

Chapter 3956

Ohio Life and Health Insurance Guaranty Association

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§ 3956.01. Definitions.

As used in this chapter:

(A) "Account" means either of the two accounts created under section 3956.06 of the Revised Code.

(B) "Contractual obligation" means any obligation under a policy, contract, or certificate under a group policy or contract, or portion of the policy or contract, for which coverage is provided under section 3956.04 of the Revised Code.

(C) "Covered policy or contract" means any policy, contract, or group certificate within the scope of section 3956.04 of the Revised Code.

(D) "Impaired insurer" means a member insurer that, after November 20, 1989, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(E) "Insolvent insurer" means a member insurer that, after November 20, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(F)(1) "Member insurer" means any insurer that holds a certificate of authority or is licensed to transact in this state any kind of insurance for which coverage is provided under section 3956.04 of the Revised Code, and includes any insurer whose certificate of authority or license in this state may have been suspended, revoked, not renewed, or voluntarily withdrawn after November 20, 1989.

(2) "Member insurer" does not include any of the following:

(a) A health insuring corporation;

(b) A fraternal benefit society;

(c) A self-insurance or joint self-insurance pool or plan of the state or any political subdivision of the state;

(d) A mutual protective association;

(e) An insurance exchange;

(f) Any person who qualifies as a "member insurer" under section 3955.01 of the Revised Code and who does not receive premiums on covered policies or contracts;

(g) Any entity similar to any of those described in divisions (F)(2)(a) to (f) of this section.

(3) "Member insurer" includes any insurer that operates any of the entities described in division (F)(2) of this section as a line of business, and not as a separate, affiliated legal entity, and otherwise qualifies as a member insurer.

(G) "Premiums" means amounts received on covered policies or contracts, less premiums, considerations, and deposits returned on the policies or contracts, and less dividends and experience credits on the policies and contracts. "Premiums" does not include either of the following:

(1) Any amounts in excess of one million dollars received on any unallocated annuity contract not issued under a governmental retirement plan established under Section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended;

(2) Any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided under section 3956.04 of the Revised Code. Division (G)(2) of this section shall not be construed to require the exclusion, from assessable premiums, of premiums paid for coverages in excess of the interest limitations specified in division (B)(2)(c) of section 3956.04 of the Revised Code or of premiums paid for coverages in excess of the limitations with respect to any one individual, any one participant, or any one contract holder specified in division (C)(2) of section 3956.04 of the Revised Code.

(H) "Resident" means any 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. 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. Citizens of the United States who are either residents of a foreign country or residents of a United States possession, territory, or protectorate that does not have an association similar to the association created by this chapter shall be considered residents of the state of domicile of the insurer that issued the policy or contract.

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

(J) "Subaccount" means any of the three subaccounts created under division (A) of section 3956.06 of the Revised Code.

(K) "Supplemental contract" means any agreement entered into for the distribution of policy or contract proceeds.

(L) "Unallocated annuity contract" means any annuity contract or group annuity certificate that 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.

Amended by 131st General Assembly File No. TBD, SB 223, §1, eff. 12/22/2015.
Effective Date: 06-04-1997

§ 3956.02. Citation of chapter.

This chapter may be cited as the Ohio life and health insurance guaranty association act.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.03. Purpose to protect life and health insurance benefits.

The purpose of this chapter is to protect, subject to certain limitations, the persons specified in division (A) of section 3956.04 of the Revised Code against failure in the performance of contractual obligations under life and health insurance policies and annuity contracts specified in division (B) of section 3956.04 of the Revised Code, due to the impairment or insolvency of the member insurer that issued the policies or contracts. To provide this protection, the Ohio life and health insurance guaranty association, an association of insurers, is to pay benefits and to continue coverages, as limited in this chapter. Members of the association are subject to assessment to provide funds to carry out the purpose of this chapter.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.04. Policies and contracts covered by chapter; persons covered; liability of association limited.

(A) This chapter provides coverage, by the Ohio life and health insurance guaranty association, for the policies and contracts specified in division (B) of this section to all of the following persons:

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

(2) Persons who are owners of or certificate holders under the policies or contracts other than structured settlement annuities, or, in the case of unallocated annuity contracts, the persons who are the contract holders, if either of the following applies:

(a) The persons are residents of this state;

(b) The persons are not residents of this state and all of the following conditions apply:

(i) The insurers that issued the policies or contracts are domiciled in this state;

(ii) At the time the policies or contracts were issued, the insurers did not hold a license or certificate of authority in the states in which the persons reside;

(iii) The states have associations similar to the association created by section 3956.06 of the Revised Code;

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

(3) Persons who are payees, or the beneficiary of a payee if the payee is deceased, under a structured settlement annuity if the payee is a resident of this state, regardless of where the contract owner resides;

(4) Persons who are payees, or the beneficiary of a payee if the payee is deceased, under a structured settlement annuity if the payee is not a resident of this state, but both of the following are true:

(a) The contract owner of the structured settlement annuity is a resident of this state or, if the contract owner of the structured settlement annuity is not a resident of this state, the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to the association created by this chapter.

(b) The payee, the beneficiary, and the contract owner are not eligible for coverage by the association of the state in which the payee or contract owner resides.

(5) Persons who are payees or beneficiaries of a contract owner resident of this state to the extent coverage is provided under division (A)(4) of this section, unless the payee or beneficiary is afforded any coverage by the association of another state.

This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter receives coverage under the laws of another state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this chapter in situations in which a person could be covered by the association of more than one state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(B)(1) This chapter provides coverage to the persons specified in division (A) of this section for direct, nongroup life, health, or annuity policies or contracts, for certificates under direct group policies and contracts, for supplemental contracts to any of the preceding, and for unallocated annuity contracts, in each case issued by member insurers, except as otherwise limited in this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(2) This chapter does not provide coverage for any of the following:

(a) 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;

(b) Any policy or contract of reinsurance, unless assumption certificates have been issued;

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

(i) Averaged over the period of four years prior to the date on which the association becomes obligated with respect to the policy or contract or if the policy or contract has been issued for a lesser period averaged over that period, exceeds the rate of interest determined by subtracting two percentage points from the monthly average-corporates as published by Moody's investors service, inc., or any successor to that service, averaged for the same period;

(ii) On and after the date on which the association becomes obligated with respect to the policy or contract, exceeds the rate of interest determined by subtracting three percentage points from the monthly average-corporates as published by Moody's investors service, inc., or any successor to that service, as most recently available. If the monthly average-corporates is no longer published, the superintendent, by rule, shall establish a substantially similar average.

(d) 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 the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association, or similar entity under any of the following:

(i) A multiple employer welfare arrangement as defined in section 3(40) of the "Employee Retirement Income Security Act of 1974," 88 Stat. 833, 29 U.S.C.A. 1002(40), as amended;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan;

(iv) An administrative services only contract.

(e) 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 policy or contract holder, in connection with the service to or administration of the policy or contract;

(f) 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 the policy or contract in this state;

(g) Any unallocated annuity contract issued to an employee benefit plan protected under the federal pension benefit guaranty corporation;

(h) Any portion of any unallocated annuity contract that is not issued to or in connection with a governmental lottery or a benefit plan of a specific employee, union, or association of natural persons;

(i) Any policy or contract issued to or for the benefit of a past or present director or officer within one year of the filing of the successful complaint that the insurer was impaired or insolvent;

(j) Any policy or contract issued by any entity described in division (F)(2) of section 3956.01 of the Revised Code;

(k) Any policy or contract issued by a member insurer if the member insurer is carrying on as a line of business, and not as a separate legal entity, the activities of any entity described in division (F)(2) of section 3956.01 of the Revised Code, and the policy or contract is issued as a product of those activities;

(l) Any policy or contract providing hospital, medical, prescription drug, or other health care benefits pursuant to 42 U.S.C. Chapter 7, Title XVIII, Parts C and D and any corresponding regulations.

(C) The benefits for which the association may become liable shall not exceed the lesser of either of the following:

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

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

(i) Three hundred thousand dollars in life insurance death benefits, but not more than one hundred thousand dollars in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars in health insurance benefits other than basic hospital, medical, and surgical insurance, major medical insurance, disability insurance, or long-term care insurance, including any net cash surrender and net cash withdrawal values;

(iii) Three hundred thousand dollars in disability insurance;

(iv) Three hundred thousand dollars in long-term care insurance;

(v) Five hundred thousand dollars in basic hospital, medical, and surgical insurance or major medical insurance;

(vi) Two hundred fifty thousand dollars in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(b) With respect to each individual participating in a governmental retirement plan established under section 401, 403(b), or 457 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C.A. 1, as amended, and covered by an unallocated annuity contract, or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars in present value annuity benefits, including net cash surrender and net cash withdrawal values.

The association is not liable to expend more than three hundred thousand dollars in the aggregate with respect to any one individual under divisions (C)(2)(a), (b), and (d) of this section combined, except with respect to benefits for basic hospital, medical, and surgical insurance and major medical insurance under division (C)(2)(a)(v) of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars with respect to any one individual.

(c) With respect to any one contract holder, covered by any unallocated annuity contract not included in division (C)(2)(b) of this section, one million dollars in benefits, irrespective of the number of those contracts held by that contract holder.

(d) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of the payee if the payee is deceased, two hundred fifty thousand dollars in present value of annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(D) The liability of the association is limited strictly by the express terms of the policies or contracts and by this chapter, and is not affected by the contents of any brochures, illustrations, advertisements in the print or electronic media, or other advertising material used in connection with the sale of the policies or contracts, or by oral statements made by agents or other sales representatives in connection with the sale of the policies or contracts. The association is not liable for extra-contractual damages, punitive damages, attorney's fees, or interest other than as provided for by the terms of the policies or contracts as limited by this chapter, that might be awarded by any court or governmental agency in connection with the policies or contracts.

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

Amended by 131st General Assembly File No. TBD, SB 223, §1, eff. 12/22/2015.
Amended by 128th General Assembly File No. 18, HB 300, §1, eff. 5/26/2010.
Effective Date: 11-20-1989

§ 3956.05. Liberal construction.

This chapter shall be liberally construed to effect its purpose as set forth in section 3956.03 of the Revised Code.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.06. Life and health insurance guaranty association created; life insurance and annuity account; health insurance account; supervision.

(A) There is hereby created a nonprofit unincorporated association to be known as the Ohio 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 the business of insurance in this state. The association shall perform its functions under the plan of operation established and approved under section 3956.10 of the Revised Code and shall exercise its powers through a board of directors established under section 3956.07 of the Revised Code. For purposes of administration and assessment, the association shall maintain the following two accounts:

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

(a) Life insurance subaccount;

(b) Annuity subaccount;

(c) Unallocated annuity subaccount which also includes all annuity contracts meeting the requirements of section 403

(b) of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended.

(2) The health insurance account.

(B) The association is subject to the supervision of the superintendent of insurance and to the applicable insurance laws of this state.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.07. Board of directors.

(A) The board of directors of the Ohio life and health insurance guaranty association shall consist of not less than nine nor more than eleven member insurers serving terms as established in the plan of operation. A majority of the members of the board shall be representatives of member insurers domiciled in this state. Three of the members of the board shall be representatives of the three member insurers that are consolidated corporations as defined in division (A)(1) of section 3923.39 of the Revised Code and that write the largest premium volumes of health insurance in this state, three of the members of the board shall be representatives of domestic life insurers, and three of the members of the board shall be representatives of foreign insurers. The members of the board shall be selected by member insurers, subject to the approval of the superintendent of insurance. 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 superintendent. To select the initial board of directors and initially organize the association, the superintendent 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 sixty days after notice of the organizational meeting, the superintendent may appoint the initial members.

(B) In approving selections or in appointing members to the board, the superintendent 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: 143 v H 89. Eff 11-20-89.

§ 3956.08. Courses of action as to impaired or insolvent member insurer and as to policyholders; corporate powers of association.

(A) (1) Subject to any conditions imposed as provided in division (A)(2) of this section, the Ohio life and health insurance guaranty association may do either of the following with respect to an impaired domestic member insurer:

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

(b) Provide the moneys, pledges, notes, guarantees, or other means that are proper to effectuate division (A)(1)(a) of this section and assure payment of the contractual obligations of the impaired insurer pending action under division (A)(1)(a) of this section.

(2) The association may impose conditions upon any action it takes under division (A)(1) of this section if all of the following apply:

(a) The condition does not impair the contractual obligations of the impaired insurer;

(b) The superintendent of insurance approves the condition;

(c) Except in cases of court-ordered conservation or rehabilitation, the impaired insurer approves the condition.

(B) (1) If a member insurer is an impaired foreign or alien insurer that is not paying claims timely, the association, subject to the conditions specified in division (B)(2) of this section, shall do either of the following:

(a) Take any of the actions specified in division (A)(1) of this section, subject to the conditions specified in division (A)(2) of this section;

(b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for all of the following:

(i) Death benefits and health claims in accordance with division (D) of this section;

(ii) Periodic annuity benefit payments;

(iii) Supplemental benefits;

(c) Except in cases of court-ordered conservation or rehabilitation, the impaired insurer approves the condition. (B) (1) If a member insurer is an impaired foreign or alien insurer that is not paying claims timely, the association, subject to the conditions specified in division (B)(2) of this section, shall do either of the following: (a) Take any of the actions specified in division (A)(1) of this section, subject to the conditions specified in division (A) (2) of this section; (b) Provide substitute benefits in lieu of the contractual obligations of the impaired insurer solely for all of the following: (i) Death benefits and health claims in accordance with division (D) of this section; (ii) Periodic annuity benefit payments; (iii) Supplemental benefits;

(ii) Neither the impaired insurer nor its assets shall be returned to the control of its shareholders or private management.

(iii) The impaired insurer shall not be permitted to solicit or accept new business or have any suspended or revoked license restored.

(b) The impaired insurer has been prohibited from soliciting or accepting new business in this state, its license or certificate of authority has been suspended or revoked in this state, and a petition for rehabilitation or liquidation has been filed in a court of

competent jurisdiction in its state of domicile by the commissioner of insurance of that state.

(C) If a member insurer is an insolvent insurer, the association shall do either of the following:

(1) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies or contracts of the insolvent insurer or assure payment of the contractual obligations of the insolvent insurer, and provide the moneys, pledges, guarantees, or other means that are reasonably necessary to discharge such duties;

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

(D) When proceeding under division (B)(1)(b) or (C)(2) of this section, the association, with respect to life and health insurance policies, shall do all of the following:

(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 of the insurer, for claims incurred within the following time limits:

(a) With respect to group policies, not later than the earlier of the next renewal date under such policies or contracts or forty-five days, but in no event less than thirty days, after the date on which the association becomes obligated with respect to such policies;

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

(2) Make diligent efforts to provide all known insureds or group policyholders with respect to group policies thirty days' notice of the termination of the benefits provided;

(3) With respect to individual policies, make available to each known insured, or owner if other than the insured, and with respect to an individual formerly insured under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of division (D)(4) of this section, if such insureds coverage on an individual basis in accordance with the provisions of division (D)(4) of this section, if such insureds had a right under law or the terminated policy to convert coverage to individual coverage or to continue an individual policy 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 had a right only to make changes in premium by class.

(4) (a) In providing the substitute coverage required under division (D)(3) of this section, the association may offer either to reissue the terminated coverage or to issue an

alternative policy.

(b) Alternative or reissued policies 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.

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

(5) (a) Alternative policies adopted by the association shall be subject to the approval of the superintendent. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(b) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premium in accordance with the 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, but shall not reflect any changes in the health of the insured after the original policy was last underwritten.

(c) Any alternative policy issued by the association shall provide coverage of a type similar to that of the policy 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, 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 superintendent or a court of competent jurisdiction.

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

(E) When proceeding under divisions (B)(1)(b) or (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 consistent with division (B)(2)(c) of section 3956.04 of the Revised Code.

(F) Nonpayment of premiums within thirty-one days after the date required under the terms of any guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall terminate the obligations of the association under the policy or coverage under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value that may be due in accordance with this chapter.

(G) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to, and be payable at the direction of, the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(H) In carrying out its duties under divisions (B) and (C) of this section, the association, subject to approval by the court, may do the following:

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

(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.

(I) If the association fails to act as provided in divisions (B)(1)(b), (C), and (D) of this section within a reasonable time, the superintendent shall have the powers and duties of the association under this chapter with respect to impaired or insolvent insurers.

(J) The association may render assistance and advice to the superintendent, upon his request, concerning any insurer that is insolvent, impaired, or potentially impaired, or concerning the rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer.

(K) The association, and any similar associations of other states, may appear or intervene before any court in this state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated under this chapter, or over a third party against whom the association or associations have or may have rights through subrogation of the insurer's policy or contract holders. The right to appear or intervene extends to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, modifying, or guaranteeing the covered policies or contracts of the impaired or insolvent insurer and the determination of the covered policies or contracts and contractual obligations. The association also has 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 policy or contract holders.

(L) (1) Any person receiving benefits under this chapter is 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 as a result of this chapter, 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 holder, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon such person.

(2) The subrogation rights of the association under this division 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 chapter.

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

(M) If the aggregate liability of the association with respect to any one life does not exceed one hundred dollars, the association is not obligated to notify claimants possessing such claims or make any payment thereto.

(N) Except with respect to claims filed under policies and contracts which are continued in force by the association past the final date set by a court for filing claims in liquidation proceedings of an insolvent insurer, the association is not liable to pay any claim filed with the association after such date.

(O) The association may do any of the following:

(1) Enter into any such contracts and take such actions as are necessary or proper in the judgment of the board of directors to protect the interests of the association, or to carry out the powers and duties of the association or the provisions and purposes of this chapter;

(2) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under section 3956.09 of the Revised Code and to settle claims or potential claims against it;

(3) Borrow money to effect the purposes of this chapter. Any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets.

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

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

(6) Exercise, for the purposes of this chapter and to the extent approved by the superintendent, the powers of a domestic life or health insurer, but in no case may the

association issue insurance policies or annuity contracts other than those issued to perform its obligations under this chapter;

(7) 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;

(8) Enter into agreements with other state associations of similar purposes to determine the residence of persons for purposes of this chapter.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.09. Assessments of member insurers; refunds; certificates of contribution; credit for certain payments.

(A) For the purpose of providing the funds necessary to carry out the powers and duties of the Ohio life and health insurance guaranty association, the board of directors shall assess the member insurers, separately for each subaccount or account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at ten per cent per year 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 and other expenses, and the cost of examinations conducted under division (E) of section 3956.12 of the Revised Code. Class A assessments may be made whether or not related to a particular impaired or insolvent insurer.

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under section 3956.08 of the Revised Code with regard to an impaired or an insolvent insurer.

(C) (1) The amount of any class A assessment shall be determined by the board and may be made on a pro rata or non-pro rata basis. If pro rata, the board may provide that it be credited against future class B assessments. A non-pro rata assessment shall not exceed two hundred dollars per member insurer in any one calendar year. The amount of any class B assessment shall be allocated for assessment purposes among the subaccounts and accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or on any other standard considered by the board in its sole discretion as being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each subaccount or account 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 subaccount or account for the most recent three 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.

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

(D) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. If an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. In determining whether the payment of an assessment would endanger the ability of a member insurer to fulfill its contractual obligations, the board shall consider the adequacy of the capital and surplus of the member insurer in relation to the premiums written, the assets, and the reserve liabilities of that member insurer.

(E) (1) The total of all assessments upon a member insurer for the life insurance and annuity account, which includes the life insurance subaccount, the annuity subaccount, and the unallocated annuity subaccount, shall not in any one calendar year exceed two per cent of the insurer's average premiums received per year in this state on the policies and contracts covered by each such subaccount, and for the health insurance account, shall not in any one calendar year exceed two per cent of the insurer's average premiums received per year in this state on the policies and contracts covered by such account, during the three calendar years preceding the year in which the impaired or insolvent insurer or insurers became impaired or insolvent. If the maximum assessment for a subaccount or account, together with the other assets of the association in the subaccount or account, does not provide in any one year in the subaccount or account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed for the subaccount or account as soon thereafter in succeeding years as permitted by division (E) of this section.

(2) If the maximum assessment under division (E)(1) of this section for any subaccount of the life insurance and annuity account in any succeeding year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to division (C)(2) of this section, the board shall allocate the necessary additional amount among the other subaccounts of the life and annuity account in the manner set forth in division (E)(1) of this section, but the maximum assessment for a subaccount shall not exceed one per cent in any one calendar year.

(3) Where assessments for two or more impaired or insolvent insurers have been made within the same calendar year, and the sum of those assessments exceeds the two per cent calendar year assessment limitation under division (E)(1) of this section, the board, with the approval of the superintendent of insurance, may allocate among the accounts of such insurers the sums assessed within the two per cent limitation.

(F) The board, by an equitable method as established in the plan of operation, may refund to member insurers, in proportion to the contribution of each insurer to that subaccount or account, the amount by which the assets of the subaccount or account

exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that subaccount or account, including assets accruing from assignment, subrogation, net realized gains, and income from investments. A reasonable amount may be retained in any subaccount or account to provide funds for the continuing expenses of the association and for future losses.

(G) A member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance within the scope of this chapter, may consider the amount reasonably necessary to meet its assessment obligations under this section.

(H) The association, upon request, shall issue to an insurer paying an assessment under this section, other than a class A assessment, a certificate of contribution, in a form approved by the superintendent, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in the form and for the amount, net of any amounts recovered through a tax offset, and for the period of time the superintendent may approve.

(I) Any member insurer that has contributed funds to pay claims of an impaired or insolvent insurer, pursuant to an agreement entered into with the superintendent and approved by the Franklin county court of common pleas during the five years preceding the effective date of this section, or at any time following the effective date of this section, shall receive a credit against any assessments levied pursuant to this section, whether the assessments are class A assessments or class B assessments, in the amount of the contribution.

If the amount of the credit exceeds the amount of assessments levied upon a member insurer in any one year, the balance of that credit shall be carried forward to subsequent years and will reduce the amount of future assessments until the total amount of the credit has been applied to the future assessments. For the purposes of this division, an impaired or insolvent insurer is an insurer that meets the definitions set forth in section 3956.01 of the Revised Code, and any insurer that would have met these definitions, if it had been in effect at the time of such contribution.

(J) Division (I) of this section does not apply if an insurer has contributed funds pursuant to that division and has offset those contributions against its premium or franchise tax liability pursuant to any provision of the Revised Code authorizing the establishment of a plan for the distribution of voluntary contributions to pay the life, sickness and accident, or annuity claims of residents of this state that are unpaid due to the insolvency of an insolvent insurer.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.10. Plan of operation of association; amendments; superintendent to adopt rules if unsuitable.

(A) (1) The Ohio life and health insurance guaranty association shall submit to the superintendent of insurance a plan of operation and any amendments to the plan necessary or suitable to ensure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments shall become effective upon the written approval of the superintendent, or unless the superintendent has not disapproved it within thirty days.

(2) If the association fails to submit a suitable plan of operation within six months following the effective date of this section or if at any time after that date the association fails to submit suitable amendments to the plan, the superintendent, after notice and hearing, shall adopt reasonable rules that are necessary or advisable to effectuate the provisions of this chapter. The rules shall continue in force until modified by the superintendent or superseded by a plan submitted by the association and approved by the superintendent.

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

(C) In addition to requirements enumerated elsewhere in this chapter, the plan of operation shall do the following:

(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 section 3956.07 of the Revised Code;

(3) Establish regular places and times for meetings, including but not limited to 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 superintendent;

(6) Establish any additional procedures for assessments under section 3956.09 of the Revised Code, including, but not limited to, allocating sums raised by assessments when two or more insolvencies occur in the same calendar year that are subject to the two per cent calendar year assessment limitation;

(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 that any or all powers and duties of the association, except those under division (O)(3) of section 3956.08 and

section 3956.09 of the Revised Code, are delegated to a corporation, association, or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two or more states. The 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 division shall take effect only with the approval of both the board of directors and the superintendent, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this chapter.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.11. Powers of superintendent; appeals to superintendent; notice of provisions.

(A) The superintendent of insurance shall:

(1) Upon request of the board of directors of the Ohio life and health insurance guaranty association, provide the association with a statement of the premiums in this 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 promptly to comply with the demand shall not excuse the association from the performance of its powers and duties under this chapter.

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

(B) The superintendent, after notice and hearing, may suspend or revoke the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation of the association. As an alternative, the superintendent may levy a forfeiture on any member insurer that fails to pay an assessment when due. The forfeiture shall not exceed five per cent of the unpaid assessment per month, but shall not be less than one hundred dollars per month.

(C) Any action of the board of directors or the association may be appealed to the superintendent by any member insurer if the appeal is taken within sixty days of the final action being appealed. If a member insurer is appealing an assessment, the amount assessed shall be paid to the association and be available to meet association obligations during the pendency of the appeal. If the appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Any

final action or order of the superintendent is subject to review under Chapter 119. of the Revised Code.

(D) The liquidator, rehabilitator, or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this chapter.

(E) Notwithstanding section 109.02 of the Revised Code, the superintendent has sole authority to select and hire legal counsel to represent the superintendent in his role as rehabilitator or liquidator of an impaired or insolvent insurer.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.12. Detection and prevention of insolvencies or impairments.

To aid in the detection and prevention of insurer insolvencies or impairments:

(A) The superintendent of insurance shall do all of the following:

(1) Notify the commissioners of insurance of all the other states, when he takes any of the following actions against a member insurer:

(a) Revocation of license;

(b) Suspension of license;

(c) Makes any formal order that such company restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus, or any other account for the security of policyholders or creditors. Notice under division (A)(1) of this section shall be mailed to all insurance commissioners within thirty days following the action taken or the date on which the action occurs.

(2) Report to the board of directors of the Ohio life and health insurance guaranty association when he has taken any of the actions set forth in division (A)(1) of this section or has received a report from any other insurance commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(3) Report to the board of directors when he has reasonable cause to believe, from any completed or ongoing examination of any member company, that the company may be an impaired or insolvent insurer;

(4) Furnish to the board of directors the national association of insurance commissioners' insurance regulatory information service (IRIS) ratios and listings of companies not included in the ratios developed by the commissioners. The board may use the information contained in this report in carrying out its duties and responsibilities under this section. The report and the information contained in the report shall be kept confidential by the members of the board of directors until such time as made public by the superintendent or other lawful authority.

(B) The superintendent may seek the advice and recommendation of the board of directors 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, upon majority vote, may make reports and recommendations to the superintendent upon any matter germane to the solvency, rehabilitation, or liquidation of any member insurer or germane to the solvency of any company seeking to do an insurance business in this state. The reports and recommendations are not public records.

(D) The board of directors, upon majority vote, may notify the superintendent of any information the board possesses that indicates any member insurer may be an impaired or insolvent insurer.

(E) The board of directors, upon majority vote, may request that the superintendent order an examination of any member insurer that the board in good faith believes may be an impaired or insolvent insurer. Within thirty days of the receipt of such request, the superintendent shall begin the examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by the persons the superintendent designates. The cost of the examination shall be paid by the association and the examination report shall be treated as are other examination reports. The examination report shall not be released to the board of directors of the association prior to its release to the public, but this shall not preclude the superintendent from complying with division (A) of this section. The superintendent shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the superintendent but it shall not be open to public inspection prior to the release of the examination report to the public.

(F) The board of directors, upon majority vote, may make recommendations to the superintendent for the detection and prevention of insurer insolvencies.

(G) The board of directors, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, may prepare a report to the superintendent containing information it may have in its possession bearing on the history and causes of such 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 the other associations.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.13. Liability for unpaid assessments of insureds; records; association deemed creditor; distribution of ownership rights; recovery of distributions.

(A) Nothing in this chapter shall be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(B) Records shall be kept of all resolutions adopted by the Ohio life and health guaranty association in carrying out its powers and duties under section 3956.08 of the Revised Code. The records shall be made public only upon the termination of a rehabilitation or liquidation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this division shall limit the duty of the association to render a report of its activities under section 3956.14 of the Revised Code.

(C) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies, reduced by any amounts to which the association is entitled as subrogee pursuant to division (L) of section 3956.08 of the Revised Code. Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. As used in this division, "assets attributable to covered policies" means that proportion of the assets that the reserves that should have been established for covered policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(D) (1) Prior to the termination of any rehabilitation or liquidation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders and policyowners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In this determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(2) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until the total amount of valid claims of the association with interest on that amount at a rate not less than the rate allowed under 96 Stat. 2478, 28 U.S.C. 1961 for funds expended in carrying out its powers and duties under section 3956.08 of the Revised Code with respect to such insurer have been fully recovered by the association.

(E) (1) If an order for rehabilitation or liquidation of an insurer domiciled in this state has been entered, the rehabilitator or liquidator may recover on behalf of the insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding

the complaint for liquidation or rehabilitation, subject to the limitations of divisions (E)(2) and (4) of this section.

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

(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two or more persons are liable with respect to the same distributions, they are jointly and severally liable.

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

(5) If any person liable under division (E)(3) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.14. Examination and regulation of association; reports.

The Ohio life and health insurance guaranty association is subject to examination and regulation by the superintendent of insurance. The board of directors shall submit to the superintendent each year, not later than four months after the end of the association's fiscal year, a financial report in a form approved by the superintendent and a report of its activities during the preceding fiscal year.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.15. Exemption from fees, taxes.

The Ohio life and health guaranty association is exempt from payment of all fees and all taxes levied by this state or any of its political subdivisions.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.16. Immunity for acts or omissions.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer or its agents or employees, the Ohio life and health guaranty association or its agents or employees, the board of directors or any member of the board, or the superintendent of insurance or his representatives, for any action or omission by them pursuant to the purposes and provisions of this chapter or in the performance of their powers and duties under this chapter. Immunity under this section extends to the participation in any organization of one or more other state associations of similar purposes as provided in division (O)(7) of section 3956.08 of the Revised Code, and to any such organization and its agents and employees.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.17. Stay of proceedings involving insolvent insurer; default judgments.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed sixty days from the date an order of rehabilitation or liquidation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict, or finding based on default, the Ohio life and health guaranty association may apply to have the judgment set aside by the same court that made the judgment and may defend against the suit on the merits.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.18. Use of existence of association to sell insurance prohibited; summary document; disclaimer; notice of noncoverage.

(A) (1) No person shall make, publish, disseminate, circulate, or place before the public, or cause to be made, published, disseminated, circulated, or placed before the public, in any newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other manner, any advertisement, announcement, or statement, written or oral, that uses the existence of the Ohio life and health insurance guaranty association for the purposes of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter.

(2) As used in division (A)(1) of this section, "person" includes but is not limited to any insurer or any agent or affiliate of any insurer.

(3) Division (A)(1) of this section does not apply to the association or any other entity that does not sell or solicit insurance.

(B) (1) Within six months after the effective date of this section, the association shall prepare a summary document, complying with division (C) of this section, describing the general purposes and current limitations of this chapter. The document shall be submitted to the superintendent of insurance for approval.

(2) On or after the sixtieth day after receiving approval under division (B)(1) of this section, no insurer shall deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code unless the document is delivered to the policy or contract holder prior to or at the time of delivery of the policy or contract, except if division (D) of this section applies. The document also shall be available upon request by a policy or contract holder.

(3) The distribution or delivery, or contents or interpretation of the document shall not be construed to mean that the policy or contract or the holder of the policy or contract is covered in the event of the impairment or insolvency of a member insurer. Failure to receive this document does not confer upon the policyholder, contract holder, certificate holder, or insured any greater rights than those stated in this chapter.

(4) The association shall revise the document as amendments to this chapter may require.

(C) The document prepared under division (B)(1) of this section shall contain a clear and conspicuous disclaimer on its face. The superintendent shall adopt a rule establishing the form and content of the disclaimer. The disclaimer shall do all of the following:

(1) State the name and address of the Ohio life and health insurance guaranty association and of the department of insurance;

(2) Prominently warn the policy or contract holder that the association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions, and conditioned on continued residence in this state;

(3) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;

(4) Emphasize that the policy or contract holder should not rely on coverage under the association when selecting an insurer;

(5) Provide other information as directed by the superintendent.

(D) No insurer or agent may deliver a policy or contract described in division (B)(1) of section 3956.04 of the Revised Code, all or a portion of which is excluded under division (B)(2)(a) of section 3956.04 of the Revised Code from coverage under this chapter unless the insurer or agent, prior to or at the time of delivery, gives the policy or contract holder a separate written notice that clearly and conspicuously discloses that the policy

or contract, or a portion of the policy or contract, is not covered by the association. The superintendent, by rule, shall specify the form and content of the notice.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.19. Prior insolvent insurers exempt.

This chapter does not apply to any insurer that is insolvent or unable to fulfill its contractual obligations on the effective date of this section.

HISTORY: 143 v H 89. Eff 11-20-89.

§ 3956.20. Offset of assessments against tax liability; refunds.

(A) (1) A member insurer may offset against its premium or franchise tax liability twenty per cent of the assessment described in division (H) of section 3956.09 of the Revised Code in each of the five calendar years following the fiscal biennium in which the assessment was paid. The offsets shall be allowed on a year-per-year basis commencing with the first tax payment due after the fiscal biennium in which the assessment was paid.

(2) If the aggregate total of the assessments described in division (A)(1) of this section and eligible for offset in a particular year exceeds a member insurer's tax liability to this state for such year, the aggregate total of the remaining eligible assessments, notwithstanding the five-year limitation set forth in division (A)(1) of this section, may be offset against such tax liability in future years.

(3) If a member insurer ceases doing business, all uncredited assessments may be credited against its premium or franchise tax liability for the year it ceases doing business.

(4) The Ohio life and health insurance guaranty association may require a member insurer to report any offset to the association.

(B) Any sums that are acquired by member insurers by refund from the association pursuant to division (F) of section 3956.09 of the Revised Code and that have been offset, prior to the refund, against premium or franchise tax liability as provided in division (A) of this section shall be paid by such insurers to this state in the manner the superintendent of insurance requires. The association shall notify the superintendent that the refunds have been made.

HISTORY: 143 v H 89. Eff 11-20-89.