to public prohibited. No person shall engage in this state in any trade practice that, although not expressly defined and prohibited in the Insurance Code, is found by the Director of the Department of Consumer and Business Services to be an unfair or deceptive act or practice in the transaction of insurance that is injurious to the insurance-buying public. [1967 c.359 s.589; 1973 c.281 s.2]

746.250 [1967 c.359 s.590; repealed by 1973 c.281 s.3]

746.260 Driving record not to be considered in issuance of motor vehicle insurance. (1) Except as provided in subsection (4) of this section, when an individual applies for a policy or a renewal of a policy of casualty insurance providing automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage or automobile physical damage coverage on an individually owned passenger vehicle including pickup and panel trucks and station wagons, an insurer shall not consider either the employment driving record or the nonemployment driving record of the individual in determining whether the policy will be issued or renewed or in determining the rates for the policy. An insurer shall not cancel such policy or discriminate in regard to other terms or conditions of the policy based upon the employment driving record or the nonemployment driving record of the individual.

(2) As used in this section, “employment driving record” and “nonemployment driving record” mean the employment driving record and nonemployment driving record described in ORS 802.200.

(3) This section is not intended to affect the enforcement of the motor vehicle laws.

(4) An insurer may use the abstract of the individual's nonemployment driving record as authorized under ORS 746.265. [1973 c.113 s.2; 1979 c.662 s.2; 1983 c.338 s.969; 1987 c.5 s.6]

746.265 Purposes for which abstract of nonemployment driving record may be considered. (1) Subject to subsection (2) of this section, when an individual applies for a policy or a renewal of a policy of casualty insurance providing automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage or automobile physical damage coverage on an individually owned passenger vehicle including pickup and panel trucks and station wagons, the insurer may consider the abstract of the nonemployment driving record of the individual under ORS 802.220:

(a) For the purpose of determining whether to issue or renew the individual's policy.

(b) For the purpose of determining the rates of the individual's policy.

(2) For the purposes specified in subsection (1) of this section, an insurer issuing or renewing a policy described in subsection (1) of this section shall not consider any:

(a) Accident or conviction for violation of motor vehicle laws that occurred more than three years immediately preceding the application for the policy or renewal of the policy;

(b) Diversion agreements under ORS 813.220 that were entered into more than three years immediately preceding the application for the policy or renewal of the policy; or

(c) Suspension of driving privileges pursuant to ORS 809.280 (7) or (9) if the suspension is based on a nondriving offense. [1987 c.5 s.5; 1989 c.853 s.1; 1991 c.860 s.7; 1999 c.59 s.231]

746.270 Use of past investment or predicted future investment experience in sale of variable life insurance policies. No person shall make or use in the offer or sale of a variable life insurance policy any illustrations of benefits payable that include projections of past investment experience into the future or predictions of future investment experience. This section is not intended to prohibit use of hypothetical assumed rates of investment return to illustrate possible levels of benefits. [1973 c.435 s.26]

746.275 Definitions for ORS 746.275 to 746.300. As used in ORS 746.275 to 746.300:

(1) “Adjuster” means a person authorized to do business under ORS 744.505 or 744.515.

(2) “Motor vehicle liability insurance policy” means an insurance policy which provides automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage or automobile physical damage coverage on motor vehicles, but does not include any insurance policy:

(a) Covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards; or

(b) Issued principally to cover personal or premises liability of an insured, even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of such insured or on the ways immediately adjoining such premises.

(3) “Motor vehicle body and frame repair shop” means a business or a division of a business organized for the purpose of effecting repairs to motor vehicles which have been physically damaged. [1977 c.785 s.1]

Note: 746.275 to 746.300 and 746.991 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 746 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

746.280 Designation of particular motor vehicle repair shop by insurer prohibited. An insurer shall not require that a particular person make the repairs to the insured's motor vehicle as a condition for recovery by the insured under a motor vehicle liability insurance policy. [1977 c.785 s.2]

Note: See note under 746.275.

746.285 Notice of prohibition in motor vehicle repair shops; size; location. A person operating a motor vehicle body and frame repair shop shall display in a conspicuous place in the shop a sign in bold face type in letters at least two inches high reading substantially as follows:

PURSUANT TO OREGON INSURANCE LAW, AN INSURANCE COMPANY MAY NOT REQUIRE THAT REPAIRS BE MADE TO A MOTOR VEHICLE BY A PARTICULAR PERSON OR REPAIR SHOP.

[1977 c.785 s.3]

Note: See note under 746.275.

746.287 Insurer requirement of installation of aftermarket crash part in vehicle. (1) Without the consent of the owner of the vehicle, an insurer may not require, directly or indirectly, that a motor vehicle body and frame repair shop supply or install any aftermarket crash part unless the part has been certified by an independent test facility to be at least equivalent to the part being replaced.

(2) For purposes of this section, an aftermarket crash part is at least equivalent to the part being replaced if the aftermarket crash part is the same kind of part and is at least the same quality with respect to fit, finish, function and

corrosion resistance. [1987 c.622 s.3]

Note: See note under 746.275.

746.289 Insurer offer of crash part warranty. Any insurer which offers a motor vehicle insurance policy that provides coverage for repair of the vehicle shall make available to its insured a crash part warranty for crash parts not made by the original equipment manufacturer as described in ORS 746.292 when the insured requests one. [1987 c.622 s.4]

Note: 746.289 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 746, ORS 746.275 to 746.300 or any other series by legislative action. See Preface to Oregon Revised Statutes for further explanation.

746.290 Notice of prohibition in policies and by adjusters. (1) An adjuster establishing loss under a motor vehicle liability insurance policy shall advise the insured of the provisions of ORS 746.280.

(2) Every motor vehicle liability insurance policy issued in this state after December 31, 1977, and any extension or renewal after that date of a policy issued before that date shall be accompanied by a statement in clear and conspicuous language approved by the director of:

(a) The rights and responsibilities of the insured when a claim is submitted; and

(b) The provisions of ORS 746.280. [1977 c.785 s.4]

Note: See note under 746.275.

746.292 Motor vehicle repair shops; invoices; estimates; warranties; prohibited practices. (1) All work done by a motor vehicle body and frame repair shop shall be recorded on an invoice and shall describe all service work done and parts supplied. If any used parts are supplied, the invoice shall clearly state that fact. If any component system installed is composed of new and used parts, such invoice shall clearly state that fact. One copy of the invoice shall be given to the customer and one copy shall be retained by the motor vehicle body and frame repair shop.

(2) Before commencing repair work and upon the request of any customer, a motor vehicle body and frame repair shop shall make an estimate in writing of the parts and labor necessary for the repair work, and shall not charge for the work done or parts supplied in excess of the estimate without the consent of such customer.

(3)(a) If crash parts to be used in the repair work are supplied by the original equipment manufacturer, the parts shall be accompanied by a warranty that guarantees the customer that the parts meet or exceed standards used in manufacturing the original equipment.

(b) If crash parts to be used in the repair work are not supplied by the original equipment manufacturer, the estimate shall include a statement that says:

This estimate has been prepared based on the use of a motor vehicle crash part not made by the original equipment manufacturer. The use of a motor vehicle crash part not made by the original equipment manufacturer may invalidate any remaining warranties of the original equipment manufacturer on that motor vehicle part. The person who prepared this estimate will provide a copy of the part warranty for crash parts not made by the original equipment manufacturer for comparison purposes.

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(4) No motor vehicle body and frame shop may:

(a) Supply or install used parts, or any component system composed of new and used parts, when new parts or component systems are or were to be supplied or installed.

(b) Supply or install, without the owner's consent, any aftermarket crash part unless the part has been certified by an independent test facility to be at least equivalent to the part being replaced. For purposes of this paragraph, an aftermarket crash part is at least equivalent to the part being replaced if the aftermarket crash part is the same kind of part and is at least the same quality with respect to fit, finish, function and corrosion resistance.

(c) Charge for repairs not actually performed, or add the cost of repairs not actually to be performed to any repair estimate.

(d) Refuse any insurer, or its insured, or their agents or employees, reasonable access to any repair facility for the purpose of inspecting or reinspecting the damaged vehicle during usual business hours.

(5) As used in ORS 746.287 and this section, “aftermarket crash part” means a motor vehicle replacement part, sheet metal or plastic, that constitutes the visible exterior of the vehicle, including an inner or outer panel, is generally repaired or replaced as the result of a collision and is not supplied by the original equipment manufacturer. [1977 c.785 s.5; 1987 c.622 s.1]

Note: See note under 746.275.

746.295 Proof and amount of loss under motor vehicle liability policies; determination by insurer. Nothing in ORS 746.275 to 746.300 or 746.991 shall prohibit an insurer from establishing proof of loss requirements for motor vehicle liability insurance policies, investigating and determining the amount of an insured's loss through its agents or employees or negotiating with any person for the repair of such loss. [1977 c.785 s.6]

Note: See note under 746.275.

746.300 Liability of insurers and motor vehicle repair shops for damages; attorney fees. An insured whose insurer violates ORS 746.280 or 746.290, or a customer whose motor vehicle body and frame repair shop violates ORS 746.292, may file an action to recover actual damages or $100, whichever is greater, for each violation. The court may award reasonable attorney fees to the prevailing party in an action under this section. [1977 c.785 s.7; 1981 c.897 s.102; 1995 c.618 s.129]

Note: See note under 746.275.

746.305 Rules. The Director of the Department of Consumer and Business Services may adopt rules to carry out the provisions of ORS 746.275 to 746.300 and 746.991. [1987 c.622 s.5]

Note: 746.305 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 746 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

746.307 [1989 c.947 s.4; renumbered 743.724 in 1991]

746.308 Violation of provisions regarding totaled vehicles as violation of Insurance Code. An insurer that violates ORS 819.014 or 819.018 shall be considered to have violated a provision of the Insurance Code. [1991 c.820 s.7]

Note: 746.308 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 746 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

UNAUTHORIZED INSURANCE

746.310 Representing or aiding unauthorized insurer prohibited; agent liable to insured. (1) No person shall in this state directly or indirectly with respect to domestic risks act as agent for or otherwise transact insurance for any insurer not then authorized to transact such insurance in this state.

(2) In the event of failure of any unauthorized insurer to pay any claim or loss within the provisions of such insurance policy, any insurance agent who assisted or in any manner aided in the procurement of such insurance policy knowing it to be procured through an unauthorized insurer shall be liable to the insured for the full amount of the claim or loss.

(3) This section does not apply to:

(a) Matters authorized to be done by the Director of the Department of Consumer and Business Services under ORS 746.320 to 746.360.

(b) Insurance written under a surplus line license in compliance with ORS 735.400 to 735.495.

(c) Any transaction with respect to reinsurance when transacted by an insurer duly authorized by its state of domicile to transact the class of insurance involved.

(d) A licensed adjuster or attorney at law representing such an insurer from time to time in such occupational or professional capacity. [1967 c.359 s.591; 1969 c.336 s.17; 1987 c.774 s.140; 1991 c.810 s.27]

746.320 Service of process equivalent to personal service on unauthorized foreign or alien insurer. (1) When an unauthorized insurer does any of the acts specified in subsection (2) of this section in this state, by mail or otherwise, the doing of such acts shall constitute an appointment by such insurer of the Director of the Department of Consumer and Business Services, and the successor in office, as its lawful attorney upon whom all process may be served in any action begun by or on behalf of an insured or beneficiary and arising out of policies of insurance between the insurer and persons residing or authorized to do business in this state. Subject to subsection (4) of this section, the doing of any such act shall signify the insurer's consent that service of process upon the director is of the same legal force and effect as personal service of process upon such insurer within this state.

(2) The acts referred to in subsection (1) of this section are:

(a) Issuing or delivering policies of insurance to persons residing or authorized to do business in this state.

(b) Soliciting applications for policies of insurance from such persons.

(c) Collecting premiums, membership fees, assessments or other considerations under policies of insurance from such persons.

(d) Any other transaction of business arising out of policies of insurance with such persons.

(3) Service of process upon the director shall be made by delivering to and leaving with the director, or with any clerk on duty in the office, two copies of such process. Immediately after service of process, the director shall send one of such copies to the defendant insurer at its principal office. The director shall keep a record of all processes served upon the director under this section.

(4) Service of process in the manner provided in this section gives jurisdiction over the person of an insurer provided:

(a) Notice of such service and a copy of the process are sent by registered mail or by certified mail with return receipt by the plaintiff, or the attorney of the plaintiff, to the defendant insurer at its principal office within 10 days after the date of service; and

(b) The defendant insurer's receipt, or receipt issued by the post office with which the letter is registered or certified, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed and an affidavit of the plaintiff, or the attorney of the plaintiff, showing compliance with this section are filed with the clerk of the court in which the action against such insurer is pending on or before the date on which such insurer is required to appear, or within such further time as the court may allow.

(5) Nothing contained in this section shall limit or abridge the right to serve any process upon an insurer in any other manner then permitted by law. [Formerly 736.252; 1991 c.249 s.71]

746.330 Judgment by default after service of process under ORS 746.320. Until the expiration of 30 days from the date of filing an affidavit of compliance under ORS 746.320, no plaintiff or complainant shall be entitled to a judgment by default in any action in which service of process is made in the manner provided in such section. [Formerly 736.254]

746.340 Conditions to be met by defendant unauthorized insurer before filing motions or pleadings. (1) Except as provided in subsection (3) of this section, before any unauthorized insurer may file or cause to be filed any motion or pleading in an action started against it by service of process in the manner provided in ORS 746.320, the defendant insurer shall either:

(a) Procure a certificate of authority to transact insurance in this state; or

(b) Deposit cash or securities or file a bond with good and sufficient sureties, approved by the court, with the clerk of the court in which such action is pending in an amount, fixed by the court, sufficient to secure the payment of any judgment which may be entered in such action. However, the court may in its discretion make an order dispensing with such deposit or bond where the insurer makes a showing satisfactory to such court that the insurer maintains in a state of the United States funds or securities, in trust or otherwise, sufficient and available to satisfy any final judgment which may be entered in such action.

(2) The court may order such postponement as may be necessary to give such insurer reasonable opportunity to comply with subsection (1) of this section and to prepare its defense in such action.

(3) Nothing in ORS 746.320 to 746.360 shall be construed to prevent a defendant unauthorized insurer from filing a motion to set aside service of process made in the manner provided in ORS 746.320 on the ground that such insurer

has not done any of the acts described in subsection (2) of such section. [Formerly 736.256]

746.350 Attorney fee allowable to prevailing party. In any action against an unauthorized insurer in which service of process was made in the manner provided in ORS 746.320, the court may award reasonable attorney fees to the prevailing party. [Formerly 736.258; 1981 c.897 s.103; 1995 c.618 s.130]

746.360 Exceptions to application of unauthorized insurer service of process law. ORS 746.320 to 746.360 do not apply to an action against an unauthorized insurer arising out of any policy of:

(1) Reinsurance or wet marine and transportation insurance;

(2) Insurance effected in compliance with ORS 744.305 to 744.405 (1985 Replacement Part);

(3) Insurance against legal liability arising out of ownership, operation or maintenance of any property having a permanent situs outside the state; or

(4) Insurance against loss of or damage to any property having a permanent situs outside this state, where such policy contains a provision designating the Director of the Department of Consumer and Business Services or a bona fide resident of this state as the insurer's lawful attorney upon whom all process may be served in any action begun by or on behalf of an insured or beneficiary and arising out of policies of insurance between the insurer and persons residing or authorized to do business in this state. [Formerly 736.260]

746.370 Records of insureds. In order that the Director of the Department of Consumer and Business Services may effectively administer ORS 746.310 to 746.370, every person for or by whom insurance has been placed with an unauthorized insurer shall, upon the director's order, produce for examination all policies and other documents evidencing the insurance, and shall disclose to the director the amount of premiums paid or agreed to be paid for the insurance. [1967 c.359 s.597]

PREMIUM FINANCING

746.405 Definitions for ORS 746.405 to 746.530. As used in ORS 746.405 to 746.530, unless the context requires otherwise:

(1) “Premium finance agreement” means an agreement by which an insured or prospective insured promises to pay to a premium finance company or to its assignee the amount advanced or to be advanced under the agreement to an insurer or to an insurance agent or broker in payment of premiums on an insurance policy together with a service charge. No mortgage, conditional sale contract or other security agreement covering property which authorizes the lienholder to pay or advance premiums for insurance with respect thereto shall be deemed to be a premium finance agreement.

(2) “Premium finance company” means a person engaged in the business of entering into premium finance agreements with insureds or of acquiring such premium finance agreements from insurance agents, brokers or other premium finance companies. [1969 c.639 s.2]

746.415 [1969 c.639 s.3; repealed by 1993 c.265 s.14]

746.420 [1989 c.700 s.22; repealed by 1993 c.265 s.14]

746.422 Inquiries from director to premium finance company. In the manner provided in ORS 731.296, the Director of the Department of Consumer and Business Services may address inquiries to a premium finance company, and a premium finance company shall reply to such inquiries. [1993 c.265 s.11]

746.425 Applicability of ORS 746.405 to 746.530. ORS 746.405 to 746.530 do not apply to:

(1) Any insurer authorized to transact business in this state who finances insurance premiums on domestic risks with a service charge no greater than that provided in ORS 746.485 and 746.495;

(2) Any bank, trust company, savings and loan association, credit union or other lending institution authorized to transact business in this state that does not possess or acquire any right, title or interest with respect to the insurance policy for which the premiums are financed other than in the proceeds thereof in the event of loss;

(3) The inclusion of a charge for insurance in connection with an installment sale in accordance with ORS 83.010 to 83.820 and 83.990; or

(4) Agents financing only their own accounts and whose aggregate charge for financing does not exceed one and one-half percent per month on the outstanding balance. [1969 c.639 s.4; 1981 c.412 s.22]

746.435 [Amended by 1969 c.639 s.5; 1971 c.231 s.36; 1989 c.700 s.19; repealed by 1993 c.265 s.14]

746.445 [1969 c.639 s.6; 1989 c.700 s.20; repealed by 1993 c.265 s.14]

746.455 [1969 c.639 s.7; 1971 c.231 s.37; repealed by 1993 c.265 s.14]

746.460 [1989 c.700 s.23; repealed by 1993 c.265 s.14]

746.465 Records required of premium finance companies; form; inspection. (1) Every premium finance company shall maintain records of its premium finance transactions and the records shall be open to examination and investigation by the Director of the Department of Consumer and Business Services. The director may at any time require the company to bring such records as the director may direct to the director's office for examination.

(2) Every premium finance company shall preserve its records of such premium finance transactions, including cards used in a card system, for at least three years after making the final entry in respect to any premium finance agreement. The preservation of records in photographic form shall constitute compliance with this requirement. [1969 c.639 s.8]

746.470 Prohibition against interfering with premium financing recommendation. No insurer shall interfere in any way with the right of any person soliciting or procuring an application for its insurance policies to recommend to an insured any premium finance company. [1983 c.239 s.5]

746.475 Premium finance agreements; contents; form; delivery; notice to insurer. (1) A premium finance agreement shall:

(a) Be dated, signed by the insured or by any person authorized in writing to act in behalf of the insured, and the printed portion thereof shall be in at least eight-point type;

(b) Contain the name and place of business of the insurance agent negotiating the related insurance policy, the name and residence or the place of business of the insured as specified by the insured, the name and place of business of the premium finance company to which payments are to be made, a description of the insurance policies involved and the amount of the premium therefor; and

(c) Set forth the following items where applicable:

(A) The total amount of the premiums.

(B) The amount of the downpayment.

(C) The principal balance (the difference between items (A) and (B)).

(D) The amount of the service charge.

(E) The balance payable by the insured (sum of items (C) and (D)).

(F) The number of payments required, the amount of each payment expressed in dollars, and the due date or period thereof.

(2) The items set out in subsection (1)(c) of this section need not be stated in the sequence or order in which they appear in such paragraph, and additional items may be included to explain the computations made in determining the amount to be paid by the insured.

(3) The premium finance company or the insurance agent shall deliver to the insured, or mail to the insured at the address shown in the agreement, a complete copy of the agreement.

(4) A premium finance company shall give notice of its financing to the insurer not later than the 30th day after the date the premium financing agreement is received by the premium finance company. A notice given under this subsection shall be effective whether or not the insured's policy number is set forth in the notice. [1969 c.639 s.9; 1971 c.231 s.38; 1983 c.239 s.3]

746.485 Regulation of service charge for premium financing; method of computation; prepayment. (1) A premium finance company shall not charge, contract for, receive, or collect a service charge other than as permitted by ORS 746.405 to 746.530.

(2) The service charge is to be computed on the balance of the premiums due (after subtracting the downpayment

made by the insured in accordance with the premium finance agreement) from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final payment of the premium finance agreement is payable.

(3) The service charge shall not exceed interest at a rate authorized under this subsection plus an additional charge of 10 percent of the amount financed or $50, whichever amount is less, per premium finance agreement. The additional charge need not be refunded upon cancellation or prepayment. The rate of interest charged by a premium finance company on the amount of financed premium shall not exceed the nominal annual rate of five percentage points in excess of the discount rate, and any surcharge thereon, on 90-day commercial paper in effect at the Federal Reserve Bank in the Federal Reserve District which includes Oregon on the effective date of the insurance coverage or 18 percent, whichever is greater.

(4) Any insured may prepay the premium finance agreement in full at any time before the due date of the final payment. In such event the unearned interest shall be refunded. The amount of any such refund shall be the total amount of interest due on the agreement less the interest earned to the installment date nearest the date of payment, computed by applying the actuarial method based on the annual percentage rate set forth on the premium finance agreement. [1969 c.639 s.10; 1971 c.231 s.39; 1983 c.239 s.1]

746.495 Delinquency charges regulated. (1) A premium finance agreement may provide for the payment by the insured of a delinquency charge for any payment that is in default for a period of 10 days or more. Such charge may be made for each month or fraction thereof that the payment is in default. The amount of such charge may be a minimum of $1 and as a maximum shall be subject to the following limits:

(a) For delinquent payments of less than $250, five percent of the payment or $5, whichever is less; or

(b) For delinquent payments of $250 or more, two percent of the payment.

(2) If a payment default results in the cancellation of any insurance policy listed in the agreement, the agreement may provide for the payment by the insured of a cancellation charge of $5, less any delinquency charges imposed in respect to the payment in default. [1969 c.639 s.11]

746.505 Cancellation of policy by premium finance company; notice required; effective date of cancellation. (1) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance policy or policies listed in the agreement, the insurance policy or policies shall not be canceled by the premium finance company unless such cancellation is effectuated in accordance with this section.

(2) Not less than 10 days' written notice shall be mailed to the insured of the intent of the premium finance company to cancel the insurance policy unless the default is cured within such 10-day period. A copy of such notice shall also be mailed to the insurance agent indicated on the premium finance agreement.

(3) After expiration of such 10-day period, the premium finance company may thereafter in the name of the insured cancel such insurance policy or policies by mailing to the insurer a notice of cancellation, and the insurance policy shall be canceled as if such notice of cancellation had been submitted by the insured, but without requiring the return of the insurance policy or policies. The premium finance company shall also mail a notice of cancellation to the insured at the last-known address of the insured and to the insurance agent indicated on the premium finance agreement.

(4) All statutory, regulatory and contractual restrictions providing that the insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation. [1969 c.639 s.12; 1983 c.239 s.2]

746.515 Return of unearned premiums on cancellation. (1) Whenever a financed insurance policy is canceled, the insurer who has been notified as provided in ORS 746.475 (4) shall return whatever gross unearned premiums are due under the insurance policy to the premium finance company for the account of the insured or insureds not later than the 30th day after the date of cancellation. If the insurer elects to return the premium through the agent, the agent shall transmit the unearned premium to the premium finance company within the 30-day period. The insurer, on written notice of any failure of the agent to transmit the premium and not later than the 30th day after the notice, shall pay the amount of return premium directly to the premium finance company.

(2) In calculating the gross unearned premium due under a financed insurance policy, the insurer shall use the prorate method of calculation.

(3) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured provided that no such refund shall be required if it amounts to less than $1. [1969 c.639 s.13; 1983 c.239 s.7]

746.525 Agreement effective as security interest. No filing of the premium finance agreement shall be necessary to perfect the validity of such agreement as a secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, successors or assigns. [1969 c.639 s.14]

746.530 Attorney fees. In any action to enforce any right created by ORS 746.405 to 746.530, the prevailing party may be awarded a reasonable amount, to be fixed by the court, as attorney fees. The amount may be taxed as part of the cost of the action and any appeal thereon. [1983 c.239 s.6]

USE AND DISCLOSURE OF INSURANCE INFORMATION

746.600 Definitions for ORS 746.600 to 746.690 and 750.055. As used in ORS 746.600 to 746.690 and 750.055:

(1) “Adverse underwriting decision” means, except as provided in subsection (2) of this section, any of the following actions with respect to insurance transactions involving insurance coverage which is individually underwritten:

(a) A declination of insurance coverage.

(b) A termination of insurance coverage.

(c) Failure of an agent to apply for insurance coverage with a specific insurer which the agent represents and which is requested by an applicant.

(d) In the case of life or health insurance coverage, an offer to insure at higher than standard rates.

(e) In the case of other kinds of insurance coverage:

(A) Placement by an insurer or agent of a risk with a residual market mechanism, an unauthorized insurer or an insurer which specializes in substandard risks.

(B) The charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(2) “Adverse underwriting decision” does not include the following actions, but the insurer or agent responsible for the occurrence of the action shall nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

(a) The termination of an individual policy form on a class or statewide basis.

(b) A declination of insurance coverage solely because the coverage is not available on a class or statewide basis.

(c) The rescission of a policy.

(3) “Affiliate of” a specified person or “person affiliated with” a specified person means a person who directly, or indirectly, through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(4) “Agent” means a person licensed by the Director of the Department of Consumer and Business Services as an insurance agent, or a person to whom the director has issued a nonresident broker's permit.

(5) “Applicant” means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage which is not individually underwritten.

(6) “Consumer report” means any written, oral or other communication of information bearing on a natural person's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living which is used or expected to be used in connection with an insurance transaction.

(7) “Consumer reporting agency” means a person who:

(a) Regularly engages, in whole or in part, in assembling or preparing consumer reports for a monetary fee;

(b) Obtains information primarily from sources other than insurers; and

(c) Furnishes consumer reports to other persons.

(8) “Control” means, and the terms “controlled by” or “under common control with” refer to, the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power of the person is the result of a corporate office held in, or an official position

held with, the controlled person.

(9) “Declination of insurance coverage” means a denial, in whole or in part, by an insurer or agent of requested insurance coverage.

(10) “Individual” means a natural person who:

(a) In the case of life or health insurance, is a past, present or proposed principal insured or certificate holder;

(b) In the case of other kinds of insurance, is a past, present or proposed named insured or certificate holder;

(c) Is a past, present or proposed policyowner;

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

(f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate which is subject to ORS 746.600 to 746.690 and 750.055.

(11) “Institutional source” means a person or governmental entity which provides information about an individual to an insurer, agent or insurance-support organization, other than:

(a) An agent;

(b) The individual who is the subject of the information; or

(c) A natural person acting in a personal capacity rather than in a business or professional capacity.

(12) “Insurance-support organization” means, except as provided in subsection (13) of this section, a person who regularly engages, in whole or in part, in assembling or collecting information about natural persons for the primary purpose of providing the information to an insurer or agent for insurance transactions, including:

(a) The furnishing of consumer reports to an insurer or agent for use in connection with insurance transactions; and

(b) The collection of personal information from insurers, agents or other insurance-support organizations for the purpose of detecting or preventing fraud, material misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(13) “Insurance-support organization” does not include insurers, agents, governmental institutions, medical care institutions or medical professionals.

(14) “Insurance transaction” means any transaction involving insurance primarily for personal, family or household needs rather than business or professional needs and which entails:

(a) The determination of an individual's eligibility for an insurance coverage, benefit or payment; or

(b) The servicing of an insurance application, policy or certificate.

(15) “Insurer,” as defined in ORS 731.106, includes every person engaged in the business of entering into policies of insurance.

(16) “Investigative consumer report” means a consumer report, or portion of a consumer report, for which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning such items of information.

(17) “Medical care institution” means a facility or institution which is licensed to provide health care services to natural persons, and includes but is not limited to health maintenance organizations, home health agencies, hospitals, medical clinics, public health agencies, rehabilitation agencies and skilled nursing facilities.

(18) “Medical professional” means a person licensed or certified to provide health care services to natural persons, and includes but is not limited to chiropractors, clinical dieticians, clinical psychologists, dentists, naturopaths, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, podiatrists, psychiatric social workers and speech therapists.

(19) “Medical record information” means personal information which:

(a) Relates to an individual's physical or mental condition, medical history or medical treatment; and

(b) Is obtained from a medical professional, a medical care institution, the individual, or the individual's spouse, parent or legal guardian.

(20) “Personal information” means information which is identifiable with an individual, which is gathered in connection with an insurance transaction and from which information judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit, health or any other personal characteristics. “Personal information” includes an individual's name and address and “medical record information” but does not include “privileged information” except for privileged information which has been disclosed in violation of ORS 746.665.

(21) “Policyholder” means a person who:

(a) In the case of individual policies of life or health insurance, is a current policyowner;

(b) In the case of individual policies of other kinds of insurance, is currently a named insured; or

(c) In the case of group policies of insurance under which coverage is individually underwritten, is a current certificate holder.

(22) “Pretext interview” means an interview wherein the interviewer, in an attempt to obtain information about a natural person, does one or more of the following:

(a) Pretends to be someone the interviewer is not.

(b) Pretends to represent a person the interviewer is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

(23) “Privileged information” means information which is identifiable with an individual and which:

(a) Relates to a claim for insurance benefits or a civil or criminal proceeding involving the individual; and

(b) Is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving the individual.

(24) “Residual market mechanism” means an association, organization or other entity involved in the insuring of risks under ORS 735.005 to 735.145, 737.312 or other provisions of the Insurance Code relating to insurance applicants who are unable to procure insurance through normal insurance markets.

(25) “Termination of insurance coverage” or “termination of an insurance policy” means either a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure of a premium to be paid as required by the policy. [1981 c.649 s.4; 1987 c.490 s.50]

746.605 Purpose. The purpose of ORS 746.600 to 746.690 and 750.055 is to:

(1) Establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurers, agents or insurance-support organizations;

(2) Maintain a balance between the need for information by those conducting the business of insurance and the public's need for fairness in insurance information practices, including the need to minimize intrusiveness;

(3) Establish a regulatory mechanism to enable natural persons to ascertain what information is being or has been collected about them in connection with insurance transactions and to have access to this information for the purpose of verifying or disputing its accuracy;

(4) Limit the disclosure of information collected in connection with insurance transactions; and

(5) Enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision. [1981 c.649 s.2; 1987 c.490 s.51]

746.610 Application of ORS 746.600 to 746.690 and 750.055. (1) The obligations imposed by ORS 746.600 to 746.690 and 750.055 apply to those insurers, agents and insurance-support organizations which, on or after January 1, 1983:

(a) In the case of life or health insurance:

(A) Collect, receive or maintain information, in connection with insurance transactions, which pertains to natural persons who are residents of this state; or

(B) Engage in insurance transactions with applicants, individuals or policyholders who are residents of this state.

(b) In the case of other kinds of insurance:

(A) Collect, receive or maintain information in connection with insurance transactions involving policies or certificates of insurance delivered, issued for delivery or renewed in this state; or

(B) Engage in insurance transactions involving policies or certificates of insurance delivered, issued for delivery or renewed in this state.

(2) The rights granted by ORS 746.600 to 746.690 and 750.055 extend to:

(a) In the case of life or health insurance, the following persons who are residents of this state:

(A) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions; and

(B) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions.

(b) In the case of other kinds of insurance, the following persons:

(A) Natural persons who are the subject of information collected, received or maintained in connection with insurance transactions involving policies or certificates of insurance delivered, issued for delivery or renewed in this state; and

(B) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions involving

policies or certificates of insurance delivered, issued for delivery or renewed in this state.

(3) For purposes of this section, a person is considered a resident of this state if the person's last-known mailing address, as shown in the records of the insurer, agent or insurance-support organization, is located in this state.

(4) Notwithstanding subsections (1) and (2) of this section, ORS 746.600 to 746.690 and 750.055 do not apply to information collected from the public records of a governmental authority and maintained by an insurer or its representatives for the purpose of insuring the title to real property located in this state. [1981 c.649 s.3; 1987 c.490 s.52]

746.615 Pretext interviews prohibited. No insurer, agent or insurance-support organization shall use or authorize the use of pretext interviews to obtain information in connection with an insurance transaction. However, a pretext interview may be undertaken to obtain information from a person or institution which does not have a generally recognized or statutorily recognized privileged relationship with the person about whom the information relates, for the purpose of investigating a claim where, based upon specific information available for review by the Director of the Department of Consumer and Business Services, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure in connection with the claim. [1981 c.649 s.5]

746.620 Notice of insurance information practices. (1) An insurer or agent shall provide a notice of information practices to all applicants or policyholders in connection with insurance transactions under the circumstances and at the times as follows:

(a) In the case of an application for insurance, a notice shall be provided no later than:

(A) At the time of delivery of the insurance policy or certificate, if personal information is collected only from the applicant or from public records; or

(B) At the time the collection of personal information is initiated, if personal information is collected from a source other than the applicant or public records.

(b) In the case of a policy renewal, a notice shall be provided no later than the policy renewal date, except that no notice shall be required in connection with a policy renewal if:

(A) Personal information is collected only from the policyholder or from public records; or

(B) A notice meeting the requirements of this section has been given within the previous 24 months.

(c) In the case of a policy reinstatement or change in insurance benefits, a notice shall be provided no later than the time a request for the policy reinstatement or change in insurance benefits is received by the insurer, except that no notice shall be required if personal information is collected only from the policyholder or from public records.

(2) The notice required by subsection (1) of this section shall be in writing and shall state:

(a) Whether personal information may be collected from persons other than the individual or individuals proposed for coverage;

(b) The types of personal information which may be collected and the types of sources and investigative techniques which may be used to collect the information;

(c) The types of disclosures identified in ORS 746.665 (1)(b) to (f), (i), (k), (L) and (n) and the circumstances under which these disclosures may be made without prior authorization. However, only those circumstances need be described which occur with such frequency as to indicate a general business practice;

(d) A description of the rights established under ORS 746.640 and 746.645 and the manner in which such rights may be exercised; and

(e) That information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons.

(3) In lieu of the notice prescribed in subsection (2) of this section, the insurer or agent may provide an abbreviated notice informing the applicant or policyholder that:

(a) Personal information may be collected from persons other than the individual or individuals proposed for coverage;

(b) Such information as well as other personal or privileged information subsequently collected by the insurer or agent may in certain circumstances be disclosed to third parties without authorization;

(c) A right of access and correction exists with respect to all personal information collected; and

(d) The notice prescribed in subsection (2) of this section will be furnished to the applicant or policyholder upon request.

(4) The obligations imposed by this section upon an insurer or agent may be satisfied by another insurer or agent authorized to act on behalf of the first insurer or agent. [1981 c.649 s.6]

746.625 Marketing and research surveys. An insurer or agent shall clearly so identify those questions which are designed to obtain information solely for marketing or research purposes from an individual in connection with an insurance transaction. [1981 c.649 s.7]

746.630 Content of disclosure authorization forms. (1) Notwithstanding any other law of this state, no insurer, agent or insurance-support organization may utilize as its disclosure authorization form in connection with insurance transactions a form or statement which authorizes the disclosure of personal or privileged information about an individual to the insurer, agent or insurance-support organization unless the form or statement:

(a) Is written in plain language;

(b) Is dated;

(c) Specifies the types of persons authorized to disclose information about the individual;

(d) Specifies the nature of the information authorized to be disclosed;

(e) Names the insurer or agent and identifies by generic reference the representatives of the insurer to whom the individual is authorizing information to be disclosed;

(f) Specifies the purposes for which the information is collected;

(g) Specifies the length of time such authorization will remain valid, which shall be no longer than:

(A) In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement or a request for change in policy benefits:

(i) Thirty months from the date the authorization is signed if the application or request involves life or health insurance; or

(ii) Twelve months from the date the authorization is signed if the application or request involves other kinds of insurance.

(B) In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy:

(i) The term of coverage of the policy and the duration of any claim extending after the term of coverage if the claim is for a health insurance benefit; or

(ii) The duration of the claim if the claim is not for a health insurance benefit; and

(h) Advises the individual or a person authorized to act on behalf of the individual that the individual or the individual's authorized representative is entitled to receive a copy of the authorization form.

(2) A disclosure authorization obtained by an insurer, agent or insurance-support organization from an individual prior to January 1, 1983, shall be considered to be in compliance with this section. [1981 c.649 s.8]

746.635 Investigative consumer reports. (1) No insurer, agent or insurance-support organization may prepare or request an investigative consumer report about an individual in connection with an insurance transaction involving an application for insurance, a policy renewal, a policy reinstatement or a change in insurance benefits unless the insurer or agent informs the individual:

(a) That the individual may request to be interviewed in connection with the preparation of the investigative consumer report; and

(b) That upon a request pursuant to ORS 746.640, the individual is entitled to receive a copy of the investigative consumer report.

(2) If an investigative consumer report is to be prepared by an insurer or agent, the insurer or agent shall institute reasonable procedures to conduct a personal interview requested by the individual.

(3) If an investigative consumer report is to be prepared by an insurance-support organization, the insurer or agent desiring the report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such requested interviews. [1981 c.649 s.9]

746.640 Access to recorded personal information. (1) If any individual, after proper identification, submits a written request to an insurer, agent or insurance-support organization for access to recorded personal information about the individual which is reasonably described by the individual and reasonably locatable and retrievable by the insurer, agent or insurance-support organization, the insurer, agent or insurance-support organization within 30 business days from the date the request is received shall:

(a) Inform the individual of the nature and substance of the recorded personal information in writing, by telephone

or by other oral communication, whichever the insurer, agent or insurance-support organization prefers;

(b) Permit the individual to see and copy, in person, the recorded personal information or to obtain a copy of the recorded personal information by mail, whichever the individual prefers, unless the recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;

(c) Disclose to the individual the identity, if recorded, of the persons to whom the insurer, agent or insurance-support organization has disclosed the recorded personal information within two years prior to the request, and if such identity is not recorded, the names of the insurers, agents, insurance-support organizations and other persons to whom such information is normally disclosed; and

(d) Provide the individual with a summary of the procedures by which the individual may request correction, amendment or deletion of recorded personal information.

(2) Any personal information provided pursuant to this section shall identify the source of the information if the source is an institutional source.

(3) Medical record information supplied by a medical care institution or medical professional and requested under this section, together with the identity of the medical professional or medical care institution which provided the information, shall be supplied either directly to the individual or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurer, agent or insurance-support organization prefers. If it elects to disclose the information to a medical professional designated by the individual, the insurer, agent or insurance-support organization shall notify the individual, at the time of the disclosure, that it has provided the information to the medical professional.

(4) Except for personal information provided under ORS 746.650, an insurer, agent or insurance-support organization may charge a reasonable fee to cover the costs incurred in providing a copy of recorded personal information to an individual.

(5) The obligations imposed by this section upon an insurer or agent may be satisfied by another insurer or agent authorized to act on its behalf. With respect to the copying and disclosure of recorded personal information pursuant to a request under this section, an insurer, agent or insurance-support organization may make arrangements with an insurance-support organization or a consumer reporting agency to copy and disclose recorded personal information on its behalf.

(6) The rights granted to individuals by this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurer, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or a civil or criminal proceeding involving them.

(7) For purposes of this section, the term “insurance-support organization” does not include “consumer reporting agency.” [1981 c.649 s.10]

746.645 Correction, amendment or deletion of recorded personal information. (1) Within 30 business days from the date of receipt of a written request from an individual to correct, amend or delete any recorded personal information about the individual within its possession, an insurer, agent or insurance-support organization shall either:

(a) Correct, amend or delete the portion of the recorded personal information in dispute; or

(b) Notify the individual of:

(A) Its refusal to make the correction, amendment or deletion;

(B) The reasons for the refusal; and

(C) The individual's right to file a statement as provided in subsection (3) of this section.

(2) If the insurer, agent or insurance-support organization corrects, amends or deletes recorded personal information in accordance with subsection (1) of this section, the insurer, agent or insurance-support organization shall so notify the individual in writing and furnish the correction, amendment or fact of deletion to:

(a) Each person specifically designated by the individual who may have, within the preceding two years, received the recorded personal information;

(b) Each insurance-support organization whose primary source of personal information is insurers, if the insurance-support organization has systematically received recorded personal information from the insurer within the preceding seven years. However, the correction, amendment or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the individual; and

(c) Each insurance-support organization that furnished the recorded personal information that has been corrected, amended or deleted.

(3) Whenever an individual disagrees with an insurer's, agent's or insurance-support organization's refusal to correct, amend or delete recorded personal information, the individual shall be permitted to file with the insurer, agent or insurance-support organization:

(a) A concise statement setting forth what the individual thinks is the correct, relevant or fair information; and

(b) A concise statement of the reasons why the individual disagrees with the insurer's, agent's or insurance-support organization's refusal to correct, amend or delete recorded personal information.

(4) In the event an individual files either or both of the statements described in subsection (3) of this section, the insurer, agent or insurance-support organization shall:

(a) File the statements with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the individual's statements and have access to them;

(b) In any subsequent disclosure by the insurer, agent or insurance-support organization of the recorded personal information that is the subject of the disagreement, clearly identify the matter or matters in dispute and provide the individual's statements along with the recorded personal information being disclosed; and

(c) Furnish the statements to the persons and in the manner specified in subsection (2) of this section.

(5) The rights granted to individuals by this section shall extend to all natural persons to the extent information about them is collected and maintained by an insurer, agent or insurance-support organization in connection with an insurance transaction. The rights granted to all natural persons by this subsection shall not extend to information about them that relates to and is collected in connection with or in reasonable anticipation of a claim or a civil or criminal proceeding involving them.

(6) For purposes of this section, the term “insurance-support organization” does not include “consumer reporting agency.” [1981 c.649 s.11]

746.650 Reasons for adverse underwriting decisions. (1) In the event of an adverse underwriting decision the insurer or agent responsible for the decision shall:

(a) Either provide the applicant, policyholder or individual proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing or advise the person that upon written request the person may receive the specific reason or reasons in writing; and

(b) Provide the applicant, policyholder or individual proposed for coverage with a summary of the rights established under subsection (2) of this section and ORS 746.640 and 746.645.

(2) Upon receipt of a written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision to an applicant, policyholder or individual proposed for coverage, the insurer or agent shall furnish to the person within 21 business days from the date of receipt of the written request:

(a) The specific reason or reasons for the adverse underwriting decision, in writing, if this information was not initially furnished in writing pursuant to subsection (1) of this section;

(b) The specific items of personal information and privileged information that support these reasons, subject, however, to the following:

(A) The insurer or agent shall not be required to furnish specific items of privileged information if it has a reasonable suspicion, based upon specific information available for review by the Director of the Department of Consumer and Business Services, that the applicant, policyholder or individual proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure.

(B) Specific items of medical record information supplied by a medical care institution or medical professional shall be disclosed either directly to the individual about whom the information relates or to a medical professional designated by the individual and licensed to provide medical care with respect to the condition to which the information relates, whichever the insurer or agent prefers; and

(c) The names and addresses of the institutional sources which supplied the specific items of information described in paragraph (b) of this subsection. However, the identity of any medical care institution or medical professional shall be disclosed either directly to the individual or to the designated medical professional, whichever the insurer or agent prefers.

(3) The obligations imposed by this section upon an insurer or agent may be satisfied by another insurer or agent authorized to act on its behalf.

(4) When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by subsection (1) of this section may be given orally. [1981 c.649 s.12]

746.655 Information concerning previous adverse underwriting decisions. No insurer, agent or insurance-

support organization may seek information in connection with an insurance transaction concerning any previous adverse underwriting decision experienced by an individual, or any previous insurance coverage obtained by an individual through a residual market mechanism, unless the inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism. [1981 c.649 s.13]

746.660 Basing adverse underwriting decision on previous adverse decision. No insurer or agent may base an adverse underwriting decision in whole or in part on:

(1) The fact of a previous adverse underwriting decision or on the fact that an individual previously obtained insurance coverage through a residual market mechanism. However, an insurer or agent may base an adverse underwriting decision on further information obtained from an insurer or agent responsible for a previous adverse underwriting decision.

(2) Personal information received from an insurance-support organization whose primary source of information is insurers. However, an insurer or agent may base an adverse underwriting decision on further personal information obtained as the result of information received from such an insurance-support organization. [1981 c.649 s.14]

746.665 Limitations and conditions on disclosure of certain information. (1) An insurer, agent or insurance-support organization shall not disclose any personal or privileged information about an individual collected or received in connection with an insurance transaction unless the disclosure meets one or more of the following conditions:

(a) Is with the written authorization of the individual, and:

(A) If the authorization is submitted by another insurer, agent or insurance-support organization, the authorization meets the requirements of ORS 746.630; or

(B) If the authorization is submitted by a person other than an insurer, agent or insurance-support organization, the authorization is:

(i) Dated;

(ii) Signed by the individual; and

(iii) Obtained one year or less prior to the date a disclosure is sought pursuant to this subsection.

(b) Is to a person other than an insurer, agent or insurance-support organization, if the disclosure is reasonably necessary to enable the person to:

(A) Perform a business, professional or insurance function for the disclosing insurer, agent or insurance-support organization and the person agrees not to disclose the information further without the individual's written authorization unless the further disclosure:

(i) Would otherwise be permitted by this section if made by an insurer, agent, or insurance-support organization; or

(ii) Is reasonably necessary for the person to perform its function for the disclosing insurer, agent or insurance-support organization; or

(B) Provide information to the disclosing insurer, agent or insurance-support organization for the purpose of:

(i) Determining an individual's eligibility for an insurance benefit or payment; or

(ii) Detecting or preventing criminal activity, fraud, material misrepresentation or material nondisclosure in connection with an insurance transaction.

(c) Is to an insurer, agent, insurance-support organization or self-insurer, if the information disclosed is limited to that which is reasonably necessary:

(A) To detect or prevent criminal activity, fraud, material misrepresentation or material nondisclosure in connection with insurance transactions; or

(B) For either the disclosing or receiving insurer, agent or insurance-support organization to perform its function in connection with an insurance transaction involving the individual.

(d) Is to a medical care institution or medical professional and discloses only such information as is reasonably necessary to accomplish one or more of the following purposes:

(A) Verifying insurance coverage or benefits.

(B) Informing an individual of a medical problem of which the individual may not be aware.

(C) Conducting an operations or services audit.

(e) Is to an insurance regulatory authority.

(f) Is to a law enforcement or other governmental authority:

(A) To protect the interests of the insurer, agent or insurance-support organization in preventing or prosecuting the perpetration of fraud upon it; or

(B) If the insurer, agent or insurance-support organization reasonably believes that illegal activities have been conducted by the individual.

(g) Is otherwise permitted or required by law.

(h) Is in response to a facially valid administrative or judicial order, including a search warrant or subpoena.

(i) Is made for the purpose of conducting actuarial or research studies, if:

(A) No individual may be identified in any resulting actuarial or research report;

(B) Materials allowing the individual to be identified are returned or destroyed as soon as they are no longer needed; and

(C) The actuarial or research organization agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurer, agent or insurance-support organization.

(j) Is to a party or a representative of a party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer, agent or insurance-support organization, if:

(A) Prior to the consummation of the sale, transfer, merger or consolidation only such information is disclosed as is reasonably necessary to enable the recipient to make business decisions about the purchase, transfer, merger or consolidation; and

(B) The recipient agrees not to disclose the information unless the disclosure would otherwise be permitted by this section if made by an insurer, agent or insurance-support organization.

(k) Is to a person whose only use of the information will be in connection with the marketing of a product or service, if:

(A) No medical record information, privileged information or personal information relating to an individual's character, personal habits, mode of living or general reputation is disclosed, and no classification derived from such information is disclosed;

(B) The individual has been given an opportunity to indicate that the individual does not want personal information disclosed for marketing purposes and has given no indication that the individual does not want the information disclosed; and

(C) The person receiving the information agrees not to use it except in connection with the marketing of a product or service.

(L) Is to an affiliate whose only use of the information will be in connection with an audit of the insurer or agent or the marketing of an insurance product or service, and the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons.

(m) Is by a consumer reporting agency, and the disclosure is to a person other than an insurer or agent.

(n) Is to a group policyholder for the purpose of reporting claims experience or conducting an audit of the insurer's or agent's operations or services, and the information disclosed is reasonably necessary for the group policyholder to conduct the review or audit.

(o) Is to a professional peer review organization for the purpose of reviewing the service or conduct of a medical care institution or medical professional.

(p) Is to a governmental authority for the purpose of determining the individual's eligibility for health benefits for which the governmental authority may be liable.

(q) Is to a policyholder or certificate holder for the purpose of providing information regarding the status of an insurance transaction.

(2) Personal or privileged information may be acquired by a group practice prepayment health care service contractor from providers which contract with the contractor and may be transferred among providers which contract with the contractor for the purpose of administering plans offered by the contractor. The information may not be disclosed otherwise by the contractor except in accordance with ORS 746.600 to 746.690 and 750.055. [1981 c.649 s.15; 1987 c.490 s.53]

746.670 Investigatory powers. (1) The Director of the Department of Consumer and Business Services shall have the power to examine and investigate into the affairs of any insurer or agent transacting insurance in this state to determine whether it has been or is engaged in any conduct in violation of ORS 746.600 to 746.690 and 750.055.

(2) The director shall have the power to examine and investigate into the affairs of any insurance-support organization acting on behalf of an insurer or agent which either transacts insurance in this state or transacts insurance outside this state which has an effect on a person residing in this state, in order to determine whether the insurance-support organization has been or is engaged in any conduct in violation of ORS 746.600 to 746.690 and 750.055. [1981 c.649 s.16; 1987 c.490 s.54]

746.675 Service of process on out-of-state insurance-support organizations. For the purpose of ORS 746.600 to 746.690 and 750.055, an insurance-support organization transacting business outside this state which has an effect on a person residing in this state shall be considered to have appointed the Director of the Department of Consumer and Business Services to accept service of process on its behalf. Notice of such service shall be given forthwith by the director as provided for orders and notices under ORS 731.248 (3). [1981 c.649 s.17; 1987 c.490 s.55]

746.680 Remedies. (1) If any insurer, agent or insurance-support organization fails to comply with ORS 746.640, 746.645 or 746.650, any person whose rights granted under those sections are violated may apply to the circuit court for the county in which the person resides, or any other court of competent jurisdiction, for appropriate equitable relief.

(2) An insurer, agent or insurance-support organization which discloses information in violation of ORS 746.665 shall be liable for damages sustained by the individual about whom the information relates. However, no individual shall be entitled to a monetary award which exceeds the actual damages sustained by the individual as a result of the violation of ORS 746.665.

(3) In any action brought pursuant to this section, the court may award the cost of the action and reasonable attorney fees to the prevailing party.

(4) An action under this section must be brought within two years from the date the alleged violation is or should have been discovered.

(5) Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of ORS 746.600 to 746.690 and 750.055. [1981 c.649 s.18; 1987 c.490 s.56; 1995 c.618 s.131]

746.685 Liability for disclosure of information. No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with ORS 746.600 to 746.690 and 750.055, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurer, agent or insurance-support organization. However, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person. [1981 c.649 s.19; 1987 c.490 s.57]

746.690 Obtaining information under false pretenses prohibited. No person shall knowingly and willfully obtain information about an individual from an insurer, agent or insurance-support organization under false pretenses. [1981 c.649 s.20]

PENALTIES

746.990 [Repealed by 1967 c.359 s.704]

746.991 Penalties. Violation of ORS 746.280 to 746.292 is a Class D violation. [1977 c.785 s.8; 1999 c.1051 s.221]

Note: See note under 746.275.