Chapter 734

2015 EDITION

Rehabilitation, Liquidation and Conservation of Insurers

734.010 [1967 c.359 §258; repealed by 1993 c.447 §122]

GENERAL PROVISIONS

734.014 Definitions. As used in this chapter:

(1) "Delinquency proceeding" means any proceeding commenced against an insurer pursuant to this chapter for the purpose of liquidating, rehabilitating or conserving the insurer.

(2) "Foreign country" means territory not in any state.

(3) "General assets" means all property, real, personal or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or a limited class or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and assets held on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(4) An insurer is "impaired" when its allowed assets do not exceed its liabilities plus its required capitalization.

(5) An insurer is "insolvent" when the insurer is unable to pay its obligations when they are due, or when its allowed assets do not exceed its liabilities.

(6) "Insurer" includes:

(a) All persons transacting or purporting to transact insurance as insurers in this state; and

(b) All persons in process of organization to become insurers.

(7) "Receiver" means receiver, rehabilitator, liquidator or conservator, as the context may require.

(8) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claims or claims against general assets. "Secured claim" also includes claims which more than four months prior to the commencement of delinquency proceedings in the state of the insurer's domicile have become liens upon specific assets by reason of judicial process.

(9) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets. [Formerly 734.020; 1993 c.447 §90]

734.018 [Formerly 751.010; and then 734.030 in 1989; repealed by 1993 c.447 §122]

734.020 [1967 c.359 §257; renumbered 734.014 in 1989]

734.022 [Formerly 734.040; repealed by 1993 c.447 §122]

734.026 "Domiciliary," "ancillary" and "reciprocal state" defined. As used in this chapter:

(1) "Domiciliary state" means the state in which an insurer is incorporated or organized or, in the case of an alien insurer, its state of entry.

(2) "Ancillary state" means any state other than a domiciliary state.

(3) "Reciprocal state" means any state other than this state in which in substance and effect the provisions of this chapter relating to delinquency proceedings are in force, including provisions requiring that the Director of the Department of Consumer and Business Services or equivalent insurance supervisory official be the receiver of a delinquent insurer and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers. [Formerly 734.050; 1993 c.447 §91]

734.030 [Formerly 751.010; renumbered 734.018 in 1989]

734.031 [Formerly 734.060; repealed by 1993 c.447 §122]

734.035 [Formerly 734.070; repealed by 1993 c.447 §122]

734.039 [Formerly 734.080; repealed by 1993 c.447 §122]

734.040 [1967 c.359 §260; renumbered 734.022 in 1989]

734.043 Supervision of insurer; order; consequences; insurer remedies. (1) For any reason stated in subsection (2) of this section, the Director of the Department of Consumer and Business Services by order may place under supervision:

(a) A domestic insurer; or

(b) A foreign or alien insurer, if the insurance regulatory official of its state of domicile or entry has asked the director to apply this section and ORS 734.047, 734.051 and 734.055 to the insurer.

(2) The director may place an insurer under supervision if upon examination or at any other time the director determines that:

(a) The condition of the insurer renders the continuance of its business hazardous to the public or to its insureds.

(b) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the director or any deputy, examiner or employee representing the director.

(c) A domestic insurer has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the insurer.

(d) The insurer has failed to comply promptly with the applicable financial re-

porting statutes or rules and any request of the Department of Consumer and Business Services relating thereto.

(e) The insurer has failed to observe an order of the director to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus.

(f) The insurer is continuing to transact insurance or write business after its certificate of authority has been revoked or suspended by the director.

(g) The insurer, by contract or otherwise, has done any of the following unlawfully, in violation of an order of the director or without first having obtained written approval of the director:

(A) Totally reinsured its entire outstanding business; or

(B) Merged or consolidated substantially its entire property or business with another insurer.

(h) The insurer has engaged in any transaction in which it is not authorized to engage under the laws of this state.

(i) The insurer has failed to comply with any other order of the director.

(j) The insurer has failed to comply with any other applicable provisions of the Insurance Code.

(k) The business of the insurer is being conducted fraudulently.

(L) The insurer agrees to supervision.

(3) If the director determines that one or more conditions set forth in subsection (2) of this section exist, the director may do all of the following:

(a) Notify the insurer of the determination of the director.

(b) Furnish to the insurer a written list of the requirements to abate the condition or conditions determined to exist.

(c) Notify the insurer that it is under the supervision of the director and that the director is applying this section and ORS 734.047, 734.051 and 734.055.

(4) The director may act as the supervisor to conduct the supervision and otherwise carry out an order under subsection (1) of this section or may appoint another person as supervisor.

(5) The director or the appointed supervisor may prohibit any person from taking any of the following actions during the period of supervision without the prior approval of the director or supervisor:

(a) Disposing of, conveying or encumbering any of the insurer's assets or its business in force.

(b) Withdrawing from any of the insurer's bank accounts.

(c) Lending any of the insurer's funds.

(d) Investing any of the insurer's funds.

(e) Transferring any of the insurer's property.

(f) Incurring any debt, obligation or liability on behalf of the insurer.

(g) Merging or consolidating the insurer with another insurer or other person.

(h) Entering into any new reinsurance contract or treaty.

(i) Approving new premiums or renewing any policies.

(j) Terminating, surrendering, forfeiting, converting or lapsing any insurance policy, certificate or contract, except for nonpayment of premiums due.

(k) Releasing, paying or refunding premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate or contract.

(L) Making any material change in management.

(m) Increasing salaries and benefits of officers or directors.

(n) Making or increasing preferential payment of bonuses, dividends or other payments determined by the director to be preferential.

(o) Any other action affecting the business or condition of the insurer.

(6) The director may apply to any circuit court for any restraining order, preliminary and permanent injunctions and other orders necessary to enforce a supervision order.

(7) During the period of supervision, the insurer may file a written request for a hearing to review the supervision or any action taken or proposed to be taken. A request under this subsection shall not suspend the supervision. The insurer must specify in the request the manner in which the action being complained of would not result in improving the condition of the insurer. The hearing shall be held within 30 days after the filing of the request. The director shall complete the review of the supervision or other action and shall take action under subsection (8) of this section if appropriate within 30 days after the record for the hearing is closed.

(8) The director shall release an insurer from supervision if the director determines upon hearing that none of the conditions giving rise to the supervision exist. [1989 c.425 §6; 1991 c.401 §6; 1993 c.447 §88]

734.047 Time for correction of condition leading to order of supervision. (1) An insurer placed under supervision must correct, eliminate or remedy the acts, transactions or practices that are the basis for the order of supervision and otherwise comply with the requirements of the Director of the Department of Consumer and Business Services within the period of time allowed by the director, not to exceed 60 days, after the date on which the order is served on the insurer.

(2) If the director determines that the conditions giving rise to the supervision still exist at the end of the supervision period established in subsection (1) of this section, the director may extend the period. [1989 c.425 §7; 1993 c.447 §89]

734.050 [1967 c.359 §261; renumbered 734.026 in 1989]

734.051 Actions by director during period of supervision. During the period of supervision of an insurer, the Director of the Department of Consumer and Business Services may institute rehabilitation or liquidation proceedings, extend the period of supervision or take any other action under the authority of the director with respect to the insurer. [1989 c.425 §8]

734.055 Action against person violating order of supervision. The Director of the Department of Consumer and Business Services or supervisor on behalf of an insurer under supervision may bring an action for damages against any person who violates any order of the director under ORS 734.043 if the violation reduces the net worth of the insurer or results in loss to the insurer that the insurer would not have suffered otherwise. The director or supervisor may recover damages to the extent of the reduction or loss. [1989 c.425 §9]

734.059 Request for court order. (1) The Director of the Department of Consumer and Business Services may file a petition with the circuit court requesting an order that:

(a) Authorizes the director to seize all or part of the property, books, accounts and other records of a domestic insurer as well as the premises occupied by the insurer for transacting its business; and

(b) Enjoins the domestic insurer from disposing of its property and transacting business except as allowed by written consent of the director.

(2) The director must include all of the following in the petition under subsection (1) of this section:

(a) An allegation that one or more grounds exist that would justify a court order for a rehabilitation or liquidation proceeding against the insurer.

(b) An allegation that the interests of policyholders, creditors or the public will be endangered by delay.

(c) The contents of the order that the director requests the court to issue. [1989 c.425 §10]

734.060 [1967 c.359 §262; renumbered 734.031 in 1989]

734.063 Court order; hearings; notice. (1) Upon petition by the Director of the Department of Consumer and Business Services under ORS 734.059, the court may issue the requested order immediately, ex parte and without hearing. The court in its order shall specify the duration of the order. The duration of an order shall be a period sufficient to enable the director to ascertain the condition of the insurer.

(2) On motion of the director or the insurer against whom an order under this section is issued, or on the court's own motion, the court may hold such hearings from time to time as the court determines are desirable, after such notice as it determines appropriate, and may extend, shorten or modify the terms of the order.

(3) The court may vacate an order issued under this section if the court determines that the director has not commenced a rehabilitation or liquidation proceeding within a reasonable time.

(4) An order of the court directing a rehabilitation or liquidation proceeding vacates the order issued under this section.

(5) Entry of a seizure order under this section does not constitute an anticipatory breach of any contract of the insurer.

(6) At any time after a court issues an order under this section, the court may direct that notice of the order be given to a person if the court determines both of the following:

(a) That the person was not notified of the hearing on the order and did not appear at the hearing.

(b) That the interest of the person is or will be substantially affected by the order. [1989 c.425 §11]

734.067 Review of court order. (1) An insurer against whom an order under ORS 734.059 is directed may petition the court for a hearing and review of the order.

(2) Not later than the 15th day after the court receives a petition under subsection (1) of this section, the court shall hold the hearing and review the order. [1989 c.425 §12]

734.070 [1967 c.359 §263; renumbered 734.035 in 1989]

734.080 [1967 c.359 §264; renumbered 734.039 in 1989]

734.110 Jurisdiction of delinquency proceedings; venue. (1) The circuit court shall have original jurisdiction of delin-

quency proceedings under this chapter, and any court with jurisdiction is authorized to make all necessary or proper orders to carry out the purposes of this chapter.

(2) The venue of delinquency proceedings and proceedings under ORS 734.059 and 734.063 against a domestic insurer and the venue of delinquency proceedings against foreign and alien insurers shall be in the Circuit Court for Marion County.

(3) At any time after the commencement of a delinquency proceeding or a proceeding under ORS 734.059 and 734.063 the court may issue an order changing the venue of the proceeding on motion of the Director of the Department of Consumer and Business Services or other interested person if the court finds the proceedings may be more economically and efficiently conducted thereby. [1967 c.359 §265; 1989 c.425 §13]

734.120 Exclusive remedy; appeal. (1) Delinquency proceedings pursuant to this chapter shall constitute the sole and exclusive method of rehabilitating, liquidating or conserving an insurer, and no court shall entertain a petition for the commencement of such proceedings, or any other similar procedure, unless the same has been filed in the name of the state on the relation of the Director of the Department of Consumer and Business Services.

(2) An appeal shall lie to the Court of Appeals from an order granting or refusing rehabilitation, liquidation, or conservation, and from every order in delinquency proceedings having the character of a final order as to the particular portion of the proceedings embraced therein. [1967 c.359 §266; 1979 c.562 §33]

734.130 Commencement of delinquency proceeding. (1) The Director of the Department of Consumer and Business Services shall commence a delinquency proceeding by an application to the court for an order directing the insurer to show cause why the director should not have the relief prayed for.

(2) The application shall be by petition, verified by the director, setting forth the ground or grounds for the proceeding and the relief demanded.

(3) If the court is satisfied from reading the director's petition that the facts therein alleged, if established, would constitute grounds for a delinquency proceeding under this chapter, the court shall issue an order to the insurer to show cause.

(4) On the return of the order to show cause, and after a full hearing, the court shall either deny the application or grant the application, together with such other relief as the nature of the case and the interests of the policyholders, creditors, stockholders, members, subscribers or the public may require.

(5) After commencement of a delinquency proceeding by the director, orders of the court may thereafter be made for any of the purposes relevant upon application of any interested person. [1967 c.359 §267]

734.140 Injunctions. (1) Upon application by the Director of the Department of Consumer and Business Services for an order to show cause under ORS 734.130, or at any time thereafter, the court may, without notice, issue an injunction restraining the insurer, its officers, directors, stockholders, members, subscribers, agents, employees and all other persons from the transaction of its business or the waste or disposition of its property until the further order of the court.

(2) The court may, at any time during a proceeding under this chapter, issue such other injunctions or orders to prevent any of the following activities:

(a) The transaction of further business.

(b) The transfer of property.

(c) Interference with the receiver or with a delinquency proceeding.

(d) Waste of the assets of an insurer.

(e) Dissipation and transfer of bank accounts.

(f) The institution or further prosecution of any actions or proceedings.

(g) The obtaining of preferences, judgments, attachments, garnishments or liens against the insurer, its assets or its policyholders.

(h) The levying of execution against the insurer, its assets or its policyholders.

(i) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer.

(j) The withholding from the receiver of books, accounts, documents or other records relating to the business of the insurer.

(k) Any other threatened or contemplated action that might lessen the value of the assets of the insurer or prejudice the rights of policyholders, creditors or shareholders, or the administration of any delinquency proceeding.

(3) Notwithstanding any other provision of law, no bond shall be required of the director as a prerequisite for the issuance of any injunction or restraining order pursuant to this section. [1967 c.359 §268; 1993 c.447 §92]

734.142 Cooperation with director in delinquency proceedings. (1) Each officer, manager, director, trustee, owner, employee or agent of an insurer, and any other person with authority over or in charge of any portion of the insurer's affairs, including any person who exercises control directly or indirectly over activities of the insurer through a holding company or other affiliate of the insurer, shall cooperate with the Director of the Department of Consumer and Business Services in any delinquency proceeding or any investigation preliminary to the proceeding. For purposes of this section, cooperation with the director includes at least the following:

(a) Replying promptly in writing to any inquiry from the director requesting such a reply; and

(b) Making available to the director any books, accounts, documents or other records, information or property of or pertaining to the insurer and in the possession, custody or control of the insurer.

(2) A person shall not obstruct or interfere with the director in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders. [1993 c.447 §94]

Note: 734.142 and 734.144 were added to and made a part of ORS chapter 734 by legislative action but were not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

734.144 Immunity of certain persons from civil liability. (1) The following persons are entitled to protection under this section:

(a) All receivers responsible for the conduct of a delinquency proceeding, including present and former receivers.

(b) All employees of the receiver. For purposes of this section, such employees include all present and former special deputies and assistant special deputies appointed by the Director of the Department of Consumer and Business Services and all persons whom the director, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding. Unless designated as special deputies, attorneys, accountants, auditors and other professional persons or firms who are retained by the receiver as independent contractors and their employees are not entitled to protection under this section.

(2) The receiver and employees of the receiver shall have official immunity and shall be immune from civil action and liability, both personally and in their official capacities, for any tort claim or demand, whether groundless or otherwise, arising out of any alleged act, error or omission of the receiver or any employee occurring in the performance of their duties. For purposes of this section, "tort" has the meaning given that term in ORS 30.260.

(3) The receiver and employees of the receiver shall be indemnified from the assets of the insurer against any tort claim arising out of any alleged act, error or omission of the receiver or any employee occurring in the performance of their duties, whether personally or in the official capacity of the receiver or employee. Any indemnification made under this subsection is an administrative expense of the insurer.

(4) The provisions of subsections (2) and (3) of this section do not apply in case of malfeasance in office or willful or wanton neglect of duty.

(5) In any legal action in which the receiver is a defendant, the portion of any settlement relating to the alleged act, error or omission of the receiver is subject to the approval of the court before which the delinquency proceeding is pending. The court may not approve the portion of the settlement if it determines:

(a) That the claim did not occur in the performance of the receiver's duties; or

(b) That the claim was caused by malfeasance in office or willful or wanton neglect of duty by of the receiver.

(6) This section shall not be construed or applied to deprive the receiver or any employee of any immunity, indemnity, benefits of law, rights or any defense otherwise available. [1993 c.447 §95]

Note: See note under 734.142.

734.150 Grounds for rehabilitation of domestic insurers. The Director of the Department of Consumer and Business Services may apply for an order directing the director to rehabilitate a domestic insurer on one or more of the following grounds:

(1) The insurer is impaired.

(2) The insurer has failed to submit its books, papers, accounts or affairs to the reasonable inspection and examination of the director.

(3) Without first obtaining the written consent of the director, the insurer has by contract of reinsurance, or otherwise, transferred or attempted to transfer substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other

person, without first having complied with ORS 732.517 to 732.546 and 742.150 to 742.162.

(4) The insurer is in such condition that its further transaction of business would be hazardous to its policyholders, creditors, stockholders or the public.

(5) The insurer has violated its articles of incorporation, its bylaws, any law of this state or any order of the director.

(6) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee or other person, has refused to be examined under oath by the director concerning its affairs, whether in this state or elsewhere, and after reasonable notice of the fact, the insurer has not promptly and effectively terminated the employment and status of the person and all influence of the person on management.

(7) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or of its property other than as authorized under the Insurance Code, and the appointment has been made or is imminent, and the appointment might deprive the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings.

(8) The insurer has consented to such an order through a majority of its directors, stockholders, members or subscribers.

(9) The insurer has failed to pay any obligation to any state or any subdivision thereof or any final judgment rendered against it in any state within 60 days after the judgment became final or within 60 days after time for taking an appeal has expired, or within 60 days after dismissal of an appeal before final determination, whichever date is the later, if the court in which the judgment was entered had jurisdiction over the subject matter.

(10) The insurer has had its certificate of authority to transact insurance in this state revoked.

(11) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer or other illegal conduct in, by or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(12) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee or other person, if the person has been found by the director to be dishonest or untrustworthy in a way affecting the insurer's business.

(13) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found to be untrustworthy.

(14) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law or within any additional time allowed by the director. [Formerly 738.450; 1993 c.447 §96; 1995 c.30 §11]

734.160 Order of rehabilitation for domestic insurers. (1) An order to rehabilitate a domestic insurer shall direct the Director of the Department of Consumer and Business Services forthwith to take possession of the property of the insurer and to conduct the business thereof, and to take such steps toward removal of the causes and conditions which have made rehabilitation necessary as the court may direct.

(2) If at any time the director deems that further efforts to rehabilitate the insurer would be useless, the director may apply to the court for an order of liquidation under ORS 734.180.

(3) The director, or any interested person upon due notice to the director, at any time may apply for an order terminating the rehabilitation proceeding and permitting the insurer to resume possession of its property and the conduct of its business, but no such order shall be granted except after a full hearing. [1967 c.359 §270]

734.170 Grounds for liquidation of domestic insurers. The Director of the Department of Consumer and Business Services may apply for an order directing the director to liquidate the business of a domestic insurer, regardless of whether there has been a prior order directing the director to rehabilitate such insurer, upon any of the grounds specified in ORS 734.150, or if the insurer:

(1) Has ceased transacting business for a period of one year;

(2) Has commenced voluntary liquidation or dissolution, or attempts to commence or prosecute any action or proceeding to liquidate its business or affairs, or to dissolve its corporate charter, or to procure the appointment of a receiver, trustee, custodian, or sequestrator under any laws except the Insurance Code;

(3) Has not organized or completed its organization and obtained a certificate of authority as an insurer within the time authorized by law; or

(4) Is insolvent. [1967 c.359 §271; 1993 c.447 §97]

734.180 Order of liquidation of domestic insurers. (1) An order to liquidate the business of a domestic insurer shall direct the Director of the Department of Consumer and Business Services forthwith to take possession of the property of the insurer, to liquidate its business, to deal with the insurer's property and business in the name of the director or in the name of the insurer as the court may direct, and to give notice to all creditors who may have claims against the insurer to present such claims.

(2) The director may apply under this chapter for an order dissolving the corporate existence of a domestic insurer:

(a) Upon the application of the director for an order of liquidation of such insurer, or at any time after such order has been granted; or

(b) Upon the grounds specified in ORS 734.170 (3), regardless of whether an order of liquidation is sought or has been obtained. [Formerly 738.470]

734.190 Grounds for conservation of foreign and alien insurers. The Director of the Department of Consumer and Business Services may apply for an order directing the director to conserve the assets within this state of a foreign or alien insurer upon any one or more of the following grounds:

(1) Any of the grounds specified in ORS 734.150; or

(2) That its property has been sequestrated in any jurisdiction. [1967 c.359 §273; 1993 c.447 §98]

734.200 Conservation or ancillary receivership of foreign and alien insurers. (1) An order to conserve the assets of a foreign or alien insurer shall direct the Director of the Department of Consumer and Business Services forthwith to take possession of the property of the insurer within this state and to conserve it, subject to the further direction of the court.

(2) Whenever a domiciliary receiver has been appointed for any foreign or alien insurer in its domiciliary state, the court shall, on application of the director, appoint the director as the ancillary receiver in this state.

(3) An order to liquidate the assets in this state of a foreign or alien insurer shall direct the director forthwith to take possession of the property of the insurer within this state and to liquidate it subject to the orders of the court and with due regard to the rights and powers of the domiciliary receiver, as provided in this chapter. [1967 c.359 §274]

734.210 Conduct of delinquency proceedings for domestic insurers. (1) Whenever under this chapter a receiver is to be appointed in delinquency proceedings for an insurer domiciled in this state, the court shall appoint the Director of the Department of Consumer and Business Services as such receiver. The court shall direct the receiver forthwith to take possession of the property of the insurer and to administer the same under the orders of the court.

(2) Any deed or other instrument executed under this chapter shall be valid and effectual for all purposes as though the same had been executed by the person affected by any proceedings under this chapter or by its officers pursuant to the direction of its governing board or authority. The filing or recording of the order directing possession to be taken, or a certified copy thereof, in the office where instruments affecting title to property are required to be filed or recorded shall impart the same notice as would be imparted by a deed, bill of sale or other evidence of title duly filed or recorded.

(3) In cases where any real property sold by the director is located in a county other than the county wherein the proceeding is pending, the director shall cause a certified copy of the order of the appointment, or order authorizing or ratifying the sale, to be filed with the recording officer for the county in which the property is located.

(4) The director as domiciliary receiver shall be responsible on the official bond of the director for the proper administration of all property coming into the possession or control of the director. The court may at any time require an additional bond from the director or the deputies of the director if deemed desirable for the protection of the property. [Formerly 751.020]

734.220 Powers of director as receiver. (1) Upon taking possession of the property and business of any person in any proceeding under this chapter, the Director of the Department of Consumer and Business Services shall, subject to the direction of the court, immediately proceed to conduct the business of the insurer or to take such steps as are authorized by the laws of this state for the purpose of rehabilitating, liquidating or conserving the insurer.

(2) Upon taking such possession of the property and business of any person, the director as receiver shall:

(a) Be vested with the insurer's title and interest in and to all assets and property of every kind, both tangible and intangible, except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers

which are prescribed in this chapter for ancillary receivers appointed in this state as to assets located in this state;

(b) Possess, in the name of the insurer or in the name of the director, all rights, privileges, powers and authority granted to insurers in this state or otherwise possessed by insurers generally, without regard to any limitations thereon prescribed in the articles or bylaws of such insurer; and

(c) Perform and do all acts which the director may deem necessary, advisable or expedient for the accomplishment or in aid of the purpose for which such possession was taken. [1967 c.359 §276]

734.230 Deputies and assistants. In connection with delinquency proceedings, the Director of the Department of Consumer and Business Services may appoint one or more special deputy directors to act for the director, and may employ such counsel, clerks, and assistants as the director deems necessary. Unless otherwise provided by the director, no person so appointed shall be deemed a state employee solely by reason of such appointment. The compensation of the special deputies, counsel, clerks or assistants and all expenses of taking possession of the delinquent insurer and of conducting the delinquency proceedings shall be paid out of the funds or assets of the insurer. Within the limits of the duties imposed upon them special deputies shall possess all the powers given to, and, in the exercise of those powers, shall be subject to all the duties imposed upon, the receiver with respect to delinquency proceedings. [1967 c.359 §277]

734.240 Conduct of delinquency proceedings for foreign insurers. (1) Whenever under this chapter an ancillary receiver is to be appointed in delinquency proceedings for an insurer not domiciled in this state, the court shall appoint the Director of the Department of Consumer and Business Services as ancillary receiver. The director shall file a petition requesting the appointment:

(a) If the director finds that there are sufficient assets of such insurer located in this state to justify the appointment of an ancillary receiver; or

(b) If 10 or more persons resident in this state having claims against such insurer file a petition with the director requesting the appointment of such ancillary receiver.

(2) The domiciliary receiver of an insurer domiciled in a reciprocal state, shall be vested by operation of law with the title to all the property, contracts and rights of action, and all the books and records of the insurer located in this state, and the domiciliary receiver shall have the immediate right to recover balances due from local insurance producers and to obtain possession of any books and records of the insurer found in this state. The domiciliary receiver shall also be entitled to recover the other assets of the insurer located in this state except that upon the appointment of an ancillary receiver in this state, the ancillary receiver shall during the ancillary receivership proceedings have the sole right to recover such other assets. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. All remaining assets the ancillary receiver shall promptly transfer to the domiciliary receiver. Subject to the provisions of this section the ancillary receiver and the deputies of the ancillary receiver shall have the same powers and be subject to the same duties with respect to the administration of such assets, as a receiver of an insurer domiciled in this state. [Formerly 751.030; 2003 c.364 §85]

734.250 Right of domiciliary receiver to sue in this state. The domiciliary receiver of an insurer domiciled in a reciprocal state may sue in this state to recover any assets of such insurer to which the domiciliary receiver may be entitled under the laws of this state. [1967 c.359 §279]

734.260 Claims of nonresidents against domestic insurers. (1) In a delinquency proceeding begun in this state against an insurer domiciled in this state, claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) Controverted claims belonging to claimants residing in reciprocal states may either:

(a) Be proved in this state as provided by law; or

(b) If ancillary proceedings have been commenced in such reciprocal states, be proved in those proceedings.

(3) In the event a claimant elects to prove a claim in ancillary proceedings, if notice of the claim and opportunity to appear and be heard is afforded the domiciliary receiver of this state as provided in ORS 734.270 with respect to ancillary proceedings in this state, the final allowance of such claim by the courts in the ancillary state shall be accepted in this state as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security lo-

cated within the ancillary state. [Formerly 751.040]

734.270 Claims of residents against foreign insurers. (1) In a delinquency proceeding in a reciprocal state against an insurer domiciled in that state, claimants against such insurer who reside within this state may file claims either with the ancillary receiver, if any, appointed in this state, or with the domiciliary receiver. All such claims must be filed on or before the last date fixed for the filing of claims in the domiciliary delinquency proceedings.

(2) Controverted claims belonging to claimants residing in this state may either:

(a) Be proved in the domiciliary state as provided by the law of that state; or

(b) If ancillary proceedings have been commenced in this state, be proved in those proceedings.

(3) In the event that any such claimant elects to prove a claim in this state, the claimant shall file a claim with the ancillary receiver in the manner provided by this chapter for the proving of claims against insurers domiciled in this state, and the claimant shall give notice in writing to the receiver in the domiciliary state, either by registered or certified mail or by personal service at least 40 days prior to the date set for hearing. The notice shall contain a concise statement of the amount of the claim, the facts on which the claim is based, and the priorities asserted, if any. If the domiciliary receiver, within 30 days after the giving of such notice, shall give notice in writing to the ancillary receiver and to the claimant, either by registered or certified mail or by personal service, of intention to contest such claim, the domiciliary receiver shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim. The final allowance of the claim by the courts of this state shall be accepted as conclusive as to its amount, and shall also be accepted as conclusive as to its priority, if any, against special deposits or other security located within this state. [Formerly 751.050]

734.280 Form of claim; notice; hearing. (1) All claims against an insurer, against which delinquency proceedings have been begun, shall set forth in reasonable detail the amount of the claim, or the basis upon which such amount can be ascertained, the facts upon which the claim is based, and the priorities asserted, if any. All such claims shall be verified by the affidavit of the claimant, or someone authorized to act on behalf of the claimant and having knowledge of the facts, and shall be supported by such documents as may be material thereto.

(2) All claims filed in this state shall be filed with the receiver, whether domiciliary or ancillary, in this state, on or before the last date for filing as specified in this chapter.

(3) After the expiration of any period for filing of claims, the receiver shall report the claims filed within such period to the court, specifying in such report the recommendation of the receiver with respect to the action to be taken thereon. Upon receipt of such report, the court shall fix a time for hearing such claims and shall direct that the claimants or the receiver, as the court shall specify, shall give such notice as the court shall determine to such persons as shall appear to the court to be interested therein. All such notices shall specify the time and place of the hearing and shall concisely state the amount and nature of the claim, the priorities asserted, if any, and the recommendation of the receiver with reference thereto.

(4) At the hearing all persons interested shall be entitled to appear and the court shall enter an order allowing, allowing in part, or disallowing the claim. Any such order shall be deemed to be an appealable order. [1967 c.359 §282]

734.290 Priority of preferred claims. (1) In a delinquency proceeding against an insurer domiciled in this state, claims owing to residents of ancillary states shall be preferred claims if like claims are preferred under the laws of this state. All such claims whether owing to residents or nonresidents shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) In a delinquency proceeding against an insurer domiciled in a reciprocal state, claims owing to residents of this state shall be preferred if like claims are preferred by the laws of that state. [1967 c.359 §283]

734.300 Priority of special deposit claims. The owners of special deposit claims against an insurer for which a receiver is appointed in this or any other state shall be given priority against their several special deposits in accordance with the provisions of the statutes governing the creation and maintenance of such deposits. If there is a deficiency in any such deposit so that claims secured thereby are not fully discharged therefrom, the claimants may share in the general assets, but such sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit. [1967 c.359 §284]

734.310 Priority of secured claims. The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender the security and file a claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this chapter, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state. [Formerly 751.080]

734.320 Attachment and garnishment of assets. During the pendency of delinquency proceedings in this or any reciprocal state no action or proceeding in the nature of an attachment, garnishment or execution shall be commenced or maintained in the courts of this state against the delinquent insurer or its assets. Any lien obtained by any such action or proceeding within four months prior to the commencement of any such delinquency proceeding or at any time thereafter shall be void as against any rights arising in such delinquency proceeding. [1967 c.359 §286]

734.330 [Formerly 751.110; repealed by 1993 c.447 §122]

734.340 Date rights fixed on liquidation. The rights and liabilities of the insurer and of its creditors, policyholders, stockholders, members, subscribers, and all other persons interested in its estate, shall, unless otherwise directed by the court, be fixed as of the date on which the order directing the liquidation of the insurer is filed in the office of the clerk of the court which makes the order, subject to the provisions of ORS 734.380 with respect to the rights of claimants holding contingent claims. [1967 c.359 §288]

734.350 Voidable transfers. (1) Any transfer of, or lien upon, the property of an insurer, other than as provided in ORS 734.320 which is made or created within four months prior to the commencement of a delinquency proceeding with the intent of giving to any creditor, or of enabling the creditor to obtain, a greater percentage of the debt than any other creditor of the same class, and which is accepted by such creditor having reasonable cause to believe that such a preference will occur, shall be voidable.

(2) Every director, officer, employee, stockholder, member, subscriber, and any other person acting on behalf of such insurer who shall be concerned in any such act or deed and every person receiving thereby any property of such insurer or the benefit thereof, shall be personally liable therefor and shall be bound to account to the Director of the Department of Consumer and Business Services.

(3) The director, as receiver in any proceeding under this chapter, may avoid any transfer of, or lien upon, the property of an insurer which any creditor, stockholder, subscriber or member of such insurer might have avoided, and may recover the property so transferred, unless such person was a bona fide holder for value prior to the commencement of the delinquency proceeding. Such property or its value may be recovered from anyone who has received it, except a bona fide holder for value as specified in this subsection. [1967 c.359 §289]

734.360 Preference of claims. Except as provided in ORS 734.310 for secured claims, the claims to be paid in full in delinquency proceedings prior to the payment of any other claims, and the order of payment, shall be:

(1) Expenses of administration of the delinquency proceedings and expenses of the Oregon Insurance Guaranty Association or similar organization in another state handling claims in accordance with ORS 734.510 to 734.710;

(2) All claims under policies, including third party claims and claims under nonassessable policies for unearned premiums, and all claims by the Oregon Insurance Guaranty Association, the Oregon Life and Health Insurance Guaranty Association or any similar organization in another state for payment of covered claims or contractual obligations;

(3) Claims legally due and owing by the insurer to the United States;

(4) If the insurer is domiciled in this state, compensation or wages actually owing to salaried employees other than officers of the insurer, for services rendered within three months prior to the commencement of the delinquency proceeding, but not exceeding $2,000 for each such employee;

(5) Claims legally due and owing by the insurer to this state; and

(6) Claims, including special deposit claims, owing to any person, including this state, that by the laws of this state is entitled to priority. [1967 c.359 §290; 1977 c.793 §7; 1983 c.223 §1; 2001 c.974 §3]

734.370 Offsets. No offsets shall be allowed in cases of mutual debts or mutual credits between the insurer and another person in connection with any domestic delin-

quency proceeding under this chapter, except for cases of policy loans and cases of reinsurance and except for insurance producers' balances, excluding unearned return commissions. [1967 c.359 §291; 1989 c.425 §14; 2003 c.364 §86]

734.380 Allowance of certain claims. (1) A contingent claim against an insurer or a claim based upon a cause of action or suit against an insured of an insurer shall be filed, presented and reported in the same manner and within the same time limitations as provided in this chapter for a noncontingent claim. Such claims shall be allowed to share in a distribution of assets in the same manner as noncontingent claims of the same class and priority, provided that before any such sharing and distribution:

(a) If the claim is a contingent claim against the insurer, it becomes an absolute claim either as a result of proof presented or litigation; or

(b) If the claim is based upon a cause of action or suit against an insured of the insurer, a judgment is obtained against the insured or it may be reasonably inferred from proof presented that the claimant would be able to obtain such a judgment; in no case, however, shall all of the claims so presented and allowed arising out of a single act of the insured exceed the maximum liability of the insurer under its policy with or affecting the insured.

(2) Nothing in subsection (1) of this section shall prevent or bar the Director of the Department of Consumer and Business Services from compromising a disputed claim with the claimant, whether contingent or noncontingent, if such compromise is justified and supported by the facts and circumstances.

(3) If full or partial distribution to noncontingent claimants is authorized or directed by the court prior to satisfaction of the requirements of subsection (1)(a) or (b) of this section, with respect to particular claims the director shall retain a sum equal to the amount which would have been paid on the contingent claim if such requirements had then been met. The amount so withheld shall be distributed to the person or persons found by the court to be entitled thereto at such time as the claim is fully established as provided in subsection (1) of this section, or the director is satisfied that the claim is without merit or cannot be so proved or established, or the statute of limitations, if timely asserted, would bar further consideration or recovery thereon.

(4) No judgment entered after the date of entry of a liquidation order shall be considered in the liquidation proceedings as evidence of liability or of the amount of damages, and no judgment entered on default or inquest or by collusion after commencement of a delinquency proceeding shall be considered as conclusive evidence in the liquidation proceeding, either of liability or of the amount of damages. [1967 c.359 §292]

734.390 Time to file claims. (1) If upon the granting of an order of liquidation under this chapter, or at any time thereafter during the liquidation proceeding, the insurer shall not be clearly solvent, the court shall, after such notice and hearing as it considers proper, make an order declaring the insurer to be insolvent. Thereupon, regardless of any prior notice which may have been given to creditors, the Director of the Department of Consumer and Business Services shall notify all persons who may have claims against the insurer and who have not filed proper proofs thereof, to present the same to the director, at a place specified in the notice, within four months from the date of the entry of such insolvency order or within such longer time as the court shall prescribe. The last day for filing of proofs of claims shall be specified in the notice. The notice shall be given in a manner determined by the court.

(2) Proofs of claims may be filed subsequent to the date specified, but no such claim shall share in the distribution of the assets until all allowed claims, proofs of which have been filed on or before such date, have been paid in full. [1967 c.359 §293]

734.400 Report for assessment; domestic mutual and reciprocal insurers. Within three years from the date an order of rehabilitation or liquidation of a domestic mutual insurer or a domestic reciprocal insurer was filed in the office of the clerk of the court by which such order was made, the Director of the Department of Consumer and Business Services may make a report to the court setting forth:

(1) The reasonable value of the assets of the insurer;

(2) The insurer's probable liabilities; and

(3) The probable necessary assessment, if any, to pay all claims and expenses in full, including expenses of administration. [1967 c.359 §294]

734.410 Levy of assessment; domestic mutual and reciprocal insurers. (1) Upon the basis of the report provided for in ORS 734.400, including any amendments thereof, the court, ex parte, may levy one or more assessments against all persons who, as shown by the records of the insurer, were members (in the case of a mutual insurer) or subscribers (in the case of a reciprocal insurer) at any time within one year prior to the commencement of the delinquency proceeding.

(2) Such assessment or assessments shall cover the excess of the probable liabilities over the reasonable value of the assets, together with the estimated cost of collection and percentage of uncollectibility thereof. The total of all assessments against any member or subscriber, with respect to any policy, whether levied pursuant to this chapter or pursuant to any other provisions of the Insurance Code, shall be no greater than the amount specified in the policy of the member or subscriber and as limited under the Insurance Code; except that, if the court finds that the policy was issued at a rate of premium below the minimum rate lawfully permitted for the risk insured, the court may determine the upper limit of such assessment on the basis of such minimum rate.

(3) No assessment shall be levied against any member or subscriber with respect to any nonassessable policy issued in accordance with the Insurance Code. [1967 c.359 §295]

734.420 Order to pay assessment. After levy of assessment as provided in ORS 734.410 and upon the filing of a further detailed report by the Director of the Department of Consumer and Business Services, the court shall issue an order directing each member (in the case of a mutual insurer) or each subscriber (in the case of a reciprocal insurer) if the member or subscriber shall not pay the amount assessed against the member or subscriber to the director on or before a day to be specified in the order, to show cause why the member or subscriber should not be held liable to pay such assessment together with costs as set forth in ORS 734.440, and why the director should not have judgment therefor. [1967 c.359 §296]

734.430 Publication and transmittal of assessment order. The Director of the Department of Consumer and Business Services shall cause a notice of the assessment order issued under ORS 734.420, which shall set forth a brief summary of the contents of such order, to be:

(1) Published in such manner as shall be directed by the court; and

(2) Enclosed in a sealed envelope, addressed and mailed, postage prepaid, to each member or subscriber liable thereunder, at the last-known address of the member or subscriber as it appears on the records of the insurer, at least 20 days before the return day of the order to show cause specified in the assessment order. [1967 c.359 §297]

734.440 Judgment upon assessment. (1) On the return day of the order to show cause specified in the assessment order issued under ORS 734.420, if the member or subscriber does not appear and serve verified objections upon the Director of the Department of Consumer and Business Services, the court shall make an order adjudging that such member or subscriber is liable for the amount of the assessment against the member or subscriber, together with $10 costs, and that the director may have judgment against the member or subscriber therefor.

(2) If on such return day the member or subscriber shall appear and serve verified objections upon the director, there shall be a full hearing before the court or a referee to hear and determine the matter. The court, after such hearing, shall make an order either negativing the liability of the member or subscriber to pay the assessment or affirming liability to pay the whole or some part thereof, together with $25 costs and the necessary disbursements incurred at such hearing, and directing that the director, in the latter case, may have judgment therefor. [1967 c.359 §298; 2003 c.576 §221]

OREGON INSURANCE GUARANTY ASSOCIATION

734.510 Definitions for ORS 734.510 to 734.710. As used in ORS 734.510 to 734.710, unless the context requires otherwise:

(1) "Association" means the Oregon Insurance Guaranty Association created by ORS 734.550.

(2) "Board" means the board of directors of the association.

(3) "Controlled insurer" means an insurer 70 percent or more of whose stock is owned by a corporation, or by two or more corporations that are under common ownership.

(4)(a) "Covered claim" means an unpaid claim, including a claim for unearned premiums and a claim by the Workers' Benefit Fund for payments made pursuant to ORS chapter 656, that arises out of and is within the coverage and limits of an insurance policy to which ORS 734.510 to 734.710 apply and which is in force at the time of the occurrence giving rise to the unpaid claim, made by a person insured under such policy or by a person suffering injury or damage for which a person insured under such policy is legally liable, if:

(A) The insurer issuing the policy becomes an insolvent insurer after September 9, 1971; and

(B) The claimant or insured is a resident of this state at the time of the occurrence giving rise to the unpaid claim, or the property for which claim arises is permanently located in this state.

(b) "Covered claim" does not include:

(A) Any amount in excess of the applicable limits of liability provided by an insur-

ance policy to which ORS 734.510 to 734.710 apply;

(B) Any amount due any reinsurer, insurer, insurance pool or underwriting association as subrogated recoveries or otherwise;

(C) Except for claims arising out of workers' compensation policies subject to ORS chapter 656, a claim filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer; or

(D) Any first party claim by an insured whose net worth exceeds $25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer, provided that an insured's net worth on such date is deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis.

(5) "Dividend" means any payment made to the stockholders of a controlled insurer, which payment is directly related to ownership of the stock.

(6) "Insolvent insurer" means a member insurer:

(a) Authorized to transact insurance in this state either at the time the policy was issued or at the time of the occurrence giving rise to the unpaid claim;

(b) Against which a final order of liquidation, with a finding of insolvency, has been entered by a court of competent jurisdiction in the insurer's domicile after September 9, 1971; and

(c) With respect to which no order, judgment or finding relating to the insolvency of the insurer, whether preliminary or temporary in nature or otherwise, has been issued by a court of competent jurisdiction or by any insurance commissioner, insurance department or similar official or body prior to September 9, 1971, or which was in fact insolvent prior to September 9, 1971, and such de facto insolvency was or should have been known by the chief insurance regulatory official of its domicile.

(7) "Member insurer" means an insurer, including a reciprocal insurer, authorized to transact insurance in this state that writes any kind of insurance to which ORS 734.510 to 734.710 apply.

(8) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which ORS 734.510 to 734.710 apply, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(9) "Plan" means the plan of operation of the association established pursuant to ORS 734.590. [1971 c.616 §5; 1977 c.793 §8; 2001 c.974 §1; 2003 c.576 §556]

734.520 Purpose. The purpose of ORS 734.510 to 734.710 is to provide for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, to provide an association to assess the cost of such protection among insurers and to assist in the liquidation of insurers as provided in this chapter. [1971 c.616 §2]

734.530 Construction. ORS 734.510 to 734.710 shall be liberally construed to effect the purposes provided in ORS 734.520. [1971 c.616 §3]

734.540 Application. ORS 734.510 to 734.710 apply to all kinds of direct insurance except life, health, title, surety, credit, mortgage guaranty, home protection insurance, wet marine and transportation insurance and 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. [1971 c.616 §4; 1977 c.600 §2; 1981 c.247 §14; 1993 c.649 §7]

734.550 Oregon Insurance Guaranty Association; all insurers required to be members; formation of operating plan. There is created the Oregon Insurance Guaranty Association. Each insurer that is a member insurer shall become and remain a member of the association as a condition of its authority to transact insurance in this state. The association shall perform its functions in accordance with a plan of operation established under ORS 734.590, and shall exercise its powers through its board of directors. [1971 c.616 §6]

734.555 Application to association of certain laws governing corporations; exception. The provisions, procedures and requirements of ORS chapter 60 relating to a registered office, registered agent and to service of process, notice and demand shall govern the Oregon Insurance Guaranty Association, except that the Director of the Department of Consumer and Business Services shall be substituted for the Secretary of State as the person with whom all filings shall be made and upon whom, in the circumstances specified by statute, such service may be effected. [1977 c.600 §6; 1987 c.846 §12]

734.560 Association board of directors; terms; vacancies; compensation and expenses; quorum. (1) The board of directors of the Oregon Insurance Guaranty Associ-

ation shall consist of nine members selected by the member insurers, subject to the approval of the Director of the Department of Consumer and Business Services. The term of each member of the board shall be as specified in the plan, but in no event for longer than four years. A vacancy on the board shall be filled for the remainder of the unexpired term in the same manner as for the initial selection. If the initial selection of members is not made within 60 days after September 9, 1971, the director may select the initial members.

(2) In making or approving selections to the board, the director shall consider, among other things, whether member insurers are fairly represented.

(3) A member of the board shall receive no compensation for services as a member. However, a member shall be reimbursed by the association for actual and necessary travel and other expenses incurred by the member in the performance of duties.

(4) A majority of the members of the board constitutes a quorum for the transaction of business. [1971 c.616 §7]

734.570 Required functions of association. The Oregon Insurance Guaranty Association shall:

(1) Be obligated to pay covered claims existing at the time of determination of insolvency of an insurer or arising within 30 days after the determination of insolvency. Except for covered claims arising out of workers' compensation policies, such obligation shall include only that amount of each covered claim that is less than $300,000. The association shall pay the full amount of any covered claim arising out of a workers' compensation policy, less any amount paid on a covered claim by the Workers' Benefit Fund pursuant to ORS chapter 656. In no event shall the association be obligated in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises, or for claims arising after the policy expiration, policy replacement by the insured or policy cancellation caused by the insured.

(2) Be the insurer to the extent of the association's obligation on the covered claims and to such extent have all the rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent.

(3) Assess member insurers the amounts necessary to pay the expenses incurred by the association in meeting its obligations and exercising its duties and powers under ORS 734.510 to 734.710. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year, but shall in no event exceed in any one year two percent of the member insurer's net direct written premiums for the preceding calendar year. Each member insurer shall be notified of an assessment not later than the 30th day before the day it is due. If the funds of the association do not provide in any one year an amount sufficient to pay the obligations and expenses of the association, the funds available shall be prorated among the obligations and expenses, and the unpaid portions shall be paid as soon thereafter as funds become available. If an assessment would cause a member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance, the association may exempt from or defer payment of the assessment, in whole or in part, by the member insurer. However, if the member insurer is a controlled insurer, the association, in making determinations regarding the exemption or deferral of assessments, shall treat all dividends paid during the three calendar years immediately preceding the year in which the assessment is made as assets of the insurer just as if such dividends had not been paid. Each member insurer designated as a servicing facility may set off against any assessment authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer in its capacity as a servicing facility.

(4) Investigate claims brought against the association and adjust, compromise, settle and pay covered claims to the extent of the association's obligation, and review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested.

(5) Reimburse servicing facilities and employees of the association for obligations and expenses incurred and paid in the handling of claims on behalf of the association, and pay all other expenses the association incurs in carrying out ORS 734.510 to 734.710. [1971 c.616 §8; 1977 c.793 §9; 2001 c.974 §9]

734.575 Refunds from association deposited in General Fund. Any sums acquired by refund from the Oregon Insurance Guaranty Association that have previously been written off by contributing insurers and offset against corporate excise taxes or fire insurance gross premiums taxes, and are not then needed for purposes of ORS 734.510 to

734.710, shall be paid by the association to the Director of the Department of Consumer and Business Services and deposited with the State Treasurer for credit to the General Fund of this state. [1977 c.793 §3; 1985 c.686 §1; 1995 c.786 §8; 2003 c.568 §4]

734.577 [1987 c.582 §1; 1991 c.67 §196; 2003 c.14 §448; repealed by 2005 c.755 §59]

734.579 Recoupment assessments; rules. (1) Each member insurer subject to an Oregon Insurance Guaranty Association assessment pursuant to ORS 734.570 (3) shall recoup the amount of the assessment through a recoupment assessment imposed on net direct written premiums. The member insurer shall fix the amount of the recoupment assessment at an amount sufficient to reimburse the member insurer for the amount of Oregon Insurance Guaranty Association assessments paid by the member insurer.

(2) Each member insurer shall annually certify to the Director of the Department of Consumer and Business Services the total amount of recoupment assessments assessed for the year and that the amount assessed does not exceed the amount of Oregon Insurance Guaranty Association assessments imposed and not previously recouped or offset against corporate excise taxes or fire insurance gross premiums taxes.

(3) The director may by rule establish a minimum threshold for which a recoupment assessment under subsection (1) of this section need not be made.

(4) The Department of Consumer and Business Services, pursuant to rules adopted by the director, may audit member insurer determinations of recoupment assessments.

(5) Recoupment assessments shall be separately stated on premium billing statements. Recoupment assessments may not be considered gross premiums for any purpose. [2003 c.568 §2]

734.580 Discretionary functions of association. The Oregon Insurance Guaranty Association may:

(1) With the approval of the Director of the Department of Consumer and Business Services, employ or retain such persons or designate such servicing facilities as are necessary to handle claims and perform the other duties of the association. Servicing facilities so designated may be foreign corporations or associations.

(2) Borrow funds necessary to carry out ORS 734.510 to 734.710, in such manner as may be specified in the plan.

(3) Sue or be sued.

(4) Negotiate and become a party to such contracts as are necessary to carry out ORS 734.510 to 734.710.

(5) At the end of any calendar year, refund to member insurers, in proportion to an insurer's payments to the association, that amount by which the board of directors find that the funds of the association exceed its current claims and expenses plus the liabilities estimated for the coming year.

(6) Perform such other acts as are necessary or proper to carry out ORS 734.510 to 734.710. [1971 c.616 §9]

734.590 Plan of operation; submission to director; rules. (1) The Oregon Insurance Guaranty Association shall submit to the Director of the Department of Consumer and Business Services not later than 90 days after September 9, 1971, a plan of operation, and may thereafter submit such amendments thereto as will provide for the reasonable and equitable exercise of the duties and powers of the association. The plan of operation, and any amendments thereto, shall become effective upon approval in writing by the director.

(2) If the association fails to submit a plan that receives the approval of the director as provided in subsection (1) of this section, or if the association thereafter fails to maintain a plan satisfactory to the director, the director shall by rule prescribe a plan of operation that meets the standards provided in subsection (1) of this section. A plan prescribed by the director shall remain in effect until the director by rule provides otherwise.

(3) No member insurer shall fail to comply with the currently effective plan of operation. [1971 c.616 §10]

734.600 Contents of plan of operation. A plan of operation shall:

(1) Establish procedures for the submission, processing and payment of claims against the Oregon Insurance Guaranty Association.

(2) Establish procedures for record keeping, payment of expenses and administration of all other financial affairs of the association.

(3) Establish times and places for meetings of the board.

(4) Establish procedures for selection of the board of directors and for approval of that selection by the Director of the Department of Consumer and Business Services.

(5) Establish a procedure for appeal by a member insurer to the director of final actions or decisions of the association.

(6) Establish such other procedures as may be necessary or proper to carry out the duties and powers of the association. [1971 c.616 §11]

734.610 Notification to association of insurer insolvency; furnishing association with premium information. The Director of the Department of Consumer and Business Services shall:

(1) Notify the Oregon Insurance Guaranty Association of the insolvency of an insurer not later than three days after the director receives notice of the determination of insolvency.

(2) Upon request of the board, provide the association with a statement of the net direct written premiums of each member insurer for the preceding calendar year. [1971 c.616 §12]

734.620 Notification of insolvency to insured persons; revocation of designation of servicing facility. The Director of the Department of Consumer and Business Services may:

(1) Require the Oregon Insurance Guaranty Association to notify the insureds of an insolvent insurer of the determination of insolvency and of their rights under ORS 734.510 to 734.710. Such notification may be by:

(a) Certified or first-class mail to the address of each such person as it last appears in the records of the director or the insurer;

(b) Publication in a newspaper of general circulation in this state if the addresses of those persons to be notified is not available from the records of the director or the insurer; or

(c) Any combination of the methods referred to in paragraphs (a) and (b) of this subsection that the association considers likely to inform the persons of their rights under ORS 734.510 to 734.710.

(2) Revoke the designation of any servicing facility that the director finds is not processing and paying claims in the manner provided in the plan and in ORS 734.510 to 734.710. [1971 c.616 §13]

734.630 Assignment of claim rights; filing statements of paid claims; effect of claim settlements. (1) Any person who recovers on a covered claim under ORS 734.510 to 734.710 thereby assigns the rights of the person under the insurance policy to the Oregon Insurance Guaranty Association to the extent of such recovery. Every person who seeks the protection of ORS 734.510 to 734.710 shall cooperate with the association to the same extent such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insureds of an insolvent insurer for any sums paid, except for those causes of action the insolvent insurer would have had if such sums had been paid by the insolvent insurer. If an insolvent insurer operates on the assessment plan, the payment of claims by the association does not reduce the liability of the insured to the receiver for unpaid assessments.

(2) Periodically the association shall file with the receiver statements of the covered claims paid by the association and estimates of anticipated claims against the association. Such filings shall preserve the rights of the association against the assets of the insolvent insurer.

(3) The receiver shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority in accordance with ORS 734.360. [1971 c.616 §14; 2001 c.974 §4]

734.635 Disbursing assets of insolvent insurer to association; court approval; notice to other states. (1) Not later than 120 days from the date the order of liquidation of a member insurer is filed in the office of the clerk of the court by which the order was made, that insurer's receiver shall make application to the court for approval of a proposal to disburse the insurer's marshalled assets to the Oregon Insurance Guaranty Association from time to time as those assets become available.

(2) A proposal made by a receiver under subsection (1) of this section shall include, but not be limited to, provisions for:

(a) Reserving amounts for the payment of those claims described in ORS 734.360;

(b) Disbursing the marshalled assets of the insolvent insurer to the association in an amount estimated to be at least equal to the claim payments to be made by the association for which the association could assert a claim against the insolvent insurer;

(c) Disbursing the marshalled assets in the amount available when the marshalled assets do not equal the amount of the claim payments to be made by the association for which the association could assert a claim against the insolvent insurer;

(d) Securing an agreement from the association to return to the receiver any assets previously disbursed that may be required to pay the claims of secured creditors and the claims described in ORS 734.360; and

(e) A complete report by the association to the receiver accounting for all assets disbursed to the association under this section, expenditures made from those assets and any interest earned by the association on those assets.

(3) When an insurer's receiver intends to make application to a court for approval of a proposal to disburse the insurer's marshalled assets to the association under

this section, the receiver shall give notice of the application, at least 30 days prior to filing the application with the court, to the insurance supervisory official and the insurance guaranty agency that performs functions similar to that of the association of each state in which the insolvent insurer was authorized. [1977 c.793 §2; 2001 c.974 §10]

734.640 Claim priority. (1) Any person who has a claim under an insurance policy against an insurer other than an insolvent insurer which would also be a covered claim against an insolvent insurer must first exhaust the remedies under such policy.

(2) Any person who has a claim that may also be recovered from one or more insurance guaranty agencies that perform functions similar to that of the Oregon Insurance Guaranty Association shall first seek recovery from whichever organization serves the place of residence of the insured, except that:

(a) Recovery on first party claims for damage to property with a permanent location shall first be sought from whichever organization serves the location of the property; and

(b) Recovery on workers' compensation claims shall first be sought from whichever organization serves the residence of the claimant.

(3) Any recovery under ORS 734.510 to 734.710 from the association shall be reduced by the amount of any recovery pursuant to subsections (1) and (2) of this section. [1971 c.616 §16; 1977 c.793 §10]

734.650 Notifying director of impaired insurers; examination; reports on impaired insurers. (1) Whenever the board obtains any information indicating that any member insurer is impaired or in a financial condition hazardous to the policyholders or the public, the board shall so notify the Director of the Department of Consumer and Business Services.

(2) The board may request the director to examine any member insurer that the board in good faith believes to be impaired or in a financial condition hazardous to the policyholders or the public. The director shall cause the examination to begin within 30 days after the receipt of any such request. Except as otherwise provided in ORS 734.510 to 734.710, the examination shall be conducted as provided in ORS chapter 731.

(3) The director shall report the results of an examination to the board and shall notify the board whenever the director has reasonable cause to believe during an examination that the insurer is impaired or insolvent. The results of the completed examination shall not be released to the board before release to the public. The request for examination shall not be available for public inspection before release of the results of the examination to the public.

(4) The board may make such reports and recommendations to the director regarding the insolvency, liquidation, rehabilitation or conservation of member insurers as the board considers appropriate. Any such reports or recommendations are not public records. [1971 c.616 §17]

734.660 Regulation of association as insurer. The Oregon Insurance Guaranty Association is subject to regulation by the Director of the Department of Consumer and Business Services in the same manner as an insurer. Not later than March 30 of each year, the board shall submit to the director, in a form approved by the director, a financial report for the preceding year. [1971 c.616 §18]

734.670 Exemption of association from payment of fees and taxes. Except for taxes levied on real or personal property, the Oregon Insurance Guaranty Association shall be exempt from the payment of all fees and taxes levied by this state or by any city, county, district or other political subdivision of this state. [1971 c.616 §19]

734.680 [1971 c.616 §20; repealed by 1977 c.793 §11]

734.690 Immunity from legal action. No person shall have a cause of action against any member insurer, the Oregon Insurance Guaranty Association or its employees or servicing facilities, any member of the board, or the Director of the Department of Consumer and Business Services or employees of the director for any action taken by them in carrying out ORS 734.510 to 734.710. [1971 c.616 §21]

734.695 Liability of insured of insolvent insurer. (1) The insured of an insolvent insurer may not be personally liable for amounts due any reinsurer, insurer, insurance pool or underwriting association as subrogation recoveries or otherwise up to the applicable limits of liability provided by the insurance policy issued by the insolvent insurer.

(2) Notwithstanding the provisions of subsection (1) of this section, and except for claims arising out of workers' compensation policies subject to ORS chapter 656, the Oregon Insurance Guaranty Association may recover from the following persons the amount of any covered claim paid on behalf of such person under ORS 734.510 to 734.710:

(a) Any insured whose net worth exceeds $25 million on December 31 of the year next preceding the date the insurer becomes an insolvent insurer and whose liability obligations to other persons are satisfied in

whole or in part by payments made under ORS 734.510 to 734.710; and

(b) Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under ORS 734.510 to 734.710. [1977 c.793 §4; 2001 c.974 §2]

734.700 Defense of claims on default of insolvent insurer. (1) Any pending proceeding in which an insolvent insurer is a party or is obligated to defend a party in any court of this state shall be stayed for 60 days after the date a receiver is appointed by the court to permit the Oregon Insurance Guaranty Association time to prepare a defense in such proceedings.

(2) If any covered claim arises from a judgment based on the default of the insolvent insurer or its failure to defend an insured, the association may apply to have such judgment set aside, and, upon such application shall be permitted to defend against the claim on the merits. [1971 c.616 §22]

734.710 Administration of delinquency proceeding claims and expenses; application of ORS 734.014, 734.026 and 734.110 to 734.440 to insurers. (1) In any delinquency proceeding involving a member insurer, the claims and expenses of the insurer shall be administered as provided in ORS 734.510 to 734.710.

(2) Except as otherwise provided in ORS 734.510 to 734.710, ORS 734.014, 734.026 and 734.110 to 734.440 apply to a member insurer. [1971 c.616 §23]

OREGON LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

734.750 Short title. ORS 734.750 to 734.890 may be cited as the Oregon Life and Health Insurance Guaranty Association Act. [1975 c.251 §2]

734.760 Definitions for ORS 734.750 to 734.890. As used in ORS 734.750 to 734.890, unless the context requires otherwise:

(1) "Account" means one of the three accounts created under ORS 734.800.

(2) "Association" means the Oregon Life and Health Insurance Guaranty Association created under ORS 734.800.

(3) "Contractual obligation" means any obligation under a covered policy or contract or a certificate under a group policy or contract.

(4) "Covered policy" means any policy or contract or a certificate under a group policy or contract to which ORS 734.750 to 734.890 apply.

(5) "Disability insurance" means health insurance that provides income payments to an insured wage earner whose income is interrupted due to an accident or illness. "Disability insurance" does not include workers' compensation insurance.

(6) "Impaired insurer" means a member insurer that is subject to an order of rehabilitation under ORS 734.063 or an order of conservation under ORS 734.200 after September 13, 1975. "Impaired insurer" does not include an insolvent insurer.

(7) "Insolvent insurer" means a member insurer that, after September 13, 1975, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(8) "Long term care insurance" has the meaning given that term in ORS 743.652.

(9)(a) "Member insurer" means any insurer currently authorized to transact in this state any kind of insurance to which ORS 734.750 to 734.890 apply, regardless of whether the insurer's authorization to transact insurance was, in the past, suspended, revoked, not renewed or voluntarily withdrawn.

(b) "Member insurer" does not include:

(A) A hospital or medical service organization, whether for-profit or nonprofit;

(B) A health maintenance organization;

(C) A fraternal benefit society;

(D) A mandatory state pooling plan;

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

(F) An insurance exchange; or

(G) An organization that has a certificate of authority limited to the issuance of charitable gift annuities under ORS 731.038.

(10) "Premiums" means direct gross insurance, including annuity, premiums written on covered policies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Premiums" does not include premiums on contracts between insurers and reinsurers or any premiums on policies or contracts excluded under ORS 734.790.

(11)(a) "Principal place of business" means:

(A) For a plan sponsor or a person other than a natural person, the state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, as determined by the association after considering the following factors:

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

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

(iii) The state in which the board of directors or governing body of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors of the entity conducts the majority of its meetings; and

(v) The state from which the management of the overall operations of the entity is directed.

(B) For a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors set forth in subparagraph (A) of this paragraph.

(C) For a plan sponsor of a benefit plan for which more than 50 percent of the participants in the benefit plan are employed in a single state, the state in which those participants are employed.

(D) Absent a specific or clear designation of a principal place of business for a plan sponsor of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the principal place of business of the association, committee, joint board of trustees or other governing body of the employer or employee organization that has the largest investment in the benefit plan.

(b) As used in this subsection, "plan sponsor" means:

(A) The employer for a benefit plan established or maintained by a single employer.

(B) The employee organization for a benefit plan established or maintained by an employee organization.

(C) For a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees or other governing bodies of the parties that establish or maintain the benefit plan.

(12) "Resident" means a person to whom contractual obligations are owed by a member insurer and who resides in this state on the date a court order is entered that determines the member insurer to be an impaired insurer or an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. A citizen of the United States who resides in a foreign country, or resides in a United States possession, territory or protectorate that does not have an association similar to the association created under ORS 734.800, shall be considered a resident of the state of domicile of the insurer that issued the policies or contracts. If a person could be covered by the association of another state, whether as an owner, payee, beneficiary or assignee, ORS 734.750 to 734.890 shall be construed with the laws of the other state to result in coverage by only one association.

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

(14) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life or health insurance policy or an annuity contract.

(15) "Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent that any annuity benefits may be guaranteed to an individual under the contract or certificate. [1975 c.251 §6; 1987 c.414 §180; 1991 c.811 §1; 2011 c.142 §1]

734.770 Purpose. The purpose of ORS 734.750 to 734.890 is to protect the persons specified in ORS 734.790, subject to certain limitations, against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in ORS 734.790, because of the impairment or insolvency of the insurer issuing such policies or contracts. To provide this protection:

(1) An association of insurers is created to enable the guarantee of payment of benefits and continuation of coverages;

(2) Members of the Oregon Life and Health Insurance Guaranty Association are subject to assessment to provide funds to carry out the purpose of ORS 734.750 to 734.890; and

(3) The association is authorized to assist the Director of the Department of Consumer and Business Services, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies. [1975 c.251 §3; 1991 c.811 §2]

734.780 Construction. ORS 734.750 to 734.890 shall be liberally construed to effect the purpose provided in ORS 734.770. [1975 c.251 §5]

734.790 Application. (1) ORS 734.750 to 734.890 provide coverage for policies and contracts specified in subsection (2) of this section to the following persons who are not provided coverage under the laws of another state:

(a) To a person who is a resident, if the person is an owner of or a certificate holder under the policy or contract other than a structured settlement annuity or, in the case of an unallocated annuity contract, an employee participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such individual if deceased.

(b) To a person who is not a resident, if the person is an owner of or a certificate holder under the policy or contract other than a structured settlement annuity or, in the case of an unallocated annuity contract, an employee participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code or the beneficiaries of each such individual if deceased. This paragraph applies to a person who is not a resident only if all of the following conditions are met:

(A) The insurer that issued the policy or contract must be a member insurer.

(B) The state in which the person resides must have an association similar to the Oregon Life and Health Insurance Guaranty Association.

(C) The person must not be eligible for coverage by an association in the state in which the person resides, as described in subparagraph (B) of this paragraph, due to the fact that the insurer was not authorized to transact insurance or licensed in that state at the time specified in the state's guaranty association law.

(c) To a person who, regardless of where the person resides, is a beneficiary, assignee or payee of the persons covered under paragraph (a) or (b) of this subsection. This paragraph does not include a nonresident certificate holder under a group policy or contract.

(d) To a person who is a payee under a structured settlement annuity, or to the beneficiary of a payee if the payee is deceased, if the payee:

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

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

(i) The contract owner of the structured settlement annuity is a resident and is not afforded any coverage by an association in another state that is similar to the association created under ORS 734.800, or the contract owner of the structured settlement annuity is not a resident but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created under ORS 734.800; and

(ii) Neither the payee or beneficiary nor the contract owner of the structured settlement annuity is eligible for coverage by the association of the state in which the payee or contract owner resides.

(2) Except as limited by ORS 734.750 to 734.890, the association shall provide coverage to the persons specified in subsection (1) of this section for direct nongroup life or health insurance policies or annuity contracts, for certificates under direct group policies or contracts, and for supplemental contracts to any of these, in each case issued by member insurers.

(3) ORS 734.750 to 734.890 do not provide coverage for:

(a) That portion of any policy or contract not guaranteed by the member insurer or under which the risk is borne by the policyholder or contract owner.

(b) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates have been issued.

(c) Any policy or contract issued by a health care service contractor complying with ORS 750.005 to 750.095.

(d) Any policy or contract issued by a fraternal benefit society.

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

(A) Exceeds, when averaged over the period of four years prior to the date on which the member insurer becomes either an impaired or insolvent insurer under ORS 734.750 to 734.890, whichever occurs first, a rate of interest determined by subtracting four percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for a lesser period if the policy or contract was issued less than four years before the member insurer becomes either an impaired or insolvent insurer under ORS 734.750 to 734.890, whichever occurred first; and

(B) Exceeds, on and after the date on which the member insurer becomes either an impaired or insolvent insurer under ORS 734.750 to 734.890, whichever occurs first, the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available.

(f) Any portion of a policy or contract issued to a plan or program of an employer, association or similar entity to provide life insurance, health insurance or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association or similar entity under any of the following:

(A) A multiple employer welfare arrangement as defined in section 3(40) (29 U.S.C. 1002(40)) of the Employee Retirement Income Security Act of 1974, as amended.

(B) A minimum premium group insurance plan.

(C) A stop-loss group insurance plan.

(D) An administrative services only contract.

(g) Any portion of a policy or contract to the extent that it provides dividends or experience rating credits or voting rights, or provides that any fees or allowances be paid to any person, including the policyholder or contract owner, in connection with the service to or administration of the policy or contract.

(h) Any policy or contract issued in this state by a member insurer at a time that the insurer did not have a certificate of authority to issue the policy or contract in this state.

(i) Any unallocated annuity contract issued to or in connection with an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan.

(j) Any portion of any unallocated annuity contract that is not issued to or in connection with a government retirement plan referred to in subsection (1) of this section, or a government lottery.

(k) Any portion of a policy or contract to the extent that the assessments required by ORS 734.815 with respect to the policy or contract are preempted by federal or state law.

(L) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the policyholder or contract owner, including but not limited to:

(A) Claims based on marketing materials;

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

(C) Misrepresentations of, or regarding, policy or contract benefits;

(D) Extracontractual claims, including but not limited to claims related to bad faith in the payment of claims, punitive or exemplary damages or attorney fees or costs; or

(E) A claim for penalties or consequential or incidental damages.

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

(n) Any portion of a policy or contract to the extent that portion provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but the changes in value have not been credited to the policy or contract, or as to which the policyholder's or contract owner's rights are subject to forfeiture, as of the date on which the member insurer becomes either an impaired or insolvent insurer, whichever occurs first. If the interest or changes in value in a policy or contract are credited less frequently than annually, for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value that is determined by using the procedures specified in the policy or contract shall be credited as if the contractual date of crediting interest or changing value was the date of the impairment or insolvency, whichever is earlier, and may not be subject to forfeiture.

(o) Any policy or contract providing any hospital, medical, prescription drug or other health care benefits under Part C or Part D of subchapter XVIII, chapter 7, Title 42 of the United States Code, or any regulations issued under those provisions.

(4) As used in this section, "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto. [1975 c.251 §4; 1987 c.414 §181; 1991 c.811 §3; 2011 c.142 §2; 2013 c.698 §13]

734.800 Oregon Life and Health Insurance Guaranty Association; required members; required accounts. (1) There is created a nonprofit legal entity to be known as the Oregon Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under ORS 734.820, and shall exercise its powers through a board of directors established under ORS 734.805. For purposes of administration and assessment, the association shall maintain three accounts:

(a) The health insurance account, composed of the following subaccounts:

(A) The disability insurance subaccount;

(B) The long term care insurance subaccount; and

(C) The major medical and all other health insurance subaccount;

(b) The life insurance account; and

(c) The annuity account.

(2) The association shall come under the immediate supervision of the Director of the Department of Consumer and Business Services and shall be subject to the applicable provisions of the insurance laws of this state. [1975 c.251 §7; 2011 c.142 §3]

734.805 Association board of directors; terms; selection; vacancies; compensation and expenses. (1) The board of directors of the Oregon Life and Health Insurance Guaranty Association shall consist of not less than five nor more than nine members who represent member insurers, serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the Director of the Department of Consumer and Business Services. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the Director of the Department of Consumer and Business Services. To select the initial board of directors, and initially organize the association, the Director of the Department of Consumer and Business Services shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one vote in person or by proxy. If the board of directors is not selected within 60 days after notice of the organizational meeting, the Director of the Department of Consumer and Business Services may appoint the initial members.

(2) In approving selections or in appointing members to the board, the Director of the Department of Consumer and Business Services shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board of directors may be reimbursed from the assets of the association for expenses incurred by them as members of the board, but members of the board may not otherwise be compensated by the association for their services. [1975 c.251 §8; 2011 c.142 §4]

734.810 Duties and powers of association; termination of obligations; limit of obligations. (1) If a member insurer is an impaired insurer, the Oregon Life and Health Insurance Guaranty Association, in its discretion and subject to any conditions imposed by the association and approved by the Director of the Department of Consumer and Business Services, other than those which impair the contractual obligations of the impaired insurer, may:

(a) Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the covered policies of the impaired insurer.

(b) Provide such moneys, pledges, notes, loans, guarantees or other means as are proper to implement paragraph (a) of this subsection and ensure payment of the contractual obligations of the impaired insurer pending action under paragraph (a) of this subsection.

(2) If a member insurer is an insolvent insurer, the association, in its discretion and subject to the approval of the director, shall take either of the following steps:

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

(B) Ensure payment of the contractual obligations of the insolvent insurer; and

(C) Provide such moneys, pledges, notes, loans, guarantees or other means as are reasonably necessary to discharge such duties.

(b) Provide benefits and coverages in accordance with the following provisions:

(A) For life and health insurance policies and annuity contracts, the association shall ensure that the payment of benefits for premiums, except for terms of conversion and renewability, under the replacement coverage provided by the association is identical to the payment of benefits for premiums that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

(i) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies or contracts.

(ii) With respect to nongroup policies and contracts, if any, not later than the earlier of the next renewal date under those policies or contracts or one year, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies or contracts.

(B) The association shall make diligent efforts to provide a 30-day notice of the termination of the benefits provided under subparagraph (A) of this paragraph to all known insureds or annuitants for nongroup policies and contracts, or to group policyholders or contract owners with respect to group policies and contracts.

(C) For nongroup life and health insurance policies and annuities covered by the association, the association shall make substitute coverage available to each known insured or annuitant, or owner if other than the insured or annuitant. For an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, the association shall make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (D) of this paragraph, if the insureds or annuitants had a right under law or under the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity that was already in force until a specified age or for a specified time, during which the insurer had no right to make changes unilaterally in any provision of the policy or annuity or had a right to make changes only to premiums or to classes of risk.

(D) In providing the substitute coverage required under subparagraph (C) of this paragraph, the association:

(i) May offer either to reissue the terminated coverage or to issue an alternative policy.

(ii) Shall offer alternative or reissued policies without requiring evidence of insurability.

(iii) May not impose any waiting period or exclusion that would not have applied under the terminated policy.

(iv) May reinsure any alternative or reissued policy.

(E) Any alternative policy adopted by the association must:

(i) Be approved by the Director of the Department of Consumer and Business Services and the court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

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

(iii) Provide coverage of a type similar to that of the policy issued by the insolvent insurer, as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate that is different from the premium rate that was charged under the terminated policy, the premium rate shall be set by the association, in accordance with the amount of insurance provided and the age and class of risk, and be subject to approval by the Director of the Department of Consumer and Business Services and the court.

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

(H) When proceeding under this subsection with respect to a policy or contract that carries a guaranteed minimum interest rate, the association shall ensure the payment or crediting of a rate of interest consistent with the provisions of ORS 734.790 (3).

(3) Nonpayment of premiums within 31 days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or substitute coverage under ORS 734.750 to 734.890 with respect to the policy, contract or substitute coverage, except with respect to any claims incurred or any net cash surrender value or net cash withdrawal value that may be due in accordance with the provisions of ORS 734.750 to 734.890.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. At the request of the liquidator of an insolvent in-

surer, the association shall provide a report to the liquidator regarding any premium collected by the association. The association is liable for unearned premiums due to policyholders or contract owners arising after the entry of the order.

(5) The protection provided by ORS 734.750 to 734.890 does not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6)(a) In carrying out its duties under subsection (2) of this section, the association may impose permanent policy liens or contract liens in connection with any guaranteed, assumption or reinsurance agreement, if the court considering the lien finds that the amounts that can be assessed under ORS 734.750 to 734.890 are less than the amounts needed to ensure full and prompt performance of the insolvent insurer's contractual obligations or that the economic or financial conditions affecting member insurers are sufficiently adverse to render the imposition of policy or contract liens to be in the public interest, and approves the specific policy liens or contract liens to be used.

(b) In carrying out its duties under subsection (2) of this section, the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans or temporary moratoriums on the right to withdraw funds held in conjunction with the policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan values, and such temporary moratoriums and liens may be imposed if they are approved by the court. In addition, in the event of a temporary moratorium or moratorium charge imposed by the court on payment of cash values or policy loan values, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loan values and other rights by the association for the period of the temporary moratorium or moratorium charge that is imposed by the court, except for claims that are covered by the association to be paid in accordance with a hardship procedure that is established by the liquidator or rehabilitator and approved by the court.

(7) If the association fails to act as required in subsection (2) of this section within a reasonable time, the director shall have the powers and duties of the association under ORS 734.750 to 734.890 with respect to insolvent insurers.

(8) The association may render assistance and advice to the director, upon request of the director, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of any impaired or insolvent insurer.

(9) The association shall have standing to intervene or appear before any court or agency in this state having jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under ORS 734.750 to 734.890 or with jurisdiction over any person or property against which the association has rights through subrogation or otherwise. Such standing shall extend to all matters germane to the powers and duties of the association including, but not limited to, proposals for reinsuring, modifying or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations. The association may also appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(10)(a) Any person receiving benefits under ORS 734.750 to 734.890 shall be considered to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy to the association to the extent of the benefits received because of ORS 734.750 to 734.890, whether the benefits are payments of or on account of contractual obligations or continuation of coverage. The association may require an assignment to the association of such rights by any payee, policyholder, contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any rights or benefits conferred by ORS 734.750 to 734.890 upon such person. The association shall be subrogated to these rights against the assets of any impaired or insolvent insurer.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under ORS 734.750 to 734.890.

(c) In addition to the rights set forth in paragraphs (a) and (b) of this subsection, the association may exercise any common law rights of subrogation or any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or to the policyholder or contract owner, beneficiary or payee of a policy or contract with respect to the policy or contract. In the case

of a structured settlement annuity, these rights include but are not limited to any rights of the policyholder or contract owner, beneficiary or payee of the annuity, to the extent of benefits received under ORS 734.750 to 734.890, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefor, with the exception of a person responsible solely by reason of serving as an assignee in respect of a qualified assignment under section 130 of the federal Internal Revenue Code.

(d) If the provisions of this subsection are determined by a court to be invalid or ineffective with respect to any person or claim for any reason, the association shall reduce the amount payable by the association with respect to the related covered obligations by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts covered by the association.

(e) If the association provides benefits with respect to a covered obligation and a person recovers amounts to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts covered by the association.

(11) The contractual obligations of the impaired or insolvent insurer for which the association becomes or may become liable may not exceed the lesser of:

(a) The contractual obligations for which the impaired or insolvent insurer is liable or would have been liable if it were not an impaired or insolvent insurer, unless such obligations are reduced as permitted by subsection (6) of this section;

(b) With respect to any one life, regardless of the number of policies or contracts:

(A) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.

(B) $100,000 in health insurance benefits other than basic hospital, medical and surgical insurance, major medical insurance, disability insurance or long term care insurance, including any net cash surrender and net cash withdrawal values.

(C) $300,000 in disability insurance benefits.

(D) $300,000 in long term care insurance benefits.

(E) $500,000 in basic hospital, medical and surgical insurance or major medical insurance.

(F) $250,000 in the present value of annuity benefits, including any net cash surrender and net cash withdrawal values;

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

(d) $250,000 in the present value of annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values, with respect to each individual participating in a governmental retirement plan established under section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased.

(12) The association may not be liable for more than:

(a) $300,000 in benefits, in the aggregate, with respect to any one life under subsection (11)(b), (c) and (d) of this section, with the exception of benefits under subsection (11)(b)(E) of this section, in which case the aggregate liability of the association may not exceed $500,000 with respect to any one life.

(b) With respect to one policyholder of multiple nongroup policies of life insurance, regardless of whether the policyholder is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, $5 million in benefits, regardless of the number of policies and contracts held by the policyholder.

(13) The limitations set forth in subsections (11) and (12) of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under ORS 734.750 to 734.890 may be met by the use of assets attributable to covered policies or reimbursed to the association under its subrogation and assignment rights.

(14) In performing its obligations to provide coverage under ORS 734.750 to 734.890, the association is not required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, any contractual obligation of the impaired or insolvent insurer or contract owner under a covered policy that does not materially affect the economic values or economic benefits of the covered policy or contract.

(15) The association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of ORS 734.750 to 734.890.

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any unpaid assessments under ORS 734.815 and to settle claims or potential claims against the association.

(c) Borrow money to effect the purposes of ORS 734.750 to 734.890. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for member insurers and may be carried as admitted assets.

(d) Employ or retain such persons as are necessary to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under ORS 734.750 to 734.890.

(e) Negotiate and contract with any liquidator, rehabilitator, conservator or ancillary receiver to carry out the powers and duties of the association.

(f) Take such legal action as may be necessary to avoid payment of improper claims.

(g) Exercise, for the purposes of ORS 734.750 to 734.890 and to the extent approved by the director, the powers of a member life or health insurer, but in no case may the association issue policies other than those issued to perform the contractual obligations of the impaired or insolvent insurer.

(h) Organize itself as a corporation or other legal form permitted by the laws of this state.

(i) Request information from a person seeking coverage from the association to aid the association in determining its obligations under ORS 734.750 to 734.890 with respect to that person.

(j) Take any other necessary or appropriate action to discharge its duties and obligations and to exercise its powers under ORS 734.750 to 734.890.

(16) The duties and powers of the association described in this section are in addition to any other duties and powers of the association described in ORS 734.750 to 734.890.

(17)(a) Within 180 days after the date of the order of liquidation, the association may succeed to the rights and obligations of the ceding member insurer that relate to policies or annuities covered, in whole or in part, by the association, in each case under any one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association sending written notice, return receipt requested, to the affected reinsurers.

(b) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association as soon as possible after commencement of formal delinquency proceedings copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(c) For any reinsurance contracts assumed by the association under paragraphs (a) and (b) of this subsection:

(A) The association is responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, related to policies or annuities covered by the reinsurance contract, in whole or in part, by the association. The association may charge policies or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of those charges to the liquidator.

(B) The association is entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies or annuities covered, in whole or in part, by the association. Upon receipt of any such amounts, the association shall pay the beneficiary under the policy or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

(i) The amount received by the association; or

(ii) The amount received by the association that is in excess of the amount equal to the benefits paid by the association on account of the policy or annuity minus the amount retained by the insurer applicable to the loss or event.

(C) Within 30 days following the association's election, the association and each reinsurer shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies or annuities

covered, in whole or in part, by the association. The calculation shall give full credit to all items paid by the insurer or its receiver or by the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any setoff for premiums unpaid for periods prior to that date, and the association or the reinsurer shall pay any remaining balance due to one another. The reinsurer and the association shall make such payments within five days after the completion of the calculation of the net balance due under each reinsurance contract. Any disputes over the amounts due to the association or the reinsurer shall be resolved by arbitration according to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association under subparagraph (B) of this paragraph, the receiver shall remit the amounts to the association as promptly as practicable.

(d) If the association, or the receiver on the association's behalf, within 60 days after the election date pays the unpaid premiums due for periods both before and after the election date that relate to policies or annuities covered, in whole or in part, by the association, the reinsurer may not terminate the reinsurance contracts for failure to pay premiums insofar as the reinsurance contracts relate to policies or annuities covered, in whole or in part, by the association, and may not set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due to the association.

(e)(A) During the period from the date of the order of liquidation until the election date or, if the election date does not occur, 180 days after the date of the order of liquidation:

(i) Neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under paragraph (a) of this subsection, whether for periods prior to or after the date of the order of liquidation; and

(ii) The reinsurer, the receiver and the association shall, to the extent practicable, provide to each other data and records that are reasonably requested.

(B) After the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by paragraph (a) of this subsection.

(f) If the association does not elect to assume a reinsurance contract by the election date under paragraph (a) of this subsection, the association shall have no rights or obligations, for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(g) When policies or annuities, or covered obligations related to policies or annuities, are transferred to an assuming insurer, the association may also transfer reinsurance on the policies or annuities for contracts assumed under paragraph (a) of this subsection, subject to the following:

(A) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred may not cover any new policies of insurance or annuities in addition to those transferred;

(B) The obligations described in paragraph (a) of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer; and

(C) The transferring party shall give notice in writing, return receipt requested, to the affected reinsurer not less than 30 days before the effective date of the transfer.

(h) The provisions of this subsection shall supersede any other provision of law or any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contract with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions.

(i) Except as otherwise provided in this subsection, nothing in this section shall:

(A) Alter or modify the terms and conditions of any reinsurance contract;

(B) Abrogate or limit any rights of any reinsurer to claim that the reinsurer is entitled to rescind a reinsurance contract;

(C) Grant a policyholder, contract owner or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;

(D) Limit or affect the association's rights as a creditor of the estate against the assets of the estate; or

(E) Apply to reinsurance agreements covering property or casualty risks.

(18) The board of directors of the association may exercise reasonable business judgment to determine the means by which the association is to provide the benefits under ORS 734.750 to 734.890 in an economical and efficient manner.

(19) If the association has arranged or offered to provide the benefits of ORS 734.750 to 734.890 to a covered person under a plan or arrangement that fulfills the association's obligations under this section, the person is not entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(20) Venue in a suit against the association arising under ORS 734.750 to 734.890 shall be in the Circuit Court for Marion County.

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

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees, or a different method for calculating interest or changes in value.

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the original policy or contract.

(c) The alternative policy or contract is substantially similar to the original policy or contract in all other material terms. [1975 c.251 §9; 1991 c.811 §4; 2010 c.26 §1; 2011 c.142 §5]

734.815 Assessment of members; classes of assessments; amounts; refunds. (1) For the purpose of providing the funds necessary to carry out the powers and duties of the Oregon Life and Health Insurance Guaranty Association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. The board shall collect the assessments after 30 days' written notice to the member insurers before payment is due.

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

(a) Class A assessments shall be made for the purpose of meeting administrative and legal costs and other general expenses whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under ORS 734.810 with regard to an impaired or insolvent insurer.

(3)(a) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or other basis. If pro rata, the board may provide that the class A assessment be credited against future class B assessments. An assessment on another basis may not exceed $300 per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the accounts in the proportion that the premiums received by the impaired or insolvent insurer on the policies covered by each account, for the last calendar year preceding the assessment in which the impaired or insolvent insurer received premiums, bears to the premiums received by such insurer for such calendar year on all covered policies.

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

(c) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer may not be made until necessary to implement the purposes of ORS 734.750 to 734.890. Classification of assessments under subsection (2) of this section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred, in whole or in part, the amount by which such assessment is abated or deferred shall be assessed against the other member insurers.

(5) A member insurer may not be required to pay assessments in any one calendar year exceeding two percent of the insurer's premiums in this state on the policies covered by the account. If a member insurer's total assessment cannot be collected in any one year because of this limitation, the remaining amount due shall be collected from the insurer in future years.

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

(7) It shall be proper for any member insurer, in determining its premium rates and policyowner dividends for any kind of insurance within the scope of ORS 734.750 to 734.890, to consider the amount reasonably necessary to meet its assessment obligations under ORS 734.750 to 734.890.

(8) The association shall issue to each insurer paying an assessment under ORS 734.750 to 734.890, other than a class A assessment, a certificate of contribution in a form prescribed by the Director of the Department of Consumer and Business Services for the amount so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the director may approve.

(9) The association may assess and collect interest on the amount of an assessment owed by a member insurer that fails to pay the assessment when due. The annual rate that may be charged under this subsection may not exceed the rate established by the director by rule. [1975 c.251 §10; 1991 c.811 §5; 2011 c.142 §6]

734.820 Plan of operation; submission of amendments to director; rules; contents of plan. (1)(a) The Oregon Life and Health Insurance Guaranty Association shall maintain on file with the Director of the Department of Consumer and Business Services a plan of operation and shall submit any amendments thereto necessary or suitable to ensure the fair, reasonable and equitable administration of the association. Amendments to the plan shall become effective upon approval in writing by the director.

(b) If the association fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to implement the provisions of ORS 734.750 to 734.890. Such rules shall continue in force until modified by the director or superseded by amendments submitted by the association and approved by the director.

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

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in ORS 734.750 to 734.890:

(a) Establish procedures for handling the assets of the association.

(b) Establish the amount and method of reimbursing members of the board of directors.

(c) Establish regular places and times for meetings of the board of directors.

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

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the director.

(f) Establish any additional procedures for assessments under ORS 734.815.

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

(h) Establish procedures for removing a member of the board of directors for cause, including removing a board member who represents a member insurer when the member insurer becomes either an impaired or insolvent insurer.

(i) Include a policy and procedures for addressing a conflict of interest.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under ORS 734.810 (15)(c) and 734.815, may be delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more states. Such corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the director, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by ORS 734.750 to 734.890. [1975 c.251 §11; 1991 c.811 §6; 2011 c.142 §7]

734.825 Powers and duties of director. In addition to the duties and powers enumerated elsewhere in ORS 734.750 to 734.820 and 734.830 to 734.890:

(1) The Director of the Department of Consumer and Business Services shall:

(a) Upon request of the board of directors, provide the Oregon Life and Health Insurance Guaranty Association with a statement of the premiums in the appropriate states for each member insurer.

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under ORS 734.750 to 734.890.

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

(3) Any action of the board of directors or the association may be appealed to the director by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the director shall be subject to judicial review in a court of competent jurisdiction.

(4) The liquidator, rehabilitator or conservator of any impaired insurer may notify all interested persons of the effect of ORS 734.750 to 734.890. [1975 c.251 §12]

734.830 Notifying director of impaired insurers; examination; reports on impaired insurers. To aid in the detection and prevention of insurer impairments and insolvencies:

(1) The board of directors shall, upon majority vote, notify the Director of the Department of Consumer and Business Services of any information indicating any member insurer may be an impaired insurer or insolvent insurer.

(2) The board of directors may, upon majority vote, request that the director order an examination of any member insurer which the board in good faith believes to be an impaired or insolvent insurer. The director may conduct such examination. The examination may be conducted as a National Association of Insurance Commissioners examination or may be conducted by such persons as the director designates. The cost of such examination shall be paid by the Oregon Life and Health Insurance Guaranty Association and the examination report shall be treated as are other examination reports in this state. In no event shall the examination report be released to the board of directors of the association prior to its release to the public, but this shall not excuse the director from the obligation to comply with subsection (3) of this section. The director shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the director but it shall not be open to public inspection prior to the release of the examination report to the public and shall be released at that time only if the examination discloses that the examined insurer is an impaired insurer or insolvent insurer.

(3) The director shall report to the board of directors when the director has reasonable cause to believe that any member insurer examined at the request of the board of directors may be an impaired insurer or insolvent insurer.

(4) The board of directors may, upon majority vote, make reports and recommendations to the director upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer. Such reports and recommendations shall not be considered public records.

(5) The board of directors may, upon majority vote, make recommendations to the director for the detection and prevention of insurer impairments or insolvencies.

(6) The board of directors shall, at the conclusion of any insurer impairment or insolvency in which the association carried out its duties under ORS 734.750 to 734.890 or exercised any of its powers under ORS 734.750 to 734.890, prepare a report on the history and causes of such impairment or insolvency, based on the information available to the association, and submit such report to the director. [1975 c.251 §13]

734.835 Assessments offset against tax liabilities; rate. (1) A member insurer may offset against its corporate excise tax liabilities to this state an assessment described in ORS 734.815 (8), at the rate of 20 percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its premium or corporate excise tax liabilities for the year it ceases doing business.

(2) Any sums acquired by refund pursuant to ORS 734.815 (6) from the Oregon Life and Health Insurance Guaranty Association

which have theretofore been written off by contributing insurers and offset against premium or corporate excise taxes as provided in subsection (1) of this section, and are not then needed for purposes of ORS 734.750 to 734.890, shall be paid by the association to the Director of the Department of Consumer and Business Services and deposited by the director with the State Treasurer for credit to the General Fund of this state. [1975 c.251 §14; 1995 c.786 §9]

Note: Section 50, chapter 913, Oregon Laws 2009, provides:

Sec. 50. ORS 734.835 does not apply to tax years beginning on or after January 1, 2022. [2009 c.913 §50; 2015 c.701 §13]

734.840 Conduct of liquidation, rehabilitation or conservation proceeding involving impaired or insolvent insurer. (1) Nothing in ORS 734.750 to 734.890 shall be construed to reduce the liability for unpaid assessments of the insureds on an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all negotiations and meetings in which the Oregon Life and Health Insurance Guaranty Association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under ORS 734.810. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under ORS 734.850.

(3) For the purpose of carrying out its obligations under ORS 734.750 to 734.890, the association shall be considered to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to ORS 734.810 (10). All assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by ORS 734.750 to 734.890. "Assets attributable to covered policies," as used in this subsection, is that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section and consistent with the provisions of ORS 731.648, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against the contractual obligations of the association as set forth in ORS 734.810. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association may apply to the court for approval of the association's own proposal to disburse those assets.

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

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under ORS 734.810 with respect to such insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations of paragraphs (b), (c) and (d) of this subsection.

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

(c) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable up to the amount of distributions the person received. Any person who was an affiliate that controlled the insurer at the time the distrib-

utions were declared shall be liable up to the amount of distributions the person would have received if they had been paid immediately. If two persons are liable with respect to the same distributions, they shall be jointly and severally liable.

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

(e) If any person liable under paragraph (c) of this subsection is insolvent, all its affiliates that controlled it at the time the dividend was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate. [1975 c.251 §15; 1991 c.811 §7; 2011 c.142 §8]

734.850 Examination and regulation of association by director; required reports. The Oregon Life and Health Insurance Guaranty Association shall be subject to examination and regulation by the Director of the Department of Consumer and Business Services. The board of directors shall submit to the director, not later than May 1 of each year, a financial report for the preceding calendar year in a form approved by the director, and a report of its activities during the preceding calendar year. [1975 c.251 §16]

734.860 Exemption of association from payment of fees and taxes. The Oregon Life and Health Insurance Guaranty Association shall be exempted from payment of all fees and all taxes levied by this state or any of its political subdivisions, except taxes levied on real property. [1975 c.251 §17]

734.870 Immunity from legal action. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Oregon Life and Health Insurance Guaranty Association or its agents or employees, members of the board of directors, or the Director of the Department of Consumer and Business Services or the representatives of the director, for any action taken by them in the performance of their powers and duties under ORS 734.750 to 734.890. The immunity provided under this section shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees. [1975 c.251 §18; 2011 c.142 §9]

734.880 Stay of proceeding involving insolvent insurer. All proceedings in which an insolvent insurer is a party in any court in this state shall be stayed 180 days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the Oregon Life and Health Insurance Guaranty Association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the association may apply to have such judgment set aside by the same court that made the judgment, and shall be permitted to defend against such suit on the merits. [1975 c.251 §19; 2011 c.142 §10]

734.890 Association not to be used in sales or solicitation. No insurer or insurance producer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement which uses the existence of the Oregon Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by the Oregon Life and Health Insurance Guaranty Association Act. This section shall not apply however to the Oregon Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or to public service institutional advertisements by individual insurers. [1975 c.251 §20; 2003 c.364 §87]