ALABAMA DEPARTMENT OF INSURANCE
INSURANCE REGULATION

CHAPTER 482-1-124

STANDARDS FOR LIFE, ACCIDENT AND HEALTH INSURANCE CLAIMS

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482-1-124-.01 Authority. This chapter is adopted under the authority of the Trade Practices Act, Sections 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12, Code of Alabama 1975.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.02 Purpose.

(1) The purpose of this chapter is to set forth minimum standards for the investigation and disposition of life, accident and health claims arising under policies or certificates issued pursuant to State law. It is not intended to cover claims involving workers' compensation nor credit insurance. Evidence of violation of this chapter and the provisions contained herein shall be utilized for the purpose of administrative and regulatory proceedings conducted by the Department of Insurance and shall not be utilized for any other purpose or admissible as evidence for any purpose in any civil or criminal court proceeding. This is merely a clarification of original intent and does not indicate any change of position.

(2) An insurer’s compliance with the standards established by Section 503 of the Employee Retirement Income Security Act of 1974 (ERISA) and regulations issued thereunder shall constitute compliance with the requirements of this chapter.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.03 Definitions. In addition to the definitions contained in the Trade Practices Act and Section 27-1-2, Code of Alabama 1975, which are incorporated by reference, the following definitions shall apply for purposes of this chapter:

(a) BENEFICIARY. The party entitled to receive the proceeds or death benefits occurring under the policy in lieu of the insured.

(b) CLAIM FILE. Any retrievable electronic file, paper file or combination of both relative to the claim, that may contain:

1. For life **insurance** and **annuities**: The file or files containing the notice of claim, claim forms, proofs of loss, medical records, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, claim handling logs, copies of checks or drafts, check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

2. For **accident** and **health insurance**: The file or files containing the notice of claim, claim forms, medical records, bills, electronically submitted bills, proofs of loss, correspondence to and from insureds and claimants or their representatives, claim investigation documentation, health facility pre-admission certification or utilization review documentation, claim handling logs, copies of explanation or benefit statements, any written communication, any documented or recorded telephone communication related to the handling of a claim, including the investigation, copies of checks or drafts, or check numbers and amounts, releases, correspondence, all applicable notices, and correspondence used for determining and concluding claim payments or denials, and any other documentation, maintained in a paper or electronic format, necessary to support claim handling activity.

(c) CLAIMANT. An insured, any beneficiary or legal representative of the insured or beneficiary, including an adult member of the insured's or beneficiary's immediate family, designated in writing by the insured or beneficiary making a claim under a policy, subject, however, to the following provisions regarding a minor beneficiary as set forth in Sections 26-1-1, 27-14-5, and 27-14-25, Code of Alabama 1975.

(d) DAYS. Calendar days, calculated as set forth in the Alabama Rules of Civil Procedure.

(e) DOCUMENTATION. All pertinent communications, transactions, notes, work papers, claim forms, bills, explanation of benefits forms, and all other records relative to the claim.

(f) INSURER. As set forth in Sections 27-1-2 and 27-1-17, Code of Alabama 1975.

(g) INSURANCE POLICY. As set forth in Section 27-14-1(1) Code of Alabama, 1975.

(h) INVESTIGATION. All activities of an insurer directly or indirectly related to the determination of liabilities under coverages afforded by an insurance policy~~,~~ insurance certificate or insurance contract.

(i) NOTICE OR NOTIFICATION OF A CLAIM. Any notice or notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

(j) PROOF OF LOSS. Written evidence, including but not limited to claim forms, medical bills, medical authorizations, death certificates or other reasonable evidence of the claim or its circumstances that is ordinarily required by the insurer of all insureds or beneficiaries submitting the claims.

(k) PRODUCER. A person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(l) REASONABLE EXPLANATION. Information sufficient to enable the insured or beneficiary to compare the allowable benefits with policy provisions and determine whether proper payment has been made.

(m) WRITTEN COMMUNICATIONS. All correspondence, regardless of source or type, that is materially related to the handling of the claim.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.04 Claims Practices.

(1) Every insurer, upon receiving notification of a claim shall, within fifteen (15) days of the notification, mail or otherwise provide necessary claim forms, instructions or reasonable assistance so the claimant can properly comply with the insurer’s reasonable requirements for filing a claim.

(2) Upon receipt of proof of loss from a claimant, the insurer shall begin processing the claim within fifteen (15) days.

(3) The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the claimant's obligation under any and all other similar policies issued by that insurer and specifically identified by the claimant to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the claimant's obligation under similar policies, the insurer may request the additional information. If multiple providers are involved, the insurer shall request any

and all available claim information from all known providers at one time. When the insurer determines that additional benefits or proceeds would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the claimant in determining the extent of the insurer's additional liability.

(4) As to life insurance claims, upon receipt of proof of loss from a claimant, the insurer shall affirm or deny liability, or inform the claimant that the claim is being investigated, within the time set forth within the life insurance policy not to exceed sixty (60) days. If the amount of the claim is determined and not in dispute, payment should be made within a reasonable time. If portions of the claim are in dispute, the insurer shall tender payment for those portions that are not disputed within sixty (60) days of the date the insurer determines those portions of the claim which are not disputed. If the investigation remains incomplete, the insurer shall, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send to the claimant a letter stating that the claim is still under investigation.

(5) With each health insurance claim payment, the insurer shall provide to the claimant an explanation of benefits that shall include the name of the provider and services covered, dates of service, and a reasonable explanation of the computation of benefits if applicable.

(6) Reimbursement of health claims shall be handled as required by Section 27-1-17, Code of Alabama 1975.

(7) An insurer may not impose a penalty upon any claimant under a health insurance policy for noncompliance with insurer requirements for precertification unless such penalty is specifically and clearly set forth in the policy.

(8) A reply shall be made within twenty (20) days on all other pertinent written communications from a claimant which requests a response.

(9) When a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination that the claim should be denied. The insurer shall state the reasons why the claim has been denied.

(10) No insurer shall deny a claim upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

(11) Insurers offering cash settlements of first party long-term disability income claims, except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability, shall develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies appropriate to the risk including, but not limited to mortality, morbidity, and interest rate assumptions, etc. A copy of the amount so calculated shall be given to and signed by the claimant at the time a settlement is entered into.

(12) Insurers shall not indicate to a claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the claimant and the insurer as to coverage and amount payable under the policy.

(13) Insurers shall not withhold any portion of any benefit payable to a claimant under a health insurance policy as a result of a claim on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless both of the following occurs:

(a) The insurer has in its files clear, documented evidence of an overpayment and written authorization from the claimant permitting such withholding procedure.

(b) The insurer has in its files clear, documented evidence that all of the following occurs:

1. The overpayment was clearly erroneous under the provisions of the policy and if the overpayment is not the subject of a reasonable dispute as to facts.

2. The error that resulted in the payment is not a mistake of the law.

3. The insurer has notified the claimant within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the health insurer notified the claimant within fifteen (15) days after the date the evidence of discovery of such error is included in its file. For the purpose of this rule, the date of the error shall be the day on which the draft for benefits is issued.

4. Such notice stated clearly the nature of the error and the amount of the overpayment.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-17-1, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.05 File and Record Documentation. Each insurer's claim files for policies or certificates are subject to examination by the Commissioner of Insurance or by the Commissioner’s duly appointed designees. To aid in such examination:

(a) The insurer shall maintain claim files that are accessible and retrievable for examination. An insurer shall be able to provide the claim number, line of coverage, date of loss, date and amount of payment of the claim, date of denial or date closed without

payment. The insurer shall be able to provide the same information (except date and amount of payment) for all claims closed without payment. This data must be available for all open and closed files for the current year and the five (5) preceding years in order to permit reconstruction of the insurer's activities relative to each claim.

(b) Each relevant document within the claim file shall reflect as to date received, date processed or date mailed.

(c) Format of Records and Disaster Recovery.

1. Any record required to be maintained by an insurer may be in the form of paper, photograph, magnetic, mechanical or electronic medium, or any process that accurately forms a durable reproduction of the record, so long as the record is capable of duplication to a hard copy that is legible. Documents that are produced and sent to an insured by use of a template and an electronic mail list shall be considered to be sufficiently reproduced if the insurer can provide proof of mailing of the document and a copy of the template. Documents that require the signature of the insured or insurer's producer shall be maintained in any format listed above provided evidence of the signature is preserved in that format.

2. The maintenance of records in a computer-based format shall be archival in nature, so as to preclude the alteration of the record after the initial transfer to a computer format. Upon request of an examiner, the records shall be capable of duplication to a hard copy that is legible. The records shall be maintained according to procedures developed and adhered to by the insurer. The procedures shall be made available to the commissioner during an examination.

3. Photographs, microfilms, or other image-processing reproductions of records shall be equivalent to the originals and may be certified as the same in actions or proceedings before the commissioner.

4. The insurer shall maintain disaster preparedness or disaster recovery procedures that include provisions for the maintenance or reconstruction of original or duplicate records at another location. These procedures shall be provided for review during an examination.

(d) Every insurer, upon receipt of any written inquiry from the Insurance Department respecting a claim shall within ten (10) working days of receipt of such inquiry furnish the Department with an adequate written response to the inquiry. This response shall be addressed to the Department employee or representative making the request.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.06 Severability. If any paragraph or a portion of a paragraph of this chapter or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
History: New May 27, 2003, Effective June 9, 2003.

482-1-124-.07 Effective Date. This chapter shall be effective upon its approval by the Commissioner of Insurance and upon its having been on file as a public document in the office of the Secretary of State for ten days.

Author: Commissioner of Insurance
Statutory Authority: Code of Alabama 1975, §§ 27-2-17, 27-1-17, 27-1-19, 27-12-21, 27-12-24, 27-15-13, 27-16-10, 27-17-11, 27-19-11 and 27-19-12
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