Chapter 746

2011 EDITION

Trade Practices

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746.991 Penalties

GENERAL PROVISIONS

746.005 Trade practices exempted from prohibitions. Nothing in this chapter shall apply to wet marine and transportation insurance or prohibit any of the following practices:

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

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

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

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

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

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

(7) The issuing of life or health insurance policies at rates less than the usual premium rates for such policies, or using modifications of premium rates based on amount of insurance, if such issuance or modification does not result in reduction in premium rates in excess of savings in administration and issuance expenses reasonably attributable to such policies. [Formerly 736.825; 1983 c.740 §254; 2003 c.364 §133]

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

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

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

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

(4)(a) An insurer may not, on the basis of the status of an insured or prospective insured as a victim of domestic violence or sexual violence, do any of the following:

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

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

(C) Designate domestic violence or sexual violence, physical or mental injuries sustained as a result of domestic violence or sexual violence or treatment received for such injuries as a preexisting condition for which coverage will be denied or reduced;

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

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

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

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

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

(e) For purposes of this subsection, "domestic violence" means the occurrence of

one or more of the following acts between family or household members:

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

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

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

(f) For purposes of this subsection, "sexual violence" means the commission of a sexual offense described in ORS 163.305 to 163.467, 163.427 or 163.525.

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

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

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

(7) Affiliated workers' compensation insurers having reinsurance agreements which result in one carrier ceding 80 percent or more of its workers' compensation premium to the other, while utilizing different workers' compensation rate levels without objective evidence to support such differences, shall be presumed to be engaging in unfair discrimination. [1967 c.359 §568; 1977 c.331 §1; 1979 c.140 §1; 1987 c.676 §2; 1987 c.884 §53; 1997 c.564 §1; 1999 c.59 §229; 2003 c.364 §134; 2007 c.70 §319; 2010 c.67 §1]

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

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

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

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

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

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

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

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

746.045 Rebates. No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the insurance producer's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy. [1967 c.359 §571; 2003 c.364 §135]

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

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

746.060 [Repealed by 1961 c.256 §5]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The primary function of the association is other than marketing insurance. [1967 c.359 §573; 1987 c.774 §147; 1989 c.701 §73; 2003 c.364 §136]

746.070 [Repealed by 1961 c.256 §5]

746.075 Misrepresentation generally. (1) A person may not engage, directly or indirectly, in any action described in subsection (2) of this section in connection with:

(a) The offer or sale of any insurance; or

(b) Any inducement or attempted inducement of any insured or person with ownership rights under an issued life insurance policy to lapse, forfeit, surrender, assign, effect a loan against, retain, exchange or convert the policy.

(2) Subsection (1) of this section applies to the following actions:

(a) Making, issuing, circulating or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages therein or the dividends or share of surplus to be received thereon;

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

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

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

(e) Employing any device, scheme or artifice to defraud;

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

(g) Engaging in any other transaction, practice or course of business that operates as a fraud or deceit upon the purchaser, insured or person with policy ownership rights; or

(h) Materially misrepresenting the provider network of an insurer offering managed health insurance or preferred provider organization insurance as defined in ORS 743.801, including its composition and the availability of its providers to enrollees in the plan. [1967 c.359 §574; 2001 c.266 §7]

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

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

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

(2) Limiting the commission or compensation payable to an insurance producer on account of a life insurance policy that provides a nonforfeiture value sold to replace an existing life insurance policy that provides a nonforfeiture value to the commission or compensation the insurance producer would have received if both the replaced and the replacement insurance policies had been carried by the insurer which issues the replacement policy. [1967 c.359 §575; 1971 c.231 §35; 2003 c.364 §137]

746.090 [Repealed by 1967 c.359 §704]

746.100 Misrepresentation in insurance applications or transactions. No person shall make a false or fraudulent statement or representation on or relative to an application for insurance, or for the purpose of obtaining a fee, commission, money or benefit from an insurer or insurance producer. [Formerly 736.460; 2003 c.364 §138]

746.110 False, deceptive or misleading statements. No person shall make, publish, disseminate, circulate, or place before the public, or cause, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of the insurance business, which is untrue, deceptive or misleading. [Formerly 736.608]

746.115 Advertisements in languages other than English. (1) An insurer or licensee who advertises in a language other than English is not required to provide an insurance policy in any language other than English so long as the advertisement states clearly that the policy that is purchased is available only in English.

(2) Advertisements regarding an insurance policy in languages other than English may not be construed to modify the policy in the event of a dispute over the provisions of the policy. [1997 c.809 §2; 2003 c.249 §1]

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

746.120 Illegal dealing in premiums. No person shall willfully collect any sum as premium or charge for insurance which is not then provided, or is not in due course to be provided subject to acceptance of the risk by the insurer, under an insurance policy issued by an insurer in conformity to the Insurance Code. [1967 c.359 §579]

746.125 Limitation on coverage of eye care services. (1) As used in this section:

(a) "Health care service contractor" has the meaning given that term in ORS 750.005.

(b) "Independent practice association" has the meaning given that term in ORS 743.801.

(2) An insurer or a health care service contractor that has a contract with an independent practice association to provide eye care services may not limit coverage of eye care services only to services provided by a physician if the eye care services are covered services and are within the lawful scope of practice of a licensed optometrist. [2005 c.442 §2]

Note: 746.125 was added to and made a part of ORS chapter 746 by legislative action but was not added to any smaller series therein. See Preface to Oregon Revised Statutes for further explanation.

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

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

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

(b) Title insurance; or

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

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

746.135 Genetic tests and information; rules. (1) If a person asks an applicant for insurance to take a genetic test in connection with an application for insurance, the use of the test shall be revealed to the applicant and the person shall obtain the specific authorization of the applicant using a form adopted by the Director of the Department of Consumer and Business Services by rule.

(2) A person may not use favorable genetic information to induce the purchase of insurance.

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

(4) A person may not use genetic information about a blood relative to reject, deny, limit, cancel, refuse to renew, increase the rates of, affect the terms and conditions of or otherwise affect any policy of insurance.

(5) For purposes of this section, "blood relative," "genetic information" and "genetic test" have the meanings given those terms in ORS 192.531. [1995 c.680 §8; 2001 c.588 §17]

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

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

(3) Each such proposal shall:

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

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

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

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

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

(4) This section shall not be construed to affect the application of any other provision of law concerning or regulating securities. [Formerly 739.562; 2003 c.364 §139]

746.145 Workers' compensation insurance; combination of group of employers; purpose; conditions. (1) Notwithstanding ORS 737.600, but subject to all other rate filing requirements of ORS chapter 737, an insurer may combine for dividend purposes the experience of a group of employers covered for workers' compensation insurance by

the insurer, subject to applicable rules adopted by the Director of the Department of Consumer and Business Services, if:

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

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

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

(2) This section does not apply to an organization of employers for which organization a workers' compensation policy was lawfully issued before October 4, 1977. The policy required by ORS 656.419 shall contain for each employer covered thereby the information required by ORS 656.419 (2). When an employer becomes an insured member of the organization the insurer shall, within 30 days after the date insured membership commenced, file a notice thereof with the director. [1977 c.405 §3; 1983 c.706 §3; 1990 c.1 §5; 2003 c.170 §11; 2007 c.241 §29]

746.147 Workers' compensation insurance; quoting premiums. An insurer or insurance producer offering workers' compensation insurance in Oregon shall not quote projected net insurance premiums based upon figures that are discretionary or terms that are not guaranteed in the workers' compensation insurance policy. [1999 c.868 §3; 2003 c.364 §140]

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

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

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

(a) Such a grouping comprises substantially homogeneous risks.

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

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

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

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

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

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

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

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

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

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

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

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

746.180 [Formerly 736.715; repealed by 2003 c.363 §16]

746.182 [1987 c.846 §18; 1989 c.701 §74; 1995 c.334 §5; 1997 c.831 §§6,6a; 2001 c.191 §57; 2001 c.377 §52; repealed by 2003 c.363 §16]

746.185 [1977 c.742 §2; 1985 c.762 §189; 1997 c.631 §551; 2001 c.377 §52a; repealed by 2003 c.363 §16]

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

746.191 [1977 c.742 §3; 2003 c.14 §451; repealed by 2003 c.363 §16]

746.195 Insurance on property securing loan or credit; certain practices by depository institutions prohibited. (1) A depository institution may not:

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

(b) Refuse to accept a written binder issued by an insurance producer as proof that temporary insurance exists covering the real or personal property that is the subject matter of, or security for, a loan or extension of credit, and that a policy of insurance will be issued covering that property. A written binder issued by an insurance producer or insurer covering real or personal property that is the subject matter of, or security for, a loan or extension of credit shall be effective until a policy of insurance is issued in lieu thereof, including within its terms the identical insurance bound under the binder and the premium therefor, or until notice of the cancellation of the binder is received by the borrower and the depository institution extending credit or offering the loan. When a depository institution closes on a binder under ORS 742.043, the insurance producer or insurer issuing the binder shall be bound to provide a policy of insurance, equivalent in coverage to the coverage set forth in the binder, within 60 days from the date of the binder. The provisions of this paragraph do not apply when prohibited by federal or state statute or regulations; or

(c) Use or disclose to any other insurance producer, other than the original insurance producer, the information relating to a policy of insurance furnished by a borrower unless the original insurance producer fails to deliver a policy of insurance within 60 days prior to expiration to the depository institution without first procuring the written consent of the borrower.

(2) As used in this section, "depository institution" means a financial institution as that term is defined in ORS 706.008. [1977 c.742 §4; 1987 c.916 §10; 2003 c.363 §12; 2003 c.364 §144a]

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

746.201 Depository institution to obtain required property insurance when borrower does not; notice required. (1) In a contract or loan agreement, or in a separate document accompanying the contract or loan agreement and signed by the mortgagor, borrower or purchaser, that provides for a loan or other financing secured by the mortgagor's, borrower's or purchaser's real or personal property and that authorizes the secured party to place insurance on the property when the mortgagor, borrower or purchaser fails to maintain the insurance as required by the contract or loan agreement or the separate document, a warning in substantially the following form shall be set forth in 10-point type:

WARNING

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

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

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

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(2) Substantial compliance by a secured party with subsection (1) of this section constitutes a complete defense to any claim arising under the laws of this state challenging the secured party's placement of insurance on the real or personal property in which the secured party has a security in-

terest, for the protection of the secured party's interest in the property.

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

(4) The failure of a secured party prior to January 1, 1996, to include in a contract or loan agreement, or in a separate document accompanying the contract or loan agreement, the notice set forth in subsection (1) of this section shall not be admissible in any court or arbitration proceeding or otherwise used to prove that a secured party's actions with respect to the placement or maintenance of insurance on real or personal property in which the secured party has a security interest are or were unlawful or otherwise improper. A secured party shall not be liable to the mortgagor, borrower or purchaser or to any other party for placing such insurance in accordance with the terms of an otherwise legal contract or loan agreement with the mortgagor, borrower or purchaser entered into prior to January 1, 1996. [1977 c.742 §5; 1995 c.313 §3; 2003 c.363 §13]

746.205 [1977 c.742 §6; repealed by 2003 c.363 §16]

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

746.211 [1977 c.742 §7; 1987 c.916 §11; repealed by 2003 c.363 §16]

746.213 Definitions for ORS 746.213 to 746.219. As used in ORS 746.213 to 746.219:

(1) "Affiliate" means any company that controls, is controlled by or is under common control with another company.

(2) "Customer" means an individual who purchases, applies to purchase or is solicited to purchase insurance products primarily for personal, family or household purposes.

(3) "Depository institution" means a financial institution as that term is defined in ORS 706.008. [2003 c.363 §2]

Note: 746.213 to 746.219 were added to and made a part of the Insurance Code by legislative action but were not added to ORS chapter 746 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

746.215 Regulation of depository institutions with regard to insurance sales or solicitations. (1) A depository institution or an affiliate of a depository institution that lends money or extends credit may not:

(a) As a condition precedent to the lending of money or extension of credit, or any renewal thereof, require that the person to whom the money or credit is extended, or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal thereof through a particular insurer or group of insurers or insurance producer or group of insurance producers.

(b) Reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or the extension of credit.

(c) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or from a particular insurer or insurance producer. This paragraph does not prohibit a depository institution or an affiliate of a depository institution from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance or that insurance is available from the depository institution or an affiliate of the depository institution.

(d) Unreasonably reject an insurance policy furnished by the customer or borrower for the protection of the property securing the credit or loan. A rejection is not considered unreasonable if it is based on reasonable standards that are uniformly applied and that relate to the extent of coverage required and to the financial soundness and the services of an insurer. The standards may not discriminate against any particular type of insurer or call for rejection of an insurance policy because the policy contains coverage in addition to that required in the credit transaction.

(e) Require that any customer, borrower, mortgagor, purchaser, insurer or insurance producer pay a separate charge in connection with the handling of any insurance policy required as security for a loan on real estate, or pay a separate charge to substitute the insurance policy of one insurer for that of another. A charge prohibited in this paragraph does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. This paragraph does not apply to charges that would be required when the depository institution or an affiliate of a depository institution is the licensed insurance producer providing the insurance.

(f) Require any procedures or conditions of an insurer or insurance producer not customarily required of insurers or insurance producers affiliated or in any way connected with the depository institution.

(g) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the depository institution or its affiliate.

(h) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the depository institution or its affiliate.

(i) Act as an insurance producer unless properly licensed in accordance with ORS 744.062, 744.063 or 744.064.

(j) Pay or receive any commission, brokerage fee or other compensation as an insurance producer, unless the depository institution or affiliate holds a valid insurance producer license for the applicable class of insurance. However, an unlicensed depository institution or affiliate may make a referral to a licensed insurance producer if the depository institution or affiliate does not negotiate, sell or solicit insurance. In the case of a referral of a customer, however, the unlicensed depository institution or affiliate may be compensated for the referral only if the compensation is a fixed dollar amount for each referral that does not depend on whether the customer purchases the insurance product from the licensed insurance producer. Any depository institution or affiliate that accepts deposits from the public in an area in which such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral that does not depend on whether the referral results in a transaction.

(k) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions.

(L) Except as provided in ORS 746.201, include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer.

(m) Solicit or sell insurance unless the insurance sales activities of the depository institution or affiliate are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions.

(n) Solicit or sell insurance unless the depository institution or affiliate maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

(2) A depository institution or an affiliate of a depository institution that lends money or extends credit and that solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or insurance producer of the customer's choice, subject only to the depository institution's right to reject a given insurer or insurance producer as provided in subsection (1)(d) of this section. The disclosure shall inform the customer that the customer's choice of insurer or insurance producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the extent of coverage chosen as provided in subsection (1)(d) of this section. [2003 c.363 §3; 2005 c.22 §497]

Note: See note under 746.213.

746.217 Disclosures to customers. (1) A depository institution that sells insurance, and any person that sells insurance on behalf of a depository institution, or on the premises of a depository institution where the depository institution is engaged in the business of taking deposits or making loans, shall disclose to the customer in writing, when practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:

(a) Is not a deposit;

(b) Is not insured by the Federal Deposit Insurance Corporation or any other federal government agency;

(c) Is not guaranteed by the depository institution or an affiliate of the depository institution if applicable, or any person that is selling insurance if applicable; and

(d) When appropriate, involves investment risk, including the possible loss of value.

(2) The requirements of subsection (1) of this section apply:

(a) To an affiliate of a depository institution only to the extent that it sells insurance on the premises of a depository institution where the depository institution is engaged in the business of taking deposits or making loans or on behalf of a depository institution.

(b) When an individual purchases insurance primarily for personal, family or house-

hold purposes and only to the extent that the disclosure would be accurate.

(3) For the purpose of subsection (1) of this section, a person is selling insurance on behalf of a depository institution, whether on the premises of the depository institution or at another location, if either one of the following applies:

(a) The person represents to the customer that the sale of the insurance is by or on behalf of the depository institution; or

(b) The depository institution refers a customer to the person that sells insurance and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral. [2003 c.363 §4]

Note: See note under 746.213.

746.219 Investigatory powers. (1) The Director of the Department of Consumer and Business Services may examine and investigate the insurance activities of any person that the director believes may be in violation of ORS 746.213, 746.215 or 746.217. Upon request and reasonable notice, a person shall make its insurance books and records available to the director and the director's staff for inspection. An affected person may submit to the director a complaint or material pertinent to the enforcement of ORS 746.213, 746.215 and 746.217.

(2) Nothing in ORS 746.213, 746.215 or 746.217 prevents a depository institution or an affiliate of a depository institution that lends money or extends credit or other lender or seller from placing insurance on real or personal property in the event the customer, borrower, mortgagor or purchaser fails to provide insurance required under the terms of the loan or credit document.

(3) ORS 746.213, 746.215 and 746.217 do not apply to credit-related insurance. [2003 c.363 §5]

Note: See note under 746.213.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) Delaying investigation or payment of claims by requiring a claimant or the physician of the claimant to submit a preliminary claim report and then requiring subsequent submission of loss forms when both require essentially the same information;

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

(m) Failing to promptly provide the proper explanation of the basis relied on in

the insurance policy in relation to the facts or applicable law for the denial of a claim.

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

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

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

(c) Other relevant evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Suspension of driving privileges pursuant to ORS 809.280 (6) or (8) if the suspension is based on a nondriving offense.

(3) Subsection (2) of this section does not apply if an insurer considers the nonemployment driving record of an individual under ORS 802.220 for the purpose of providing a discount to the individual. [1987 c.5 §5; 1989 c.853 §1; 1991 c.860 §7; 1999 c.59 §231; 2001 c.327 §1; 2011 c.355 §25]

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

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

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

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

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

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

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

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

746.280 Designation of particular motor vehicle repair shop by insurer prohibited; notice; limitation of costs. (1) An insurer may not require that a particular person make the repairs to the insured's motor vehicle as a condition for recovery by the insured under a motor vehicle liability insurance policy.

(2) Prior to providing a recommendation that a particular person make repairs to the insured's motor vehicle, the person adjusting the claim on behalf of the insurer shall inform the insured of the rights conferred by subsection (1) of this section by communicating in a statement substantially similar to the following:

OREGON LAW PROHIBITS US FROM REQUIRING YOU TO GET REPAIRS TO YOUR VEHICLE AT A PARTICULAR MOTOR VEHICLE REPAIR SHOP. YOU HAVE THE RIGHT TO SELECT THE MOTOR VEHICLE REPAIR SHOP OF YOUR CHOICE.

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(3) If an insured elects to have the motor vehicle repaired at a motor vehicle repair shop other than a shop recommended by the insurer, the insurer may not limit the cost of repairs necessary to return the motor vehicle to a preloss condition relative to safety, function and appearance other than as stated in the policy or as otherwise allowed by law.

(4) If an insured accepts the insurer's recommendation, the insurer shall provide, electronically or in printed form, a statement to the insured within three business days after the date of acceptance in substantially the following form:

WE HAVE RECOMMENDED A MOTOR VEHICLE REPAIR SHOP. IF YOU AGREE TO USE OUR RECOMMENDED REPAIR SHOP, YOUR VEHICLE WILL RECEIVE REPAIRS RETURNING IT TO A PRELOSS CONDITION RELATIVE TO SAFETY, FUNCTION AND APPEARANCE AT NO ADDITIONAL COST TO YOU OTHER THAN AS STATED IN THE INSURANCE POLICY OR AS OTHERWISE ALLOWED BY LAW.

[1977 c.785 §2; 2007 c.506 §1]

Note: See note under 746.275.

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

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

[1977 c.785 §3]

Note: See note under 746.275.

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

(2) For purposes of this section, an aftermarket crash part is at least equivalent to the part being replaced if the aftermarket crash part is the same kind of part and is at least the same quality with respect to fit, finish, function and corrosion resistance. [1987 c.622 §3]

Note: See note under 746.275.

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

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

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

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

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

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

Note: See note under 746.275.

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

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

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

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

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

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

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

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

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

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

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

Note: See note under 746.275.

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

Note: See note under 746.275.

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

Note: See note under 746.275.

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

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

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

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

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

UNAUTHORIZED INSURANCE

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

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

(3) This section does not apply to:

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

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

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

(d) A licensed adjuster or attorney at law representing such an insurer from time to time in such occupational or professional capacity. [1967 c.359 §591; 1969 c.336 §17; 1987 c.774 §140; 1991 c.810 §27; 2003 c.364 §145]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) Nothing in ORS 746.320 to 746.360 shall be construed to prevent a defendant unauthorized insurer from filing a motion to set aside service of process made in the manner provided in ORS 746.320 on the ground that such insurer has not done any of the acts described in subsection (2) of such section. [Formerly 736.256]

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

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

(1) Reinsurance or wet marine and transportation insurance;

(2) Insurance effected in compliance with ORS 735.400 to 735.495;

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

(4) Insurance against loss of or damage to any property having a permanent situs outside this state, where such policy contains a provision designating the Director of the Department of Consumer and Business Services or a bona fide resident of this state as the insurer's lawful attorney upon whom all process may be served in any action begun by or on behalf of an insured or beneficiary and arising out of policies of insurance between the insurer and persons residing or authorized to do business in this state. [Formerly 736.260; 2005 c.185 §6]

746.370 Records of insureds. In order that the Director of the Department of Consumer and Business Services may effectively administer ORS 746.310 to 746.370, every

person for or by whom insurance has been placed with an unauthorized insurer shall, upon the director's order, produce for examination all policies and other documents evidencing the insurance, and shall disclose to the director the amount of premiums paid or agreed to be paid for the insurance. [1967 c.359 §597]

PREMIUM FINANCING

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

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

(2) "Premium finance company" means a person engaged in the business of entering into premium finance agreements with insureds or of acquiring such premium finance agreements from insurance producers or other premium finance companies. [1969 c.639 §2; 2003 c.364 §146]

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

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

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

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

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

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

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

(4) Insurance producers financing only their own accounts and whose aggregate charge for financing does not exceed one and one-half percent per month on the outstanding balance. [1969 c.639 §4; 1981 c.412 §22; 2003 c.364 §147]

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

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

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

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

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

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

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

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

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

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

(c) Set forth the following items where applicable:

(A) The total amount of the premiums.

(B) The amount of the down payment.

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

(D) The amount of the service charge.

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

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

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

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

(4) A premium finance company shall give notice of its financing to the insurer not later than the 30th day after the date the premium financing agreement is received by the premium finance company. A notice given under this subsection shall be effective whether or not the insured's policy number is set forth in the notice. [1969 c.639 §9; 1971 c.231 §38; 1983 c.239 §3; 2003 c.364 §148]

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

(2) The service charge is to be computed on the balance of the premiums due (after subtracting the down payment made by the insured in accordance with the premium finance agreement) from the effective date of the insurance coverage, for which the premiums are being advanced, to and including the date when the final payment of the premium finance agreement is payable.

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

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

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

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

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

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

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

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

(3) After expiration of such 10-day period, the premium finance company may thereafter in the name of the insured cancel such insurance policy or policies by mailing to the insurer a notice of cancellation, and the insurance policy shall be canceled as if such notice of cancellation had been submitted by

the insured, but without requiring the return of the insurance policy or policies. The premium finance company shall also mail a notice of cancellation to the insured at the last-known address of the insured and to the insurance producer indicated on the premium finance agreement.

(4) All statutory, regulatory and contractual restrictions providing that the insurance policy may not be canceled unless notice is given to a governmental agency, mortgagee, or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee, or other third party on or before the second business day after the day it receives the notice of cancellation from the premium finance company and shall determine the effective date of cancellation taking into consideration the number of days' notice required to complete the cancellation. [1969 c.639 §12; 1983 c.239 §2; 2003 c.364 §149]

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

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

(3) In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured provided that no such refund shall be required if it amounts to less than $1. [1969 c.639 §13; 1983 c.239 §7; 2003 c.364 §150]

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

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

USE AND DISCLOSURE OF INSURANCE INFORMATION

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

(1)(a) "Adverse underwriting decision" means any of the following actions with respect to insurance transactions involving insurance coverage that is individually underwritten:

(A) A declination of insurance coverage.

(B) A termination of insurance coverage.

(C) Failure of an insurance producer to apply for insurance coverage with a specific insurer that the insurance producer represents and that is requested by an applicant.

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

(E) In the case of insurance coverage other than life or health insurance coverage:

(i) Placement by an insurer or insurance producer of a risk with a residual market mechanism, an unauthorized insurer or an insurer that specializes in substandard risks.

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

(iii) An increase in any charge imposed by the insurer for any personal insurance in connection with the underwriting of insurance. For purposes of this sub-subparagraph, the imposition of a service fee is not a charge.

(b) "Adverse underwriting decision" does not mean any of the following actions, but the insurer or insurance producer responsible for the occurrence of the action must nevertheless provide the applicant or policyholder with the specific reason or reasons for the occurrence:

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

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

(C) The rescission of a policy.

(2) "Affiliate of" a specified person or "person affiliated with" a specified person means a person who directly, or indirectly, through one or more intermediaries, con-

trols, or is controlled by, or is under common control with, the person specified.

(3) "Applicant" means a person who seeks to contract for insurance coverage, other than a person seeking group insurance coverage that is not individually underwritten.

(4) "Consumer" means an individual, or the personal representative of the individual, who seeks to obtain, obtains or has obtained one or more insurance products or services from a licensee that are to be used primarily for personal, family or household purposes, and about whom the licensee has personal information.

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

(6) "Consumer reporting agency" means a person that, for monetary fees or dues, or on a cooperative or nonprofit basis:

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

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

(c) Furnishes consumer reports to other persons.

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

(8) "Covered entity" means:

(a) A health insurer;

(b) A health care provider that transmits any health information in electronic form to carry out financial or administrative activities in connection with a transaction covered by ORS 746.607 or by rules adopted under ORS 746.608; or

(c) A health care clearinghouse.

(9) "Credit history" means any written or other communication of any information by a consumer reporting agency that:

(a) Bears on a consumer's creditworthiness, credit standing or credit capacity; and

(b) Is used or expected to be used, or collected in whole or in part, as a factor in determining eligibility, premiums or rates for personal insurance.

(10) "Customer" means a consumer who has a continuing relationship with a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

(11) "Declination of insurance coverage" or "decline coverage" means a denial, in whole or in part, by an insurer or insurance producer of an application for requested insurance coverage.

(12) "Health care" means care, services or supplies related to the health of an individual.

(13) "Health care operations" includes but is not limited to:

(a) Quality assessment, accreditation, auditing and improvement activities;

(b) Case management and care coordination;

(c) Reviewing the competence, qualifications or performance of health care providers or health insurers;

(d) Underwriting activities;

(e) Arranging for legal services;

(f) Business planning;

(g) Customer services;

(h) Resolving internal grievances;

(i) Creating de-identified information; and

(j) Fundraising.

(14) "Health care provider" includes but is not limited to:

(a) A psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist licensed or otherwise authorized to practice under ORS chapter 675 or an employee of the psychologist, occupational therapist, regulated social worker, professional counselor or marriage and family therapist;

(b) A physician, podiatric physician and surgeon, physician assistant or acupuncturist licensed under ORS chapter 677 or an employee of the physician, podiatric physician and surgeon, physician assistant or acupuncturist;

(c) A nurse or nursing home administrator licensed under ORS chapter 678 or an employee of the nurse or nursing home administrator;

(d) A dentist licensed under ORS chapter 679 or an employee of the dentist;

(e) A dental hygienist or denturist licensed under ORS chapter 680 or an employee of the dental hygienist or denturist;

(f) A speech-language pathologist or audiologist licensed under ORS chapter 681 or an employee of the speech-language pathologist or audiologist;

(g) An emergency medical services provider licensed under ORS chapter 682;

(h) An optometrist licensed under ORS chapter 683 or an employee of the optometrist;

(i) A chiropractic physician licensed under ORS chapter 684 or an employee of the chiropractic physician;

(j) A naturopathic physician licensed under ORS chapter 685 or an employee of the naturopathic physician;

(k) A massage therapist licensed under ORS 687.011 to 687.250 or an employee of the massage therapist;

(L) A direct entry midwife licensed under ORS 687.405 to 687.495 or an employee of the direct entry midwife;

(m) A physical therapist licensed under ORS 688.010 to 688.201 or an employee of the physical therapist;

(n) A medical imaging licensee under ORS 688.405 to 688.605 or an employee of the medical imaging licensee;

(o) A respiratory care practitioner licensed under ORS 688.815 or an employee of the respiratory care practitioner;

(p) A polysomnographic technologist licensed under ORS 688.819 or an employee of the polysomnographic technologist;

(q) A pharmacist licensed under ORS chapter 689 or an employee of the pharmacist;

(r) A dietitian licensed under ORS 691.405 to 691.485 or an employee of the dietitian;

(s) A funeral service practitioner licensed under ORS chapter 692 or an employee of the funeral service practitioner;

(t) A health care facility as defined in ORS 442.015;

(u) A home health agency as defined in ORS 443.005;

(v) A hospice program as defined in ORS 443.850;

(w) A clinical laboratory as defined in ORS 438.010;

(x) A pharmacy as defined in ORS 689.005;

(y) A diabetes self-management program as defined in ORS 743.694; and

(z) Any other person or entity that furnishes, bills for or is paid for health care in the normal course of business.

(15) "Health information" means any oral or written information in any form or medium that:

(a) Is created or received by a covered entity, a public health authority, a life insurer, a school, a university or a health care provider that is not a covered entity; and

(b) Relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(16) "Health insurer" means:

(a) An insurer who offers:

(A) A health benefit plan as defined in ORS 743.730;

(B) A short term health insurance policy, the duration of which does not exceed six months including renewals;

(C) A student health insurance policy;

(D) A Medicare supplemental policy; or

(E) A dental only policy.

(b) The Oregon Medical Insurance Pool operated by the Oregon Medical Insurance Pool Board under ORS 735.600 to 735.650.

(17) "Homeowner insurance" means insurance for residential property consisting of a combination of property insurance and casualty insurance that provides coverage for the risks of owning or occupying a dwelling and that is not intended to cover an owner's interest in rental property or commercial exposures.

(18) "Individual" means a natural person who:

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

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

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

(d) Is a past or present applicant;

(e) Is a past or present claimant; or

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

(19) "Individually identifiable health information" means any oral or written health information that is:

(a) Created or received by a covered entity or a health care provider that is not a covered entity; and

(b) Identifiable to an individual, including demographic information that identifies the individual, or for which there is a reasonable basis to believe the information can be used to identify an individual, and that relates to:

(A) The past, present or future physical or mental health or condition of an individual;

(B) The provision of health care to an individual; or

(C) The past, present or future payment for the provision of health care to an individual.

(20) "Institutional source" means a person or governmental entity that provides information about an individual to an insurer, insurance producer or insurance-support organization, other than:

(a) An insurance producer;

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

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

(21) "Insurance producer" or "producer" means a person licensed by the Director of the Department of Consumer and Business Services as a resident or nonresident insurance producer.

(22) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model or other process that is based in whole or in part on credit history.

(23)(a) "Insurance-support organization" means a person who regularly engages, in whole or in part, in assembling or collecting information about natural persons for the primary purpose of providing the information to an insurer or insurance producer for insurance transactions, including:

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

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

(b) "Insurance-support organization" does not mean insurers, insurance producers, governmental institutions or health care providers.

(24) "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails:

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

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

(25) "Insurer" has the meaning given that term in ORS 731.106.

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

(27) "Licensee" means an insurer, insurance producer or other person authorized or required to be authorized, or licensed or required to be licensed, pursuant to the Insurance Code.

(28) "Loss history report" means a report provided by, or a database maintained by, an insurance-support organization or consumer reporting agency that contains information regarding the claims history of the individual property that is the subject of the application for a homeowner insurance policy or the consumer applying for a homeowner insurance policy.

(29) "Nonaffiliated third party" means any person except:

(a) An affiliate of a licensee;

(b) A person that is employed jointly by a licensee and by a person that is not an affiliate of the licensee; and

(c) As designated by the director by rule.

(30) "Payment" includes but is not limited to:

(a) Efforts to obtain premiums or reimbursement;

(b) Determining eligibility or coverage;

(c) Billing activities;

(d) Claims management;

(e) Reviewing health care to determine medical necessity;

(f) Utilization review; and

(g) Disclosures to consumer reporting agencies.

(31)(a) "Personal financial information" means:

(A) Information that is identifiable with an individual, gathered in connection with an insurance transaction from which judgments can be made about the individual's character, habits, avocations, finances, occupations, general reputation, credit or any other personal characteristics; or

(B) An individual's name, address and policy number or similar form of access code for the individual's policy.

(b) "Personal financial information" does not mean information that a licensee has a reasonable basis to believe is lawfully made available to the general public from federal, state or local government records, widely distributed media or disclosures to the public that are required by federal, state or local law.

(32) "Personal information" means:

(a) Personal financial information;

(b) Individually identifiable health information; or

(c) Protected health information.

(33) "Personal insurance" means the following types of insurance products or services that are to be used primarily for personal, family or household purposes:

(a) Private passenger automobile coverage;

(b) Homeowner, mobile homeowners, manufactured homeowners, condominium owners and renters coverage;

(c) Personal dwelling property coverage;

(d) Personal liability and theft coverage, including excess personal liability and theft coverage; and

(e) Personal inland marine coverage.

(34) "Personal representative" includes but is not limited to:

(a) A person appointed as a guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions;

(b) A person appointed as a health care representative under ORS 127.505 to 127.660 or 127.700 to 127.737 to make health care decisions or mental health treatment decisions;

(c) A person appointed as a personal representative under ORS chapter 113; and

(d) A person described in ORS 746.611.

(35) "Policyholder" means a person who:

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

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

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

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

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

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

(c) Misrepresents the true purpose of the interview.

(d) Refuses upon request to identify the interviewer.

(37) "Privileged information" means information that is identifiable with an individual and that:

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

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

(38)(a) "Protected health information" means individually identifiable health information that is transmitted or maintained in any form of electronic or other medium by a covered entity.

(b) "Protected health information" does not mean individually identifiable health information in:

(A) Education records covered by the federal Family Educational Rights and Privacy Act (20 U.S.C. 1232g);

(B) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); or

(C) Employment records held by a covered entity in its role as employer.

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

(40) "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or a nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure of a premium to be paid as required by the policy.

(41) "Treatment" includes but is not limited to:

(a) The provision, coordination or management of health care; and

(b) Consultations and referrals between health care providers. [1981 c.649 §4; 1987 c.490 §50; 2001 c.191 §50; 2001 c.377 §25; 2003 c.87 §6; 2003 c.364 §151; 2003 c.590 §§2,4; 2003 c.599 §§5,7; 2003 c.788 §1a; 2005 c.253 §§6,7; 2005 c.489 §§1,2; 2009 c.442 §48; 2009 c.833 §31; 2011 c.703 §47; 2011 c.715 §22]

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

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

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

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

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

(5) Enable insurance applicants and policyholders to obtain the reasons for any adverse underwriting decision. [1981 c.649 §2; 1987 c.490 §51; 2003 c.87 §7; 2003 c.364 §152]

746.606 Information privacy standards for health insurers. ORS 746.607 and 746.608 establish standards for health insurers that are subject to the information privacy provisions of both the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the federal Gramm-Leach-Bliley Act (P.L. 106-102). These standards address:

(1) Use and disclosure of personal information;

(2) Access of individuals to personal information;

(3) Notice of privacy practices for personal information;

(4) Amendment of personal information; and

(5) Accounting of disclosures of personal information. [2003 c.87 §2]

746.607 Use and disclosure of personal information. A health insurer:

(1) May use or disclose personal information of an individual in a manner that is consistent with an authorization provided by the individual or a personal representative of the individual.

(2) May use or disclose protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) For its own treatment, payment or health care operations; or

(b) As otherwise permitted or required by state or federal law or by order of the court.

(3) May disclose, subject to any requirements established by rule under ORS 746.608 and consistent with federal law, protected health information of an individual without obtaining an authorization from the individual or a personal representative of the individual:

(a) To another covered entity for health care operations activities of the entity that receives the information if:

(A) Each entity has or had a relationship with the individual who is the subject of the protected health information; and

(B) The protected health information pertains to the relationship and the disclosure is for the purpose of:

(i) Health care operations listed in ORS 746.600 (13)(a) or (b); or

(ii) Health care fraud and abuse detection or compliance;

(b) To another covered entity or any other health care provider for treatment activities of a health care provider; or

(c) To another covered entity or any other health care provider for the payment activities of the entity that receives the information.

(4) May use or disclose personal financial information of an individual:

(a) To perform a business, professional or insurance function, subject to any requirements established by rule under ORS 746.608 for an authorization by an individual or a personal representative of an individual; or

(b) Without obtaining an authorization by the individual or the personal representative of the individual as otherwise permitted or required by state or federal law or by order of the court.

(5) May charge a reasonable, cost-based fee, provided that the fee includes only the cost of:

(a) Copying personal information requested by an individual or a personal representative of the individual, including the cost of supplies for and labor of copying;

(b) Postage, when an individual or a personal representative of the individual has requested that copies of personal information

or an explanation or summary of protected health information be mailed; or

(c) Preparing an explanation or summary of personal information if requested by an individual or a personal representative of the individual.

(6) Shall provide adequate notice of the uses and disclosures of personal information that may be made by the health insurer and of the individual's rights and the health insurer's legal duties with respect to personal information.

(7) Shall permit an individual or a personal representative of an individual to request:

(a) Access to inspect or obtain a copy of the individual's personal financial information or protected health information that is maintained in a designated record set about the individual; or

(b) That the health insurer correct, amend or delete personal information. [2003 c.87 §3]

746.608 Rules. (1) The Director of the Department of Consumer and Business Services shall adopt rules implementing ORS 746.607. In adopting rules under this section, the director shall consider the information privacy provisions of the federal Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) and the federal Gramm-Leach-Bliley Act (P.L. 106-102).

(2) The rules adopted under subsection (1) of this section shall include but are not limited to:

(a) Permitted uses and disclosures of:

(A) Personal financial information for business, professional or insurance purposes; and

(B) Protected health information for treatment, payment and health care operations.

(b) Requirements for notice of privacy practices for protected health information and notice of information practices for personal financial information. [2003 c.87 §4]

746.609 Exemptions for health insurers. ORS 746.620, 746.630, 746.640, 746.645 and 746.665 do not apply to health insurers. [2003 c.87 §5]

746.610 Application of ORS 746.600 to 746.690. (1) Except as otherwise provided in ORS 746.606, 746.607, 746.608 and 746.609, the obligations imposed by ORS 746.600 to 746.690 apply to those insurers, insurance producers and insurance-support organizations that:

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

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

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

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

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

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

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

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

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

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

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

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

(B) Applicants, individuals or policyholders who engage in or seek to engage in insurance transactions involving policies or certificates of insurance delivered, issued for delivery or renewed in this state.

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

(4) Notwithstanding subsections (1) and (2) of this section, ORS 746.600 to 746.690 do not apply to personal information collected from the public records of a governmental authority and maintained by an insurer or its representatives for the purpose of insuring the title to real property located in this state. [1981 c.649 §3; 1987 c.490 §52; 2003 c.87 §8; 2003 c.364 §153]

746.611 Personal representative of deceased person. If no person has been appointed as a personal representative under ORS chapter 113 or a person appointed as a

personal representative under ORS chapter 113 has been discharged, the personal representative of a deceased individual shall be the first of the following persons, in the following order, who may be located upon reasonable effort by the covered entity and who is willing to serve as the personal representative:

(1) A person appointed as guardian under ORS 125.305, 419B.370, 419C.481 or 419C.555 with authority to make medical and health care decisions at the time of the individual's death.

(2) The individual's spouse.

(3) An adult designated in writing by the persons listed in this section, if no person listed in this section objects to the designation.

(4) A majority of the adult children of the individual who can be located.

(5) Either parent of the individual or an individual acting in loco parentis to the individual.

(6) A majority of the adult siblings of the individual who can be located.

(7) Any adult relative or adult friend. [2005 c.253 §5]

746.612 No right of action. Nothing in ORS 746.607 may be construed to create a new private right of action against a health insurer. [2003 c.87 §18a]

746.615 Pretext interviews prohibited. An insurer, insurance producer or insurance-support organization may not use or authorize the use of pretext interviews to obtain personal information in connection with an insurance transaction. However, a pretext interview may be undertaken to obtain information from a person or institution that does not have a generally recognized or statutorily recognized privileged relationship with the person about whom the information relates, for the purpose of investigating a claim where, based upon specific information available for review by the Director of the Department of Consumer and Business Services, there is a reasonable basis for suspecting criminal activity, fraud, material misrepresentation or material nondisclosure in connection with the claim. [1981 c.649 §5; 2003 c.87 §9; 2003 c.364 §154]

746.620 Notice of insurance information practices; rules. (1) A licensee must provide a clear and conspicuous notice of personal information practices to individuals in connection with insurance transactions under the circumstances and at the times as follows:

(a) Except as provided in this paragraph, to a consumer who becomes a customer of the licensee, not later than the date that the licensee establishes a continuing relationship under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes. A licensee may provide the notice within a reasonable time after the date the licensee establishes a customer relationship if:

(A) Establishing the customer relationship is not at the customer's election; or

(B) Providing notice not later than the date that the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

(b) To a consumer other than as described in paragraph (a) of this subsection, before the licensee discloses any personal information about the consumer pursuant to the requirements of ORS 746.665, unless the disclosure meets one or more of the conditions specified in ORS 746.665.

(2) A licensee shall provide a clear and conspicuous notice to a customer that accurately reflects the privacy policies and practices not less than annually during the continuation of the relationship described in subsection (1)(a) of this section. For the purpose of this subsection, a notice is given annually if it is given at least once in any period of 12 consecutive months during which the relationship exists. A licensee may define the period of 12 consecutive months, but the licensee must apply the period to the customer on a consistent basis.

(3) The privacy notice required by subsections (1) and (2) of this section must be in writing and clear and conspicuous. The notice may be provided in electronic form if the recipient agrees. In addition to any other personal information the licensee wishes to provide, the notice shall include the following items of personal information that apply to the licensee and to the individuals to whom the licensee sends the notice:

(a) The categories of personal information that the licensee collects.

(b) The categories of personal information that the licensee discloses.

(c) The categories of affiliates and nonaffiliated third parties to whom the licensee discloses personal information other than persons to whom the licensee discloses information under ORS 746.665.

(d) The categories of personal information about former customers of the licensee that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses personal information about the licensee's former customers, other than persons to whom the licensee

discloses personal information under ORS 746.665.

(e) If a licensee discloses personal information to a nonaffiliated third party under ORS 746.665, a separate description of the categories of personal information the licensee discloses and the categories of nonaffiliated third parties with whom the licensee has contracted.

(f) An explanation of the individual's right under ORS 746.630 to authorize disclosure of personal information, including the methods by which the individual may exercise that right.

(g) Any disclosure that the licensee makes under section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii)) regarding the ability to opt out of disclosures of personal information among affiliates.

(h) The policies and practices of the licensee with respect to protecting the confidentiality and security of personal information.

(i) Any disclosure that the licensee makes under subsection (4) of this section.

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

(4) If a licensee discloses personal information as authorized under ORS 746.665, the licensee is not required to list those exceptions in the privacy notices required by this section. When describing the categories of parties to whom disclosure is made, the licensee must state only that the licensee makes disclosures to other affiliated parties or nonaffiliated third parties, as applicable, as authorized by law.

(5) In lieu of the notice required in subsection (3) of this section, the licensee may provide to a consumer an abbreviated notice, in writing or in electronic form if the consumer agrees, informing the consumer that:

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

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

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

(d) The notice prescribed in subsection (3) of this section shall be furnished to the consumer upon request.

(6) The Director of the Department of Consumer and Business Services by rule may apply the categories of consumer and customer as defined in ORS 746.600 for the purpose of establishing specific requirements for notice of personal information practices, authorization for disclosure of personal information, conditions for disclosure of personal information under this section and ORS 746.630 and 746.665, and exceptions. The director shall consider applicable definitions and terms used in the federal Gramm-Leach-Bliley Act (P.L. 106-102), applicable definitions and requirements used in the model "Privacy of Consumer Financial and Health Information Regulation" adopted by the National Association of Insurance Commissioners and other sources as may be needed so that the terms defined in ORS 746.600 and applicable to this section and ORS 746.630 and 746.665:

(a) Facilitate compliance with requirements in federal law and the laws of other states that establish protections of nonpublic personal information; and

(b) Establish separate and discrete requirements relating to the privacy notice and its contents and delivery for customers and consumers, so that the requirements provide reasonable notice and facilitate compliance with requirements in federal law and in the laws of other states.

(7) The director shall determine by rule:

(a) When a privacy notice must be provided to a certificate holder or beneficiary of a group policy and to a third-party claimant.

(b) When the obligation to provide annual notice ceases.

(c) Requirements for revision of the notice by a licensee.

(8) An insurance producer is not subject to the requirements of this section when the insurer on whose behalf the insurance producer acts otherwise complies with the requirements of this section and the insurance producer does not disclose any personal information to any person other than the insurer or its affiliate, or as otherwise authorized by law.

(9) A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee may also provide a notice on behalf of a financial institution.

(10) The obligations imposed by this section upon a licensee may be satisfied by another licensee authorized to act on behalf of the first licensee.

(11) For purposes of this section and ORS 746.630 and 746.665, an individual is not the consumer of a licensee solely because the individual is covered under a group life insurance policy issued by the licensee or is a participant or beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary, if:

(a) The licensee provides to the policyholder the initial, annual and revised notices under this section; and

(b) The licensee does not disclose to a nonaffiliated third party personal information about the individual other than as permitted by ORS 746.665.

(12) When an individual becomes a consumer of a licensee under subsection (11) of this section, this section and ORS 746.630 and 746.665 apply to the licensee with respect to the individual. [1981 c.649 §6; 2001 c.377 §26; 2003 c.87 §10; 2003 c.364 §155]

746.625 Marketing and research surveys. An insurer or insurance producer shall clearly identify those questions that are designed to obtain personal information solely for marketing or research purposes from an individual in connection with an insurance transaction. [1981 c.649 §7; 2003 c.87 §11; 2003 c.364 §156]

746.630 Authorization for disclosure of certain information; forms; revocation. (1) Notwithstanding any other law of this state, a licensee or insurance-support organization may not use as its disclosure authorization form in connection with insurance transactions a form or statement that authorizes the disclosure of personal or privileged information about an individual to the licensee or insurance-support organization unless the form or statement is clear and conspicuous, and contains all of the following:

(a) The identity of the individual who is the subject of the personal information.

(b) A general description of the categories of personal information to be disclosed.

(c) General descriptions of the parties to whom the licensee discloses personal information, the purpose of the disclosure and how the personal information may be used.

(d) The signature of the individual who is the subject of the personal information or the individual who is legally empowered to grant authority and the date signed.

(e) Notice of the length of time for which the authorization is valid, that the individual may revoke the authorization at any time and the procedure for making a revocation.

(2) An authorization is not valid for more than 24 months.

(3) An individual who is the subject of personal information may revoke an authorization provided pursuant to this section at any time, subject to the rights of any individual who acted in reliance on the authorization prior to notice of the revocation.

(4) A licensee must retain the authorization of an individual or a copy thereof in the record of the individual who is the subject of the personal information.

(5) A disclosure authorization obtained by an insurer, insurance producer or insurance-support organization from an individual prior to January 1, 1983, is considered to be in compliance with this section. [1981 c.649 §8; 2001 c.377 §27; 2003 c.87 §12; 2003 c.364 §157]

746.632 Genetic information used for treatment; authorization; disclosure. (1) Notwithstanding ORS 192.537 (3), a health insurer may retain genetic information of an individual without obtaining an authorization from the individual or a personal representative of the individual if the retention is for treatment, payment or health care operations by the insurer.

(2) Notwithstanding ORS 192.539 (1), a health insurer may disclose genetic information of an individual without obtaining an authorization from the individual or a personal representative of the individual if the insurer discloses the genetic information in accordance with ORS 746.607 (3).

(3) As used in this section, "retain genetic information" has the meaning given that term in ORS 192.531.

(4) As used in this section, "health care operations" does not include underwriting activities.

(5) Nothing in this section shall be construed to interfere with or limit the requirements of ORS 746.135. [2007 c.800 §8]

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

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

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

(2) If an investigative consumer report is to be prepared by an insurer or insurance producer, the insurer or insurance producer

shall institute reasonable procedures to conduct a personal interview requested by the individual.

(3) If an investigative consumer report is to be prepared by an insurance-support organization, the insurer or insurance producer desiring the report shall inform the insurance-support organization whether a personal interview has been requested by the individual. The insurance-support organization shall institute reasonable procedures to conduct such requested interviews. [1981 c.649 §9; 2003 c.364 §158]

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

(a) Inform the individual of the nature and substance of the recorded personal information in writing, by telephone or by other oral communication, whichever the insurer, insurance producer or insurance-support organization prefers;

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

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

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

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

(3) If an individual requests individually identifiable health information supplied by a health care provider, the insurer, insurance producer or insurance-support organization shall provide the information, including the identity of the health care provider either directly to the individual or to a health care provider designated by the individual and licensed to provide health care with respect to the condition to which the information relates, whichever the insurer, insurance producer or insurance-support organization prefers. If the insurer, insurance producer or insurance-support organization elects to disclose the information to a health care provider designated by the individual, the insurer, insurance producer or insurance-support organization shall notify the individual, at the time of the disclosure, that the insurer, insurance producer or insurance-support organization has provided the information to the health care provider.

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

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

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

(7) For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency." [1981 c.649 §10; 2003 c.87 §13; 2003 c.364 §159a]

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

producer or insurance-support organization shall either:

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

(b) Notify the individual of:

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

(B) The reasons for the refusal; and

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) For purposes of this section, the term "insurance-support organization" does not include "consumer reporting agency." [1981 c.649 §11; 2003 c.364 §160]

746.650 Reasons for adverse underwriting decisions. Except as otherwise provided in ORS 743.804, 743.806, 743.857 and 743.861:

(1) In the event of an adverse underwriting decision, the insurer or insurance producer responsible for the decision must:

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

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

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

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

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

(A) The insurer or insurance producer is not required to furnish specific items of privileged information if the insurer or insurance producer has a reasonable suspicion, based upon specific information available for review by the Director of the Department of Consumer and Business Services, that the consumer proposed for coverage has engaged in criminal activity, fraud, material misrepresentation or material nondisclosure; and

(B) Specific items of individually identifiable health information supplied by a health care provider shall be disclosed either directly to the consumer about whom the information relates or to a health care provider designated by the consumer and licensed to provide health care with respect to the condition to which the information relates, whichever the insurer or insurance producer prefers; and

(c) The names and addresses of the institutional sources that supplied the specific items of information described in paragraph (b) of this subsection. However, the identity of any health care provider must be disclosed either directly to the consumer or to the designated health care provider, whichever the insurer or insurance producer prefers.

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

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

(5) Notwithstanding subsection (1) of this section, when an adverse underwriting decision is based in whole or in part on credit history or insurance score, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A summary of no more than four of the most significant credit reasons for the adverse underwriting decision, listed in decreasing order of importance, that clearly identifies the specific credit history or insurance score used to make the adverse underwriting decision. An insurer or insurance producer may not use "poor credit history" or a similar phrase as a reason for an adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the consumer report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the credit history of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's consumer report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a consumer report furnished by the consumer reporting agency.

(6) Notwithstanding subsection (1) of this section, an insurer or insurance producer responsible for an adverse underwriting decision that is based in whole or in part on credit history or insurance score must provide the notice required by subsection (5) of this section only when the insurer or insurance producer makes the initial adverse underwriting decision regarding a consumer.

(7) Notwithstanding subsection (1) of this section, when an adverse underwriting decision relating to homeowner insurance is based in whole or in part on a loss history report, the insurer or insurance producer responsible for the decision must provide the consumer proposed for coverage with the specific reason or reasons for the adverse underwriting decision in writing. The notice must include the following:

(a) A description of a specific claim or claims that are the basis for the specific loss history report used to make the adverse underwriting decision.

(b) The name, address and telephone number, including a toll-free telephone number, of the consumer reporting agency that provided the information for the loss history report.

(c) A statement that the consumer reporting agency used by the insurer or insurance producer to obtain the loss history report of the consumer did not make the adverse underwriting decision and is unable to provide the consumer with specific reasons

why the insurer or insurance producer made an adverse underwriting decision.

(d) Information on the right of the consumer:

(A) To obtain a free copy of the consumer's loss history report from the consumer reporting agency described in paragraph (b) of this subsection, including the deadline, if any, for obtaining a copy; and

(B) To dispute the accuracy or completeness of any information in a loss history report furnished by the consumer reporting agency.

(8) When an adverse underwriting decision relating to homeowner insurance is based in part on credit history and in part on a loss history report, the insurer or insurance producer responsible for the adverse underwriting decision may provide the notices required by subsections (5) and (7) of this section in a single notice. [1981 c.649 §12; 2003 c.87 §15; 2003 c.364 §161; 2003 c.788 §2a; 2005 c.489 §7; 2011 c.500 §42]

746.655 Information concerning previous adverse underwriting decisions. No insurer, insurance producer or insurance-support organization may seek information in connection with an insurance transaction concerning any previous adverse underwriting decision experienced by an individual, or any previous insurance coverage obtained by an individual through a residual market mechanism, unless the inquiry also requests the reasons for any previous adverse underwriting decision or the reasons why insurance coverage was previously obtained through a residual market mechanism. [1981 c.649 §13; 2003 c.364 §162]

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

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

(2) Personal information received from an insurance-support organization whose primary source of information is insurers. However, an insurer or insurance producer may base an adverse underwriting decision on further personal information obtained as the result of information received from such an insurance-support organization. [1981 c.649 §14; 2003 c.364 §163]

746.661 Use of credit history or insurance score. (1) An insurer that issues personal insurance policies in this state:

(a) May not cancel or nonrenew personal insurance that has been in effect for more than 60 days based in whole or in part on a consumer's credit history or insurance score.

(b) May use a consumer's credit history to decline coverage of personal insurance in the initial underwriting decision only in combination with other substantive underwriting factors. An offer of placement with an affiliate insurer does not constitute a declination of insurance coverage.

(c) May not use the following types of credit history to decline coverage of personal insurance, calculate an insurance score or determine personal insurance premiums or rates:

(A) The absence of credit history or the inability to determine the consumer's credit history, if the insurer has received accurate and complete information from the consumer, unless the insurer does one of the following:

(i) If the insurer presents information that the absence of credit history or the inability to determine the consumer's credit history relates to the risk for the insurer, uses the absence of a credit history or inability to determine a consumer's credit history as allowed by rules adopted by the Director of the Department of Consumer and Business Services;

(ii) Treats the consumer as if the applicant or insured has neutral credit history, as defined by the insurer; or

(iii) Excludes the use of credit information as a factor and uses only other underwriting criteria.

(B) Credit inquiries not initiated by the consumer or inquiries requested by the consumer for the consumer's own credit information.

(C) Inquiries identified on a consumer's credit report relating to insurance coverage.

(D) Multiple lender inquiries identified as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered.

(E) Multiple lender inquiries identified as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

(F) The consumer's total available line of credit. However, an insurer may consider the total amount of outstanding debt in relation to the total available line of credit.

(d) May not rerate an existing policy or rerate a customer based on a customer's credit history or the credit history compo-

nent of a customer's insurance score when the marital status of the customer changes due to death or divorce.

(2)(a) If an insurer uses the consumer's credit history or insurance score at any time in the rating of a personal insurance policy, the consumer may request, no more than once per insurer per policy line annually, that the insurer rerate the consumer according to the standards that the insurer would apply if the consumer were initially applying for the same insurance policy.

(b) The insurer shall rerate the consumer within 30 days after receiving a request from the consumer. After rerating the consumer based upon the request, the insurer may not use credit information from rerating to increase the premium on any personal insurance policy the consumer holds. If the consumer qualifies for a more favorable rating category, the insurer shall reduce the premiums on all the personal insurance policies the consumer holds in the related policy line for which the consumer's credit history and insurance score would entitle the consumer to lower premiums if the consumer were applying for a new policy. The effective date of any rate change is the date of the consumer's request.

(c) If a request to rerate a policy is received within 60 days prior to a renewal date, or if the difference between the current rate and the improved rate is less than $10, the insurer may provide the consumer with the difference between the current rate and the improved rate over the remainder of the current period as a credit upon renewal. If the policy is canceled or not renewed, the insurer shall refund the unearned premium. Any existing claim-related discounts or surcharges shall carry forward for each rerated policy.

(3) If an insurer uses disputed credit history to determine eligibility for coverage of personal insurance and places a consumer with an affiliate that charges higher premiums or offers less favorable policy terms:

(a) The insurer shall rerate the policy retroactive to the effective date of the current policy term; and

(b) The policy, as reissued or rerated, shall provide the premiums and policy terms for which the consumer would have been eligible if accurate credit history had been used to determine eligibility.

(4) If an insurer charges higher premiums due to disputed credit history, the insurer shall rerate the policy retroactive to the effective date of the current policy term. As rerated, the insurer shall charge the consumer the same premiums the consumer would have been charged if accurate credit history had been used to calculate an insurance score.

(5) Subsections (3) and (4) of this section apply only if the consumer resolves the credit dispute under the process set forth in the federal Fair Credit Reporting Act (15 U.S.C. 1681) and notifies the insurer in writing that the dispute has been resolved.

(6) Except as provided in subsections (2), (3) and (4) of this section, an insurer may only use rating factors other than credit history or insurance score to rerate the policy at renewal. [2003 c.788 §4; 2005 c.464 §1; 2009 c.422 §1]

746.662 Filing of insurance scoring models. (1) An insurer may not use credit history to determine personal insurance eligibility, premiums or rates for coverage unless the insurer has filed the insurance scoring models used by the insurer with the Director of the Department of Consumer and Business Services. An insurance scoring model includes all attributes and factors used in the calculation of an insurance score.

(2) Insurance scoring models filed with the director under subsection (1) of this section are confidential and not subject to disclosure under ORS 192.410 to 192.505. [2003 c.788 §5]

746.663 Cancellation or nonrenewal of personal insurance policies based on credit history or insurance score. (1) An insurer that issues personal insurance policies in this state may not cancel or nonrenew a policy of personal insurance based in whole or in part on a consumer's credit history or insurance score.

(2) If, prior to January 1, 2004, an insurer has assigned a consumer to a less favorable rating category for a policy of personal insurance based in whole or in part on the consumer's credit history or insurance score, the consumer may request, no more than once annually, that the insurer rerate the consumer according to the standards that the insurer would apply to the consumer if the consumer were initially applying for the same personal insurance on or after January 1, 2004.

(3) An insurer that receives a request under subsection (2) of this section may not consider that the consumer was assigned to a less favorable rate category when the insurer rerates the consumer.

(4) If an insurer uses disputed credit history to determine eligibility for coverage of personal insurance and places a consumer with an affiliate that charges higher premiums or offers less favorable policy terms:

(a) The insurer shall rerate the policy retroactive to the effective date of the current policy term; and

(b) The policy, as reissued or rerated, shall provide the premiums and policy terms for which the consumer would have been eligible if accurate credit history had been used to determine eligibility.

(5) If an insurer charges higher premiums due to disputed credit history, the insurer shall rerate the policy retroactive to the effective date of the current policy term. As rerated, the insurer shall charge the consumer the same premiums the consumer would have been charged if accurate credit history had been used to calculate an insurance score.

(6) Subsections (4) and (5) of this section apply only if the consumer resolves the credit dispute under the process set forth in the federal Fair Credit Reporting Act (15 U.S.C. 1681) and notifies the insurer in writing that the dispute has been resolved.

(7) Except as provided in subsections (2), (4) and (5) of this section, an insurer may only use rating factors other than credit history or insurance score to rerate the policy at renewal. [2003 c.788 §7]

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

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

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

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

(i) Dated;

(ii) Signed by the individual; and

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

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

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

(i) Would otherwise be permitted by this section if made by a licensee or insurance-support organization; or

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

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

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

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

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

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

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

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

(A) Verifying insurance coverage or benefits.

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

(C) Conducting an operations or services audit.

(e) Is to an insurance regulatory authority.

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

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

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

(g) Is otherwise permitted or required by law.

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

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

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

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

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

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

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

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

(k) Is to a nonaffiliated third party whose only use of the information will be in connection with the marketing of a product or service, if all of the following conditions are met:

(A) No privileged information or personal information is disclosed, and no classification derived from such information may be disclosed.

(B) The individual must have been given the notice described in ORS 746.620 and an opportunity to indicate that the individual does not want personal information disclosed for marketing purposes and must have given no indication that the individual does not want the information disclosed. The individual need not have been given the opportunity described in this subparagraph if the disclosure is made pursuant to a joint marketing agreement. As used in this subparagraph, "joint marketing agreement" means a formal written contract pursuant to which an insurer jointly offers, endorses or sponsors a financial product or service with a financial institution. When the opportunity is required, the statement that offers the opportunity must state that the insurer may disclose personal information to nonaffiliates and that the individual has a right to indicate that the individual does not want personal information disclosed for marketing purposes, and must describe the method for exercising that right. The statement must be in writing but may be in an electronic form if the individual agrees. The individual who is given the opportunity must be provided a reasonable time to exercise the opportunity. An individual may exercise the opportunity at any time. A statement by an individual barring disclosure of personal information remains effective until the individual who made the statement revokes the statement in writing or, if the individual agrees, in electronic form.

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

(L) Is to an affiliate whose only use of the information will be in connection with an audit of the licensee or the marketing of a financial product or service, and the affiliate agrees not to disclose the information for any other purpose or to unaffiliated persons. This paragraph does not apply to the disclosure of individually identifiable health information for the purpose of marketing a financial product or service.

(m) Is by a consumer reporting agency, and the disclosure is to a person other than a licensee.

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

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

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

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

(2) Personal or privileged information may be acquired by a group practice prepayment health care service contractor from providers which contract with the contractor and may be transferred among providers which contract with the contractor for the purpose of administering plans offered by the contractor. The information may not be disclosed otherwise by the contractor except in accordance with ORS 746.600 to 746.690. [1981 c.649 §15; 1987 c.490 §53; 2001 c.377 §28; 2003 c.87 §14]

746.668 Relationship of ORS 746.620, 746.630 and 746.665 to federal Fair Credit Reporting Act. Nothing in ORS 746.620, 746.630 or 746.665 may be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.) and no inference may be drawn on the basis of ORS 746.620, 746.630 or 746.665 regarding whether personal information is transaction information or experience information under section 603 of the federal

Fair Credit Reporting Act (15 U.S.C. 1681 et seq.). [2001 c.377 §28c; 2003 c.87 §16]

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

(2) The director may examine and investigate into the affairs of any insurance-support organization acting on behalf of an insurer or insurance producer which either transacts insurance in this state or transacts insurance outside this state which has an effect on a person residing in this state, in order to determine whether the insurance-support organization has been or is engaged in any conduct in violation of ORS 746.600 to 746.690. [1981 c.649 §16; 1987 c.490 §54; 2003 c.87 §17; 2003 c.364 §164]

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

746.680 Remedies. (1) A person whose rights granted under ORS 746.607 (7), 746.640, 746.645 or 746.650 are violated may apply to the circuit court for the county in which the person resides, or any other court of competent jurisdiction, for appropriate equitable relief if an insurer, insurance producer or insurance-support organization fails to comply with ORS 746.607 (7), 746.640, 746.645 or 746.650.

(2) A licensee or insurance-support organization that discloses information in violation of ORS 746.665 or a health insurer that uses or discloses information in violation of ORS 746.607 (1) or (2) is liable for damages sustained by the individual about whom the information relates. However, an individual is not entitled to a monetary award that exceeds the actual damages sustained by the individual as a result of the violation of ORS 746.607 (1) or (2) or 746.665.

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

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

(5) Except as specifically provided in this section, there shall be no remedy or recovery available to individuals, in law or in equity, for occurrences constituting a violation of any provision of ORS 746.600 to 746.690. [1981 c.649 §18; 1987 c.490 §56; 1995 c.618 §131; 2001 c.377 §28a; 2003 c.87 §18; 2003 c.364 §165a]

746.685 Liability for disclosure of information. No cause of action in the nature of defamation, invasion of privacy or negligence shall arise against any person for disclosing personal or privileged information in accordance with ORS 746.600 to 746.690 and 750.055, nor shall such a cause of action arise against any person for furnishing personal or privileged information to an insurer, insurance producer or insurance-support organization. However, this section shall provide no immunity for disclosing or furnishing false information with malice or willful intent to injure any person. [1981 c.649 §19; 1987 c.490 §57; 2003 c.364 §166]

746.686 Use of prior claim or inquiry in determination to issue or renew homeowner insurance policy; rules. (1) When a consumer applies for a homeowner insurance policy, an insurer may not use:

(a) A prior claim of the consumer or a claim relating to the property to be insured, when the date of loss of the claim is more than five years preceding the date of application, to determine whether to issue the policy or to determine rates or other terms and conditions of the policy. This paragraph does not apply when the insurer uses claim experience of the consumer or of the property to provide a discount to the consumer.

(b) The first claim that the consumer made on a homeowner insurance policy within the five-year period immediately preceding the date of application to determine whether to issue the policy.

(c) A prior claim relating to the property to be insured that occurred prior to purchase of the property by the consumer, when the consumer demonstrates to the insurer's satisfaction that the risk associated with damage resulting from the accident or occurrence that gave rise to the prior claim has been mitigated, to determine whether to issue the policy or to determine rates or other terms and conditions of the policy. For purposes of this paragraph, a risk is mitigated if the consumer has fully restored the damaged property and has repaired, replaced, restored or eliminated the condition, system or use of the property that was the underlying cause of the loss.

(2) When renewing a homeowner insurance policy, an insurer may not use:

(a) A prior claim of the consumer or a claim relating to the property to be insured, when the date of loss of the claim is more than five years before the upcoming renewal date, to determine whether to renew the policy or to determine rates or other terms and conditions of the policy. This paragraph does not apply when the insurer uses claim experience of the consumer or of the property to provide a discount to the consumer at renewal.

(b) The first claim of the consumer made within the five-year period immediately preceding the upcoming renewal date to determine whether to renew the policy.

(3) An insurer or insurance producer may not use an inquiry made by any means by the consumer to the insurer or to an insurance producer regarding the terms, conditions or coverage of an insurance policy, including an inquiry about an actual loss or claim filing process, to determine whether to issue or renew a policy or to determine rates or other terms and conditions of a policy if the consumer is not making a claim as part of the inquiry. An insurer or insurance producer may verify whether the consumer is making a claim as part of the inquiry. If the consumer affirms that the inquiry is not a claim, the insurer or insurance producer may rely on the affirmation to rebut a later assertion to the contrary. This subsection does not apply to an inquiry by a consumer relating to the possibility of a third party claim against the consumer. The Director of the Department of Consumer and Business Services may adopt rules establishing procedures to implement this subsection.

(4) This section does not prohibit an insurer from taking any underwriting or rating action that is:

(a) Based on the known condition or use of the property;

(b) Based on fraudulent acts of the consumer; or

(c) Otherwise allowed by law. [2005 c.489 §4]

746.687 Cancellation of homeowner insurance policy. (1) Except as provided in subsection (6) of this section, an insurer may cancel a homeowner insurance policy before the expiration of the policy only for one or more of the following reasons:

(a) Nonpayment of premium;

(b) Fraud or material misrepresentation affecting the policy or in the presentation of a claim under the policy;

(c) Violation of any of the terms and conditions of the policy;

(d) Substantial increase in the risk of loss after insurance coverage has been issued or renewed, including but not limited to an increase in exposure due to rules, legislation or court decision; or

(e) Determination by the Director of the Department of Consumer and Business Services that the continuation of a line of insurance or class of business to which the policy belongs will jeopardize an insurer's solvency or place the insurer in violation of the insurance laws of Oregon or any other state, whether because of a loss or decrease in reinsurance covering the risk or other reason determined by the director.

(2) The insurer shall give the policyholder written notice of the cancellation, including the effective date of the cancellation and the reasons for the cancellation.

(3) The insurer must mail or deliver a notice of cancellation to the policyholder at the address shown in the policy:

(a) At least 10 days prior to the effective date of cancellation, if the cancellation is for the reason described in subsection (1)(a) or (b) of this section.

(b) At least 30 days prior to the effective date of cancellation, if the cancellation is for the reason described in subsection (1)(c), (d) or (e) of this section.

(4) An insurer shall mail or deliver to a policyholder, at the address shown in the policy, a notice of renewal or nonrenewal of a homeowner insurance policy at least 30 days prior to the expiration of the policy period. This subsection does not apply when the policy is in lapse status under the terms of the policy.

(5) Proof of mailing notice of cancellation or nonrenewal to the policyholder at the address shown in the policy is sufficient proof of notice under this section.

(6) This section does not apply to a homeowner insurance policy that has been in effect fewer than 60 days at the time the notice of cancellation is mailed or delivered by the insurer unless it is a renewal policy. An insurer may not use the fact that a claim was filed on the policy within the 60-day period as a basis for canceling the policy within the 60-day period, for increasing the premium rate or for altering the terms of the policy during the current policy term. An insurer may, within the 60-day period, use any other information consistent with the insurer's rating or underwriting program, including but not limited to, conditions or uses of the property discovered by the insurer, as a basis for cancellation or for offering to continue coverage at an increased rate or on different terms. At renewal of the policy, the insurer may treat a claim that occurred

within the 60-day period the same as any other claim occurring during the policy period for the purposes of rating, nonrenewing and altering the terms of the policy. [2005 c.489 §5]

746.688 Use of loss history reports; notice to consumer. (1) An insurer or insurance producer shall notify a consumer that the insurer or insurance producer will request a loss history report relating to the consumer or property to be insured before the insurer or insurance producer may obtain the report. The notice may be oral, in writing or in the same medium as the medium in which previous communication between the consumer and the insurer or insurance producer has been conducted.

(2) An insurance producer may provide a single notice under subsection (1) of this section to a consumer if the insurance producer makes loss history inquiries of one or more insurers in response to a request by the consumer relating to a homeowner insurance policy.

(3) An insurer that uses loss history reports for underwriting or rating homeowner insurance shall instruct the insurer's insurance producers that an insurance producer must notify the consumer that the insurance producer has requested a loss history report before the insurance producer may obtain the report.

(4) An insurer that uses a loss history report of a consumer when considering an application for a homeowner insurance policy shall notify the consumer during the application process that the consumer may request a free copy of the loss history report from the consumer reporting agency and a written statement describing the insurer's use of the report. The notice to the applicant may be in writing or in the same medium as the medium in which the application is made. The written statement must contain the following explanations:

(a) The ways in which the insurer uses loss history reports;

(b) How often the insurer reviews a consumer's loss history report; and

(c) The procedures a consumer may use to obtain additional information. [2005 c.489 §6]

746.690 Obtaining information under false pretenses prohibited. No person shall knowingly and willfully obtain information about an individual from an insurer, insurance producer or insurance-support organization under false pretenses. [1981 c.649 §20; 2003 c.364 §167]

PENALTIES

746.990 [Repealed by 1967 c.359 §704]

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

Note: See note under 746.275.