New Jersey
Insurance Code

TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT AND INSOLVENCY

17B:32A-1

"New Jersey life and health insurance guaranty association act"

Sections 2 through 19 of this act* shall be known and may be cited as the "New Jersey Life and Health Insurance Guaranty Association Act."

*Sections 17B:32A- 2 through 17B:32A- 19.

History	L. 1991, c. 208, s 1.

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17B:32A-2

Purpose

a. The purpose of this act is to protect, subject to certain limitations, those persons specified in subsection a. of section 3 of this act* from hardship because of the impairment or insolvency of any member insurer that issued the life and health insurance policies and annuity contracts specified in subsection b. of section 3 of this act.

b. To provide this protection, an association of insurers is created to pay benefits and to continue coverages, as limited by this act, and members of the association are subject to assessment to provide funds to carry out the purposes of this act.

*Section 17B:32A- 3.

History	L. 1991, c. 208, s 2.

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17B:32A-3

Scope of provisions

a. This act shall provide coverage, for the policies and contracts specified in subsection b. of this section, to:

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

(2) persons who are owners of or certificate holders under those policies or contracts, or in the case of unallocated annuity contracts, to the persons who are the contract holders and who:

(a) are residents, or

(b) are not residents, but only if:

(i) the insurers which issued the policies or contracts are domiciled in this State;

(ii) those insurers never held a license or certificate of authority in the states in which those persons reside;

(iii) those states have associations and coverage provisions with respect to residency similar to the association created by this act; and

(iv) those persons are not eligible for coverage by those associations.

b. This act shall provide coverage to the persons specified in subsection a. of this section for:

(1) direct, non-group life, health, annuity and supplemental policies or contracts, for certificates under direct group life, health, annuity and supplemental policies and contracts, for individual and group long-term care insurance policies and contracts, and for unallocated annuity contracts, issued by member insurers, except as limited by this act; and

(2) policies or contracts issued by medical service corporations declared to be insolvent or impaired by a court of competent jurisdiction on or after September 1, 1987, but prior to the effective date of this act, except as otherwise limited by this act.

c. This act shall not provide coverage for:

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

(2) any policy or contract of reinsurance, unless assumption certificates have been issued;

(3) any portion of a policy or contract to the extent that the rate of interest on which it is based:

(a) averaged over the four-year period prior to the date on which the association becomes obligated with respect to that policy or contract, exceeds the lesser of:

(i) the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period, or for such lesser period if the policy or contract was issued less than four years before the association became obligated, or

(ii) the rate of interest specified in the standard valuation law, or the rules of this State for determining the minimum standard for the valuation of policies or contracts issued during the year of insolvency; and

(b) on and after the date on which the association becomes obligated with respect to that policy or contract, exceeds the rate of interest determined by subtracting four percentage points from Moody's Corporate Bond Yield Average as most recently available; except that the limitation of this paragraph shall not preclude the association from providing more extensive coverage if it is proceeding under the authority of section 7 of this act*;

(4) any plan or program of an employer, association or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that such plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or similar entity under:

(a) a Multiple Employer Welfare Arrangement as defined in the Employee Retirement Income Security Act of 1974 (29 U.S.C. s 1002);

(b) a minimum premium group insurance plan;

(c) a stop-loss group insurance plan; or

(d) an administrative services only contract;

(5) any portion of a policy or contract to the extent that it provides dividends or experience rating credits, or provides that any fees or allowances be paid to any person, including the holder of the policy or contract, in connection with the service to or administration of that policy or contract;

(6) any policy or contract issued in this State by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue that policy or contract in this State;

(7) any unallocated annuity contract issued to an employee benefit plan covered by the Pension Benefit Guaranty Corporation and whose benefits will be paid under such system; and

(8) any portion of any unallocated annuity contract which is not issued to or in connection with a specific plan providing benefits to employees or an association of natural persons.

d. The benefits for which the association may become liable shall in no event exceed the lesser of:

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

(2) with respect to any one insured individual, regardless of the number of policies or contracts:

(a) $500,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(b) $500,000 in present value annuity benefits, including net cash surrender and net cash withdrawal values, but not more than $100,000 in net cash surrender and net cash withdrawal values for annuity benefits; provided, however, that in no event shall the association be liable to expend more than $500,000 in the aggregate with respect to any one individual under this paragraph (2); or

(3) with respect to any one unallocated annuity contract, $2,000,000 in benefits; or

(4) with respect to any one group, blanket, or individual accident or health insurance or group, blanket or individual accident or health insurance policy, unlimited benefits.

e. A provider of health care services, in order to receive payment directly from the association upon a claim of the provider against an insured, shall agree to forgive the insured of 20% of the obligation which would otherwise be paid by the insurer had it not been insolvent. The obligations of solvent insurers to pay all or part of the covered claim are not diminished by the forgiveness provided in this paragraph. The association is not bound by an assignment of benefits executed with respect to the coverage provided by the insolvent insurer. The association may aggregate all claims owed health care providers when negotiating direct payment of claims of all covered individuals.

*Section 17B:32A- 7.

History	L. 1991, c. 208, s 3.

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17B:32A-4

Definitions

As used in this act:

"Account" means either of the two accounts created under subsection b. of section 5 of this act.{Footnote 1}

"Association" means the New Jersey Life and Health Insurance Guaranty Association created in subsection a. of section 5 of this act.

"Commissioner" means the Commissioner of Insurance.

"Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof, for which coverage is provided under section 3 of this act, but does not include unearned premium under a health insurance policy or contract.

"Covered policy" means any policy or contract within the scope of this act as provided by section 3 of this act.{Footnote 2}

"Department" means the Department of Insurance.

"Impaired insurer" means a member insurer which, after the effective date of this act: (1) is determined by the commissioner to be potentially unable to fulfill its contractual obligations; or (2) is placed under an order of receivership, rehabilitation or conservation by a court of competent jurisdiction.

"Insolvent insurer" means a member insurer which, after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

"Member insurer" means any insurer licensed in this State or which holds a certificate of authority to transact any kind of insurance in this State for which coverage is provided under section 3 of this act, and includes any insurer whose license or certificate of authority in this State may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(1) A dental service corporation established pursuant to the provisions of P.L. 1968, c. 305 (C. 17:48C- 1 et seq.);

(2) A dental plan organization established pursuant to the provisions of P.L. 1979, c. 478 (C. 17:48D- 1 et seq.);

(3) A health maintenance organization established pursuant to the provisions of P.L. 1973, c. 337 (C. 26:2J- 1 et seq.);

(4) A fraternal benefit society established pursuant to the provisions of P.L. 1959, c. 167 (C. 17:44A- 1 et seq.);

(5) A mandatory state pooling plan;

(6) A mutual assessment company or any entity that operates on an assessment basis to the extent of the assessment liability of its members;

(7) An insurance exchange; or

(8) An entity similar to any of the above.

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

"Person" means an individual or natural person, corporation, partnership, association or voluntary organization.

"Premiums" means amounts or considerations received in any calendar year on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon. "Premiums" shall not include any amounts or considerations received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under subsection b. of section 3 of this act except that assessable premium shall not be reduced as the result of the application of: paragraph (3) of subsection c. of section 3 relating to interest limitations; or paragraph (2) of subsection d. of section 3 relating to limitations with respect to any one insured individual. "Premiums" shall not include any premiums in excess of $2,000,000 per contract on any unallocated annuity contract.

"Resident" means a person who resides in this State at the time a member insurer is determined to be an impaired or insolvent insurer and to whom a contractual obligation is owed. For the purposes of this act a person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business.

"Supplemental contract" means an agreement entered into for the distribution of policy or contract proceeds.

"Unallocated annuity contract" means: (1) an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under that contract or certificate; or (2) any unallocated life insurance or health insurance funding agreement, where insurance certificates or contracts are not issued to and owned by individuals, except to the extent of any life insurance or health insurance benefits guaranteed to an individual by an insurer under such funding agreement.

{Footnote 1} Section 17B:32A- 5.

{Footnote 2} Section 17B:32A- 3.

History	L. 1991, c. 208, s 4.

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17B:32A-5

Establishment of association

a. There is created a nonprofit legal entity to be known as the New Jersey Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance in this State. Any member insurer shall remain a member insurer for four years after it ceases to hold a certificate of authority or license. The association shall perform its functions under the plan of operation established and approved pursuant to section 9 of this act{Footnote 1} and shall exercise its powers through the board of directors established under section 6 of this act.{Footnote 2} The association shall be under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this State. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

b. For purposes of administration and assessment the association shall maintain two accounts:

(1) The life insurance and annuity account which shall include the following subaccounts:

(a) life insurance subaccount;

(b) annuity subaccount; and

(c) unallocated annuity subaccount.

(2) The health insurance account.

{Footnote 1} Section 17B:32A- 9.

{Footnote 2} Section 17B:32A- 6.

History	L. 1991, c. 208, s 5.

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17B:32A-6

Board of directors

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

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

c. Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

History	L. 1991, c. 208, s 6.

New Jersey
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TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT AND INSOLVENCY

17B:32A-7

Powers and duties of association

a. If a member insurer is an impaired domestic insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not unreasonably impair the contractual obligations of the impaired insurer, that are approved by the commissioner, and that are, except in cases of court ordered receivership, conservation or rehabilitation, also approved by the impaired insurer:

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

(2) provide such monies, pledges, notes, guarantees, or other means as are proper to effectuate the provisions of paragraph (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (1); or

(3) loan money to the impaired insurer.

b. (1) If a member insurer is an impaired insurer, whether domestic, foreign or alien, and the insurer is not paying claims in a timely manner, then subject to the preconditions specified in paragraph (2) of this subsection, the association shall, in its discretion, either:

(a) take any of the actions specified in subsection a. of this section, subject to the conditions therein; or

(b) provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for health insurance claims, periodic annuity benefit payments, death benefits, supplemental benefits, and cash withdrawals for policy or contract owners who petition therefor under claims of emergency or hardship in accordance with standards proposed by the association and approved by the commissioner.

(2) The association shall be subject to the requirements of paragraph (1) of this subsection only if:

(a) the laws of the impaired insurer's state or country of domicile provide that, until all payments of, or on account of, the impaired insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the impaired insurer shall have been approved by the guaranty associations,

(i) the delinquency proceeding shall not be dismissed,

(ii) neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management, and

(iii) it shall not be permitted to solicit or accept new business or have any suspended or revoked license restored; and

(b)(i) in the case of a domestic insurer, it has been placed under an order of receivership or rehabilitation by a court of competent jurisdiction in this State, or

(ii) in the case of a foreign or alien insurer, it has been prohibited from soliciting or accepting new contracts in this State, except as approved by the commissioner and as part of a plan of rehabilitation approved by a court of competent jurisdiction.

(3)(a) The limitations of paragraphs (3) and (4) of subsection c. of section 3 of this act{Footnote 1} shall not preclude the association from providing more extensive coverage or guarantees, if it is proceeding under the authority of this section and if that additional coverage is an essential element in allowing a rehabilitation plan to succeed as determined by the commissioner and a court of competent jurisdiction.

(b) The commissioner and the association shall utilize the authority of this section if a reasonable prospect exists that the ultimate liabilities to be paid by the association and its member insurers will be reduced as compared to the present liabilities incurred if the association were to proceed under paragraph (2) of subsection d. of section 3 of this act.{Footnote 1}

(c) In proceeding under paragraph (1) subsection b. of this section, without limitation on any authority or right of the association under this act or any right of contract, the association may enter into agreements with other guaranty associations to secure coordination between associations and performance by those associations with respect to policy or contract holders covered by those associations equivalent to that provided to individuals covered by this act.

(d) In proceeding under paragraph (1) of subsection b. of this section, any funds actually expended by a member insurer for benefits received by a person covered by this act, which were subject to a plan of rehabilitation approved by the commissioner and a court of competent jurisdiction, shall qualify as an assessment under section 8 of this act{Footnote 2} after a final accounting.

(e) When the association is proceeding under paragraph (1) of subsection b. of this section, the court shall authorize the establishment of liens upon policy and contract holder cash surrender values and cash withdrawal values limiting the ability of policy and contract holders to withdraw deposits, surrender their policies or contracts and receive the net cash surrender values and net cash withdrawal values, for a term of not less than three nor more than five years. The court, in establishing liens upon cash surrender values or cash withdrawal values, shall approve such liens upon the motion of the receiver as are necessary to enable the impaired insurer to meet its death and disability claims and fund the necessary operating expenses associated with its receivership to the greatest extent possible with the available assets of the impaired insurer within the time period covered by rehabilitation plan. The standard to be applied by the court with respect to preferential treatment is that all options offered to policy and contract holders must represent the same pro rata claim on the

general account assets of the impaired insurer and be actuarially equivalent in present value terms at the time they are approved.

c. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

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

(b) assure payment of the contractual obligations of the insolvent insurer; and

(c) provide those monies, pledges, guarantees, or other means as are reasonably necessary to discharge those obligations; or

(2) with respect only to life and health insurance policies, provide benefits and coverages in accordance with subsection d. of this section.

d. When proceeding under subparagraph (b) of paragraph (1) of subsection b. or paragraph (2) of subsection c. of this section, the association shall, with respect only to life and health insurance policies or contracts:

(1) assure payment of benefits for premiums identical to the premiums and benefits, except for terms of conversion and renewability, that would have been payable under the policies or contracts of the impaired or insolvent insurer, for claims incurred:

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

(b) with respect to individual policies or contracts, not later than the earlier of the next renewal date, if any, under those policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to those policies or contracts;

(2) make a diligent effort to provide all known insureds, or group policyholders with respect to group policies or contracts, 30 days notice of the termination of the benefits provided; and

(3) with respect to individual policies or contracts, and with respect to individuals formerly insured under group policies or contracts who are not eligible for replacement group coverage, make available to each known insured, or owner of an individual policy or contract if other than the insured, substitute coverage on an individual basis in accordance with the provisions of paragraph (4) of this subsection, if the insured had a right under law or the terminated policy or contract to convert coverage to individual coverage or to continue an individual policy or contract in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provision of the policy or contract or had a right only to make changes in premium by class.

(4)(a) In providing the substitute coverage required by paragraph (3), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract.

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

(c) The association may reinsure any alternative or reissued policy or contract.

(5)(a) Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner.

(b) Alternative policies or contracts shall contain at least the minimum statutory provisions required in this State and provide benefits that shall not be unreasonable in relation to the premium charged under reasonable actuarial assumptions. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured.

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

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

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

e. When proceeding under subparagraph (b) of paragraph (1) of subsection b. or subsection c. of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest at least equal to that specified in paragraph (3) of subsection c. of section 3 of this act.

f. Nonpayment of premiums within 31 days after the date required, after effective notice shall have been given of the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage, shall terminate the association's obligations under that policy, contract or coverage under this act with respect to that policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this act.

g. Premiums due for coverage after entry of an order of receivership or liquidation of any insolvent insurer shall belong to, and be payable at the direction of, the association.

h. The protection provided by this act shall not apply if any guaranty protection is provided to residents of this State by the law of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this State.

i. In carrying out its duties under subsections b. and c. of this section, the association may, subject to approval by the court:

(1) impose reasonable and necessary policy or contract liens in connection with any guaranty, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this act are less than the amounts needed to assure full and prompt performance of the association's duties under this act, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of those policy or contract liens, to be in the public interest; or

(2) impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value.

j. If the association fails to act within a reasonable period of time as provided in subparagraph (b) of paragraph (1) of subsection b. and subsections c. and d. of this section, the commissioner shall have the powers and duties of the association provided by this act with respect to impaired or insolvent insurers.

k. The association may render assistance and advice to the commissioner concerning the receivership, conservation, rehabilitation, liquidation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

l. The association shall have standing to appear before any court in this State with jurisdiction over an impaired or insolvent insurer with respect to which the association is or may become obligated under this act. That standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the termination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a third party against whom the association may have rights through subrogation of the insurer's policyholders.

m. (1) Any person receiving benefits under this act shall be deemed to have assigned the rights under, and any causes of action relating to, the covered policy or contract to the association to the extent of the benefits received pursuant to this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and causes of action by any payee, policy or contract owner, beneficiary, insured or annuitant as condition precedent to the receipt of any right or benefits conferred by this act upon that person.

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

(3) In addition to the rights of subrogation contained in paragraphs (1) and (2) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy which would have been available to the impaired or insolvent insurer or holder of a policy or contract with respect to that policy or contract.

(4) In addition to the rights contained in paragraphs (1), (2) and (3) of this subsection, in the case of any unallocated annuity contract for which benefits are paid by the association under this act, the association shall be deemed to have assigned to it the rights and causes of action of any employee or association of natural persons against the contract holder of such unallocated annuity contract for the amounts paid by the association under this act.

n. The association may:

(1) enter into any contracts necessary or proper to carry out the provisions and purposes of this act;

(2) sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments imposed pursuant to section 8 of this act and to settle claims or potential claims against it;

(3) borrow money to effectuate the purposes of this act. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(4) employ or retain persons necessary to handle the financial transactions of the association, and to perform other functions as are necessary or proper under this act;

(5) take any legal action necessary to avoid payment of improper claims;

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

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

{Footnote 1} Section 17B:32A- 3.

{Footnote 2} Section 17B:32A- 8.

History	L. 1991, c. 208, s 7.

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17B:32A-8

Assessments

a. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than 30 days after prior written notice to the member insurers and shall accrue interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money, on and after the due date.

b. There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative and legal costs of the association which are not objected to by the commissioner and other expenses and examinations conducted under the authority of subsection e. of section 11 of this act.{Footnote 1} Class A assessments shall also be made, upon the request of the commissioner, for the purpose of meeting costs incurred by or on behalf of the department in the administration of an insolvent insurer to the extent those costs exceed assets of the insolvent insurer available for that purpose. Class A assessments need not be related to a particular impaired or insolvent insurer. The amount of any Class A assessment shall be determined by the board.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 7 of this act{Footnote 2} with respect to an impaired or an insolvent insurer. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

c. (1) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this State by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this State for such calendar years by all assessed member insurers.

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

d. The association shall exempt, abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the commissioner, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations or places the member insurer in an unsafe or unsound financial condition. In the event an assessment against a member insurer is exempted, abated or deferred, in whole or in part, the amount by which that assessment is exempted, abated or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section.

e. (1) The total of all assessments imposed under subsection b. of this section upon a member insurer for the life insurance and annuity account and for each subaccount thereunder shall not in any one calendar year exceed two percent and for the health insurance account shall not in any one calendar year exceed two percent of that insurer's average premiums, as reported in the annual statement in a form prescribed by the commissioner, received in this State on the policies and contracts covered by the account during the three calendar years preceding the year in which the insurer became an impaired or insolvent insurer. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this act.

(2) If a one percent assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to paragraph (1) of subsection c. of this section, the board shall assess all subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in paragraph (1) of this subsection.

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

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

g. Except for that portion of assessments which may be offset against premium taxes pursuant to section 18 of this act{Footnote 3} , it shall be proper for any member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this act, to consider the amount reasonably necessary to meet its assessment obligations under this act.

h. The association shall issue to each insurer paying an assessment pursuant to this act, other than a Class A assessment, a certificate of contribution, in a form and manner prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to

amount or date of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in such form and manner and for such amount and period of time as the commissioner may approve.

{Footnote 1} Section 17B:32A- 11.

{Footnote 2} Section 17B:32A- 7.

{Footnote 3} Section 17B:32A- 18.

History	L. 1991, c. 208, s 8; L. 1994, c. 180, s 1.

New Jersey
Insurance Code

TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT AND INSOLVENCY

17B:32A-9

Plan of operation

a. (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or at the expiration of 30 days after submission if it has not been disapproved.

(2) If the association fails to submit a suitable plan of operation within 120 days following the effective date of this act or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt such plan or amendments necessary to effectuate the provisions of this act. The plan or amendments shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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

c. The plan of operation shall, in addition to requirements enumerated elsewhere in this act:

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

(2) establish the amount and method of reimbursing members of the board of directors under subsection c. of section 6 of this act;{Footnote 1}

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

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

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

(6) establish any additional procedures for the imposition of assessments under section 8 of this act;{Footnote 2} and

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

d. The plan of operation may provide for the delegation of any or all powers and duties of the association, except those set forth in paragraph (3) of subsection m. of section 7 and section 8 of this act,{Footnote 3} to a corporation, association, or other organization which performs or will perform functions similar to those of the association, or its equivalent, in two or more other states. Such a corporation, association, or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection d. shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable or effective than that provided by this act.

{Footnote 1} Section 17B:32A- 6.

{Footnote 2} Section 17B:32A- 8.

{Footnote 3} Sections 17B:32A- 7 and 17B:32A- 8.

History	L. 1991, c. 208, s 9.

New Jersey
Insurance Code

TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT AND INSOLVENCY

17B:32A-10

Powers and duties of commissioner

a. In addition to the duties and powers enumerated elsewhere in this act, the commissioner shall:

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

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

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

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

c. Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if that appeal is taken within 30 days of the final action being appealed. If a member company is appealing an assessment, the amount assessed shall be paid to the association and made available to meet association obligations during the pendency of an appeal. If the appeal of an assessment is upheld, the amount paid in error or excess shall be returned to the member company. Any final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction.

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

History	L. 1991, c. 208, s 10.

New Jersey
Insurance Code

TITLE 17B -- INSURANCE ... Subtitle 3 -- Life and Health Insurance Code ... Chapter 32A -- IMPAIRMENT AND INSOLVENCY

17B:32A-11

Prevention of insolvencies

a. To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner may:

(1) notify the commissioners of insurance or comparable officials of all the other states, territories of the United States and the District of Columbia when he takes any of the following actions against a member insurer:

(a) revokes its certificate of authority or license;

(b) suspends its certificate of authority or license; or

(c) makes any formal order that the insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from this State, reinsure all or part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors.

Notice shall be made in any form the commissioner deems appropriate, including notification under the auspices of the National Association of Insurance Commissioners, hereinafter referred to as NAIC.

(2) report to the board of directors when he has taken any of the actions set forth in paragraph (1) of this subsection or has received notification from the commissioner of insurance or comparable official of any other jurisdiction that any such action has been taken in that jurisdiction. The report to the board of directors shall contain all significant details of the action taken or of any such notification received from another jurisdiction.

(3) report to the board of directors when he has reasonable cause to believe from any examination, whether completed or in process, of any member company that the company may be an impaired or insolvent insurer. The report and the information therein shall be kept confidential by the board of directors.

(4) furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and a list of companies not included in the ratios developed by the NAIC. The board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

b. The commissioner may seek the advice and recommendations of the board of directors or member insurers concerning any matter affecting his duties and

responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this State.

c. The board of directors or any member thereof may make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, conservation or receivership of any member insurer or germane to the solvency of any company seeking to do insurance business in this State. Reports and recommendations made pursuant to this subsection shall not be considered public documents.

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

e. The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Such an examination may be conducted as a NAIC examination or may be conducted by those persons as the commissioner designates. The cost of the examination may be paid by the association and the examination report shall be treated as are other examination reports. In no event shall the examination report be released to the board of directors of the association prior to its release to the public, but this shall not preclude the commissioner from taking action permitted by subsection a. of this section.

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

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

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

History	L. 1991, c. 208, s 11.