Chapter 742

2007 EDITION

Insurance Policies Generally; Property and Casualty Policies

MORTGAGE INSURANCE

SURETY INSURANCE

REIMBURSEMENT INSURANCE FOR SERVICE CONTRACTS

MEDICAL MALPRACTICE INSURANCE

DISCOUNT MEDICAL PLANS

MOTOR VEHICLE LIABILITY INSURANCE

(Issuance of Insurance Card)

(Generally)

(Age-Based Discount)

(Uninsured Motorist Coverage)

(Personal Injury Protection Benefits)

GENERAL PROVISIONS

742.001 Scope of ORS chapters 742, 743 and 743A. This chapter and ORS chapters 743 and 743A apply to all insurance policies delivered or issued for delivery in this state except:

(1) Reinsurance.

(2) Wet marine and transportation insurance policies.

(3) Surplus lines insurance policies. [Formerly 743.003; 2005 c.185 §14]

742.003 Filing and approval of policy forms; rules. (1) Except where otherwise provided by law, no basic policy form, or application form where written application is required and is to be made a part of the policy, or rider, indorsement or renewal certificate form shall be delivered or issued for delivery in this state until the form has been filed with and approved by the Director of the Department of Consumer and Business Services. This section does not apply to:

(a) Forms of unique character which are designed for and used with respect to insurance upon a particular risk or subject;

(b) Forms issued at the request of a particular life or health insurance policy owner or certificate holder and which relate to the manner of distribution of benefits or to the reservation of rights and benefits thereunder;

(c) Forms of group life or health insurance policies, or both, that have been agreed upon as a result of negotiations between the policyholder and the insurer; or

(d) Forms complying with specific requirements regarding delivery or issuance for delivery in this state established by the director by rule.

(2) The director shall within 30 days after the filing of any such form approve or disapprove the form. The director shall give written notice of such action to the insurer proposing to deliver such form and when a form is disapproved the notice shall show wherein such form does not comply with the law.

(3) The 30-day period referred to in subsection (2) of this section may be extended by the director for an additional period not to exceed 30 days if the director gives written notice within the first 30-day period to the insurer proposing to deliver the form that the director needs such additional time for the consideration of such form.

(4) The director may at any time request an insurer to furnish the director a copy of any form exempted under subsection (1) of this section. [Formerly 736.300 and then 743.006; 2001 c.943 §7]

Note: Sections 1, 3 and 4, chapter 544, Oregon Laws 2007, provide:

Sec. 1. (1) Notwithstanding any other provision of law, the Director of the Department of Consumer and Business Services by rule may specify categories of life insurance, annuities or disability insurance for which the director need not consider or review an individual policy form that an insurer has filed before approving the form for delivery or issuance for delivery in this state. Policy forms that the Interstate Insurance Product Regulation Commission has approved are subject to approval in the manner specified in this section if the director finds that the commission's approval process, taken as a whole, gives policyholders substantially the same protection as or better protections than the approval process available under the laws of this state, when considered in light of:

(a) The product standards and review procedures the commission uses;

(b) The nature of the insurance product reviewed; and

(c) The consumer needs that the insurance product serves.

(2) Nothing in this section affects the director's power to withdraw approval of any policy form under ORS 742.007 or to regulate the marketing and use of any approved policy form under the laws of this state. [2007 c.544 §1]

Sec. 3. The Director of the Department of Consumer and Business Services shall report the director's findings under section 1 of this 2007 Act to the Seventy-fifth Legislative Assembly by January 31, 2009, and to the Seventy-sixth Legislative Assembly by January 31, 2011, in the manner provided in ORS 192.245. In the report the director shall evaluate the extent to which the Interstate Insurance Product Regulation Commission approval process gives policyholders substantially the same protection as or better protection than would approval under the laws of this state. [2007 c.544 §3]

Sec. 4. Section 1 of this 2007 Act is repealed on January 2, 2012. [2007 c.544 §4]

742.005 Grounds for disapproval of policy forms. The Director of the Department of Consumer and Business Services shall disapprove any form requiring the director's approval:

(1) If the director finds it does not comply with the law;

(2) If the director finds it contains any provision, including statement of premium, or has any label, description of its contents, title, heading, backing or other indication of its provisions, which is unintelligible, uncertain, ambiguous or abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued;

(3) If, in the director's judgment, its use would be prejudicial to the interests of the insurer's policyholders;

(4) If the director finds it contains provisions which are unjust, unfair or inequitable;

(5) If the director finds sales presentation material disapproved by the director pursuant to ORS 742.009 is being used with respect to the form; or

(6) If, with respect to any of the following forms, the director finds the benefits pro-

vided therein are not reasonable in relation to the premium charged:

(a) Individual health insurance policy forms, including benefit certificates issued by fraternal benefit societies and individual policies issued by health care service contractors, but excluding policies referred to in ORS 743.402 as exempt from the application of ORS 743.405 to 743.498, 743A.160 and 743A.164;

(b) Small employer group health benefit plan forms for small employers as that term is defined in ORS 743.730, including small employer group policies issued by health care service contractors; or

(c) Credit life and credit health insurance forms subject to ORS 743.371 to 743.380. [Formerly 743.009; 1991 c.182 §1; 1999 c.987 §4]

742.007 Director's withdrawal of approval. (1) The Director of the Department of Consumer and Business Services may, at any time after a hearing held not less than 20 days after written notice to the insurer, withdraw the director's approval of any form on any ground set forth in ORS 742.005. The written notice of such hearing shall state the reason for the proposed withdrawal.

(2) When the director notifies an insurer of a hearing on a form under subsection (1) of this section, if the director in the director's own discretion determines that the public may suffer serious injury because of continued use of the form, the director also may order the insurer to suspend delivery of the form in this state until the director has decided whether to withdraw approval of the form.

(3) No insurer shall deliver in this state:

(a) A form subject to an order of suspension under subsection (2) of this section, after the effective date of the order and until the director withdraws the order.

(b) A form for which the director has withdrawn approval, after the effective date of such withdrawal. The effective date of withdrawal shall be as the director may prescribe but not less than 30 days after the giving of notice of withdrawal. [Formerly 743.012]

742.009 Regulation of sales material; rules. (1) The Director of the Department of Consumer and Business Services, if the director considers it necessary, may require the filing by an insurer or insurance producer of any sales presentation material for use in the sale or the presentation for sale of any policy. The director, within 60 days after the filing of the sales presentation material, shall disapprove any such sales presentation material if the director finds that, in whole or in part, it is false, deceptive or misleading. Upon disapproval, such sales presentation material shall not be made, issued, circulated, displayed or given other use by the insurer or by insurance producers.

(2) The director, by rule, shall require any insurance producer who sells or attempts to sell insurance to provide to each prospective insured such information as the director considers necessary to adequately inform the prospective insured regarding the insurance transaction. [Formerly 743.021; 2003 c.364 §100]

742.010 [Amended by 1953 c.718 §3; 1959 c.281 §1; 1965 c.611 §2; 1967 c.359 §654; renumbered 750.005]

742.011 Insurable interest in property. No policy of insurance of property or of any interest in property or arising from property shall be enforceable as to the insurance except for the benefit of persons having an insurable interest in the things insured as at the time of the loss. [Formerly 743.033]

742.013 Representations in applications. (1) All statements and descriptions in any application for an insurance policy by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealments of facts and incorrect statements shall not prevent a recovery under the policy unless the misrepresentations, omissions, concealments of fact and incorrect statements:

(a) Are contained in a written application for the insurance policy, and a copy of the application is indorsed upon or attached to the insurance policy when issued;

(b) Are shown by the insurer to be material, and the insurer also shows reliance thereon; and

(c) Are either:

(A) Fraudulent; or

(B) Material either to the acceptance of the risk or to the hazard assumed by the insurer.

(2) This section does not apply to surety insurance. [Formerly 743.042]

742.015 [1965 c.611 §3; 1967 c.359 §655; renumbered 750.015]

742.016 Policy constitutes entire contract; oral representations by insured. (1) Except as provided in ORS 742.043, every contract of insurance shall be construed according to the terms and conditions of the policy. When the contract is made pursuant to a written application therefor, if the insurer delivers a copy of such application with the policy to the insured, thereupon such application shall become a part of the insurance policy. Any application that is not so delivered to the insured shall not be a part of the insurance policy and the insurer shall be precluded from introducing such application as evidence in any action based upon or involving the policy. Any oral re-

presentations by the insured that are not included in an application shall not be a part of the insurance policy and the insurer shall be precluded from introducing such representations as evidence in any action based upon or involving the policy.

(2) If any life or health insurance policy is reinstated or renewed, and the insured or assignee or beneficiary with a vested interest under such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within 30 days after the receipt at its home or branch office of such request and of satisfactory evidence of such requesting beneficiary's vested interest, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving such policy or its reinstatement or renewal.

(3) This section does not apply to surety insurance. [Formerly 736.305 and then 743.045]

742.018 Provision for construction according to foreign law prohibited. No policy of insurance shall contain any condition, stipulation or agreement requiring such policy to be construed according to the laws of any other state or country. Any such condition, stipulation or agreement shall be invalid. [Formerly 736.315 and then 743.048]

742.020 [Amended by 1965 c.611 §4; repealed by 1967 c.359 §704]

742.021 Standard provisions in general. (1) Insurance policies shall contain such standard or uniform provisions as are required by the applicable provisions of the Insurance Code. However, the insurer may at its option substitute for one or more of such provisions corresponding provisions of different wording approved by the Director of the Department of Consumer and Business Services which are in each instance not less favorable in any respect to the insured or the beneficiary.

(2) If any standard or uniform provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the director, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of a provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(3) Except as provided in subsection (2) of this section, no policy shall contain any provision inconsistent with or contradictory to any standard or uniform provision used or required to be used. [Formerly 743.051]

742.023 Contents of policies in general. (1) Every policy shall specify:

(a) The names of the parties to the contract.

(b) The subject of the insurance.

(c) The hazards or perils insured against.

(d) The time when the insurance thereunder takes effect and the period during which the insurance is to continue.

(e) The premium.

(f) The conditions and provisions pertaining to the insurance.

(2) If under the policy the exact amount of premium is determinable only at stated intervals or termination of the contract, a statement of the basis and rates upon which the premium is to be determined and paid shall be included.

(3) This section does not apply to surety insurance policies, or to group life or health insurance policies. [Formerly 743.054]

742.025 [1965 c.611 §5; 1967 c.359 §656; renumbered 750.025]

742.026 Underwriters' and combination policies. (1) Two or more authorized insurers may jointly issue, and shall be jointly and severally liable on, an underwriters' policy bearing their names. Any one insurer may issue policies in the name of an underwriter's department and such policy shall plainly show the true name of the insurer.

(2) Two or more insurers may, with the approval of the Director of the Department of Consumer and Business Services, issue a combination policy which shall contain provisions substantially as follows:

(a) That the insurers executing the policy shall be severally liable for the full amount of any loss or damage, according to the terms of the policy, or for specified percentages or amounts thereof, aggregating the full amount of insurance under the policy, and

(b) That service of process, or of any notice or proof of loss required by such policy, upon any of the insurers executing the policy, shall constitute service upon all such insurers.

(3) This section does not apply to cosurety obligations. [Formerly 743.057]

742.028 Additional policy contents. A policy may contain additional provisions not inconsistent with the Insurance Code and which are:

(1) Required to be inserted by the laws of the insurer's domicile;

(2) Necessary, on account of the manner in which the insurer is constituted or operated, in order to state the rights and obligations of the parties to the contract; or

(3) Desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included therein. [Formerly 743.060]

742.030 [Repealed by 1967 c.359 §704]

742.031 Bankruptcy clause required in certain liability policies. A policy of insurance against loss or damage resulting from accident to or injury suffered by an employee or other person and for which the person insured is liable, or against loss or damage to property caused by horses or by any vehicle drawn, propelled or operated by any motive power, and for which loss or damage the person insured is liable, shall contain within such policy a provision substantially as follows: "Bankruptcy or insolvency of the insured shall not relieve the insurer of any of its obligations hereunder. If any person or legal representative of the person shall obtain final judgment against the insured because of any such injuries, and execution thereon is returned unsatisfied by reason of bankruptcy, insolvency or any other cause, or if such judgment is not satisfied within 30 days after it is rendered, then such person or legal representatives of the person may proceed against the insurer to recover the amount of such judgment, either at law or in equity, but not exceeding the limit of this policy applicable thereto." [Formerly 743.783 and then 743.772]

742.033 Charter and bylaw provisions. No policy shall contain any provision purporting to make any portion of the charter, bylaws or other constituent document of the insurer (other than the subscriber's agreement or power of attorney of a reciprocal insurer) a part of the contract unless such portion is set forth in full in the policy. Any policy provision in violation of this section shall be invalid. [Formerly 743.063]

742.035 [1965 c.611 §19; 1967 c.359 §657; renumbered 750.035]

742.036 Assessment policies, special contents. Every policy issued on the assessment plan, and the form of any application for such a policy to be signed by the applicant, shall have conspicuously printed near the top of the face thereof in boldfaced type of a size not smaller than used for any caption in the policy or application, as applicable, the words "The policyholder is subject to assessment by the company" or such other words as the Director of the Department of Consumer and Business Services may require. [Formerly 743.066]

742.038 Validity and construction of noncomplying forms. (1) A policy in violation of the Insurance Code, but otherwise binding on the insurer, shall be held valid, but shall be construed as provided in the Insurance Code.

(2) Any insurance policy issued and otherwise valid which contains any condition, omission or provision not in compliance with the Insurance Code, shall not be thereby rendered invalid but shall be construed and applied in accordance with such conditions and provisions as would have applied had such policy been in full compliance with the Insurance Code. [Formerly 743.069]

742.040 [Amended by 1965 c.611 §6; repealed by 1967 c.359 §704]

742.041 Permissible classes of insurance in one policy. (1) Except as provided in this section, when more than one class of insurance as defined in ORS 731.150 to 731.194 is effected by an insurer each class shall be written in a separate and distinct policy. Any such policy may be canceled, surrendered or otherwise terminated without affecting other premiums paid or policies held by the same insured.

(2) Except as provided in this section, the same policy shall not include insurance coverages as to which the liability of the insurer for unearned premiums or the reserve for unpaid, deferred or undetermined loss claims is estimated in a different manner.

(3) Insurance in one policy may be effected upon automobiles and vehicles, and the accessories and other property transported upon and used in connection therewith, against loss or damage by fire, collision and explosion, and against loss by legal liability for damage to persons or property, or both, resulting from the maintenance, use or operation of such automobiles or vehicles, and against loss by burglary, embezzlement or theft, or any one or more of them. Premiums and losses for such insurance are to be reported to the Director of the Department of Consumer and Business Services under the title "automobile insurance." For this purpose an insurer need not use the standard fire insurance policy required by ORS 742.202.

(4) Insurance in one policy may be effected against loss or damage of property and against personal injury and death, and liability therefor, from explosion of steam boilers, tanks and engines, pipes and machinery connected therewith, and breakage of flywheels and machinery. Premiums and losses for such insurance are to be reported to the director under the title "steam boiler insurance."

(5) Insurance under the classes of life and health insurance may be effected in one policy.

(6) Insurance in one policy effected against any physical loss or damage occurring to properties may include coverage as to other perils, either on an unspecified basis as to coverage or for a single premium.

(7) Insurance in one policy effected against loss or destruction of baggage while traveling which is written on a single premium nonrenewable basis may include travel ticket health insurance benefits.

(8) Insurance under more than one class of insurance may be effected in one policy if the director finds that the issuance of the policy is in the best interest of the public. [Formerly 736.310 and then 743.072; 2005 c.185 §2]

742.043 Binders. (1) Binders or other contracts for temporary insurance may be made orally or in writing, and shall be deemed to include all the usual terms of the policy as to which the binder was given together with such applicable indorsements as are designated in the binder, except as superseded by the clear and express terms of the binder.

(2) Except as provided in subsection (3) of this section and ORS 746.195, within 90 days after issue of a binder a policy shall be issued in lieu thereof, including within its terms the identical insurance bound under the binder and the premium therefor.

(3) If the policy has not been issued a binder may be extended or renewed beyond such 90 days with the written approval of the Director of the Department of Consumer and Business Services, or in accordance with such rules relative thereto as the director may promulgate.

(4) This section does not apply to life or health insurance. [Formerly 743.075]

742.045 [1953 c.605 §3; 1965 c.611 §7; repealed by 1967 c.359 §704]

742.046 Delivery of policy. (1) Subject to the insurer's requirements as to payment of premium, every policy shall be mailed or delivered to the insured or to the person entitled thereto within a reasonable period of time after its issuance except where a condition required by the insurer has not been met by the insured.

(2) In the event the original policy is delivered or is so required to be delivered to or for deposit with any vendor, mortgagee, or pledgee of any motor vehicle, and in which policy any interest of the vendee, mortgagor, or pledgor in or with reference to such vehicle is insured, a duplicate of such policy setting forth the name and address of the insurer, insurance classification of vehicle, type of coverage, limits of liability, premiums for the respective coverages, and duration of the policy, or memorandum thereof containing the same such information, shall be delivered by the vendor, mortgagee, or pledgee to each such vendee, mortgagor, or pledgor named in the policy or coming within the group of persons designated in the policy to be so included. If the policy does not provide coverage of legal liability for injury to persons or damage to the property of third parties, a statement of such fact shall be printed, written, or stamped conspicuously on the face of such duplicate policy or memorandum. This subsection does not apply to inland marine floater policies. [Formerly 743.078]

742.048 Effective date and time of coverage; applicability. (1) Except as provided in subsections (2), (4) and (5) of this section, every policy of insurance shall contain a provision stating that coverage commences at 12:01 a.m. of the date upon which the insurance takes effect.

(2) A policy of insurance may provide that the time at which coverage commences shall not be prior to the time at which the policy of insurance is applied for.

(3) Any statement of time in a policy shall mean time according to the legal standard of time in effect:

(a) If the policy insures real property, at the location of such property; or

(b) If the policy does not insure real property, at the principal place of business within Oregon of the insured; or, if the insured has no place of business within Oregon, at the residence within Oregon of the insured.

(4) A binder or other contract for temporary insurance may commence coverage at an hour different from 12:01 a.m. in order to provide coverage from the agreed hour of commencement of coverage to 12:01 a.m. of the date on which the written policy as to which such binder or other contract was issued takes effect.

(5) This section does not apply to life, health, mortgage, title, surety or wet marine and transportation insurance. [Formerly 743.080]

742.050 [Amended by 1955 c.372 §1; 1957 c.4 §1; 1965 c.611 §8; 1967 c.359 §658; renumbered 750.045]

742.051 Renewal by certificate. Any insurance policy terminating by its terms at a specified expiration date and not otherwise renewable, may be renewed or extended at the option of the insurer, if renewed or extended upon a currently authorized policy form at the premium rate then required therefor, for a specific additional period or periods by certificate or by indorsement of the policy, without requiring the issuance of a new policy. [Formerly 743.081]

742.053 Forms for proof of loss. (1) An insurer shall furnish, upon written request of any person claiming to have a loss under an insurance policy issued by such insurer, forms of proof of loss for completion by such person, but such insurer shall not, by reason of the requirement so to furnish forms, have any responsibility for or with reference to the completion of such proof or the manner of any such completion or attempted completion.

(2) With respect to fire insurance, an insured shall have 90 days after receipt of proof of loss forms to furnish proof of loss, notwithstanding anything more restrictive contained in the policy. [Formerly 743.093]

742.055 [1955 c.236 §1; 1965 c.611 §9; repealed by 1967 c.359 §704]

742.056 Certain conduct not deemed waiver. Without limitation of any right or defense of an insurer otherwise, none of the following acts by or on behalf of an insurer shall be deemed to constitute a waiver of or estoppel to assert any provision of a policy or of any defense of the insurer thereunder:

(1) Acknowledgment of the receipt of notice of loss or claim under the policy.

(2) Furnishing forms for reporting a loss or claim, for giving information relative thereto, or for making proof of loss, or receiving or acknowledging receipt of any such forms or proofs completed or uncompleted.

(3) Investigating any loss or claim under the policy or engaging in negotiations looking toward a possible settlement of any such loss or claim. [Formerly 743.096]

742.058 Return of premium on destruction of property. (1) In the event of the total destruction of any insured property, if the total amount of loss or agreed loss is less than the total amount insured thereon, the insurer or insurers shall return to the insured the portion of insurance premium paid for the excess of the insurance over the loss. This amount shall be paid at the same time and in the same manner as the loss.

(2) This section does not apply to insurance on stocks of merchandise or property of fluctuating values where the reduced rate percentage clause is made a part of the policy. [Formerly 744.090 and then 743.111]

742.060 [Amended by 1965 c.611 §10; repealed by 1967 c.359 §704]

742.061 Recovery of attorney fees in action on policy or contractor's bond. (1) Except as otherwise provided in subsections (2) and (3) of this section, if settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought in any court of this state upon any policy of insurance of any kind or nature, and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the costs of the action and any appeal thereon. If the action is brought upon the bond of a contractor or subcontractor executed and delivered as provided in ORS 279B.055, 279B.060, 279C.380 or 701.430 and the plaintiff's recovery does not exceed the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed and allowed to the defendant as part of the costs of the action and any appeal thereon. If in an action brought upon such a bond the surety is allowed attorney fees and costs and the contractor or subcontractor has incurred expenses for attorney fees and costs in defending the action, the attorney fees and costs allowed the surety shall be applied first to reimbursing the contractor or subcontractor for such expenses.

(2) Subsection (1) of this section does not apply to actions to recover personal injury protection benefits if, in writing, not later than six months from the date proof of loss is filed with the insurer:

(a) The insurer has accepted coverage and the only issue is the amount of benefits due the insured; and

(b) The insurer has consented to submit the case to binding arbitration.

(3) Subsection (1) of this section does not apply to actions to recover uninsured or underinsured motorist benefits if, in writing, not later than six months from the date proof of loss is filed with the insurer:

(a) The insurer has accepted coverage and the only issues are the liability of the uninsured or underinsured motorist and the damages due the insured; and

(b) The insurer has consented to submit the case to binding arbitration. [Formerly 736.325 and then 743.114; 1999 c.790 §1; 2003 c.794 §328]

742.063 Filing and approval of liability form that includes cost of defense within limits of liability. (1) A liability insurance form that provides that the cost of defending a claim is included within the stated limits of liability may not be delivered or issued for delivery in this state until the form has been filed with and approved by the Director of the Department of Consumer and Business Services. In determining whether to approve or disapprove a form filed under this section, the director shall consider, in addition to the factors specified in ORS 742.005, the circumstances and insurance needs of the proposed insureds.

(2) A liability insurance form filed under this section may not be approved unless the form contains a statement approved by the

director disclosing that the costs of defending a claim under the policy are included in the policy limits. [Formerly 743.115]

742.065 Insurance against risk of loss assumed under less than fully insured employee health benefit plan. (1) Insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan, whether issued or delivered as health or casualty insurance, is subject to the following:

(a) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members or participants;

(b) Payment by the insurer must be made to the employer, to the trustee or other sponsor of the plan, or to the plan itself, but not to the employees, members, participants or health care providers;

(c) If the policy establishes an aggregate attaching point or retention, the point or retention must not be less than 120 percent of the expected claims; and

(d) If the policy establishes an attaching point or retention applicable to each individual covered by the plan, the point or retention must not be less than $10,000.

(2) Insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan, whether issued or delivered as health or casualty insurance, is subject to this section and to ORS 743.523, 743.524 and 743.526, but is otherwise not subject to provisions of ORS chapters 743 and 743A.

(3) An insurer shall not issue or deliver to a small employer, as defined in ORS 743.730, a policy of insurance against the risk of economic loss assumed under a less than fully insured employee health benefit plan. [1993 c.649 §2; 1995 c.506 §13]

742.070 [Amended by 1955 c.372 §2; 1965 c.611 §11; repealed by 1967 c.359 §704]

742.080 [1953 c.605 §3; 1965 c.611 §12; repealed by 1967 c.359 §704]

742.090 [1965 c.611 §13; repealed by 1967 c.359 §704]

742.100 [1965 c.611 §7a; repealed by 1967 c.359 §704]

742.110 [1965 c.35 §4; repealed by 1967 c.359 §704]

742.120 [1965 c.573 §5; repealed by 1967 c.359 §704]

ASSUMPTION REINSURANCE AGREEMENTS

742.150 Approval by director; limitations on authority of insurer; definition. (1) A domestic insurer shall not enter a transaction in which the domestic insurer assumes or transfers obligations or risks on policies under an assumption reinsurance agreement as defined in this section, unless the Director of the Department of Consumer and Business Services first approves the transaction. A domestic insurer must submit with its request for approval a proposed notice of transfer required in ORS 742.156.

(2) A domestic insurer shall not assume obligations or risks on policies issued to or owned by policyholders residing in any other state unless it is authorized or licensed in the other state to transact insurance or unless the insurance regulatory official of that state has approved the assumption.

(3) An authorized insurer shall not transfer obligations or risks on policies issued to or owned by residents of this state to any unauthorized insurer.

(4) If each authorized foreign insurer entering an assumption reinsurance agreement that transfers the obligations or risks on policies issued to or owned by residents of this state is domiciled in a state that imposes requirements on an assumption reinsurance agreement that are substantially similar to requirements of this state, then when each such insurer enters the agreement, the insurer shall file or cause to be filed with the director the following:

(a) The assumption certificate.

(b) A copy of the notice of transfer required to be sent to policyholders.

(c) An affidavit that the transaction is subject to substantially similar requirements in the state or states of domicile of both the transferring and assuming insurers.

(5) If any authorized foreign insurer entering an assumption reinsurance agreement that transfers the obligations or risks on policies issued to or owned by residents of this state is domiciled in a state that does not impose requirements on an assumption reinsurance agreement that are substantially similar to requirements of this state, each insurer entering into the agreement shall obtain prior approval of the director and is otherwise subject to all other requirements of ORS 742.156 and 742.158 with respect to residents of this state.

(6) For purposes of this section, "assumption reinsurance agreement" means a contract that both:

(a) Transfers insurance obligations or risks of existing or in-force policies from a transferring insurer to an assuming insurer that acquires the obligations or risks from the transferring insurer; and

(b) Is intended to effect a novation of the transferred policies with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the insurance obligations and risks of the transferring insurer under the policies are extinguished. [1995 c.30 §2]

742.152 Limitations on applicability of ORS 742.150. ORS 742.150 does not apply to any of the following:

(1) A reinsurance agreement or transaction in which the ceding insurer remains directly liable for its insurance obligations or risks under the policies that are subject to the reinsurance agreement.

(2) The substitution of one insurer for another upon the expiration of insurance coverage pursuant to statutory or contractual requirements and the issuance of a new policy by another insurer.

(3) The transfer of policies pursuant to a merger or consolidation of two or more insurers to the extent that the merger or consolidation is regulated by statute.

(4) An insurer that is subject to a judicial order of liquidation or rehabilitation.

(5) Any reinsurance agreement or transaction to which a state insurance guaranty association is a party, but only if policyholders do not lose any rights or claims afforded under their original policies pursuant to ORS 734.510 to 734.710 or 734.750 to 734.890.

(6) The transfer of liabilities from one insurer to another under a single group policy upon the request of the group policyholder.

(7) A plan of conversion or reorganization to which ORS 732.600 to 732.630 apply. [1995 c.30 §3; 1997 c.771 §23]

742.154 Factors to be considered by director in determining whether to approve assumption reinsurance agreement. The Director of the Department of Consumer and Business Services shall consider the following factors, along with other factors that the director determines to be appropriate, in reviewing a request for approval of an assumption reinsurance agreement to which ORS 742.150 applies:

(1) The financial condition of the transferring and assuming insurers and the effect the transaction will have on the financial condition of each insurer.

(2) The competence, experience and integrity of the persons controlling the operation of the assuming insurer.

(3) The plans or proposals of the assuming party with respect to the administration of the policies subject to the proposed transfer.

(4) Whether the transfer is fair and reasonable to the policyholders of both insurers.

(5) Whether the notice of transfer to be provided by the insurer under ORS 742.156 is fair, adequate and not misleading. [1995 c.30 §4]

742.156 Notice of transfer under assumption reinsurance agreement. (1) The transferring insurer in an assumption reinsurance agreement to which ORS 742.150 applies shall provide or cause to be provided a notice of transfer meeting the requirements established under this section to the following persons:

(a) Each policyholder who has the right to terminate or otherwise alter the terms of a policy.

(b) Each certificate holder whose certificate is in force on the proposed effective date of the assumption if the certificate holder has the right to keep the certificate in force without change in benefit following termination of the group policy. The right to keep the certificate in force does not include the right to elect individual coverage under the Consolidated Omnibus Budget Reconciliation Act, section 601 et seq., of the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1161 et seq.).

(c) The transferring insurer's agents of record on the affected policies.

(2) The Director of the Department of Consumer and Business Services shall prescribe the contents of the notice of transfer, methods by which insurers must give notice of the transfer and notice of opportunity to accept or reject the assumption and methods of response by the policyholders and certificate holders. [1995 c.30 §5]

742.158 Rejection of transfer by policyholder; payment of premium as acceptance of transfer; failure of policyholder to respond to notice. (1) A policyholder or certificate holder described in ORS 742.156 may reject the transfer and novation of the policy under an assumption reinsurance agreement to which ORS 742.150 applies. A policyholder or certificate holder electing to reject the assumption transaction must give notice of rejection according to the manner of response established by rule.

(2) If the premium notice sent by an assuming insurer to a policyholder or a certificate holder described in ORS 742.156 satisfies the requirements of this subsection, payment of any premium to the assuming insurer during the 12-month period after the notice is received constitutes the policyholder's acceptance of the transfer to the assuming insurer. Upon such a payment, a novation is effected. The premium notice must state that payment of the premium to the assuming insurer constitutes acceptance of the transfer and must provide a method for the policyholder to pay the premium while reserving the right to reject the transfer. This subsection does not apply to a policy for which premiums are collected on a

weekly or monthly basis by an insurance producer who is an agent of the insurer nor to any other insurance not using premium notices.

(3) After not less than 12 months from the mailing of the first notice of transfer required under ORS 742.156, if the transferring insurer has not received the consent to or rejection of the transfer and assumption from a policyholder or consent by the policyholder has not occurred under subsection (2) of this section, the transferring insurer shall send to the policyholder a second and final notice of transfer. The notice must conform to the requirements established under ORS 742.156 and must also state that the policyholder must accept or reject the transfer not later than the 30th day after the postmark date. Failure by the policyholder to accept or reject the transfer during that period constitutes consent by the policyholder and novation of the contract will be effected. For a policy for which premiums are collected on a weekly or monthly basis by an insurance producer who is an agent of the insurer or for any other insurance not using premium notices, the 12-month period and the 30-day period shall be measured from the date of delivery of the notice of transfer provided under ORS 742.156.

(4) If a policyholder responds to the notice of transfer by mail, receipt of the response by the transferring insurer occurs on the date the response is postmarked. If a policyholder responds to the notice of transfer by facsimile or other electronic transmission or by registered mail, express delivery or courier service, receipt of the response by the transferring insurer occurs on the date of actual receipt by the transferring insurer.

(5) If the notice of transfer for a policy for which premiums are collected on a weekly or monthly basis by an insurance producer who is an agent of the insurer or for any other insurance not using premium notices satisfies the requirements of this subsection, payment of any premium to the assuming insurer during the 12-month period after the notice is received constitutes the policyholder's acceptance of the transfer to the assuming insurer. Upon such a payment, a novation is effected. The notice of transfer must state that payment of the premium to the assuming insurer constitutes acceptance of the transfer and must provide a method for the policyholder to pay the premium while reserving the right to reject the transfer. [1995 c.30 §6; 2003 c.364 §101]

742.160 Effect of novation of policy under assumption reinsurance agreement. If a policyholder consents to a transfer as provided in ORS 742.158, or if a transfer is effected under ORS 742.162, the effect of the novation of the policy subject to the assumption reinsurance agreement is that the transferring insurer is relieved of all insurance obligations or risks transferred under the assumption reinsurance agreement and the assuming insurer becomes directly and solely liable to the policyholder for those insurance obligations and risks. [1995 c.30 §7]

742.162 Transfer and novation of policy effected by director. (1) A transfer and novation effected as provided in this section is not an assumption reinsurance agreement to which ORS 742.150 applies.

(2) The Director of the Department of Consumer and Business Services may effect a transfer and novation of the policies issued by a domestic insurer if the director determines that the insurer is in hazardous financial condition according to standards established under ORS 731.385, if a rehabilitation or liquidation proceeding has been instituted against the insurer or if an administrative supervision proceeding has been instituted against the insurer, and if the director determines that the transfer of the policies is in the best interest of the policyholders. The director may give notice of such a transfer to policyholders that the director determines to be adequate under the circumstances.

(3) The director may accept a transfer and novation of policies issued by a foreign insurer that insure residents of this state when the transfer and novation are effected by the insurance regulatory official of the domiciliary state of the foreign insurer if the director determines that the domiciliary state has a substantially similar law and if the official has determined that the transfer of the policies is in the best interest of the policyholders and:

(a) The official has determined that the insurer is in hazardous financial condition;

(b) A rehabilitation or liquidation proceeding has been instituted against the insurer; or

(c) An administrative proceeding has been instituted against the insurer for the purpose of supervising, reorganizing or conserving the insurer. [1995 c.30 §8]

FIRE INSURANCE

742.200 Fire insurance not to exceed value of property insured. (1) No insurer, insurance producer or insured shall knowingly issue or procure any fire insurance policy upon property within this state for an amount which with any existing insurance exceeds the fair value of the risk insured or of the interest of the insured therein.

(2) This section does not apply to insurance on stocks of merchandise or property of fluctuating values where the reduced rate percentage value clause is made a part of the policy. [Formerly 744.070 and then 743.603; 2003 c.364 §102]

742.202 Standard fire insurance policy. Except as provided in ORS 742.204, no fire insurer, its officers or agents, shall use any fire insurance policy or renew any fire insurance policy on property in this state unless it contains the provisions set forth in ORS 742.206 to 742.242, which shall form a portion of the contract between the insurer and the insured. [Formerly 743.606]

742.204 Exceptions to standard fire insurance policy requirements. Any insurance policy that includes, either on an unspecified basis as to coverage or for a single premium, coverage against the peril of fire and substantial coverage against other perils need not comply with the provisions of ORS 742.202 and 742.246, if such policy:

(1) Affords coverage with respect to the peril of fire, not less than the substantial equivalent of the coverage afforded by the provisions of the standard fire insurance policy as required by ORS 742.202;

(2) After a review under ORS 742.005 by the Director of the Department of Consumer and Business Services, is found by the director not to violate ORS 742.005 (2); and

(3) Is complete as to all its terms without reference to the standard fire insurance policy or any other policy. [Formerly 743.607; 2001 c.85 §1]

742.206 Insuring agreement. A fire insurance policy shall contain provisions as follows: "In consideration of the provisions and stipulations herein or added hereto and of _____ dollars ($_____) premium this company, for the term of _____ from the _____ day of _____, 2____, to the _____ day of _____, 2____, at 12:01 a.m., at location of property involved, to an amount not exceeding _____ dollars ($_____), does insure _____ and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business or manufacture, nor in any event for more than the interest of the insured, against all direct loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as hereinafter provided, to the property described hereinafter while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere.

"Assignment of this policy shall not be valid except with the written consent of this company.

"This policy is made and accepted subject to the foregoing provisions and stipulations and those hereinafter stated, which hereby are made a part of this policy, together with such other provisions, stipulations and agreements as may be added hereto, as provided in this policy.

"In witness whereof, this company has executed and attested these presents.

_____

Secretary.

_____

President."

[Formerly 743.609]

742.208 Concealment; fraud; representations by insured. A fire insurance policy shall contain the following provisions:

(1) Subject to subsections (2) and (3) of this section, this entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.

(2) All statements made by or on behalf of the insured, in the absence of fraud, shall be deemed representations and not warranties. No such statements that arise from an error in the application shall be used in defense of a claim under the policy unless:

(a) The statements are contained in a written application; and

(b) A copy of the application is indorsed upon or attached to the policy when issued.

(3) In order to use any representation by or on behalf of the insured in defense of a claim under the policy, the insurer must show that the representations are material and that the insurer relied on them. [Formerly 743.612]

742.210 Uninsurable and excepted property. A fire insurance policy shall contain a provision as follows: "This policy shall not cover accounts, bills, currency, deeds, evidences of debt, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts." [Formerly 743.615]

742.212 Perils not included. A fire insurance policy shall contain a provision as follows: "This company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: (a) Enemy attack by armed forces, including action taken by military, naval or air forces in resisting an actual or an immediately impending enemy attack; (b) invasion; (c) insurrection; (d) rebellion; (e) revolution; (f) civil war; (g) usurped power; (h) order of any civil authority except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided that such fire did not originate from any of the perils excluded by this policy; (i) neglect of the insured to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises; (j) nor shall this company be liable for loss by theft." [Formerly 743.618]

742.214 Other insurance. A fire insurance policy shall contain a provision as follows: "Other insurance may be prohibited or the amount of insurance may be limited by indorsement attached hereto." [Formerly 743.621]

742.216 Conditions suspending insurance. A fire insurance policy shall contain a provision as follows: "Unless otherwise provided in writing added hereto this company shall not be liable for loss occurring:

"(1) While the hazard is increased by any means within the control or knowledge of the insured; or

"(2) While a described building, whether intended for occupancy by owner or tenant, is vacated or unoccupied beyond a period of 60 consecutive days; or

"(3) As a result of explosion or riot, unless fire ensues, and in that event for loss by fire only." [Formerly 743.624]

742.218 Additional perils insured. A fire insurance policy shall contain a provision as follows: "Any other peril to be insured against or subject of insurance to be covered in this policy shall be by indorsement in writing hereon or added hereto." [Formerly 743.627]

742.220 Added provisions. A fire insurance policy shall contain a provision as follows: "The extent of the application of insurance under this policy and of the contribution to be made by this company in case of loss, and any other provision or agreement not inconsistent with the provisions of this policy, may be provided for in writing added hereto, but no provision may be waived except such as by the terms of this policy is subject to change." [Formerly 743.630]

742.222 Waiver provisions. A fire insurance policy shall contain a provision as follows: "No permission affecting this insurance shall exist, or waiver of any provision be valid, unless granted herein or expressed in writing added hereto. No provision, stipulation or forfeiture shall be held to be waived by any requirement or proceeding on the part of this company relating to appraisal or to any examination provided for herein." [Formerly 743.633]

742.224 Cancellation. (1) A fire insurance policy shall contain a provision as follows: "This policy shall be canceled at any time at the request of the insured, in which case this company shall, upon demand and surrender of this policy, refund the excess of paid premium above the customary short rates for the expired time."

(2) The policy also shall provide:

(a) That the insurer may cancel the policy at any time by giving 10 days' written notice of cancellation to the insured in the event of nonpayment of premium or 30 days' written notice for any other reason. However, when fire insurance coverage is part of a package policy including commercial liability insurance, cancellation of the policy is governed by the provisions of ORS 742.702.

(b) That cancellation by the insurer may be made with or without tender of the excess of paid premium above the pro rata premium for the expired time, and that the excess, if not tendered with the cancellation, will be refunded on demand.

(3) When an insurer gives notice of cancellation, the notice shall state that the excess of paid premium above the pro rata premium for the expired time, if not tendered with the notice, will be refunded on demand. [Formerly 743.636; 1991 c.768 §2]

742.226 Mortgagee interest and obligation of mortgagee. A fire insurance policy shall contain provisions as follows:

(1) "If loss hereunder is made payable, in whole or in part, to a designated mortgagee not named herein as the insured, such interest in this policy may be canceled by giving to such mortgagee a 10 days' written notice of cancellation."

(2) "If the insured fails to render proof of loss such mortgagee, upon notice, shall render proof of loss in the form herein specified within 60 days thereafter and shall be subject to the provisions hereof relating to appraisal and time of payment and of bringing suit. If this company shall claim that no liability existed as to the mortgagor or owner, it shall, to the extent of payment of loss to the mortgagee, be subrogated to all the mortgagee's rights of recovery, but without impairing mortgagee's right to sue; or it

may pay off the mortgage debt and require an assignment thereof and of the mortgage. Other provisions relating to the interests and obligations of such mortgagee may be added hereto by agreement in writing." [Formerly 743.639]

742.228 Pro rata liability of insurer. A fire insurance policy shall contain a provision as follows: "This company shall not be liable for a greater proportion of any loss than the amount hereby insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not." [Formerly 743.642]

742.230 Requirements in case loss occurs. A fire insurance policy shall contain a provision as follows: "The insured shall give immediate written notice to this company of any loss, protect the property from further damage, forthwith separate the damaged and undamaged personal property, put it in the best possible order, furnish a complete inventory of the destroyed, damaged and undamaged property, showing in detail quantities, costs, actual cash value and amount of loss claimed; and within 90 days after receipt of proof of loss forms from the company, unless such time is extended in writing by this company, the insured shall render to this company a proof of loss, signed and sworn to by the insured, stating the knowledge and belief of the insured as to the following: The time and origin of the loss, the interest of the insured and of all others in the property, the actual cash value of each item thereof and the amount of loss thereto, all encumbrances thereon, all other contracts of insurance, whether valid or not, covering any of said property, any changes in the title, use, occupation, location, possession or exposures of said property since the issuing of this policy, by whom and for what purpose any building herein described and the several parts thereof were occupied at the time of loss and whether or not it then stood on leased ground, and shall furnish a copy of all the descriptions and schedules in all policies and, if required, verified plans and specifications of any building, fixtures or machinery destroyed or damaged. The insured, as often as may be reasonably required, shall exhibit to any person designated by this company all that remains of any property herein described, and submit to examinations under oath by any person named by this company, and subscribe the same; and, as often as may be reasonably required, shall produce for examination all books of account, bills, invoices, and other vouchers, or certified copies thereof if originals be lost, at such reasonable time and place as may be designated by this company or its representative, and shall permit extracts and copies thereof to be made." [Formerly 743.645]

742.232 Appraisal. A fire insurance policy shall contain a provision as follows: "In case the insured and this company shall fail to agree as to the actual cash value or the amount of loss, then, on the written demand of either, each shall select a competent and disinterested appraiser and notify the other of the appraiser selected within 20 days of such demand. The appraisers shall first select a competent and disinterested umpire; and failing for 15 days to agree upon such umpire, then, on request of the insured or this company, such umpire shall be selected by a judge of a court of record in the state in which the property covered is located. The appraisers shall then appraise the loss, stating separately actual cash value and loss to each item; and, failing to agree, shall submit their differences, only, to the umpire. An award in writing, so itemized, of any two when filed with this company shall determine the amount of actual cash value and loss. Each appraiser shall be paid by the party selecting the appraiser and the expenses of appraisal and umpire shall be paid by the parties equally." [Formerly 743.648]

742.234 Insurer's options. A fire insurance policy shall contain a provision as follows: "It shall be optional with this company to take all, or any part, of the property at the agreed or appraised value, and also to repair, rebuild or replace the property destroyed or damaged with other of like kind and quality within a reasonable time, on giving notice of its intention so to do within 30 days after the receipt of the proof of loss herein required." [Formerly 743.651]

742.236 Abandonment. A fire insurance policy shall contain a provision as follows: "There can be no abandonment to this company of any property." [Formerly 743.654]

742.238 When loss payable. A fire insurance policy shall contain a provision as follows: "The amount of loss for which this company may be liable shall be payable 60 days after proof of loss, as herein provided, is received by this company and ascertainment of the loss is made either by agreement between the insured and this company expressed in writing or by the filing with this company of an award as herein provided." [Formerly 743.657]

742.240 Suit on policy. A fire insurance policy shall contain a provision as follows:

"No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless all the requirements of this policy shall have been complied with, and unless commenced within 24 months next after inception of the loss." [Formerly 743.660; 1991 c.437 §1]

742.242 Subrogation. A fire insurance policy shall contain a provision as follows: "This company may require from the insured an assignment of all right of recovery against any party for loss to the extent that payment therefor is made by this company." [Formerly 743.663]

742.244 Coverage for loss from nuclear reaction or radiation. Insurers issuing the standard fire insurance policy pursuant to ORS 742.202 are authorized to affix thereto or include therein a written statement that the policy does not cover loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination, all whether directly or indirectly resulting from an insured peril under said policy. However, nothing contained in this section shall be construed to prohibit the attachment to any such policy of an indorsement or indorsements specifically assuming coverage for loss or damage caused by nuclear reaction or nuclear radiation or radioactive contamination. [Formerly 744.125 and then 743.666]

742.246 Other fire insurance policy provisions permitted. (1) A fire insurer may add to the provisions required by ORS 742.202 other conditions, provisions and agreements not in conflict with law or contrary to public policy.

(2) Any provision restricting or abridging the rights of the insured under the policy must be preceded by a sufficiently explanatory title printed or written in type not smaller than eight-point capital letters.

(3) This section applies only to standard fire insurance policies as described in ORS 742.202 and does not apply to any other insurance policies. [Formerly 744.130 and then 743.669; 2001 c.85 §2]

742.248 Mutual fire insurers policyholders′ liability; nonassessable policies. (1) Each person accepting a policy in a mutual fire insurer thereby becomes a member of the insurer and liable for a proportionate share of losses and operating expenses.

(2) Any person or persons holding property in trust may insure the same in a mutual fire insurer, and as such trustee assume the liabilities and be entitled to the rights of a member, but shall not be personally liable upon such insurance policy.

(3) A mutual fire insurer may fix the contingent and mutual liability of its members for payment of losses and expenses by a uniform rule set forth in its bylaws and policies. Such mutual liability shall not be less than twice the amount of the usual advance assessment written in the policy.

(4) A mutual fire insurer that received a certificate of authority prior to September 2, 1963, and has accumulated in the regular course of business assets of not less than $200,000, of which not less than $100,000 is surplus determined as provided in the Insurance Code, may while in that condition and subject to the approval of the Director of the Department of Consumer and Business Services adopt bylaws limiting the liability of its policyholders to the premium specified in its policies. The power to issue policies with such limitation of liability continues only during the time the insurer is in such financial condition.

(5) A mutual fire insurer that received a certificate of authority after September 2, 1963, and has $500,000 in surplus determined as provided in the Insurance Code, may while in that condition and subject to the approval of the director adopt bylaws limiting the liability of its policyholders to the premium specified in its policies. The power to issue policies with such limitation of liability continues only during the time the insurer is in such financial condition.

(6) Every mutual fire insurer which has not limited the liability of its policyholders in accordance with subsections (4) and (5) of this section must print upon its policies such bylaws as will define the liability of a policyholder in addition to the statement required by ORS 742.036. [Formerly 744.430 and then 743.672]

742.250 Mutual fire insurer′s action to recover assessment. An action may be brought against any member of a mutual fire insurer who neglects or refuses to pay any assessment levied by the insurer to recover the whole amount of contingent liability with costs of the action. Execution shall issue on a judgment recovered in such an action for assessments and costs only as they accrue. [Formerly 744.440 and then 743.675]

742.252 Mutual fire insurers; withdrawal of members. Any member of a mutual fire insurer may withdraw at any time by surrendering the member′s policy to the insurer, giving written notice to the secretary of intention to withdraw and paying the member′s share of all losses which have accrued and all assessments then due, accrued or pending. [Formerly 744.450 and then 743.678]

742.254 Mutual fire insurance policy cancellation. (1) A mutual fire insurer may cancel or terminate any fire insurance policy by giving the insured five days′ written notice and returning to the insured any unearned assessment computed pro rata.

(2) A mutual fire insurer shall use and issue only the standard form of policy required by ORS 742.202, except that:

(a) It is not required upon cancellation of the insurance policy or certificate of membership to return any part of any policy,

certificate, membership or inspection fee that may have been charged.

(b) Where a definite part of the amount charged has been collected for and designated as an expense assessment, it may by bylaw determine the amount of refund that shall be made from such expense assessment.

(c) If it is on an assessment basis, levying assessments at such times and in such amounts as are necessary to defray its losses and expenses, it may provide by bylaw that no part of the assessments shall be returned.

(d) If it is organized for the insurance of a single class of risks and the assessment charged in a flat sum, it may provide in the insurance policy that no return assessment shall be paid upon cancellation. [Formerly 744.460 and then 743.681]

CHILD CARE FACILITY

742.260 Cancellation of homeowner or fire policy; coverage for child care; definition. (1) An insurer offering homeowner or renter liability or fire insurance may not cancel or refuse to issue or renew a policy on a private home solely on the basis that the policyholder operates a child care facility if the policyholder is registered or certified pursuant to ORS 657A.030 and 657A.250 to 657A.450.

(2) A homeowner or renter liability or fire insurance policy may not provide coverage for losses arising out of or in connection with child care provided by a registered or certified child care facility. Coverage for losses arising out of or in connection with child care by a registered or certified child care facility may be provided only by a separate policy or indorsement for which premiums are assessed and paid.

(3) As used in this section, "child care facility" has the meaning given in ORS 657A.250. [1995 c.685 §2; 1999 c.743 §23]

HOME PROTECTION INSURANCE

742.280 Home protection insurance; rules. (1) A home protection policy shall specify:

(a) The home, home components and personal property relating to the home or its components that are covered by the policy.

(b) The exclusions to and limitations on the coverage.

(c) The period during which the policy will be in effect and the renewal terms, if any.

(d) The particulars regarding the performance of services, if any, by or on behalf of the insurer, including but not necessarily limited to the following:

(A) The kinds of services to be performed by or on behalf of the insurer, and the terms and conditions of the performance.

(B) The service fee or deductible amount, if any, to be charged for the services.

(C) All limitations regarding the performance of services, including any restrictions on the time period during which, or geographical area within which, services may be requested or will be performed.

(D) A statement that services will be performed upon the insured's telephoned request to the insurer, without any requirement that a claim form or service application be filed before service is performed.

(E) A representation that services will be initiated by or under the direction of the insurer within 48 hours after request is made for services.

(e) All other provisions which are required by the Insurance Code or by rules issued by the Director of the Department of Consumer and Business Services.

(2) A home protection policy shall be noncancellable during the term for which it is originally written, except for nonpayment of the premium charge for the policy or for fraud or misrepresentation of facts material to the issuance of the policy. However, a policy providing coverage while the subject home is being offered for sale is cancellable in accordance with the policy provisions if no sale is made. A home protection policy is not renewable unless its terms provide otherwise.

(3) The director may adopt rules regarding home protection policies in order to protect the interests of persons affected by the policy contract. The director may not adopt rules specifying the home components or related personal property which must be covered by a home protection policy, except to the extent necessary to:

(a) Obtain fairness in the exclusions from coverage; or

(b) Avoid illusory coverage caused by the nature or extent of the exclusions from coverage. [Formerly 743.690]

MORTGAGE INSURANCE

742.282 Limitations on issuance of mortgage insurance. (1) No mortgage insurer shall provide insurance with respect to an obligation which exceeds, solely or in combination with liens existing at the time the insured loan is made:

(a) Ninety-five percent of the fair market value of the securing property at the time the loan is made, or such higher percentage as may be authorized by the Director of the Department of Consumer and Business Ser-

vices and permitted by the insurer's domicile, if the obligation insured is secured by a mortgage, deed of trust or other instrument constituting a first lien or first charge.

(b) Ninety percent of the fair market value of the securing property at the time the loan is made, or such higher percentage as may be authorized by the director and permitted by the insurer's domicile, if the obligation insured is secured by a mortgage, deed of trust or other instrument constituting a junior lien or junior charge. In determining the 90 percent limitation, the full amount of a line of credit to be secured by a junior lien shall be considered the amount of the loan.

(2) A mortgage insurer at its option may limit its coverage net of reinsurance to a maximum of 25 percent of the amount of the obligation insured if the obligation insured is secured by a mortgage, deed of trust or other instrument constituting a first lien or first charge. In such event, the mortgage insurer may, in lieu of acquiring title to the property securing the obligation and paying the entire obligation, elect to pay its coverage percent of the obligation. In computing the aggregate amount of insured obligations under ORS 731.516, only the percent of the coverage net of reinsurance on the insured obligation shall be included in the aggregate amount.

(3) A mortgage insurer may insure an obligation secured by a mortgage, deed of trust or other instrument constituting a junior lien or junior charge, subject to the following provisions:

(a) The mortgage insurer shall limit its coverage net of reinsurance to a maximum of 25 percent of the amount of the obligation insured and all liens existing at the time the insured loan is made. In computing the aggregate amount of insured obligations under ORS 731.516, only the percent of the coverage net of reinsurance shall be included in the aggregate amount.

(b) Notwithstanding paragraph (a) of this subsection, the mortgage insurer may elect to insure a portfolio of loans secured by instruments constituting a junior lien on real estate, provided that the total amount at risk in any one portfolio shall not at any time exceed 20 percent of the original principal mortgage loans insured.

(c) In lieu of acquiring title to the property securing an obligation to which this subsection applies and paying the entire obligation, the mortgage insurer may elect to pay its coverage percent of the obligation.

(4) A mortgagor shall not be required to pay, directly or indirectly, the cost of mortgage insurance on a loan secured by a junior lien when the indebtedness evidencing that loan, combined with all existing mortgage loan amounts at the time the loan is made, is less than 60 percent of the fair market value of the real estate at the time the junior loan is made. No mortgagee or financial institution shall be required to obtain mortgage insurance or junior lien mortgage insurance by reason of this section.

(5) No mortgage insurer shall issue a policy of lease insurance with respect to real property not improved by a building or buildings designed to be occupied for industrial or commercial purposes. [Formerly 746.030 and then 743.705; 1991 c.67 §197; 1995 c.582 §2]

742.284 Insured obligations as legal investments and securities for deposit. (1) Obligations insured by mortgage insurance policies issued in conformity with the Insurance Code shall be legal investments for all trust funds held by any executor, administrator, conservator, trustee or other person or corporation holding trust funds, and also for the funds of banks, banking institutions and trust companies, and shall be accepted by this state and its officers and officials as securities constituting any part of any fund or deposit required by law to be made with this state, or any officer or official thereof, by any trust company doing business in this state. All premiums required to be paid according to the terms of any such mortgage insurance policy may be charged to or paid out of the income from the obligations covered thereby. In the case of such fund or deposit required by law, such obligations must constitute a first lien on real property that is worth at least double the amount of such lien.

(2) The provisions of subsection (1) of this section with respect to legal investments for funds shall also apply to obligations not so insured if:

(a) The obligation constitutes a first lien upon a marketable title to real property;

(b) There exists a lease insurance policy covering the property securing the obligation, issued in conformity with the Insurance Code;

(c) The aggregate lease payments so insured exceeds the amount of the obligation; and

(d) The insurer is legally bound to remit all lease insurance proceeds directly to the owner of the obligation. [Formerly 746.080 and then 743.708]

742.286 Mortgage insurance; who may write. All policies and contracts of insurance covering liens or security interests in real property shall be written by authorized mortgage insurers. No other class of insurer may write any form of mortgage insurance. [Formerly 743.711]

742.300 [Formerly 743.720; repealed by 1993 c.265 §14]

742.302 [Formerly 743.723; repealed by 1993 c.265 §14]

SURETY INSURANCE

742.350 Bonds, undertakings and other obligations required by law may be executed by surety insurers. (1) Whenever any bond, undertaking, recognizance, or other obligation is by law or the charter, ordinance, rules or regulations of any municipality, board, body, organization, court, judge or public officer required or permitted to be made, given, tendered or filed with surety or sureties, and whenever the performance of any act, duty or obligation, or the refraining from any act is required or permitted to be guaranteed, such bond, undertaking, obligation, recognizance or guaranty may be executed by an authorized surety insurer.

(2) The execution by such an insurer of any such obligation is in all respects a full and complete compliance with every requirement that it be executed by one surety, or by one or more sureties, or that such sureties be residents or householders, or freeholders, or either or both, or possess any other qualification.

(3) A surety insurer may be required to justify as surety. It shall be sufficient justification for such surety insurer when examined as to its qualifications to exhibit the certificate of authority issued to it by the Director of the Department of Consumer and Business Services or a certified copy thereof. [Formerly 747.080 and then 743.732]

742.352 Reimbursement of private persons required to give bond, letter of credit or other obligation. Any receiver, assignee, guardian, conservator, trustee, executor, administrator or other fiduciary, required by law or the order of any court or judge to give a bond, letter of credit or other obligation as such, may include as a part of the lawful expense of executing the trust, such reasonable sum paid an insurer for becoming surety on the bond or an issuer of a letter of credit as may be allowed by the court in which, or judge before whom, the person is required to account. Such sum shall not exceed one percent per annum of the amount of the bond or letter of credit. [Formerly 747.100 and then 743.735; 1991 c.331 §129]

742.354 Reimbursement of public officials required to give bond or letter of credit. Any state, county or municipal officer or officer of any school district, public board or public commission within this state, or any deputy employed in the office of any such official, who is required by law, ordinance, regulation or public policy to give a bond or letter of credit for the faithful performance of duties, shall be allowed a reasonable sum paid a surety insurer for becoming surety on the bond, or paid to a letter of credit issuer for issuing a letter of credit. Such sum shall not exceed one-half of one percent per annum of the amount of the bond or letter of credit. Such premium or fee shall be paid out of the proper state, county, municipal, district, board or commission funds. [Formerly 747.110 and then 743.738; 1991 c.331 §130]

742.356 Surety insurer may take measures to reduce risk of loss. (1) Any surety insurer may contract for and receive and hold on deposit and in trust property of any kind as collateral security on any policy of guaranty or suretyship executed by it. The insurer may manage, realize on and dispose of the property so received and held on deposit as may be agreed to between it and the person making the deposit.

(2) Any receiver, assignee, guardian, conservator, trustee, executor, administrator or other fiduciary or party from whom a policy of guaranty or suretyship is by law required or permitted may agree and arrange with the surety insurer for the deposit for safekeeping of any or all moneys, assets and other property for which the person is or may be responsible in a bank, savings bank, safe deposit or trust company authorized by law to do business as such, in such manner as to prevent the withdrawal or alienation of such money, assets or other property, or any part thereof, without the written consent of the surety insurer or an order of a court of competent jurisdiction or a judge thereof made on such notice to the surety insurer as the court or judge may direct.

(3) Generally, it shall be lawful for a surety insurer to enter into any contract of indemnity or security with any person if such contract is not otherwise prohibited by law or against public policy. [Formerly 747.130 and then 743.741]

742.358 Release of surety on official bonds by action of obligee. (1) Any official whose duty it is to approve any bond or undertaking given in favor of the state or any county, city, school district, drainage or irrigation district, board or commission within the state may cancel the bond or undertaking by serving written notice of its election so to do upon the principal and surety or sureties on such bond or undertaking 10 days before it desires the cancellation of the obligation to take effect.

(2) The official at the time of serving such notice shall also file with the officer or official occupying the position of secretary or clerk of the state, county, city, school district, drainage or irrigation district, board or commission, as the case may be, at the

regular place of business of such secretary or clerk, a certified copy of such notice. At the expiration of 10 days from the filing of such notice, the surety or sureties upon such bond or undertaking shall be discharged from further liability thereon. [Formerly 747.140 and then 743.744]

742.360 Release of surety on bond of public official by action of surety. (1) The surety or sureties on the bond of any public official in this state shall be released from any future liability thereon upon giving notice of election to be released as provided in this section.

(2) A surety desiring to be released from liability on the bond of any state officer may file with the Governor or Secretary of State 30 days before the surety desires the release to take effect, a notice in writing, duly subscribed by the surety or someone in behalf of the surety, setting forth the name and office of the person for whom the surety is surety, the amount for which the surety is liable as such, and the desire of the surety to be released from further liability on account thereof. A duplicate of such notice shall also be served personally on the officer unless the officer has left this state, in which case it may be served by publication for 20 days in some newspaper printed at the seat of government, or if none is printed there, then in such newspaper as shall be designated by the Governor or Secretary of State.

(3) A surety desiring to be released from liability on the bond of any county officer may file and serve a similar notice. The notice, except when it concerns the county clerk personally, shall be filed with the county clerk. When the county clerk is personally concerned the notice shall be filed with the county treasurer.

(4) A surety desiring to be released from liability on the bond of any city officer may file and serve a similar notice with the city clerk or mayor.

(5) A surety desiring to be released from any other official bond or undertaking shall file and serve a similar notice with the officer, person or authority whose duty it is to approve such bonds.

(6) A notice which under this section may be served by publication may be published in a newspaper in the same county or, if no newspaper is published therein, then in an adjoining or other county, without any order from any court or other authority. In all cases for which publication is provided, a printed or written notice posted in at least three conspicuous places in the county for the time specified shall be deemed legal notice thereof. [Formerly 747.150 and then 743.747]

742.362 Release of surety on depository bond; provision required in such bonds. (1) A surety wishing to terminate the liability undertaken upon any bank depository bond or undertaking given to guarantee the safekeeping and return of any public moneys deposited in the bank may do so by giving notice of election so to do to the principal and to the official whose duty it is to approve such bond or undertaking. A surety is released from any future liability upon any such depository bond or undertaking at the expiration of 30 days after the giving of such notice.

(2) Where the form of depository bond or undertaking given to protect any public moneys is prescribed by statute or regulation the right to cancel such bond or undertaking shall be expressed in such bonds or undertakings by adding a paragraph to the prescribed form in substantially the following form: "The above-named surety shall have the right to terminate any future liability hereunder by serving written notice of election so to do upon the principal and (here insert the official title of the state or county treasurer, or other officials whose duty it is to approve such bond), and thereupon the said surety shall be discharged from any future liability hereunder for any default of the said principal occurring after the expiration of 30 days from and after the service of such notice." The purpose of such cancellation privilege is to afford the surety a means of obtaining definite release from its liability.

(3) Any official or officials whose duty it is to approve any bank depository bond given to protect the deposits of any official moneys, on the official's own motion or upon written request from any bank in whose behalf such a bond is issued, may terminate the future liability on the bond by giving notice to the surety of elections so to do. Thereupon the surety shall be discharged from any future liability upon any such depository bond for any default of the principal occurring after the expiration of 30 days from and after the service of such notice. [Formerly 743.750]

742.364 Fixing amount of new bond after release from original. Whenever a notice is filed, or filed and served, as provided in ORS 742.358, 742.360 and 742.362, or received after mailed as provided in ORS 742.366, the proper authority shall prescribe the penalty or amount in which a new or additional bond or undertaking shall be filed. If no such order is made the new or additional bond or undertaking shall be executed for the same amount as the original. [Formerly 747.170 and then 743.753]

742.366 Cancellation of bond by surety. (1) As used in this section:

(a) "Bond" means any undertaking, recognizance or other obligation required by statute, ordinance or regulation to be executed by a surety and given to a public body by any person as a condition to the granting of a permit, license or franchise by a public body.

(b) "Public body" means the state and any department, agency, board or commission of the state, any city, county, school district or other political subdivision or municipal or public corporation, any instrumentality thereof and any court.

(2) The surety may cancel a bond by sending notice of cancellation by registered or certified mail to the public body with which the bond is filed and to the principal at the principal's address of record with the surety. Such cancellation takes effect on the date specified in the notice but not earlier than the 30th day after the date of mailing. The surety shall have no liability under the bond for an act or default occurring after the effective date of such cancellation.

(3) Notwithstanding subsection (2) of this section, a statute, ordinance, regulation or the provisions of a bond may provide procedures for release of surety on a bond. [Formerly 743.755]

742.368 Surety insurer may not deny power to execute bond; construction of policies. A surety insurer executing any bond or undertaking under the provisions of the Insurance Code is estopped in any proceeding, to deny its corporate power to execute such bond or undertaking or to assume such liability, and all such bonds or undertakings shall in any action be construed by the rules applicable to insurance policies and indemnity contracts. [Formerly 747.180 and then 743.756]

742.370 Bond construed as including omitted statutory provisions. Whenever any person is required by the provisions of any statute to give a bond to this state or any of its political subdivisions and the statute requires to be included therein any specific provisions, the bond shall have the same legal effect as though such provisions were included therein, although such provisions were omitted. [Formerly 747.190 and then 743.759]

742.372 Guaranteed arrest bond certificate. As used in ORS 742.374 and 742.376, "guaranteed arrest bond certificate" means any printed certificate which:

(1) Is issued by an automobile club or automobile association to any of its members;

(2) Is signed by the member to whom it is issued; and

(3) Contains a printed statement that the automobile club or automobile association and a named surety insurer guarantee the appearance of the member whose signature appears on the certificate and that, if the member does not make the appearance in court to guarantee which the certificate is posted, they will pay in an amount not to exceed $1,000 any fine or forfeiture imposed against the individual. [Formerly 747.082 and then 743.762]

742.374 Surety may issue guaranteed arrest bond certificate not to exceed $1,000. Upon compliance with ORS 742.376, any authorized domestic or foreign surety insurer may become surety in an amount not to exceed $1,000 with respect to any unexpired guaranteed arrest bond certificate that is issued by an automobile club or association. [Formerly 747.084 and then 743.765]

742.376 Requirements to issue guaranteed arrest bond certificate. To become surety under ORS 742.374 with respect to an unexpired guaranteed arrest bond certificate that is accepted during any year under ORS 810.320, the surety insurer shall file with the Director of the Department of Consumer and Business Services on a form prescribed by the director an undertaking so to become surety for that year. The undertaking shall state:

(1) The name and address of each automobile club or automobile association with respect to any guaranteed arrest bond certificate of which the surety insurer undertakes to be surety; and

(2) The unqualified obligation of the surety insurer to pay the fine or forfeiture in an amount not to exceed $1,000 with respect to any individual who:

(a) Posts an unexpired guaranteed arrest bond certificate with respect to which under this section the surety insurer has undertaken to be surety; and

(b) Fails to make the appearance in court to guarantee which the guaranteed arrest bond certificate was posted. [Formerly 747.086 and then 743.768]

REIMBURSEMENT INSURANCE FOR SERVICE CONTRACTS

742.390 Reimbursement insurance policy; contents; definitions. (1) A reimbursement insurance policy insuring service contracts issued, sold or offered for sale in this state shall conspicuously state that, upon failure of the obligor to perform under the contract, the insurer that issued the policy shall pay on behalf of the obligor any sums the obligor is legally obligated to pay or shall provide the service that the obligor is legally obligated to perform according to

the obligor's contractual obligations under the service contracts issued by the obligor.

(2) For purposes of this section and ORS 742.392:

(a) "Obligor" has the meaning given in ORS 646A.152.

(b) A "reimbursement insurance policy" is a policy of insurance providing reimbursement coverage for all obligations and liabilities under the terms of the service contract issued by the obligor including claims against the obligor for return of the unearned purchase price of the service contract.

(c) "Service contract" has the meaning given in ORS 646A.154. [1995 c.801 §7]

Note: 742.390 and 742.392 were added to and made a part of the Insurance Code by legislative action but were not added to or made a part of ORS chapter 742 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

742.392 Termination of reimbursement insurance policy. An insurer that issues a reimbursement insurance policy shall not terminate the policy until a notice of termination has been mailed or delivered to the Director of the Department of Consumer and Business Services. The notice of termination shall be mailed or delivered to the director at least 30 days prior to the date of termination. The termination of a reimbursement insurance policy shall not reduce the issuer's responsibility for service contracts sold by or on behalf of obligors prior to the date of the termination. [1995 c.801 §8]

Note: See note under 742.390.

MEDICAL MALPRACTICE INSURANCE

742.400 Duty to report claim of professional negligence to licensing board; contents of report; public disclosure and posting of reports. (1) As used in this section:

(a) "Claim" means a written demand for payment from or on behalf of a covered practitioner for an injury alleged to have been caused by professional negligence that is made in a complaint filed with a court of appropriate jurisdiction.

(b) "Covered practitioner" means a physician, podiatric physician and surgeon, physician assistant, nurse practitioner, optometrist, dentist, dental hygienist or naturopath.

(c) "Disposition of a claim" means:

(A) A judgment or award against the covered practitioner by a court, a jury or an arbitrator;

(B) A withdrawal or dismissal of the claim; or

(C) A settlement of the claim.

(d) "Reporter" means:

(A) A primary insurer;

(B) A public body required to defend, save harmless and indemnify an officer, employee or agent of the public body under ORS 30.260 to 30.300;

(C) An entity that self-insures or indemnifies for claims alleging professional negligence on the part of a covered practitioner; or

(D) A health maintenance organization as defined in ORS 750.005.

(2) Within 30 days after receiving notice of a claim, a reporter shall report the claim to the appropriate board, as follows:

(a) The Oregon Medical Board if the covered practitioner is a physician, podiatric physician and surgeon or physician assistant;

(b) The Oregon State Board of Nursing if the covered practitioner is a nurse practitioner;

(c) The Oregon Board of Optometry if the covered practitioner is an optometrist;

(d) The Oregon Board of Dentistry if the covered practitioner is a dentist or dental hygienist; or

(e) The Board of Naturopathic Examiners if the covered practitioner is a naturopath.

(3) The report required under subsection (2) of this section shall include:

(a) The name of the covered practitioner;

(b) The name of the person that filed the claim;

(c) The date on which the claim was filed; and

(d) The reason or reasons for the claim, except that the report may not disclose any data that is privileged under ORS 41.675.

(4) Within 30 days after the date of an action taken in disposition of a claim, a reporter shall notify the appropriate board identified in subsection (2) of this section of the disposition.

(5)(a) A board that receives a report of a claim under this section shall publicly post the report on the board's website if the claim results in a judicial finding or admission of liability or a money judgment, award or settlement that involves a payment to the claimant. The board may not publicly post information about claims that did not result in a judicial finding or admission of liability or a money judgment, award or settlement that involves a payment to the claimant but shall make the information available to the public upon request. The board shall remove from the board's website any record based on a reported claim against a covered practitioner if the board does not receive another

report of a claim against the practitioner within four years after the date reported under subsection (3)(c) of this section.

(b) If a board discloses information about a claim that is the subject of a report received under this section, the board shall indicate in the disclosure whether the claim resulted in a judicial finding or an admission of liability or a money judgment, an award or a settlement that involves a payment to the claimant. A board may not publicly disclose or publish any allegations or factual assertions included in the claim unless the complaint resulted in a judicial finding or an admission of liability or a money judgment, an award or a settlement that involves a payment to the claimant.

(c) For purposes of this subsection, "judicial finding" means a finding of liability by a court, a jury or an arbitrator.

(6) A board that receives a report under this section shall provide copies of the report to each health care facility licensed under ORS 441.015 to 441.087, 441.525 to 441.595, 441.815, 441.820, 441.990, 442.342, 442.344 and 442.400 to 442.463 that employs or grants staff privileges to the covered practitioner.

(7) A person that reports in good faith concerning any matter required to be reported under this section is immune from civil liability by reason of making the report. [Formerly 743.780 and then 743.770; 1991 c.401 §7; 1997 c.131 §3; 2007 c.803 §1]

742.405 Conditions for issuance of medical malpractice insurance. (1) No insurer may require membership in a professional association as a condition of issuance of medical malpractice insurance to a physician. However, nothing in this subsection prohibits an insurer from requiring as a condition of coverage of a nonmember that the nonmember agrees to be subject to reasonable risk management, loss control or other similar programs and conditions to which members are subject, whether imposed by the insurer or the association.

(2) No insurer who issues medical malpractice insurance to a physician may assess any surcharge or offer any discount to the physician based on whether or not the physician is a member of a professional association.

(3) For purposes of this section, joint underwriting associations and risk retention groups shall be considered insurers. [Formerly 743.771]

Note: 742.405 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 742 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

DISCOUNT MEDICAL PLANS

742.420 Definitions for ORS 742.420 to 742.440. As used in ORS 742.420 to 742.440:

(1) "Discount medical plan" means a contract, agreement or other business arrangement between a discount medical plan organization and a plan member in which the organization, in exchange for fees, service or subscription charges, dues or other consideration, offers or purports to offer the plan member access to providers and the right to receive medical and ancillary services at a discount from providers.

(2) "Discount medical plan organization" means a person that contracts on behalf of plan members with a provider, a provider network or another discount medical plan organization for access to medical and ancillary services at a discounted rate and determines what plan members will pay as a fee, service or subscription charge, dues or other consideration for a discount medical plan.

(3) "Licensee" means a discount medical plan organization that has obtained a license from the Director of the Department of Consumer and Business Services in accordance with ORS 742.426.

(4) "Medical and ancillary services" means, except when administered by or under contract with the State of Oregon, any care, service, treatment or product provided for any dysfunction, injury or illness of the human body including, but not limited to, physician care, inpatient care, hospital and surgical services, emergency and ambulance services, audiology services, dental care services, vision care services, mental health services, substance abuse counseling or treatment, chiropractic services, podiatric care services, laboratory services, home health care services, medical equipment and supplies or prescription drugs.

(5) "Plan member" means an individual who pays fees, service or subscription charges, dues or other consideration in exchange for the right to participate in a discount medical plan.

(6)(a) "Provider" means a person that has contracted or otherwise agreed with a discount medical plan organization to provide medical and ancillary services to plan members at a discount from the person's ordinary or customary fees or charges.

(b) "Provider" does not include:

(A) A person that, apart from any agreement or contract with a discount medical plan organization, provides medical and ancillary services at a discount or at fixed or scheduled prices to patients or customers the person serves regularly; or

(B) A person that does not charge fees, service or subscription charges, dues or other consideration in exchange for providing medical and ancillary services at a discount or at fixed or scheduled prices.

(7) "Provider network" means a person that negotiates directly or indirectly with a discount medical plan organization on behalf of more than one provider that provides medical or ancillary services to plan members. [2007 c.272 §2]

Note: 742.420 to 742.440 become operative July 1, 2008. See section 15, chapter 272, Oregon Laws 2007.

Note: 742.420 to 742.440 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 742 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

742.422 License requirement for conducting business as discount medical plan organization. (1) A person may not conduct business as or purport to conduct business as a discount medical plan organization unless the person first obtains a license to operate as a discount medical plan organization from the Director of the Department of Consumer and Business Services in accordance with ORS 742.426.

(2) The license requirement set forth in subsection (1) of this section does not apply to an insurer that offers a discount medical plan. [2007 c.272 §3]

Note: See notes under 742.420.

742.424 Requirement for contract with provider; contents of contract; retention of record. (1) A discount medical plan organization shall have a written contract or other written agreement with all providers or provider networks that the organization includes or purports to include in a discount medical plan, or with an entity that contracts with or enters into an agreement with a provider network on the organization's behalf.

(2) The contract or other agreement between a discount medical plan organization and a provider must include:

(a) A list of the medical and ancillary services included in the discount medical plan;

(b) The provider's discount rate or rates or a schedule that reflects the provider's fixed or discounted prices for the medical and ancillary services subject to the discount medical plan; and

(c) A provision in which the provider agrees not to charge plan members more for medical and ancillary services than the amount listed in the provider's price schedule or an amount that reflects the application of the provider's discount rate.

(3) The contract or other agreement between a discount medical plan organization and a provider network, or between an entity and a provider network when the entity contracts with or enters into an agreement with a provider network on the organization's behalf, shall require the provider network to have written agreements with providers that, in addition to meeting the requirements of subsection (2) of this section:

(a) Authorize the provider network to contract with or enter into an agreement with the discount medical plan organization or the entity on behalf of the provider; and

(b) Require the provider network to maintain an up-to-date list of the providers that are part of the provider network and to provide the updated list each month to the discount medical plan organization.

(4) A discount medical plan organization shall retain copies of the contracts or agreements and other documents described in this section at all times during which the organization operates in this state. [2007 c.272 §4]

Note: See notes under 742.420.

742.426 License application; investigation; issuance; grounds for denial. (1) Each applicant for a license to operate as a discount medical plan organization shall apply to the Director of the Department of Consumer and Business Services in a form and manner that the director prescribes by rule. An application for a license under this section must contain all of the following:

(a) The applicant's name, fictitious name, assumed business name and any other identity the applicant uses in conducting business.

(b) The applicant's business address, mailing address, electronic mail address and the Internet address of any website the applicant maintains for public access.

(c) The applicant's federal employer identification number or Internal Revenue Service taxpayer identification number.

(d) The applicant's principal place of business inside or outside this state.

(e) The name of and contact information for a person that the applicant has designated to provide information to consumers or answer consumer questions.

(f) The name and address of the applicant's agent for the service of process, notice or demand, or a power of attorney that the applicant has executed and by which the applicant appoints the director as the applicant's agent for the service of process, notice or demand.

(g) A list of individual providers or providers included in the provider network that provide services in this state and a list of the

medical and ancillary services the applicant offers or intends to offer to plan members as part of a discount medical plan or the Internet address of a website that lists the providers and services offered.

(h) A list of the persons that the applicant has authorized or intends to authorize to market a discount medical plan in this state under a name that is different from the applicant's name.

(i) The name, trade name, service mark or other means by which a consumer can identify the discount medical plan the applicant offers or intends to offer and any different name, trade name, service mark or other means the applicant uses to identify the same discount medical plan to persons other than consumers.

(j) A statement that discloses:

(A) Any criminal conviction in the five-year period before the date of application involving the applicant, a member of the board of directors or an officer of the applicant and any person owning or having the right to acquire 10 percent or more of the voting securities of the applicant; and

(B) Any pending investigation into the applicant's business activities brought by a licensing, regulatory or law enforcement authority in any jurisdiction.

(k) A statement in which the applicant agrees to submit to the personal jurisdiction of the courts of this state.

(L) A statement that discloses any instance in which another jurisdiction has denied the applicant a license or other authority to operate as a discount medical plan organization or has suspended or revoked any such license or other authority after issuance.

(m) Other information the director may require that enables the director, after reviewing all of the information submitted under this subsection, to determine whether the applicant:

(A) Is financially responsible;

(B) Has adequate experience and expertise to operate a discount medical plan organization; and

(C) Is of good character.

(2) Upon receipt of a completed application for a license to operate as a discount medical plan organization, the director may investigate the applicant as necessary to verify the information contained in the application. Except as provided in subsection (3) of this section, if the director is satisfied that the information contained in the application is accurate and complete, the director shall issue a license to the applicant.

(3) The director may deny a license to any applicant if the director finds in writing that:

(a) The applicant has provided false, misleading, incomplete or inaccurate information in the application; or

(b) The applicant is not qualified to operate as a discount medical plan organization because the applicant is not financially responsible, does not have adequate experience or expertise, or has engaged in dishonest, fraudulent or illegal practices or conduct in any business or profession.

(4) If the director denies a license under this section, the applicant may request a hearing under ORS 183.435. Upon receiving the applicant's request, the director shall grant the applicant a hearing under ORS 183.413 to 183.470. [2007 c.272 §5]

Note: See notes under 742.420.

742.428 Duties of licensee. A licensee shall:

(1) Notify the Director of the Department of Consumer and Business Services immediately whenever the licensee's license or other form of authority to operate as a discount medical plan organization in another jurisdiction is suspended, revoked or not renewed in that jurisdiction.

(2) Describe in a notice to the director any change in the name, address or contact information of the discount medical plan organization provided in the application under ORS 742.426 within 30 days after making the change. [2007 c.272 §6]

Note: See notes under 742.420.

742.430 License term; renewal; rules. A license obtained under ORS 742.426 is effective for one year, or for a longer period if the Director of the Department of Consumer and Business Services so prescribes by rule. The director shall prescribe by rule conditions and procedures under which a licensee may renew a license that has expired. [2007 c.272 §7]

Note: See notes under 742.420.

742.432 Duties of discount medical plan organization. A discount medical plan organization shall establish or provide, in connection with every discount medical plan:

(1) A 30-day period in which new plan members may review the discount medical plan and decide whether to continue or to cancel the plan for any reason. The discount medical plan organization shall provide to a member who cancels a discount medical plan within the 30-day period a full and unconditional refund for any fees, service or subscription charges, dues or other consideration the member paid, except that the discount medical plan organization may

retain the amount of any one-time processing fee that is less than an amount established by the Director of the Department of Consumer and Business Services by rule. The 30-day period begins on the day following the date on which the member completed any application for the plan or the day following the date on which the member paid any fees, service or subscription charges, dues or other consideration, whichever is later.

(2) A standard set of procedures by which a new plan member may obtain a refund under subsection (1) of this section.

(3) A toll-free telephone line and an Internet website. The toll-free telephone line must enable plan members to contact the discount medical plan organization with questions and requests for assistance. The website must list all providers in the organization's provider network, and the organization must provide the same information to plan members in writing upon request.

(4) Disclosures, in writing in a font not less than 12 points in size and on the first content page of advertisements, marketing materials or brochures made available to the public and relating to a discount medical plan, that:

(a) The discount medical plan is not insurance; and

(b) Plan members must pay for all medical and ancillary services, but will receive a discount from providers. [2007 c.272 §8]

Note: See notes under 742.420.

742.434 Prohibited activities. (1) A person may not use or disseminate in marketing, advertising, promotional, sales or plan documents or other informational materials for discount medical plans or in communications with plan members or prospective plan members:

(a) Misleading, deceptive or false statements; or

(b) The terms "health plan," "coverage," "copay," "copayments," "deductible," "preexisting condition," "guaranteed issue," "premium," "preferred provider organization" or other terms in a manner that could reasonably mislead an individual into believing that the discount medical plan is insurance.

(2) For the purposes of subsection (1) of this section, "misleading, deceptive or false statements" includes, but is not limited to, statements that:

(a) Are misleading in fact or implication, including statements that, while containing truthful elements, conceal or omit information necessary or relevant for a consumer to make informed decisions concerning discount medical plans; or

(b) Have a capacity or tendency to mislead or deceive based on the overall impression a reasonable consumer may form after seeing or hearing the statements.

(3) A person may not represent in any marketing, advertising, promotional, sales or plan documents or other informational materials for a discount medical plan or in communications with plan members or prospective plan members that the State of Oregon reviews or approves the discount medical plan.

(4) Before a person uses an advertisement, a brochure, a discount card or promotional or marketing material for marketing, promoting, selling or distributing a discount medical plan, the discount medical plan organization shall approve the material in writing.

(5) At the request of the Director of the Department of Consumer and Business Services, a discount medical plan organization shall submit to the director an advertisement, a brochure, a discount card or promotional or marketing material used for marketing, promoting, selling or distributing a discount medical plan. [2007 c.272 §9]

Note: See notes under 742.420.

742.436 Investigative powers of director; expenses. The Director of the Department of Consumer and Business Services may investigate a person operating or purporting to operate as a discount medical plan organization and may require the person at any time to produce marketing, promotional and advertising materials, records, books, files or other information the person uses in conducting business as a discount medical plan organization. During an investigation, the person shall respond to the director's inquiries promptly and truthfully and in the manner or form the director requires. The person subject to an investigation under this section shall pay the expenses incurred in conducting the investigation. [2007 c.272 §10]

Note: See notes under 742.420.

742.438 License suspension, revocation or failure to renew; grounds; effect. (1) The Director of the Department of Consumer and Business Services by order may suspend, revoke or refuse to renew a license issued under ORS 472.426 if the director finds in writing that:

(a) Any fact or condition exists that, if the fact or condition had existed at the time the licensee applied for a license to operate as a discount medical plan organization, would have been grounds for the director to deny a license to the licensee;

(b) The licensee has not complied or is not complying with the licensee's obligations under ORS 742.424, 742.426, 742.428, 742.432

or 742.436 or any rule adopted thereunder or the licensee has violated or is violating a prohibition under ORS 742.434; or

(c) The licensee's license or other authority to operate as a discount medical plan organization in another state has been suspended or revoked or has not been renewed.

(2) A licensee subject to an order of the director suspending or revoking a license shall have an opportunity for a hearing under ORS 183.413 to 183.470.

(3) After the director issues a final order to suspend or revoke a license, the person subject to the order may not conduct further business as a discount medical plan organization in this state. Immediately after the director issues a final order suspending or revoking a license, the person subject to the order shall:

(a) Cease operations as a discount medical plan organization in this state;

(b) Cancel all pending transactions with plan members and refund any fees, service or subscription charges, dues or other consideration collected in exchange for services the person would have provided to plan members in connection with a discount medical plan after the effective date of the final order suspending or revoking the person's license; and

(c) Wind up all business conducted in connection with the person's operations as a discount medical plan organization in this state, if necessary. [2007 c.272 §11]

Note: See notes under 742.420.

742.440 Injunction; damages; venue; time for commencing action. (1) A person, a municipal or other public corporation or, at the request of the Director of the Department of Consumer and Business Services, the Attorney General may bring an action in a circuit court of this state against a person that operates or purports to operate as a discount medical plan organization but that has not obtained a license under ORS 742.426, to:

(a) Enjoin the person from operating or purporting to operate as a discount medical plan organization or from violating ORS 742.432 or 742.434 or any rule adopted thereunder; or

(b) Recover actual damages or statutory damages under this section that arise from the person's violation of ORS 742.432 or 742.434 or any rule adopted thereunder.

(2) A plaintiff may bring an action under this section in the county where:

(a) The plaintiff resides or conducts business; or

(b) The defendant marketed, offered for sale or sold, promoted, distributed or advertised a discount medical plan.

(3) If the court finds that the defendant has violated ORS 742.422, 742.432 or 742.434 or any rule adopted thereunder, the court shall enjoin the defendant from continuing the violation.

(4) Unless a plaintiff seeks actual or statutory damages under this section, the plaintiff need not allege or prove actual damages to bring an action for an injunction under this section.

(5) In addition to injunctive relief, the plaintiff who prevails in an action brought under this section is entitled to recover from the defendant:

(a) $100 for each discount medical plan membership sold or otherwise distributed within this state or $10,000, whichever is greater;

(b) Three times the amount of actual damages, if any, that the plaintiff sustained;

(c) Reasonable attorney fees;

(d) Costs; and

(e) Any other relief the court deems proper.

(6) A plaintiff must commence an action under this section within two years after the date on which the violation described in subsection (1) of this section occurred or within two years after the plaintiff bringing the action discovered or in the exercise of reasonable diligence should have discovered the violation. The plaintiff may have an additional 180 days after the two-year period provided in this subsection within which to commence an action if the plaintiff can prove by a preponderance of the evidence that the plaintiff failed to timely commence the action because of conduct by the defendant calculated solely to induce the plaintiff to refrain from or postpone commencement of the action.

(7) The remedies provided in this section are cumulative and are in addition to any other applicable criminal, civil or administrative penalties. [2007 c.272 §12]

Note: See notes under 742.420.

MOTOR VEHICLE LIABILITY INSURANCE

(Issuance of Insurance Card)

742.447 Insurance card. Every insurer that issues motor vehicle insurance that is designed to meet either the financial or future responsibility requirements of ORS chapter 806 shall issue with the policy a card that shows the effective date and the expiration date of the insurance. [1993 c.746 §1]

Note: 742.447 was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 742 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

(Generally)

742.449 Prohibition on assignment to high risk category on certain grounds. An insurer issuing motor vehicle liability insurance policies in this state may not assign an insured or applicant for insurance to a higher risk category than the person would otherwise be assigned to solely because the person has:

(1) Let a prior motor vehicle liability policy lapse, unless the person was in violation of ORS 806.010 at any time after the prior policy lapsed; or

(2) Had driving privileges suspended pursuant to ORS 809.280 (7) or (9) if the suspension is based on a nondriving offense. [1989 c.419 §2; 1991 c.860 §6]

742.450 Contents of motor vehicle liability policy; permitted exclusions. (1) Every motor vehicle liability insurance policy issued for delivery in this state shall state the name and address of the named insured, the coverage afforded by the policy, the premium charged therefor, the policy period and the limits of liability.

(2) Every motor vehicle liability insurance policy issued for delivery in this state shall contain an agreement or indorsement stating that, as respects bodily injury and death or property damage, or both, the insurance provides either:

(a) The coverage described in ORS 806.070 and 806.080; or

(b) The coverage described in ORS 806.270.

(3) The agreement or indorsement required by subsection (2) of this section shall also state that the insurance provided is subject to all the provisions of the Oregon Vehicle Code relating to financial responsibility requirements as defined in ORS 801.280 or future responsibility filings as defined in ORS 801.290, as appropriate.

(4) Every motor vehicle liability insurance policy issued for delivery in this state shall provide liability coverage to at least the limits specified in ORS 806.070.

(5) Every motor vehicle liability insurance policy issued for delivery in this state shall provide liability coverage, up to the limits of coverage under the policy for a vehicle owned by the named insured, for the operation by the named insured of a motor vehicle provided to the named insured, without regard to whether the named insured is charged for the use of the motor vehicle, if:

(a) The motor vehicle is provided to the named insured by a person engaged in the business of repairing or servicing motor vehicles; and

(b) The motor vehicle is provided to the named insured as a temporary replacement vehicle while the named insured's vehicle is being repaired or serviced.

(6) A motor vehicle liability insurance policy issued for delivery in this state may exclude by name from coverage required by subsection (2)(a) of this section any person other than the named insured, for any of the reasons stated in subsection (7) of this section. When an insurer excludes a person as provided by this subsection, the insurer shall obtain a statement or indorsement, signed by each of the named insureds, that the policy will not provide any coverage required by subsection (2)(a) of this section when the motor vehicle is driven by any named excluded person.

(7) A person may be excluded from coverage under a motor vehicle liability insurance policy as provided in subsection (6) of this section:

(a) Because of the driving record of the person. The Director of the Department of Consumer and Business Services by rule may establish restrictions on the use of the driving record in addition to other restrictions established by law.

(b) Because of any reason or set of criteria established by the director by rule.

(8) Every motor vehicle liability insurance policy issued for delivery in this state shall contain a provision that provides liability coverage for each family member of the insured residing in the same household as the insured in an amount equal to the amount of liability coverage purchased by the insured. [Formerly 486.541 and then 743.776; 1991 c.768 §3; 1999 c.438 §2; 2007 c.782 §1]

742.454 Liabilities that need not be covered. The motor vehicle liability insurance policy required by ORS 806.010, 806.060, 806.080, 806.240 or 806.270 need not insure any liability under any workers' compensation law; nor any liability on account of bodily injury to or death of an employee of the insured while engaged in the employment, other than domestic, of the insured, or while engaged in the operation, maintenance or repair of a vehicle; nor any liability for damage to property owned by, rented to, in charge of, or transported by the insured. [Formerly 486.546 and then 743.778]

742.456 When insurer's liability accrues; nonforfeiture provisions. The liability of an insurer with respect to the motor vehicle liability insurance policy required by ORS 806.060, 806.240 or 806.270

shall become absolute whenever injury or damage covered by the policy occurs. The policy may not be canceled or annulled as to such liability by any agreement between the insurer and the insured after the occurrence of the injury or damage. No statement made by the insured or on behalf of the insured and in violation of the policy shall defeat or void the policy. This section does not apply to motor vehicle liability insurance policies other than those required in connection with ORS 806.060, 806.240 or 806.270. [Formerly 486.551 and then 743.779]

742.458 General provisions governing liability policies. Every motor vehicle liability insurance policy shall be subject to the following provisions, which need not be contained therein:

(1) The policy, the written application therefor, if any, and any rider or indorsement that does not conflict with the laws relating to motor vehicle liability insurance policies shall constitute the entire contract between the parties.

(2) The satisfaction by the insured of a judgment for injury or damage shall not be a condition precedent to the right or duty of the insurer to make payment on account of such injury or damage.

(3) Any binder issued pending the issuance of a motor vehicle liability insurance policy shall be deemed to fulfill the requirements for such a policy. [Formerly 486.556 and then 743.781]

742.460 Insurer's right to provide for reimbursement and proration. Any motor vehicle liability insurance policy may provide that the insured shall reimburse the insurer for any payment the insurer would not have been obligated to make under the terms of the policy except for the provisions of ORS 742.450 to 742.464, 806.080 and 806.270 and it may further provide for the prorating of the insurance thereunder with other valid and collectible insurance. [Formerly 486.561 and then 743.782; 1995 c.79 §363]

742.462 Insurer's right to settle claims. The insurer shall have the right to settle any claim covered by the policy, and if such settlement is made in good faith, the amount thereof shall be deductible from the limits of liability specified in respect to a motor vehicle liability insurance policy. [Formerly 486.564 and then 743.784]

742.464 Excess coverage permitted; combining policies to meet requirements. Any policy which grants the coverage required for a motor vehicle liability insurance policy under ORS 742.450, 806.080 and 806.270 may also grant any lawful coverage in excess of or in addition to the required coverage, and such excess or additional coverage shall not be subject to the provisions of ORS 742.031, 742.400 and 742.450 to 742.464. With respect to a policy which grants such excess or additional coverage only that part of the coverage which is required by ORS 806.080 and 806.270 is subject to the requirements of those sections. [Formerly 486.566 and then 743.785]

742.466 Disputes over coverage for physical damage; independent appraisal; rules. (1) In the event of a dispute between the insurer and insured under a motor vehicle liability policy concerning coverage for physical damage, if the policy contains a provision authorizing the insured to obtain an independent appraisal by a disinterested party of the physical damage, that provision shall apply.

(2) If a motor vehicle liability policy does not contain a provision described in subsection (1) of this section, then notwithstanding any other provision of the policy, any resolution of the dispute shall be subject to rules adopted by the Director of the Department of Consumer and Business Services. [Formerly 743.840]

742.468 Certain policies not considered motor vehicle liability policies. For purposes of statutes mandating kinds or amounts of coverage that motor vehicle liability policies must contain, the following shall not be considered motor vehicle liability policies:

(1) Comprehensive general liability policies.

(2) Excess liability policies.

(3) Umbrella liability policies. [1993 c.709 §10]

(Age-Based Discount)

742.490 Premium reduction; conditions; application. (1) Any rate, rating plan or rating system filed with the Director of the Department of Consumer and Business Services for a motor vehicle insurance policy offering liability, personal injury protection or collision coverage, shall provide an appropriate reduction in premium charges for such coverage if:

(a) The principal operator of the covered vehicle is an insured 55 years of age or older.

(b) The principal operator of the covered vehicle has successfully completed, within the appropriate time as specified in this subsection, a motor vehicle accident prevention course approved by the Department of Transportation. To meet the requirements of this subsection, a course must be completed no more than three years prior to the beginning of the policy period for which the discounted rate applies if the person is less than 70 years of age at the time of taking the course or no more than two years prior to

the beginning of the policy period for which the discounted rate applies if the person is 70 years of age or more at the time of taking the course.

(c) There are no persons under 25 years of age who regularly operate the vehicle.

(d) The vehicle is not classified for underwriting purposes as used for a business.

(2) If the person qualifying for a premium reduction under subsection (1) of this section is the principal operator of two or more vehicles, the premium discount shall apply to only one vehicle. No more than one premium discount may be applied to one vehicle. [1989 c.379 §§2,4]

742.492 Duration of reduction. Except as otherwise provided in this section, the premium reduction required by ORS 742.490 (1) shall be effective for an insured for a three-year period after successful completion of the approved course if the person is less than 70 years of age at the time of taking the course or for a two-year period after successful completion of an approved course if the person is 70 years of age or more at the time of taking the course. An insurer may require, as a condition of maintaining the discount, that the insured:

(1) Not be involved in an accident for which the insured is at fault; and

(2) Not be convicted of or plead guilty or nolo contendere to a moving traffic violation. [1989 c.379 §3]

742.494 Certification of completion of course. Any organization offering a motor vehicle accident prevention course approved by the Department of Transportation shall issue a certificate to each person who successfully completes the course. The person shall present the certificate to an insurer to qualify for the premium discount required under ORS 742.490 (1). [1989 c.379 §5]

742.496 Limitation on qualification for discount. No person shall receive a discount under ORS 742.490 to 742.494 if the person takes the approved course as a punishment, specified by a court or other government entity, for a moving traffic violation. [1989 c.379 §6]

(Uninsured Motorist Coverage)

742.500 Definitions for ORS 742.500 to 742.506. As used in ORS 742.500 to 742.506:

(1) "Uninsured motorist coverage" means coverage within the terms and conditions specified in ORS 742.504 insuring the insured, the heirs or legal representative of the insured for all sums which the insured or they shall be legally entitled to recover as damages for bodily injury or death caused by accident and arising out of the ownership, maintenance or use of an uninsured motor vehicle in amounts or limits not less than the amounts or limits prescribed for bodily injury or death under ORS 806.070.

(2) "Motor vehicle" means every self-propelled device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include:

(a) Devices used exclusively upon stationary rails or tracks;

(b) Motor trucks as defined in ORS 801.355 that have a registration weight, as defined by ORS 803.430 of more than 8,000 pounds, when the insured has employees who operate such trucks and such employees are covered by any workers′ compensation law, disability benefits law or any similar law; or

(c) Farm-type tractors or self-propelled equipment designed for use principally off public highways. [Formerly 743.786]

742.502 Uninsured motorist coverage; underinsurance coverage. (1) Every motor vehicle liability policy insuring against loss suffered by any natural person resulting from liability imposed by law for bodily injury or death arising out of the ownership, maintenance or use of a motor vehicle shall provide in the policy or by indorsement on the policy uninsured motorist coverage when the policy is either:

(a) Issued for delivery in this state; or

(b) Issued or delivered by an insurer doing business in this state with respect to any motor vehicle then principally used or principally garaged in this state.

(2)(a) A motor vehicle bodily injury liability policy shall have the same limits for uninsured motorist coverage as for bodily injury liability coverage unless a named insured in writing elects lower limits. The insured may not elect limits lower than the amounts prescribed to meet the requirements of ORS 806.070 for bodily injury or death. Uninsured motorist coverage shall include underinsurance coverage for bodily injury or death caused by accident and arising out of the ownership, maintenance or use of a motor vehicle with motor vehicle liability insurance that provides recovery in an amount that is less than the insured′s uninsured motorist coverage. Underinsurance coverage shall be equal to uninsured motorist coverage less the amount recovered from other motor vehicle liability insurance policies.

(b) If a named insured elects lower limits, the named insured shall sign a statement electing lower limits within 60 days of the time the named insured makes the election. The statement shall acknowledge that a named insured was offered uninsured motorist coverage with the limits equal to those

for bodily injury liability. The statement shall contain a brief summary, which may not be construed as part of the insurance contract, of what uninsured and underinsured motorist coverages provide and shall state the price for coverage with limits equal to the named insured's bodily injury liability limits and the price for coverage with the lower limits requested by the named insured. The statement shall remain in force until rescinded in writing by a named insured or until the motor vehicle bodily injury liability limits are changed. The form of statement used to comply with this paragraph shall be approved by the Department of Consumer and Business Services.

(c) A statement electing lower limits need not be signed when vehicles are either added to or subtracted from a policy or when the policy is amended, renewed, modified or replaced by the same company or group of companies under common ownership or control unless the liability limits of the policy are changed.

(3) The insurer issuing the policy may offer one or more options of uninsured motorist coverage larger than the amounts prescribed to meet the requirements of ORS 806.070 and in excess of the limits provided under the policy for motor vehicle bodily injury liability insurance. Offers of uninsured motorist coverage shall include underinsurance coverage for bodily injury or death caused by accident and arising out of the ownership, maintenance or use of a motor vehicle with motor vehicle liability insurance that provides recovery in an amount that is less than the insured's uninsured motorist coverage. Underinsurance coverage shall be equal to uninsured motorist coverage less the amount recovered from other motor vehicle liability insurance policies.

(4) Underinsurance coverage is subject to ORS 742.504 and 742.542.

(5) Uninsured motorist coverage and underinsurance coverage shall provide coverage for bodily injury or death when:

(a) The limits for uninsured motorist coverage of the insured equal the limits of the liability policy of the person whose fault caused the bodily injury or death; and

(b) The amount of liability insurance recovered is less than the limits for uninsured motorist coverage of the insured.

(6) Uninsured motorist coverage and underinsurance coverage shall provide coverage for bodily injury or death if the amount recovered from a self-insurer is less than the limits for uninsured motorist coverage of the insured.

(7) As used in this section and except as otherwise provided in this subsection, "amount recovered from other motor vehicle liability insurance policies" means the proceeds of liability insurance or the proceeds received from a public body under ORS 30.270 recovered by or on behalf of the injured party. Proceeds recovered on behalf of the injured party include proceeds received by the injured party's insurer as reimbursement for personal injury protection benefits provided to the injured person, proceeds received by the medical providers of the injured person and proceeds received as attorney fees on the claim of the injured person. Where applicable liability insurance policy limits are exhausted upon payment, settlement or judgment by division among two or more injured persons, "amount recovered from other motor vehicle liability insurance policies" means the proceeds that are recovered by or on behalf of the injured person but does not include any proceeds of that liability policy received by other injured persons. [Formerly 743.789; 1993 c.709 §11; 1997 c.808 §1; 2003 c.220 §1; 2005 c.235 §1; 2007 c.287 §2; 2007 c.782 §2]

742.504 Required provisions of uninsured motorist coverage. Every policy required to provide the coverage specified in ORS 742.502 shall provide uninsured motorist coverage that in each instance is no less favorable in any respect to the insured or the beneficiary than if the following provisions were set forth in the policy. However, nothing contained in this section requires the insurer to reproduce in the policy the particular language of any of the following provisions:

(1)(a) Notwithstanding ORS 30.270, the insurer will pay all sums that the insured, the heirs or the legal representative of the insured is legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle because of bodily injury sustained by the insured caused by accident and arising out of the ownership, maintenance or use of the uninsured vehicle. Determination as to whether the insured, the insured's heirs or the insured's legal representative is legally entitled to recover such damages, and if so, the amount thereof, shall be made by agreement between the insured and the insurer, or, in the event of disagreement, may be determined by arbitration as provided in subsection (10) of this section.

(b) No judgment against any person or organization alleged to be legally responsible for bodily injury, except for proceedings instituted against the insurer as provided in this policy, shall be conclusive, as between the insured and the insurer, on the issues of liability of the person or organization or of the amount of damages to which the insured is legally entitled.

(2) As used in this policy:

(a) "Bodily injury" means bodily injury, sickness or disease, including death resulting therefrom.

(b) "Hit-and-run vehicle" means a vehicle that causes bodily injury to an insured arising out of physical contact of the vehicle with the insured or with a vehicle the insured is occupying at the time of the accident, provided:

(A) The identity of either the operator or the owner of the hit-and-run vehicle cannot be ascertained;

(B) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of the accident for damages against a person or persons whose identities are unascertainable, and setting forth the facts in support thereof; and

(C) At the insurer's request, the insured or the legal representative of the insured makes available for inspection the vehicle the insured was occupying at the time of the accident.

(c) "Insured," when unqualified and when applied to uninsured motorist coverage, means:

(A) The named insured as stated in the policy and any person designated as named insured in the schedule and, while residents of the same household, the spouse of any named insured and relatives of either, provided that neither the relative nor the spouse is the owner of a vehicle not described in the policy and that, if the named insured as stated in the policy is other than an individual or husband and wife who are residents of the same household, the named insured shall be only a person so designated in the schedule;

(B) Any child residing in the household of the named insured if the insured has performed the duties of a parent to the child by rearing the child as the insured's own although the child is not related to the insured by blood, marriage or adoption; and

(C) Any other person while occupying an insured vehicle, provided the actual use thereof is with the permission of the named insured.

(d) "Insured vehicle," except as provided in paragraph (e) of this provision, means:

(A) The vehicle described in the policy or a newly acquired or substitute vehicle, as each of those terms is defined in the public liability coverage of the policy, insured under the public liability provisions of the policy; or

(B) A nonowned vehicle operated by the named insured or spouse if a resident of the same household, provided that the actual use thereof is with the permission of the owner of the vehicle and the vehicle is not owned by nor furnished for the regular or frequent use of the insured or any member of the same household.

(e) "Insured vehicle" does not include a trailer of any type unless the trailer is a described vehicle in the policy.

(f) "Occupying" means in or upon or entering into or alighting from.

(g) "Phantom vehicle" means a vehicle that causes bodily injury to an insured arising out of a motor vehicle accident that is caused by a vehicle that has no physical contact with the insured or the vehicle the insured is occupying at the time of the accident, provided:

(A) The identity of either the operator or the owner of the phantom vehicle cannot be ascertained;

(B) The facts of the accident can be corroborated by competent evidence other than the testimony of the insured or any person having an uninsured motorist claim resulting from the accident; and

(C) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of the accident for damages against a person or persons whose identities are unascertainable, and setting forth the facts in support thereof.

(h) "State" includes the District of Columbia, a territory or possession of the United States and a province of Canada.

(i) "Stolen vehicle" means an insured vehicle that causes bodily injury to the insured arising out of a motor vehicle accident if:

(A) The vehicle is operated without the consent of the insured;

(B) The operator of the vehicle does not have collectible motor vehicle bodily injury liability insurance;

(C) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer or to the equivalent department in the state where the accident occurred; and

(D) The insured or someone on behalf of the insured cooperates with the appropriate law enforcement agency in the prosecution of the theft of the vehicle.

(j) "Sums that the insured, the heirs or the legal representative of the insured is legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle" means the amount of damages that:

(A) A claimant could have recovered in a civil action from the owner or operator at the time of the injury after determination of fault or comparative fault and resolution of any applicable defenses;

(B) Are calculated without regard to the tort claims limitations of ORS 30.260 to 30.300; and

(C) Are no larger than benefits payable under the terms of the policy as provided in subsection (7) of this section.

(k) "Uninsured vehicle," except as provided in paragraph (L) of this provision, means:

(A) A vehicle with respect to the ownership, maintenance or use of which there is no collectible motor vehicle bodily injury liability insurance, in at least the amounts or limits prescribed for bodily injury or death under ORS 806.070 applicable at the time of the accident with respect to any person or organization legally responsible for the use of the vehicle, or with respect to which there is collectible bodily injury liability insurance applicable at the time of the accident but the insurance company writing the insurance denies coverage or the company writing the insurance becomes voluntarily or involuntarily declared bankrupt or for which a receiver is appointed or becomes insolvent. It shall be a disputable presumption that a vehicle is uninsured in the event the insured and the insurer, after reasonable efforts, fail to discover within 90 days from the date of the accident, the existence of a valid and collectible motor vehicle bodily injury liability insurance applicable at the time of the accident.

(B) A hit-and-run vehicle.

(C) A phantom vehicle.

(D) A stolen vehicle.

(E) A vehicle that is owned or operated by a self-insurer:

(i) That is not in compliance with ORS 806.130 (1)(c); or

(ii) That provides recovery to an insured in an amount that is less than the limits for uninsured motorist coverage of the insured.

(L) "Uninsured vehicle" does not include:

(A) An insured vehicle, unless the vehicle is a stolen vehicle;

(B) Except as provided in paragraph (k)(E) of this subsection, a vehicle that is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law;

(C) A vehicle that is owned by the United States of America, Canada, a state, a political subdivision of any such government or an agency of any such government;

(D) A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle;

(E) A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads; or

(F) A vehicle owned by or furnished for the regular or frequent use of the insured or any member of the household of the insured.

(m) "Vehicle" means every device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include devices moved by human power or used exclusively upon stationary rails or tracks.

(3) This coverage applies only to accidents that occur on and after the effective date of the policy, during the policy period and within the United States of America, its territories or possessions, or Canada.

(4)(a) This coverage does not apply to bodily injury of an insured with respect to which the insured or the legal representative of the insured shall, without the written consent of the insurer, make any settlement with or prosecute to judgment any action against any person or organization who may be legally liable therefor.

(b) This coverage does not apply to bodily injury to an insured while occupying a vehicle, other than an insured vehicle, owned by, or furnished for the regular use of, the named insured or any relative resident in the same household, or through being struck by the vehicle.

(c) This coverage does not apply so as to inure directly or indirectly to the benefit of any workers' compensation carrier, any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or any similar law or the State Accident Insurance Fund Corporation.

(d) This coverage does not apply with respect to underinsured motorist benefits unless:

(A) The limits of liability under any bodily injury liability insurance applicable at the

time of the accident regarding the injured person have been exhausted by payment of judgments or settlements to the injured person or other injured persons;

(B) The described limits have been offered in settlement, the insurer has refused consent under paragraph (a) of this subsection and the insured protects the insurer's right of subrogation to the claim against the tortfeasor;

(C) The insured gives credit to the insurer for the unrealized portion of the described liability limits as if the full limits had been received if less than the described limits have been offered in settlement, and the insurer has consented under paragraph (a) of this subsection; or

(D) The insured gives credit to the insurer for the unrealized portion of the described liability limits as if the full limits had been received if less than the described limits have been offered in settlement and, if the insurer has refused consent under paragraph (a) of this subsection, the insured protects the insurer's right of subrogation to the claim against the tortfeasor.

(e) When seeking consent under paragraph (a) or (d) of this subsection, the insured shall allow the insurer a reasonable time in which to collect and evaluate information related to consent to the proposed offer of settlement. The insured shall provide promptly to the insurer any information that is reasonably requested by the insurer and that is within the custody and control of the insured. Consent will be presumed to be given if the insurer does not respond within a reasonable time. For purposes of this paragraph, a "reasonable time" is no more than 30 days from the insurer's receipt of a written request for consent, unless the insured and the insurer agree otherwise.

(5)(a) As soon as practicable, the insured or other person making claim shall give to the insurer written proof of claim, under oath if required, including full particulars of the nature and extent of the injuries, treatment and other details entering into the determination of the amount payable hereunder. The insured and every other person making claim hereunder shall submit to examinations under oath by any person named by the insurer and subscribe the same, as often as may reasonably be required. Proof of claim shall be made upon forms furnished by the insurer unless the insurer fails to furnish the forms within 15 days after receiving notice of claim.

(b) Upon reasonable request of and at the expense of the insurer, the injured person shall submit to physical examinations by physicians selected by the insurer and shall, upon each request from the insurer, execute authorization to enable the insurer to obtain medical reports and copies of records.

(6) If, before the insurer makes payment of loss hereunder, the insured or the legal representative of the insured institutes any legal action for bodily injury against any person or organization legally responsible for the use of a vehicle involved in the accident, a copy of the summons and complaint or other process served in connection with the legal action shall be forwarded immediately to the insurer by the insured or the legal representative of the insured.

(7)(a) The limit of liability stated in the declarations as applicable to "each person" is the limit of the insurer's liability for all damages because of bodily injury sustained by one person as the result of any one accident and, subject to the above provision respecting each person, the limit of liability stated in the declarations as applicable to "each accident" is the total limit of the company's liability for all damages because of bodily injury sustained by two or more persons as the result of any one accident.

(b) Any payment made under this coverage to or for an insured shall be applied in reduction of any amount that the insured may be entitled to recover from any person who is an insured under the bodily injury liability coverage of this policy.

(c) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by:

(A) All sums paid on account of the bodily injury by or on behalf of the owner or operator of the uninsured vehicle and by or on behalf of any other person or organization jointly or severally liable together with the owner or operator for the bodily injury, including all sums paid under the bodily injury liability coverage of the policy; and

(B) The amount paid and the present value of all amounts payable on account of the bodily injury under any workers' compensation law, disability benefits law or any similar law.

(d) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by the credit given to the insurer pursuant to subsection (4)(d)(C) or (D) of this section.

(e) The amount payable under the terms of this coverage may not be reduced by the amount of liability proceeds offered, described in subsection (4)(d)(B) or (D) of this section, that has not been paid to the injured person. If liability proceeds have been offered

and not paid, the amount payable under the terms of the coverage shall include the amount of liability limits offered but not accepted due to the insurer's refusal to consent. The insured shall cooperate so as to permit the insurer to proceed by subrogation or assignment to prosecute the claim against the uninsured motorist.

(8) No action shall lie against the insurer unless, as a condition precedent thereto, the insured or the legal representative of the insured has fully complied with all the terms of this policy.

(9)(a) With respect to bodily injury to an insured:

(A) While occupying a vehicle owned by a named insured under this coverage, the insurance under this coverage is primary.

(B) While occupying a vehicle not owned by a named insured under this coverage, the insurance under this coverage shall apply only as excess insurance over any primary insurance available to the occupant that is similar to this coverage, and this excess insurance shall then apply only in the amount by which the applicable limit of liability of this excess coverage exceeds the sum of the applicable limits of liability of all primary insurance available to the occupant.

(b) If an insured is an insured under other primary or excess insurance available to the insured that is similar to this coverage, then the insured's damages are deemed not to exceed the higher of the applicable limits of liability of this insurance or the additional primary or excess insurance available to the insured, and the insurer is not liable under this coverage for a greater proportion of the insured's damages than the applicable limit of liability of this coverage bears to the sum of the applicable limits of liability of this insurance and other primary or excess insurance available to the insured.

(c) With respect to bodily injury to an insured while occupying any motor vehicle used as a public or livery conveyance, the insurance under this coverage shall apply only as excess insurance over any other insurance available to the insured that is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all other insurance.

(10) If any person making claim hereunder and the insurer do not agree that the person is legally entitled to recover damages from the owner or operator of an uninsured vehicle because of bodily injury to the insured, or do not agree as to the amount of payment that may be owing under this coverage, then, in the event the insured and the insurer elect by mutual agreement at the time of the dispute to settle the matter by arbitration, the arbitration shall take place as described in section 2, chapter 328, Oregon Laws 2007. Any judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof, provided, however, that the costs to the insured of the arbitration proceeding do not exceed $100 and that all other costs of arbitration are borne by the insurer. "Costs" as used in this provision does not include attorney fees or expenses incurred in the production of evidence or witnesses or the making of transcripts of the arbitration proceedings. The person and the insurer each agree to consider themselves bound and to be bound by any award made by the arbitrators pursuant to this coverage in the event of such election. At the election of the insured, the arbitration shall be held:

(a) In the county and state of residence of the insured;

(b) In the county and state where the insured's cause of action against the uninsured motorist arose; or

(c) At any other place mutually agreed upon by the insured and the insurer.

(11) In the event of payment to any person under this coverage:

(a) The insurer shall be entitled to the extent of the payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the person against any uninsured motorist legally responsible for the bodily injury because of which payment is made;

(b) The person shall hold in trust for the benefit of the insurer all rights of recovery that the person shall have against such other uninsured person or organization because of the damages that are the subject of claim made under this coverage, but only to the extent that the claim is made or paid herein;

(c) If the insured is injured by the joint or concurrent act or acts of two or more persons, one or more of whom is uninsured, the insured shall have the election to receive from the insurer any payment to which the insured would be entitled under this coverage by reason of the act or acts of the uninsured motorist, or the insured may, with the written consent of the insurer, proceed with legal action against any or all persons claimed to be liable to the insured for the injuries. If the insured elects to receive payment from the insurer under this coverage, then the insured shall hold in trust for the benefit of the insurer all rights of recovery the insured shall have against any other person, firm or organization because of the damages that are the subject of claim made

under this coverage, but only to the extent of the actual payment made by the insurer;

(d) The person shall do whatever is proper to secure and shall do nothing after loss to prejudice such rights;

(e) If requested in writing by the insurer, the person shall take, through any representative not in conflict in interest with the person, designated by the insurer, such action as may be necessary or appropriate to recover payment as damages from such other uninsured person or organization, such action to be taken in the name of the person, but only to the extent of the payment made hereunder. In the event of a recovery, the insurer shall be reimbursed out of the recovery for expenses, costs and attorney fees incurred by the insurer in connection therewith; and

(f) The person shall execute and deliver to the insurer any instruments and papers as may be appropriate to secure the rights and obligations of the person and the insurer established by this provision.

(12)(a) The parties to this coverage agree that no cause of action shall accrue to the insured under this coverage unless within two years from the date of the accident:

(A) Agreement as to the amount due under the policy has been concluded;

(B) The insured or the insurer has formally instituted arbitration proceedings;

(C) The insured has filed an action against the insurer; or

(D) Suit for bodily injury has been filed against the uninsured motorist and, within two years from the date of settlement or final judgment against the uninsured motorist, the insured has formally instituted arbitration proceedings or filed an action against the insurer.

(b) For purposes of this subsection:

(A) "Date of settlement" means the date on which a written settlement agreement or release is signed by an insured or, in the absence of these documents, the date on which the insured or the attorney for the insured receives payment of any sum required by the settlement agreement. An advance payment as defined in ORS 31.550 shall not be deemed a payment of a settlement for purposes of the time limitation in this subsection.

(B) "Final judgment" means a judgment that has become final by lapse of time for appeal or by entry in an appellate court of an appellate judgment. [Formerly 743.792; 1993 c.18 §156; 1993 c.596 §38; 1997 c.808 §2; 2003 c.175 §2; 2005 c.22 §490; 2005 c.236 §1; 2005 c.246 §2; 2005 c.247 §2; 2007 c.131 §1; 2007 c.287 §3; 2007 c.328 §5; 2007 c.457 §1; 2007 c.782 §3]

Note: The amendments to 742.504 by section 6, chapter 328, Oregon Laws 2007, become operative January 2, 2012, and apply to motor vehicle liability policies issued or renewed on or after January 2, 2012. See sections 7 and 11, chapter 328, Oregon Laws 2007. The text that is operative on and after January 2, 2012, is set forth for the user's convenience.

742.504. Every policy required to provide the coverage specified in ORS 742.502 shall provide uninsured motorist coverage that in each instance is no less favorable in any respect to the insured or the beneficiary than if the following provisions were set forth in the policy. However, nothing contained in this section requires the insurer to reproduce in the policy the particular language of any of the following provisions:

(1)(a) Notwithstanding ORS 30.270, the insurer will pay all sums that the insured, the heirs or the legal representative of the insured is legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle because of bodily injury sustained by the insured caused by accident and arising out of the ownership, maintenance or use of the uninsured vehicle. Determination as to whether the insured, the insured's heirs or the insured's legal representative is legally entitled to recover such damages, and if so, the amount thereof, shall be made by agreement between the insured and the insurer, or, in the event of disagreement, may be determined by arbitration as provided in subsection (10) of this section.

(b) No judgment against any person or organization alleged to be legally responsible for bodily injury, except for proceedings instituted against the insurer as provided in this policy, shall be conclusive, as between the insured and the insurer, on the issues of liability of the person or organization or of the amount of damages to which the insured is legally entitled.

(2) As used in this policy:

(a) "Bodily injury" means bodily injury, sickness or disease, including death resulting therefrom.

(b) "Hit-and-run vehicle" means a vehicle that causes bodily injury to an insured arising out of physical contact of the vehicle with the insured or with a vehicle the insured is occupying at the time of the accident, provided:

(A) The identity of either the operator or the owner of the hit-and-run vehicle cannot be ascertained;

(B) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of the accident for damages against a person or persons whose identities are unascertainable, and setting forth the facts in support thereof; and

(C) At the insurer's request, the insured or the legal representative of the insured makes available for inspection the vehicle the insured was occupying at the time of the accident.

(c) "Insured," when unqualified and when applied to uninsured motorist coverage, means:

(A) The named insured as stated in the policy and any person designated as named insured in the schedule and, while residents of the same household, the spouse of any named insured and relatives of either, provided that neither the relative nor the spouse is the owner of a vehicle not described in the policy and that, if the named insured as stated in the policy is other than an individual or husband and wife who are residents of the same household, the named insured shall be only a person so designated in the schedule;

(B) Any child residing in the household of the named insured if the insured has performed the duties of a parent to the child by rearing the child as the in-

sured's own although the child is not related to the insured by blood, marriage or adoption; and

(C) Any other person while occupying an insured vehicle, provided the actual use thereof is with the permission of the named insured.

(d) "Insured vehicle," except as provided in paragraph (e) of this provision, means:

(A) The vehicle described in the policy or a newly acquired or substitute vehicle, as each of those terms is defined in the public liability coverage of the policy, insured under the public liability provisions of the policy; or

(B) A nonowned vehicle operated by the named insured or spouse if a resident of the same household, provided that the actual use thereof is with the permission of the owner of the vehicle and the vehicle is not owned by nor furnished for the regular or frequent use of the insured or any member of the same household.

(e) "Insured vehicle" does not include a trailer of any type unless the trailer is a described vehicle in the policy.

(f) "Occupying" means in or upon or entering into or alighting from.

(g) "Phantom vehicle" means a vehicle that causes bodily injury to an insured arising out of a motor vehicle accident that is caused by a vehicle that has no physical contact with the insured or the vehicle the insured is occupying at the time of the accident, provided:

(A) The identity of either the operator or the owner of the phantom vehicle cannot be ascertained;

(B) The facts of the accident can be corroborated by competent evidence other than the testimony of the insured or any person having an uninsured motorist claim resulting from the accident; and

(C) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of the accident for damages against a person or persons whose identities are unascertainable, and setting forth the facts in support thereof.

(h) "State" includes the District of Columbia, a territory or possession of the United States and a province of Canada.

(i) "Stolen vehicle" means an insured vehicle that causes bodily injury to the insured arising out of a motor vehicle accident if:

(A) The vehicle is operated without the consent of the insured;

(B) The operator of the vehicle does not have collectible motor vehicle bodily injury liability insurance;

(C) The insured or someone on behalf of the insured reported the accident within 72 hours to a police, peace or judicial officer or to the equivalent department in the state where the accident occurred; and

(D) The insured or someone on behalf of the insured cooperates with the appropriate law enforcement agency in the prosecution of the theft of the vehicle.

(j) "Sums that the insured, the heirs or the legal representative of the insured is legally entitled to recover as general and special damages from the owner or operator of an uninsured vehicle" means the amount of damages that:

(A) A claimant could have recovered in a civil action from the owner or operator at the time of the injury after determination of fault or comparative fault and resolution of any applicable defenses;

(B) Are calculated without regard to the tort claims limitations of ORS 30.260 to 30.300; and

(C) Are no larger than benefits payable under the terms of the policy as provided in subsection (7) of this section.

(k) "Uninsured vehicle," except as provided in paragraph (L) of this provision, means:

(A) A vehicle with respect to the ownership, maintenance or use of which there is no collectible motor vehicle bodily injury liability insurance, in at least the amounts or limits prescribed for bodily injury or death under ORS 806.070 applicable at the time of the accident with respect to any person or organization legally responsible for the use of the vehicle, or with respect to which there is collectible bodily injury liability insurance applicable at the time of the accident but the insurance company writing the insurance denies coverage or the company writing the insurance becomes voluntarily or involuntarily declared bankrupt or for which a receiver is appointed or becomes insolvent. It shall be a disputable presumption that a vehicle is uninsured in the event the insured and the insurer, after reasonable efforts, fail to discover within 90 days from the date of the accident, the existence of a valid and collectible motor vehicle bodily injury liability insurance applicable at the time of the accident.

(B) A hit-and-run vehicle.

(C) A phantom vehicle.

(D) A stolen vehicle.

(E) A vehicle that is owned or operated by a self-insurer:

(i) That is not in compliance with ORS 806.130 (1)(c); or

(ii) That provides recovery to an insured in an amount that is less than the limits for uninsured motorist coverage of the insured.

(L) "Uninsured vehicle" does not include:

(A) An insured vehicle, unless the vehicle is a stolen vehicle;

(B) Except as provided in paragraph (k)(E) of this subsection, a vehicle that is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law;

(C) A vehicle that is owned by the United States of America, Canada, a state, a political subdivision of any such government or an agency of any such government;

(D) A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle;

(E) A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads; or

(F) A vehicle owned by or furnished for the regular or frequent use of the insured or any member of the household of the insured.

(m) "Vehicle" means every device in, upon or by which any person or property is or may be transported or drawn upon a public highway, but does not include devices moved by human power or used exclusively upon stationary rails or tracks.

(3) This coverage applies only to accidents that occur on and after the effective date of the policy, during the policy period and within the United States of America, its territories or possessions, or Canada.

(4)(a) This coverage does not apply to bodily injury of an insured with respect to which the insured or the legal representative of the insured shall, without the written consent of the insurer, make any settlement with or prosecute to judgment any action against any person or organization who may be legally liable therefor.

(b) This coverage does not apply to bodily injury to an insured while occupying a vehicle, other than an insured vehicle, owned by, or furnished for the regular use of, the named insured or any relative resident in the same household, or through being struck by the vehicle.

(c) This coverage does not apply so as to inure directly or indirectly to the benefit of any workers' compensation carrier, any person or organization qualifying as a self-insurer under any workers' compensation or disability benefits law or any similar law or the State Accident Insurance Fund Corporation.

(d) This coverage does not apply with respect to underinsured motorist benefits unless:

(A) The limits of liability under any bodily injury liability insurance applicable at the time of the accident regarding the injured person have been exhausted by payment of judgments or settlements to the injured person or other injured persons;

(B) The described limits have been offered in settlement, the insurer has refused consent under paragraph (a) of this subsection and the insured protects the insurer's right of subrogation to the claim against the tortfeasor;

(C) The insured gives credit to the insurer for the unrealized portion of the described liability limits as if the full limits had been received if less than the described limits have been offered in settlement, and the insurer has consented under paragraph (a) of this subsection; or

(D) The insured gives credit to the insurer for the unrealized portion of the described liability limits as if the full limits had been received if less than the described limits have been offered in settlement and, if the insurer has refused consent under paragraph (a) of this subsection, the insured protects the insurer's right of subrogation to the claim against the tortfeasor.

(e) When seeking consent under paragraph (a) or (d) of this subsection, the insured shall allow the insurer a reasonable time in which to collect and evaluate information related to consent to the proposed offer of settlement. The insured shall provide promptly to the insurer any information that is reasonably requested by the insurer and that is within the custody and control of the insured. Consent will be presumed to be given if the insurer does not respond within a reasonable time. For purposes of this paragraph, a "reasonable time" is no more than 30 days from the insurer's receipt of a written request for consent, unless the insured and the insurer agree otherwise.

(5)(a) As soon as practicable, the insured or other person making claim shall give to the insurer written proof of claim, under oath if required, including full particulars of the nature and extent of the injuries, treatment and other details entering into the determination of the amount payable hereunder. The insured and every other person making claim hereunder shall submit to examinations under oath by any person named by the insurer and subscribe the same, as often as may reasonably be required. Proof of claim shall be made upon forms furnished by the insurer unless the insurer fails to furnish the forms within 15 days after receiving notice of claim.

(b) Upon reasonable request of and at the expense of the insurer, the injured person shall submit to physical examinations by physicians selected by the insurer and shall, upon each request from the insurer, execute authorization to enable the insurer to obtain medical reports and copies of records.

(6) If, before the insurer makes payment of loss hereunder, the insured or the legal representative of the insured institutes any legal action for bodily injury against any person or organization legally responsible for the use of a vehicle involved in the accident, a copy of the summons and complaint or other process served in connection with the legal action shall be forwarded immediately to the insurer by the insured or the legal representative of the insured.

(7)(a) The limit of liability stated in the declarations as applicable to "each person" is the limit of the insurer's liability for all damages because of bodily injury sustained by one person as the result of any one accident and, subject to the above provision respecting each person, the limit of liability stated in the declarations as applicable to "each accident" is the total limit of the company's liability for all damages because of bodily injury sustained by two or more persons as the result of any one accident.

(b) Any payment made under this coverage to or for an insured shall be applied in reduction of any amount that the insured may be entitled to recover from any person who is an insured under the bodily injury liability coverage of this policy.

(c) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by:

(A) All sums paid on account of the bodily injury by or on behalf of the owner or operator of the uninsured vehicle and by or on behalf of any other person or organization jointly or severally liable together with the owner or operator for the bodily injury, including all sums paid under the bodily injury liability coverage of the policy; and

(B) The amount paid and the present value of all amounts payable on account of the bodily injury under any workers' compensation law, disability benefits law or any similar law.

(d) Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by the credit given to the insurer pursuant to subsection (4)(d)(C) or (D) of this section.

(e) The amount payable under the terms of this coverage may not be reduced by the amount of liability proceeds offered, described in subsection (4)(d)(B) or (D) of this section, that has not been paid to the injured person. If liability proceeds have been offered and not paid, the amount payable under the terms of the coverage shall include the amount of liability limits offered but not accepted due to the insurer's refusal to consent. The insured shall cooperate so as to permit the insurer to proceed by subrogation or assignment to prosecute the claim against the uninsured motorist.

(8) No action shall lie against the insurer unless, as a condition precedent thereto, the insured or the legal representative of the insured has fully complied with all the terms of this policy.

(9)(a) With respect to bodily injury to an insured:

(A) While occupying a vehicle owned by a named insured under this coverage, the insurance under this coverage is primary.

(B) While occupying a vehicle not owned by a named insured under this coverage, the insurance under this coverage shall apply only as excess insurance over any primary insurance available to the occupant that is similar to this coverage, and this excess insurance shall then apply only in the amount by which the applicable limit of liability of this excess coverage exceeds the sum of the applicable limits of liability of all primary insurance available to the occupant.

(b) If an insured is an insured under other primary or excess insurance available to the insured that is similar to this coverage, then the insured's damages are deemed not to exceed the higher of the applicable limits of liability of this insurance or the additional primary or excess insurance available to the insured, and the insurer is not liable under this coverage for a greater proportion of the insured's damages than the applicable limit of liability of this coverage bears to the sum of the

applicable limits of liability of this insurance and other primary or excess insurance available to the insured.

(c) With respect to bodily injury to an insured while occupying any motor vehicle used as a public or livery conveyance, the insurance under this coverage shall apply only as excess insurance over any other insurance available to the insured that is similar to this coverage, and this insurance shall then apply only in the amount by which the applicable limit of liability of this coverage exceeds the sum of the applicable limits of liability of all other insurance.

(10) If any person making claim hereunder and the insurer do not agree that the person is legally entitled to recover damages from the owner or operator of an uninsured vehicle because of bodily injury to the insured, or do not agree as to the amount of payment that may be owing under this coverage, then, in the event the insured and the insurer elect by mutual agreement at the time of the dispute to settle the matter by arbitration, the arbitration shall take place under the arbitration laws of the State of Oregon or, if the parties agree, according to any other procedure. Any judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof, provided, however, that the costs to the insured of the arbitration proceeding do not exceed $100 and that all other costs of arbitration are borne by the insurer. "Costs" as used in this provision does not include attorney fees or expenses incurred in the production of evidence or witnesses or the making of transcripts of the arbitration proceedings. The person and the insurer each agree to consider themselves bound and to be bound by any award made by the arbitrators pursuant to this coverage in the event of such election. At the election of the insured, the arbitration shall be held:

(a) In the county and state of residence of the insured;

(b) In the county and state where the insured's cause of action against the uninsured motorist arose; or

(c) At any other place mutually agreed upon by the insured and the insurer.

(11) In the event of payment to any person under this coverage:

(a) The insurer shall be entitled to the extent of the payment to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the person against any uninsured motorist legally responsible for the bodily injury because of which payment is made;

(b) The person shall hold in trust for the benefit of the insurer all rights of recovery that the person shall have against such other uninsured person or organization because of the damages that are the subject of claim made under this coverage, but only to the extent that the claim is made or paid herein;

(c) If the insured is injured by the joint or concurrent act or acts of two or more persons, one or more of whom is uninsured, the insured shall have the election to receive from the insurer any payment to which the insured would be entitled under this coverage by reason of the act or acts of the uninsured motorist, or the insured may, with the written consent of the insurer, proceed with legal action against any or all persons claimed to be liable to the insured for the injuries. If the insured elects to receive payment from the insurer under this coverage, then the insured shall hold in trust for the benefit of the insurer all rights of recovery the insured shall have against any other person, firm or organization because of the damages that are the subject of claim made under this coverage, but only to the extent of the actual payment made by the insurer;

(d) The person shall do whatever is proper to secure and shall do nothing after loss to prejudice such rights;

(e) If requested in writing by the insurer, the person shall take, through any representative not in conflict in interest with the person, designated by the insurer, such action as may be necessary or appropriate to recover payment as damages from such other uninsured person or organization, such action to be taken in the name of the person, but only to the extent of the payment made hereunder. In the event of a recovery, the insurer shall be reimbursed out of the recovery for expenses, costs and attorney fees incurred by the insurer in connection therewith; and

(f) The person shall execute and deliver to the insurer any instruments and papers as may be appropriate to secure the rights and obligations of the person and the insurer established by this provision.

(12)(a) The parties to this coverage agree that no cause of action shall accrue to the insured under this coverage unless within two years from the date of the accident:

(A) Agreement as to the amount due under the policy has been concluded;

(B) The insured or the insurer has formally instituted arbitration proceedings;

(C) The insured has filed an action against the insurer; or

(D) Suit for bodily injury has been filed against the uninsured motorist and, within two years from the date of settlement or final judgment against the uninsured motorist, the insured has formally instituted arbitration proceedings or filed an action against the insurer.

(b) For purposes of this subsection:

(A) "Date of settlement" means the date on which a written settlement agreement or release is signed by an insured or, in the absence of these documents, the date on which the insured or the attorney for the insured receives payment of any sum required by the settlement agreement. An advance payment as defined in ORS 31.550 shall not be deemed a payment of a settlement for purposes of the time limitation in this subsection.

(B) "Final judgment" means a judgment that has become final by lapse of time for appeal or by entry in an appellate court of an appellate judgment.

Note: Sections 2 and 4, chapter 328, Oregon Laws 2007, provide:

Sec. 2. Unless the parties agree otherwise, arbitration proceedings under ORS 742.504 shall be conducted as follows:

(1) Parties to an arbitration proceeding shall submit the dispute to arbitration by a panel of three arbitrators. The panel shall consist of one arbitrator chosen by each party and one arbitrator chosen by the two arbitrators previously chosen to sit on the panel.

(2) An arbitration proceeding shall be conducted under local court rules in the county where the arbitration is held. [2007 c.328 §2]

Sec. 4. Section 2 of this 2007 Act is repealed on January 2, 2012. [2007 c.328 §4]

742.506 Allocation of responsibility among insurers. Notwithstanding the contrary provisions of any policy, the provisions of ORS 742.504 (9)(a) to (c) shall control allocation of responsibility between insurers, except that if all policies potentially involved expressly allocate responsibility between insurers, or self-insurers, without repugnancy, then the terms of the policies shall control. [Formerly 743.795]

742.508 Definitions for ORS 742.508 and 742.510. As used in this section and ORS 742.510:

(1) "Covered motor vehicle" means a private passenger motor vehicle or a self-propelled mobile home that is owned by the named insured for which a premium has been paid for coverage under this section and ORS 742.510.

(2) "Insured vehicle" means a motor vehicle described in the declarations for which a specific premium charge indicates that underinsured motorists coverage is afforded but the term "insured vehicle" shall not include a vehicle while used as a public or livery conveyance.

(3) "Private passenger motor vehicle" means a four-wheel passenger or station wagon type motor vehicle not more than 12 years old and not used as a public or livery conveyance, and includes any other four-wheel motor vehicle of the utility, pickup body, sedan delivery or panel truck type not used for wholesale or retail delivery.

(4)(a) "Uninsured vehicle" means:

(A) A vehicle with respect to the ownership, maintenance or use of which there is no collectible property damage insurance, in at least the amounts or limits prescribed under ORS 806.070 (2)(c) applicable at the time of the accident with respect to any person or organization legally responsible for the use of such vehicle, or with respect to which there is such collectible insurance applicable at the time of the accident but the insurance company writing the same denies coverage thereunder or, within two years of the date of the accident, such company writing the same becomes voluntarily or involuntarily declared bankrupt or for which a receiver is appointed or becomes insolvent. It shall be a disputable presumption that a vehicle is uninsured in the event the insured and the insurer, after reasonable efforts, fail to discover within 90 days from the date of the accident, the existence of valid and collectible property damage insurance applicable at the time of the accident.

(B) A hit-and-run vehicle as defined in subsection (5) of this section.

(C) A phantom vehicle as defined in subsection (5) of this section.

(b) As used in this section and ORS 742.510, "uninsured vehicle" does not include:

(A) An insured vehicle;

(B) A vehicle which is owned or operated by a self-insurer within the meaning of any motor vehicle financial responsibility law, motor carrier law or any similar law;

(C) A vehicle which is owned by the United States of America, Canada, a state, a political subdivision of any such government or an agency of any of the foregoing;

(D) A land motor vehicle or trailer, if operated on rails or crawler-treads or while located for use as a residence or premises and not as a vehicle;

(E) A farm-type tractor or equipment designed for use principally off public roads, except while actually upon public roads; or

(F) A vehicle owned by or furnished for the regular or frequent use of the insured or any member of the household of the insured.

(5) As used in this section:

(a) "Hit-and-run vehicle" means a vehicle that causes damage to the covered vehicle of an insured arising out of physical contact between the vehicles, provided:

(A) There cannot be ascertained the identity of either the operator or the owner of such hit-and-run vehicle;

(B) The insured or someone on behalf of the insured reports the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and files with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof; and

(C) At the insurer's request, the insured or the legal representative of the insured makes available for inspection the vehicle which was insured at the time of the accident.

(b) "Phantom vehicle" means a vehicle that causes damage to the covered vehicle of an insured, although there is no physical contact between the vehicles, provided:

(A) There cannot be ascertained the identity of either the operator or the owner of such phantom vehicle;

(B) The facts of such accident can be corroborated by competent evidence other than the testimony of the insured or any passenger in the insured motor vehicle; and

(C) The insured or someone on behalf of the insured shall have reported the accident within 72 hours to a police, peace or judicial officer, to the Department of Transportation or to the equivalent department in the state where the accident occurred, and shall have filed with the insurer within 30 days thereafter a statement under oath that the insured or the legal representative of the insured has a cause or causes of action arising out of

such accident for damages against a person or persons whose identity is unascertainable, and setting forth the facts in support thereof. [Formerly 743.796; 2003 c.175 §3]

Note: 742.508 and 742.510 [formerly 743.796 and 743.797] were added to and made a part of ORS chapter 743 by legislative action but were not added to ORS chapter 742 or any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

742.510 Property damage coverage for damage to vehicle caused by uninsured vehicle. (1) Every insurer issuing motor vehicle liability insurance policies on private passenger motor vehicles or on self-propelled mobile homes for delivery in this state shall have for sale coverage for property damage to a vehicle of the insured caused by an uninsured vehicle. Coverage offered under this section shall be at least the amount prescribed to meet the requirements of ORS 806.070 for insurance for injury to or destruction of the property of others in any one accident.

(2) A policy with the coverage described in this section does not cover the first $300 of property damage to the covered motor vehicle as the result of an accident with a hit-and-run vehicle or phantom vehicle. In all other cases the first $200 damage is not covered.

(3) Coverage for property damage described in this section:

(a) Applies only to the amount of damages the insured may be legally entitled to recover.

(b) Does not include coverage for loss of use of the covered vehicle. [Formerly 743.797; 1991 c.768 §5]

Note: See note under 742.508.

(Personal Injury Protection Benefits)

742.518 Definitions for ORS 742.518 to 742.542. As used in ORS 742.518 to 742.542:

(1) "Evaluation services" means physical examinations or reviews of medical records of beneficiaries conducted at the request of an insurer by either an employee of the insurer or a third-party medical record or bill review service to determine whether the provision or continuation of medical services is necessary or reasonable.

(2) "Managed care services" means any system of health care delivery that attempts to control or coordinate use of health care services in order to contain health care expenditures or improve quality of health care services.

(3) "Motor vehicle" means a self-propelled land motor vehicle or trailer, other than:

(a) A farm-type tractor or other self-propelled equipment designed for use principally off public roads, while not upon public roads;

(b) A vehicle operated on rails or crawler-treads; or

(c) A vehicle located for use as a residence or premises.

(4) "Motorcycle" and "moped" have the meanings given those terms in ORS 801.345 and 801.365.

(5) "Occupying" means in, or upon, or entering into or alighting from.

(6) "Pedestrian" means a person while not occupying a self-propelled vehicle other than a wheelchair or a similar low-powered motorized or mechanically propelled vehicle that is designed specifically for use by a person with a physical disability and that is determined to be medically necessary for the occupant of the wheelchair or other low-powered vehicle.

(7) "Personal injury protection benefits" means the benefits described in ORS 742.518 to 742.542.

(8) "Private passenger motor vehicle" means a four-wheel passenger or station wagon type motor vehicle not used as a public or livery conveyance, and includes any other four-wheel motor vehicle of the utility, pickup body, sedan delivery or panel truck type not used for wholesale or retail delivery other than farming, a self-propelled mobile home and a farm truck.

(9) "Proof of loss" means documentation that allows an insurer to determine whether a person is entitled to personal injury protection benefits and the amount of any benefit that is due.

(10) "Provider" has the meaning given that term in ORS 743.801. [2005 c.465 §2; 2007 c.70 §318; 2007 c.692 §1]

742.520 Personal injury protection benefits for motor vehicle liability policies; applicability. (1) Every motor vehicle liability policy issued for delivery in this state that covers any private passenger motor vehicle shall provide personal injury protection benefits to the person insured thereunder, members of that person's family residing in the same household, children not related to the insured by blood, marriage or adoption who are residing in the same household as the insured and being reared as the insured's own, passengers occupying the insured motor vehicle and pedestrians struck by the insured motor vehicle.

(2) Personal injury protection benefits apply to a person's injury or death resulting:

(a) In the case of the person insured under the policy and members of that person's family residing in the same household, from

the use, occupancy or maintenance of any motor vehicle, except the following vehicles:

(A) A motor vehicle, including a motorcycle or moped, that is owned or furnished or available for regular use by any of such persons and that is not described in the policy;

(B) A motorcycle or moped which is not owned by any of such persons, but this exclusion applies only when the injury or death results from such person's operating or riding upon the motorcycle or moped; and

(C) A motor vehicle not included in subparagraph (A) or (B) of this paragraph and not a private passenger motor vehicle. However, this exclusion applies only when the injury or death results from such person's operating or occupying the motor vehicle.

(b) In the case of a passenger occupying or a pedestrian struck by the insured motor vehicle, from the use, occupancy or maintenance of the vehicle.

(3) Personal injury protection benefits consist of payments for expenses, loss of income and loss of essential services as provided in ORS 742.524.

(4) An insurer shall pay all personal injury protection benefits promptly after proof of loss has been submitted to the insurer.

(5) The potential existence of a cause of action in tort does not relieve an insurer from the duty to pay personal injury protection benefits.

(6) Disputes between insurers and beneficiaries about the amount of personal injury protection benefits, or about the denial of personal injury protection benefits, shall be decided by arbitration if mutually agreed to at the time of the dispute. Arbitration under this subsection shall take place as described in ORS 742.521.

(7) An insurer:

(a) May not enter into or renew any contract that provides, or has the effect of providing, managed care services to beneficiaries.

(b) May enter into or renew any contract that provides evaluation services for beneficiaries. [Formerly 743.800; 1991 c.768 §6; 1993 c.282 §1; 1993 c.596 §39; 1995 c.658 §114; 1997 c.344 §§1,2; 1997 c.808 §§3,4; 1999 c.434 §1; 2003 c.813 §1; 2005 c.465 §3; 2007 c.328 §8]

742.521 Conditions applicable to arbitration proceedings. (1) Arbitration proceedings under ORS 742.520 shall be conducted under local court rules in the county where the arbitration is held.

(2) Findings and awards made in an arbitration proceeding under this section:

(a) Are binding on the parties to the arbitration proceeding;

(b) Are not binding on any other party; and

(c) May not be used for the purpose of collateral estoppel. [2007 c.328 §3]

Note: 742.521 was added to and made a part of ORS chapter 742 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

742.522 Binding arbitration under ORS 742.520; costs. (1) Costs to the insured of the arbitration proceeding under ORS 742.520 (6) shall not exceed $100 and all other costs of arbitration shall be borne by the insurer.

(2) As used in this section, "costs" does not include attorney fees or expenses incurred in the production of evidence or witnesses or the making of transcripts of the arbitration proceedings. [Formerly 743.802; 2007 c.328 §9]

742.524 Contents of personal injury protection benefits; deductibles. (1) Personal injury protection benefits as required by ORS 742.520 shall consist of the following payments for the injury or death of each person:

(a) All reasonable and necessary expenses of medical, hospital, dental, surgical, ambulance and prosthetic services incurred within one year after the date of the person's injury, but not more than $15,000 in the aggregate for all such expenses of the person. Expenses of medical, hospital, dental, surgical, ambulance and prosthetic services shall be presumed to be reasonable and necessary unless the provider is given notice of denial of the charges not more than 60 calendar days after the insurer receives from the provider notice of the claim for the services. At any time during the first 50 calendar days after the insurer receives notice of claim, the provider shall, within 10 business days, answer in writing questions from the insurer regarding the claim. For purposes of determining when the 60-day period provided by this paragraph has elapsed, counting of days shall be suspended if the provider does not supply written answers to the insurer within 10 days and shall not resume until the answers are supplied.

(b) If the injured person is usually engaged in a remunerative occupation and if disability continues for at least 14 days, 70 percent of the loss of income from work during the period of the injured person's disability until the date the person is able to return to the person's usual occupation. This benefit is subject to a maximum payment of $1,250 per month and a maximum payment period in the aggregate of 52 weeks. As used in this paragraph, "income" includes but is not limited to salary, wages, tips, commis-

sions, professional fees and profits from an individually owned business or farm.

(c) If the injured person is not usually engaged in a remunerative occupation and if disability continues for at least 14 days, the expenses reasonably incurred by the injured person for essential services that were performed by a person who is not related to the injured person or residing in the injured person's household in lieu of the services the injured person would have performed without income during the period of the person's disability until the date the person is reasonably able to perform such essential services. This benefit is subject to a maximum payment of $30 per day and a maximum payment period in the aggregate of 52 weeks.

(d) All reasonable and necessary funeral expenses incurred within one year after the date of the person's injury, but not more than $5,000.

(e) If the injured person is a parent of a minor child and is required to be hospitalized for a minimum of 24 hours, $25 per day for child care, with payments to begin after the initial 24 hours of hospitalization and to be made for as long as the person is unable to return to work if the person is engaged in a remunerative occupation or for as long as the person is unable to perform essential services that the person would have performed without income if the person is not usually engaged in a remunerative occupation, but not to exceed $750.

(2) With respect to the insured person and members of that person's family residing in the same household, an insurer may offer forms of coverage for the benefits required by subsection (1)(a), (b) and (c) of this section with deductibles of up to $250. [Formerly 743.805; 1991 c.768 §7; 2003 c.813 §2; 2005 c.341 §1]

742.525 Provider charges. (1) Except as provided in subsection (2) of this section, a provider shall charge a person who receives personal injury protection benefits or that person's insurer the lesser of:

(a) An amount that does not exceed the amount the provider charges the general public; or

(b) An amount that does not exceed the fee schedules for medical services published pursuant to ORS 656.248 for expenses of medical, hospital, dental, surgical, ambulance and prosthetic services.

(2) For expenses of hospital services that are subject to the adjusted cost-to-charge ratio specified for a hospital in the hospital fee schedule published pursuant to ORS 656.248, a provider of hospital services shall charge a person who receives personal injury protection benefits or that person's insurer the greater of:

(a) The amount of the hospital charges multiplied by the adjusted cost-to-charge ratio specified for the hospital; or

(b) Ninety percent of the hospital charges. [2003 c.813 §4; 2005 c.341 §4]

Note: 742.525 was added to and made a part of 742.518 to 742.542 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

742.526 Primary nature of benefits. (1) The personal injury protection benefits with respect to:

(a) The insured and members of the family of the insured residing in the same household injured while occupying the insured motor vehicle shall be primary.

(b) Passengers injured while occupying the insured motor vehicle shall be primary.

(c) The insured and members of family residing in the same household injured as pedestrians shall be primary.

(d) The insured and members of family residing in the same household injured while occupying a motor vehicle not insured under the policy shall be excess.

(e) Pedestrians injured by the insured motor vehicle, other than the insured and members of family residing in the same household, shall be excess over any other collateral benefits to which the injured person is entitled, including but not limited to insurance benefits, governmental benefits or gratuitous benefits.

(2) The personal injury protection benefits may be reduced or eliminated, if it is so provided in the policy, when the injured person is entitled to receive, under the laws of this state or any other state or the United States, workers' compensation benefits or any other similar medical or disability benefits. [Formerly 743.810]

742.528 Notice of denial of payment of benefits. An insurer who denies payment of personal injury protection benefits to or on behalf of an insured shall:

(1) Provide written notice of the denial, within 60 calendar days of receiving a claim from the provider, to the insured, stating the reason for the denial and informing the insured of the method for contesting the denial; and

(2) Provide a copy of the notice of the denial, within 60 calendar days of receiving a claim from the provider, to a provider of services under ORS 742.524 (1)(a). [Formerly 743.812; 1993 c.265 §1]

742.529 Payment based on incorrect determination of responsibility; notice; repayment. If personal injury protection benefits are paid based on information that appeared to establish proof of loss and the

insurer paying the benefits later determines the insurer was not responsible for the payment, the insurer shall give notice and explanation to the provider that the payment was incorrectly issued. Immediately after receiving the notice and explanation the provider shall promptly repay the insurer. [2007 c.692 §3]

Note: 742.529 was added to and made a part of 742.518 to 742.542 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

742.530 Exclusions from coverage. (1) The insurer may exclude from the coverage for personal injury protection benefits any injured person who:

(a) Intentionally causes self-injury;

(b) Is participating in any prearranged or organized racing or speed contest or practice or preparation for any such contest; or

(c) Willfully conceals or misrepresents any material fact in connection with a claim for personal injury protection benefits.

(2) The insurer may exclude from the coverage for the benefits required by ORS 742.524 (1)(b) and (c) any person injured as a pedestrian in an accident outside this state, other than the insured person or a member of that person's family residing in the same household. [Formerly 743.815; 2005 c.341 §2]

742.532 Benefits may be more favorable than those required by ORS 742.520, 742.524 and 742.530. Nothing in ORS 742.518 to 742.542 is intended to prevent an insurer from providing more favorable benefits than the personal injury protection benefits described in ORS 742.520, 742.524 and 742.530. [Formerly 743.820]

742.534 Reimbursement of other insurers paying benefits; arbitrating issues of liability and amount of reimbursement. (1) Except as provided in ORS 742.544, every authorized motor vehicle liability insurer whose insured is or would be held legally liable for damages for injuries sustained in a motor vehicle accident by a person for whom personal injury protection benefits have been furnished by another such insurer, or for whom benefits have been furnished by an authorized health insurer, shall reimburse such other insurer for the benefits it has so furnished if it has requested such reimbursement, has not given notice as provided in ORS 742.536 that it elects recovery by lien in accordance with that section and is entitled to reimbursement under this section by the terms of its policy. Reimbursement under this subsection, together with the amount paid to injured persons by the liability insurer, shall not exceed the limits of the policy issued by the insurer.

(2) In calculating such reimbursement, the amount of benefits so furnished shall be diminished in proportion to the amount of negligence attributable to the person for whom benefits have been so furnished, and the reimbursement shall not exceed the amount of damages legally recoverable by the person.

(3) Disputes between insurers as to such issues of liability and the amount of reimbursement required by this section shall be decided by arbitration.

(4) Findings and awards made in such an arbitration proceeding are not admissible in any action at law or suit in equity.

(5) If an insurer does not request reimbursement under this section for recovery of personal injury protection payments, then the insurer may only recover personal injury protection payments under the provisions of ORS 742.536 or 742.538. [Formerly 743.825; 1993 c.709 §7; 2007 c.392 §1]

742.536 Notice of claim or legal action to insurer; insurer to elect manner of recovery of benefits furnished; lien of insurer. (1) When an authorized motor vehicle liability insurer has furnished personal injury protection benefits, or an authorized health insurer has furnished benefits, for a person injured in a motor vehicle accident, if such injured person makes claim, or institutes legal action, for damages for such injuries against any person, such injured person shall give notice of such claim or legal action to the insurer by personal service or by registered or certified mail. Service of a copy of the summons and complaint or copy of other process served in connection with such a legal action shall be sufficient notice to the insurer, in which case a return showing service of such notice shall be filed with the clerk of the court but shall not be a part of the record except to give notice.

(2) The insurer may elect to seek reimbursement as provided in this section for benefits it has so furnished, out of any recovery under such claim or legal action, if the insurer has not been a party to an interinsurer reimbursement proceeding with respect to such benefits under ORS 742.534 and is entitled by the terms of its policy to the benefit of this section. The insurer shall give written notice of such election within 30 days from the receipt of notice or knowledge of such claim or legal action to the person making claim or instituting legal action and to the person against whom claim is made or legal action instituted, by personal service or by registered or certified mail. In the case of a legal action, a return showing service of such notice of election shall be filed with the clerk of the court but shall not be a part of the record except to give notice to the

claimant and the defendant of the lien of the insurer.

(3) If the insurer so serves such written notice of election and, where applicable, such return is so filed:

(a) The insurer has a lien against such cause of action for benefits it has so furnished, less the proportion, not to exceed 100 percent, of expenses, costs and attorney fees incurred by the injured person in connection with the recovery that the amount of the lien before such reduction bears to the amount of the recovery.

(b) The injured person shall include as damages in such claim or legal action the benefits so furnished by the insurer.

(c) In the case of a legal action, the action shall be taken in the name of the injured person.

(4) As used in this section, "makes claim" or "claim" refers to a written demand made and delivered for a specific amount of damages and which meets other requirements reasonably established by the director's rule. [Formerly 743.828]

742.538 Subrogation rights of insurers to certain amounts received by claimant; recovery actions against persons causing injury. If a motor vehicle liability insurer has furnished personal injury protection benefits, or a health insurer has furnished benefits, for a person injured in a motor vehicle accident, and the interinsurer reimbursement benefit of ORS 742.534 is not available under the terms of that section, and the insurer has not elected recovery by lien as provided in ORS 742.536, and is entitled by the terms of its policy to the benefit of this section:

(1) The insurer is entitled to the proceeds of any settlement or judgment that may result from the exercise of any rights of recovery of the injured person against any person legally responsible for the accident, to the extent of such benefits furnished by the insurer less the insurer's share of expenses, costs and attorney fees incurred by the injured person in connection with such recovery.

(2) The injured person shall hold in trust for the benefit of the insurer all such rights of recovery which the injured person has, but only to the extent of such benefits furnished.

(3) The injured person shall do whatever is proper to secure, and shall do nothing after loss to prejudice, such rights.

(4) If requested in writing by the insurer, the injured person shall take, through any representative not in conflict in interest with the injured person designated by the insurer, such action as may be necessary or appropriate to recover such benefits furnished as damages from such responsible person, such action to be taken in the name of the injured person, but only to the extent of the benefits furnished by the insurer. In the event of a recovery, the insurer shall also be reimbursed out of such recovery for the injured person's share of expenses, costs and attorney fees incurred by the insurer in connection with the recovery.

(5) In calculating respective shares of expenses, costs and attorney fees under this section, the basis of allocation shall be the respective proportions borne to the total recovery by:

(a) Such benefits furnished by the insurer; and

(b) The total recovery less (a).

(6) The injured person shall execute and deliver to the insurer such instruments and papers as may be appropriate to secure the rights and obligations of the insurer and the injured person as established by this section.

(7) Any provisions in a motor vehicle liability insurance policy or health insurance policy giving rights to the insurer relating to subrogation or the subject matter of this section shall be construed and applied in accordance with the provisions of this section. [Formerly 743.830]

742.540 Rules. The Director of the Department of Consumer and Business Services shall have authority to issue such rules as are reasonably necessary to carry out the purposes of ORS 742.518 to 742.542. [Formerly 743.833]

742.542 Effect of personal injury protection benefits paid. Payment by a motor vehicle liability insurer of personal injury protection benefits for its own insured shall be applied in reduction of the amount of damages that the insured may be entitled to recover from the insurer under uninsured or underinsured motorist coverage for the same accident but may not be applied in reduction of the uninsured or underinsured motorist coverage policy limits. [Formerly 743.835; 1997 c.808 §10]

742.544 Reimbursement for personal injury protection benefits paid. (1) A provider of personal injury protection benefits shall be reimbursed for personal injury protection payments made on behalf of any person only to the extent that the total amount of benefits paid exceeds the economic damages as defined in ORS 31.710 suffered by that person. As used in this section, "total amount of benefits" means the amount of money recovered by a person from:

(a) Applicable underinsured motorist benefits described in ORS 742.502 (2);

(b) Liability insurance coverage available to the person receiving the personal injury protection benefits from other parties to the accident;

(c) Personal injury protection payments; and

(d) Any other payments by or on behalf of the party whose fault caused the damages.

(2) Nothing in this section requires a person to repay more than the amount of personal injury protection benefits actually received. [1993 c.709 §9]

(Cancellation)

742.560 Definitions for ORS 742.560 to 742.572. As used in ORS 742.560 to 742.572:

(1) "Cancellation" means termination of coverage by an insurer, other than termination at the request of the insured, during a policy period.

(2) "Expiration" means termination of coverage by reason of the policy having reached the end of the term for which it was issued or the end of the period for which a premium has been paid.

(3) "Nonpayment of premium" means failure of the named insured to discharge when due any of the insured's obligations in connection with the payment of premiums on the policy, or any installment of such premium, whether the premium is payable directly to the insurer or an insurance producer who is its agent or indirectly under any premium finance plan or extension of credit.

(4) "Nonrenewal" means a notice by an insurer to the named insured that the insurer is unwilling to renew a policy.

(5) "Policy" means any insurance policy that provides automobile liability coverage, uninsured motorist coverage, automobile medical payments coverage or automobile physical damage coverage on individually owned private passenger vehicles, including pickup and panel trucks and station wagons, that are not used as a public or livery conveyance for passengers, nor rented to others. However, ORS 742.560 to 742.572 do not apply to any policy:

(a) Issued under an automobile assigned risk plan;

(b) Insuring more than four automobiles;

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

(d) 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.

(6) "Renewal" or "to renew" means to continue coverage for an additional policy period upon expiration of the current policy period of a policy. Any policy with a policy period or term of less than six months shall for the purpose of ORS 742.560 to 742.572 be considered as if written for a policy period or term of six months. Any policy written for a term longer than one year or any policy with no fixed expiration date shall for the purpose of ORS 742.560 to 742.572 be considered as if written for successive policy periods or terms of one year but not extending beyond the actual term for which the policy was written. [Formerly 743.900; 2003 c.364 §103; 2007 c.71 §239]

742.562 Grounds for cancellation of policies; notice required; applicability. (1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium.

(b) Fraud or material misrepresentation affecting the policy or in the presentation of a claim thereunder, or violation of any of the terms or conditions of the policy.

(c) The named insured or any operator either resident in the same household or who customarily operates an automobile insured under the policy has had driving privileges suspended or revoked pursuant to law during the policy period, or, if the policy is a renewal, during its policy period or the 180 days immediately preceding its effective date. An insurer may not cancel a policy for the reason that the driving privileges of the named insured or operator were suspended pursuant to ORS 809.280 (7) or (9) if the suspension was based on a nondriving offense.

(2) This section shall not apply to any policy or coverage which has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy.

(3) This section shall not apply to nonrenewal. [Formerly 743.905; 1991 c.860 §7a]

742.564 Manner of giving cancellation notice. (1) No notice of cancellation of a policy to which ORS 742.562 applies shall be effective unless mailed or delivered by the insurer to the named insured at least 30 days prior to the effective date of cancellation and accompanied by a statement of the reason or reasons for cancellation, provided, however, that where cancellation is for nonpayment of premium at least 10 days' notice of cancellation accompanied by the reason therefor shall be given.

(2) This section shall not apply to nonrenewal. [Formerly 743.910]

742.566 Renewal of policies; requirements for refusal to renew. (1) An insurer shall offer renewal of a policy, contingent upon payment of premium as stated in the offer, to an insured unless the insurer mails or delivers to the named insured, at the address shown in the policy, at least 30 days' advance notice of nonrenewal. Such notice shall contain or be accompanied by a statement of the reason or reasons for nonrenewal.

(2) The insurer shall not be required to notify the named insured or any other insured of nonrenewal of the policy if the insurer has mailed or delivered a notice of expiration or cancellation on or prior to the 30th day preceding expiration of the policy period.

(3) Notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any replacement or succeeding automobile insurance policy, with respect to any automobile designated in both policies.

(4) An insurer may not refuse to renew a policy for the reason that the driving privileges of the named insured or any operator either resident in the same household or who customarily operates an automobile insured under the policy were suspended pursuant to ORS 809.280 (7) or (9) if the suspension was based on a nondriving offense. [Formerly 743.916; 1991 c.860 §7b]

742.568 Proof of cancellation or nonrenewal notice. Proof of mailing notice of cancellation, or of intention not to renew or of reasons for cancellation, to the named insured at the address shown in the policy, shall be sufficient proof of notice. [Formerly 743.920]

742.570 Notifying insured under canceled or unrenewed policy of eligibility for participation in insurance pool. When automobile bodily injury and property damage liability coverage is canceled, other than for nonpayment of premium, or in the event of failure to renew automobile bodily injury and property damage liability coverage to which ORS 742.566 applies, the insurer shall notify the named insured of possible eligibility for automobile liability insurance through any insurance pool or facility operating in this state, whether voluntarily or under statute or rule. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew. [Formerly 743.925]

742.572 Immunity from liability of persons furnishing information regarding cancellation or nonrenewal of policies. There shall be no liability on the part of and no cause of action of any nature shall arise against the Director of the Department of Consumer and Business Services or against any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reasons for cancellation or nonrenewal, for any statement made by any of them in any written notice of cancellation or nonrenewal, or in any other communication, oral or written, specifying the reasons for cancellation or nonrenewal, or providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith. [Formerly 743.930]

(Report by Insurer to Department of Transportation)

742.580 Report of cancellation, nonrenewal or issuance of motor vehicle liability policy. Every insurer that issues motor vehicle insurance that is designed to meet either the financial or future responsibility requirements of ORS chapter 806 shall report to the Department of Transportation within 30 days of the day that a person or the insurer cancels or fails to renew such a policy and within 15 days of the day that an insurer issues such a policy. The insurer shall report the person's name and residence address, the vehicle identification number of each vehicle covered by the policy, whether the policy was bought, canceled or not renewed and any other information required by the department by rule under ORS 806.195. [1993 c.746 §4]

CANCELLATION AND NONRENEWAL OF CASUALTY OR COMMERCIAL LIABILITY POLICIES

(Cancellation Based on Holding Public Office)

742.690 Limitations on cancellation; refusal to issue or renew insurance. (1) An insurer offering casualty insurance or commercial liability insurance may not cancel or refuse to issue or renew a policy solely on the basis that the policyholder holds a public office.

(2) An insurer offering casualty insurance or commercial liability insurance may

not include a provision in the insurance contract limiting coverage under the contract solely on the basis that the policyholder holds a public office. [1997 c.778 §2]

(Commercial Liability Policies)

742.700 Definitions for ORS 742.700 to 742.710. As used in ORS 742.700 to 742.710:

(1) "Cancellation" means termination of a policy at a date other than its expiration date.

(2) "Expiration date" means the date upon which coverage under a policy ends. For a policy written for a term longer than one year or with no fixed expiration date, "expiration date" means the annual anniversary date of the policy.

(3) "Nonpayment of premium" means the failure or inability of the named insured to discharge any obligation in connection with the payment of premium on a policy of insurance subject to ORS 742.700 to 742.710, whether the payments are payable directly to the insurer or an insurance producer who is its agent or indirectly payable under a premium finance plan or extension of credit.

(4) "Nonrenewal" means the refusal of an insurer to renew a policy at its expiration date.

(5) "Renewal" or "renew" means the issuance of, or the offer to issue by an insurer, a policy succeeding a policy previously issued and delivered by the same insurer or the issuance of a certificate or notice extending the terms of an existing policy for a specified period beyond its expiration date. [Formerly 743.940; 2003 c.364 §104]

742.702 Grounds for cancellation; notice. (1) Except as provided in ORS 742.710, a contract of commercial liability insurance may not be canceled by an insurer before the expiration of the policy, except on one or more of the following grounds:

(a) Nonpayment of premium.

(b) Fraud or material misrepresentation made by or with the knowledge of the named insured in obtaining the policy, continuing the policy or in presenting a claim under the policy.

(c) Substantial increase in the risk of loss after insurance coverage has been issued or renewed, including but not limited to an increase in exposure due to rules, legislation or court decision.

(d) Failure to comply with reasonable loss control recommendations.

(e) Substantial breach of contractual duties, conditions or warranties.

(f) Determination by the Director of the Department of Consumer and Business Services that the continuation of a line of insurance or class of business to which the policy belongs will jeopardize a company's solvency or will place the insurer in violation of the insurance laws of Oregon or any other state.

(g) Loss or decrease in reinsurance covering the risk.

(h) Any other reason approved by the director by rule.

(2) Cancellation of a commercial liability policy shall not be effective until at least 10 working days after the insured receives a written notice of cancellation. The notice shall state the effective date of and the reason for cancellation and shall inform the insured of the hearing rights established by ORS 742.704.

(3) This section does not apply to policies canceled because of action by an insurer under ORS 731.482. [Formerly 743.942]

742.704 Hearing. Within 30 days after receiving a notice of cancellation under ORS 742.702, an insured may request a hearing before the Director of the Department of Consumer and Business Services. The purpose of this hearing shall be limited to establishing the existence of the proof or evidence given by the insurer in its notice of cancellation. The burden of proving the reason for cancellation shall be upon the insurer. [Formerly 743.944]

742.706 Renewal; nonrenewal. (1) If an insurer offers or purports to renew a commercial liability policy, but on terms less favorable to the insured or at higher rates, the new terms or rates may take effect on the renewal date, if the insurer provides the insured, and the insurance producer if any, 45 days' written notice. If the insurer does not provide such notice, the insured may cancel the renewal policy within 45 days after receipt of the notice or delivery of the renewal policy. Earned premium for the period of time the renewal policy was in force shall be calculated pro rata at the lower of the current or previous year's rate. If the insured accepts the renewal, any premium increase or changes in terms shall be effective immediately following the prior policy's expiration date.

(2) Nonrenewal of a commercial liability policy shall not be effective until at least 45 days after the insured receives a written notice of nonrenewal. If, after an insurer pro-

vides a notice of nonrenewal as described in this subsection, the insurer extends the policy 90 days or less, an additional notice of nonrenewal is not required with respect to the extension.

(3) Subsection (1) of this section does not apply:

(a) If the change is a rate, form or plan filed with the Director of the Department of Consumer and Business Services and applicable to the entire line of insurance or class of business to which the policy belongs; or

(b) To a premium increase based on the altered nature or extent of the risk insured against.

(4) If a commercial liability policy is issued for a term longer than one year, and for additional consideration a premium is guaranteed, the insurer may not refuse to renew the policy or increase the premium for the term of that policy. [Formerly 743.946; 2003 c.364 §105; 2005 c.102 §1]

742.708 Proof of receipt of notice. A post office certificate of mailing to the named insured at the named insured's last-known address shall constitute conclusive proof that the named insured received the notice of cancellation or nonrenewal on the third calendar day after the date of the certificate of mailing. [Formerly 743.948]

742.710 Exemptions from provisions of ORS 742.700 to 742.708. (1) ORS 742.700 to 742.708 do not apply to:

(a) Any commercial liability insurance policy that has not been previously renewed if the policy has been in effect less than 60 days at the time notice of cancellation is mailed or otherwise delivered.

(b) Any policy subject to the provisions of ORS 742.560 to 742.572.

(c) Workers' compensation insurance.

(d) Any assigned risk program.

(e) Any excess liability insurance policy, including any commercial umbrella policy and any excess umbrella policy.

(2) The Director of the Department of Consumer and Business Services may suspend, in whole or in part, the applicability of ORS 742.700 to 742.708 to any insurer if, in the director's discretion, its application will endanger the ability of the insurer to fulfill its contractual obligations. [Formerly 743.950; 2005 c.185 §15]