LINE OF BUSINESS Workers' Compensation & Employers Liability

Code: 16.0000

Standard Workers' Compensation 16.0004
Employers Liability 16.0002
Alternative Workers' Compensation 16.0001
The Oklahoma Option 16.0003

IF CHECKLIST IS NOT APPLICABLE, PLEASE EXPLAIN:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
GENERAL REQUIREMENTS FOR ALL FILINGS			
COPIES, RETURN ENVELOPES, ETC	O.R. 365: 15-1-3 (b)(4) O.R. 365: 15-7-3(b)(4)	All filings including exhibits, forms, rate sheets and additional information shall be submitted with one (1) legible copy of all material. Such filings and exhibits shall be typewritten or printed. Companies that filed as a group listing all companies on the Transmittal Document may accomplish this requirement by submitting one copy of all material.	
COVER LETTER AND EXPLANATORY MEMORANDUM			
FILING SUBMISSION	O.R. 365:15-1-3 O.R. 365: 15-7-3	Filing Requirements	
FREE CONTRACT PROHIBITED			
LIMITATIONS/RESTRICTIONS ON TRANSACTING BUSINESS	36 O.S. 612.2	Insurer must maintain policyholder surplus in excess of $5,000,000.00.	
LINE OF AUTHORITY			
SIDE-BY-SIDE COMPARISON	O.R. 365:15-1-3(b)(9)(D) O.R. 365: 15-7-3(b)(10)(D)	A complete description and full explanation of the changes made by the filing including, reasoning therefore, illustrative examples, including "John Doe" specimen form, and a comparison of currently approved and proposed materials.	
EFFECTIVE DATE WORDING	36 O.S. 3613(B)(5) O.R. 365:15-1-13	Every policy shall specify: The time when the insurance thereunder takes effect and the period during which the insurance is to continue. All policies shall expire at 12:01 a.m. Standard Time on the expiration date stated in the policy.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
NAIC #			
THIRD PARTY FILERS AUTHORITY		Must include letter of authorization	
TRANSACTING OTHER BUSINESS			
FORMS POLICY PROVISION			
ACCESS TO COURTS			
AD&D BENEFITS			
AGGREGATE LIMITS			
AMBIGUOUS & MISLEADING	36 O.S. 3611 (A)(2)(3)	Commissioner shall disapprove and form or withdraw any previous approval if it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or exceptions. Coverage(s) must be identified within each endorsement. The name of the coverage form(s) or name of the policy(s) that the form(s) amends or is attached.	
APPLICATIONS	36 O.S. 3610	If an application is attached to and made a part of the policy, it must be submitted for approval.	
Witness Clause and Officer Signature	36 O.S. 3618	A. Every insurance policy shall be executed in the name of and on behalf of the insurer by its officer, attorney-in-fact, employee, or representative duly authorized by the insurer. A facsimile signature of any such executing individual may be used in lieu of an original signature.	
ASSESSIBLE POLICIES			
BLANK ENDORSEMENTS	365:15-1-19	An endorsement to an insurance policy without specific language is not a complete form and shall not be approved. The Insurance Commissioner may approve a blank endorsement if the insurer provides a detailed description of how the form will be used.	
Return Premium	36 O.S. 1241.1	Every policy shall contain a provision relating to process for premium refund if the insured cancels the policy prior to the end of policy period.	
Suspension			

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
CONSUMER INFORMATION			
Credit Scoring Notice			
Privacy Notice			
VSI Warning			
Notification Form			
CONTENT OF POLICIES	36 O.S. 3613 O.R. 365:15-1-10	Contents of policies in general see statute for requirements.	
COUNTERSIGNATURES	36 O.S. 627	Repealed 11/1/2005.	
DECLARATIONS PAGE	36 O.S. 3610	Must be filed for approval.	
Notice of Cancellation	36 O.S. 3639		
Notice of Non-renewal	36 O.S. 3639		
Permissible Reasons for Cancellation	36 O.S. 3639		
Permissible Reasons for Non-renewal			
Terrorism	Bulletin No: PC 2002-03 PC 2005-08 PC 2015-01	Terrorism exclusions not allowed.	
Minimum Retained Premium	36 O.S. 3623.1	A minimum premium charge is considered premium within the definition of this Code, and shall be subject to premium tax as provided in this Code. Minimum premium charge is the smallest acceptable premium for which an insurance company will write a policy. This minimum charge is necessary to cover fixed expenses, other than those expenses defined as fees above, in placing the policy on the books. A minimum premium charge includes, but is not limited to, minimum earned premium and minimum retained premium. An insurance consultant, insurance producer, limited lines producer, managing general agent or surplus lines insurance broker cannot charge a duplicate fee or minimum premium charge.	
DISCLOSURES			
DEFINITIONS			
DISCRIMINATION			
DUTY TO DEFEND			
EMPLOYERS LIABILITY			
EXCESS COVERAGE			

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
Asbestos			
Lead			
Mold			
GROUP POLICIES	O.R. 365: 15-1-3(b)(13)	Filings that are made on behalf of more than one insurer, shall list the insurer or insurers by individual name and not by Company group.	
Asbestos			
Lead			
Mold			
GROUP POLICIES	O.R. 365: 15-1-3(b)(13)	Filings that are made on behalf of more than one insurer, shall list the insurer or insurers by individual name and not by Company group.	
Extra-Territorial Approval Authority			
Extra-Territorial Approval Authority			
FICTITIOUS GROUPS	36 O.S. 6001 36 O.S. 6001.1 36 O.S. 6002 O.R. 365:15-1-7	No insurer, admitted or non-admitted, shall make available through any rating plan or form, property, marine, vehicle, casualty or surety insurance to any firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such firm, corporation or association of individuals.	
FORMS MISCELLANEOUS	36 O.S. 3610	Prior approval	
Conditional Renewal	36 O.S. 3639	An insurer may refuse to renew a policy if the insurer gives to the first-named insured at the address shown on the policy written notice that the insurer will not renew the policy. Such notice shall be given at least forty-five (45) days before the expiration date. If notice is given by mail, said notice shall be deemed to have been given on the day said notice is mailed. If the notice is mailed less than forty-five (45) days before expiration, coverage shall remain in effect until forty-five (45) days after notice is mailed. Earned premium for any period of coverage that extends beyond the expiration date shall be considered pro rata based upon the previous year's rate. For purposes of this section, the transfer of a policyholder between companies within the same insurance group is not a refusal to renew. In addition, changing deductibles, changes in premium, changes in the amount of insurance, or reductions in policy	

		limits or coverage are not refusals to renew.	
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD

CANCELLATION & NON-RENEWAL	36 O.S. 3639	After coverage has been in effect for more than forty-five (45) business days or after the effective date of the renewal of a commercial marine, commercial automobile, commercial property, commercial casualty or commercial fire insurance policy, a notice of cancellation shall not be issued by any licensed insurer or surplus or excess lines insurer unless it is based on at least one of the following reasons with at least ten (10) days notice to the insured: 1. Nonpayment of premium; 2. Discovery of fraud or material misrepresentation in the procurement of the insurance or with respect to any claims submitted thereunder; 3. Discovery of willful or reckless acts or omissions on the part of the named insured which increase any hazard insured against; 4. The occurrence of a change in the risk which substantially increases any hazard insured against after insurance coverage has been issued or renewed; 5. A violation of any local fire, health, safety, building, or construction regulation or ordinance with respect to any insured property or the occupancy thereof which substantially increases any hazard insured against; 6. A determination by the Commissioner that the continuation of the policy would place the insurer in violation of the insurance laws of this state; 7. Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against; or 8. Loss of or substantial changes in applicable reinsurance.	
INSURER'S NAME AND ADRESS	O.R. 365: 15-1-10(b)	Insurer's name and address required on policy.	
GROUP POLICIES			
Extra-Territorial Approval Authority			
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD

FRAUD WARNING	36 O.S. 3613.1 O.R. 365:15-1-10 (c)	Every insurance policy or application and every insurance claim form shall contain a statement that clearly indicates in substance the following: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. (Print in 10 point type or larger).	
LIMITS			
LOSS SETTLEMENTS			
Appraisal			
Payment of Loss Time Period	36 O.S. 1250.7	Within 45 days after receipt of properly executed proofs of loss, claimant shall be advised of acceptance/denial or further investigation necessary.	
Loss Valuation			
NOTICE REQUIREMENTS			
EXCLUSIONS & LIMITATIONS	O.R. 365:15-1-3(b)(20)	Any endorsement which eliminates or restricts coverage and which is issued during the policy term shall be identified as accepted by the insured, by the signature of the insured thereon, and a signed copy (original or computer generated) of such endorsement shall be retained in the files of the insurer for one year after the expiration of the policy.	
SUBROGATION			
TIMELINESS			
Suit			
Defense Costs	O.R. 365:15-1-15	No insurance policy or contract shall be made, issued or delivered by any insurer or by any agent or representative thereof, that includes defense expenses within the limit of liability. The Insurance Commissioner may waive this requirement based upon factors such as noncompetitive market or type of insurance coverage. If the Insurance Commissioner waives this requirement, the initial page of the policy shall include a conspicuous notice indicating that the contract contains defense expenses within the limit of liability and advising the policyholder to read its provisions.	
MEDICAL PAYMENTS			
PERSONAL INJURY PROTECTION			
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD

Action Against Company	36 O.S. 3617	No policy delivered or issued for delivery in Oklahoma and covering a subject of insurance resident, located, or to be performed in Oklahoma, shall contain any condition, stipulation or agreement (1) requiring such policy to be construed according to the laws of any other state or country, except as necessary to meet the requirements of the motor vehicle financial responsibility laws or compulsory disability benefit laws of such other state or country, or (2) preventing the bringing of an action against any such insurer for more than six (6) months after the cause of action accrues, or (3) limiting the time within which an action may be brought to a period of less than two (2) years from the time the cause of action accrues in connection with all insurances other than property and marine and transportation insurances; in property and marine and transportation policies such time shall not be limited to less than one (1) year from the date of occurrence of the event resulting in the loss. Any such condition, stipulation or agreement shall be void, but such voidance shall not affect the validity of the other provisions of the policy.	
POLICY MUST CONTAIN CONTRACT			
PREMIUM AUDIT			
Policy Fees	36 O.S. 3623.1	Nothing in this code shall be construed to prevent an insurer from charging and collecting separate initial membership fees and policy fees in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax.	
PARTICIPATING POLICIES	36 O.S. 2121	If so provided in its articles of incorporation, a domestic stock or domestic mutual insurer may issue any or all of its policies with or without participation in profits, savings, or unabsorbed portions of premiums, may classify policies issued on a participating or nonparticipating basis, and may determine the right to participate and the extent of participation of any class or classes of policies. No dividend, otherwise earned, shall be made contingent upon the payment of renewal premium on any policy.	
PRIMARY/UNDERLYING COVERAGE			
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD

PRIOR APPROVAL	36 O.S. 3610	Policy forms must be approved prior to use.	
PUNITIVE DAMAGES			
Execution of Policies	36 O.S. 3618	Every policy must be signed (facsimile) by officer.	
Policy Restrictions Voided	36 O.S. 3617	No policy shall be construed according to the laws of another state, except to meet motor vehicle financial responsibility laws, or can limit the time an action can be brought against an insurer except as provided by this statute.	
Exclusionary Endorsement	O.R. 365:15-1-3(b)(20)	Endorsements that eliminate or restrict coverage issued during the policy term must be signed by the insured. This includes blank endorsements.	
Coverage of Trustor	36 O.S. 3616.1	Unless specifically excluded, a trustor of property shall be a named insured.	
USE & FILE			
VICARIOUS LIABILITY			
VOIDANCE			
WARRANTIES			
WORKERS' COMPENSATION EXCESS			
OTHER			
READABILITY			
REBATES	36 O.S. 1204 (8)	Not permitted directly or indirectly.	
Withdrawal of Pending Filings	O.R. 365: 15-1-3 (b) (10)	Pending filings may be withdrawn by the filing entity upon notice to the Insurance Department prior to the approval or disapproval thereof.	
Filing Fees Fee Requirements	36 O.S. 348.1 O.R. 365: 15-1-3 (b) (2)	Form filings-$50.00 for each individual insurer.	

Administrative Workers' Compensation Act – Optional Deductibles	85A O.S. 95 365:15-1-3.1	A. Each insurer issuing a policy under the Administrative Workers' Compensation (AWCA) Act shall offer, as a part of the policy or as an optional endorsement to the policy, deductible optional to the policyholder for benefits payable under the AWCA. Deductible amounts offered shall be fully disclosed to the prospective policyholder in writing. The policyholder exercising the deductible option shall choose only one deductible amount. B. Optional deductibles shall be offered in each policy insuring liability for workers' compensation that is issued, delivered, issued for delivery, or renewed under this act on or after approval by the Insurance Commissioner, unless an insured employer and insurer agree to renegotiate a workers' compensation policy in effect on that date so as to include a provision allowing for a deductible. C. If the policyholder exercises the option and chooses a deductible, the insured employer shall be liable for the amount of the deductible for benefits paid for each compensable claim of work injury suffered by an employee. The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or medical provider entitled to the benefits conferred by this act and seek reimbursement from the insured employer for the applicable deductible amount. The payment or nonpayment of deductible amounts by the insured employer to the insurer shall be treated under the policy insuring the liability for workers' compensation in the same manner as payment or nonpayment of premiums. D. If the Insurance Commissioner determines it to be feasible, and under such rules as he or she may adopt, premium reduction for deductibles may be determined before the application of any experience modification, premium surcharge, or premium discounts, and, to the extent that an employer's experience rating or safety record is based on benefits paid, money paid by the insured employer under a deductible as provided in this section may not be included as benefits paid so as to harm the experience rating of the employer. E. This section shall not apply to employers who are approved to self-insure against liability for workers' compensation or group self-insurance funds for workers' compensation.	

WORKERS' COMPENSATION - **OPTIONAL DEDUCTIBLE FORM**	**O.R. 365:15-1-3.1**	(a) The Administrative Workers' Compensation Act, 85A O.S. § 95 ("AWCA"), requires insurers issuing policies of workers' compensation insurance to offer, as a part of the policy or as an endorsement to the policy, deductibles, optional to the policyholder, for benefits payable under the AWCA. Each policy of workers' compensation that is issued, delivered, issued for delivery, or renewed under the AWCA shall include such optional deductible. The mandatory optional deductible required by the AWCA will be satisfied by the offer of a "Small Deductible" as defined in this Section. If an applicant and insurer mutually agree to a Large or Mega Deductible, such agreement shall satisfy the requirement of the AWCA that insurers offer optional deductibles. The selection of a Small, Large, or Mega Deductible shall be evidenced by signature of the applicant employer on the Commissioner's designated Acceptance/Rejection Form as contained in Appendix "B" to this Chapter. As used in this Section: (1) "Deductible" means a policy provision or endorsement that, while requiring the insurer to pay 100% of each covered claim, creates a corresponding obligation of the insured employer to reimburse the insurance company for any portion of that claim that is part of the deductible. (2) "Small Deductible" means a combined medical benefits and indemnity claims deductible of $1,000.00; $2,000.00; $3,000.00; $4,000.00, or $5,000.00 per claim. (3) "Large Deductible" means a combined medical benefits and indemnity claims deductible greater than $5,000.00 but not more than $100,000.00 per claim. A Large Deductible may be offered to applicants, on negotiated terms, based upon the applicant's financial condition, industry, claims experience, and collateral. (4) "Mega Deductible" means a combined medical benefits and indemnity claims deductible greater than $100,000.00 per claim. Mega Deductibles are subject to OAC	

WORKERS' COMPENSATION - **OPTIONAL DEDUCTIBLE FORM – Cont.**	**O.R. 365:15-1-3.1**	(b) Insurers may offer a contractual limit on the employer's aggregate reimbursement liability. (c) Obligations If Deductible Option Is Selected (1) If the policyholder chooses a deductible, the insured employer shall be liable for the amount of the deductible for benefits paid for each compensable claim of work injury suffered by an employee. (2) The insurer shall pay all or part of the deductible amount, whichever is applicable to a compensable claim, to the person or medical providers entitled to the benefits conferred by the AWCA, and seek reimbursement from the insured employer for the applicable deductible amount. (3) The insured employer must reimburse the insurer within sixty (60) days of a written demand. If the insured employer fails to reimburse the insurer within sixty (60) days, the insurer may seek to recover the full amount of such claim from the insured employer. In addition, the non-payment of deductible amounts shall be treated in the same manner as non-payment of premiums for purposes of cancellation. (d) Experience Modification for Small Deductibles. Premium reduction for deductibles shall be determined after the application of any experience modification, premium surcharge, or premium discounts. Benefits paid by the insured employer in connection with a small deductible shall not constitute benefits paid and shall not be charged against the experience of the employer. (e) Experience Modification for Large or Mega Deductibles. Premium reduction for deductibles shall be determined after the application of any experience modification, premium surcharge, or premium discounts. Benefits paid by the insured employer in connection with a large or mega deductible shall constitute benefits paid and shall be charged against the experience of the employer.	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES**	O.R. 365:15-1-3.2	(a) Every insurer issuing mega deductible workers' compensation policies ("MDWC"), as defined in subsection c of this Section, shall comply with the following requirements: (1) The MDWC policy shall require collateralization, as provided herein, of the outstanding deductible reimbursement obligations of the policyholder for any prospective period of coverage. "Collateralization" means deposit by the policyholder with the insurance company of assets to serve as security in the event that a policyholder fails to reimburse the insurer for losses within the deductible. (2) For purposes of this section, only the following assets shall qualify as "collateral": (A) Assets admissible pursuant to Article 16 of Title 36 of the Oklahoma Statutes; (B) A surety bond issued by a surety insurer authorized to transact business by the Commissioner and whose financial strength and size ratings from A.M. Best Company are not less than "A" and "V", respectively; (C) An irrevocable letter of credit, utilizing a form designated by the Commissioner, issued by a financial institution whose deposits are federally insured. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification, or amendment, whichever first occurs; provided however, that a letter of credit must be replaced within three months after the date of the institution's failure to meet applicable standards of issuer acceptability; (D) Guaranty of a solvent parent of affiliated entity that has:	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES – Cont.**	O.R. 365:15-1-3.2	(i) been continuously engaged in business for not less than three (3) years immediately preceding the application for the MDWC policy; (ii) at least one hundred (100) employees (all states included); and (iii) at least One Million Dollars ($1,000,000.00) in net assets, as shown in its immediately preceding year-end GAAP audited financial statements. For purposes of this subparagraph, "affiliated" shall have the meaning ascribed in 36 O.S. § 1651; or (E) Any combination of the foregoing. (3) When a policy is written with an aggregate deductible option, the amount of the collateral may not exceed the aggregate deductible. (4) Collateral held pursuant to this subsection shall be under the direct control of the insurer. Collateral shall be held for the express and sole purpose of securing the policyholder's obligations under the mega deductible workers' compensation policy. Collateral shall not be commingled with the assets of the insurer. Insurers shall not permit policyholders or agents or affiliates of policyholders, or any third party with any contractual or other relationship to the policyholder, directly or indirectly, to access such collateral. (5) Claims information for each mega deductible insured employer and co-employer shall be maintained in the possession of the insurer for at least six years. (6) Insurers shall not permit policyholders or agents or affiliates of policyholders, or any third party with any contractual or other relationship to the policyholder, directly or indirectly, to administer claims under a mega deductible workers' compensation policy.	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES – Cont**	O.R. 365:15-1-3.2	(7) All agreements between insurers and policyholders relating to handling of claims by third parties shall be maintained by the insurer and made available to the Commissioner upon request. (8) Notwithstanding any other limitation on the insurer's right to cancel the insurance, the policy shall provide that the policyholder's failure to post collateral as required by the policy or pay deductible reimbursements when due, are grounds for policy cancellation, upon 10 days prior notice. (9) Before issuing or renewing a mega deductible workers' compensation policy, the insurer shall obtain an audited financial statement for the policyholder, or a financially strong parent or affiliate that has issued an unconditional financial guaranty of the policyholder's deductible obligations. The amount of the policyholder's aggregate deductible obligation is limited to no more than 20% of the total net worth of the policyholder and guarantor, at each policy inception and renewal. Net worth shall be determined as of the fiscal year-end GAAP audited financial statements next preceding such inception or renewal. The Commissioner may request and consider more recent unaudited GAAP financial statements. (10) If the policy covers employers, co-employers, subcontractors, or other employers in addition to the policyholder, the policy shall provide that deductible reimbursements are the sole obligation of the policyholder, unless such additional covered employer has given informed written consent to be jointly obligated and the employer's maximum reimbursement obligation is limited to an amount consistent with paragraph 9 of this subsection. (11) No insurer shall issue a mega deductible workers' compensation policy to a professional employer organization as defined by 40 O.S. § 600.2, which is affiliated with such insurer.	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES – Cont**	O.R. 365:15-1-3.2	(b) An insurer is exempt from the requirements of this Section, with the exception of paragraph 7 of subsection a, if the insurer, at the time of issuance or renewal of the policy, has an A.M. Best Company rating of A- or above, or a comparable rating accepted by the Commissioner, and either: (1) has at least $200,000,000.00 in policyholder surplus, or (2) upon application to the Commissioner, has been exempted by the Commissioner for good cause shown. (c) The term "MDWC policy" means any workers' compensation insurance policy that is subject to endorsements or other direct or indirect agreements between the insurer and the policyholder or others that have the effect, singly or in combination, of requiring the policyholder to bear a combined risk of loss of greater than $100,000.00 per covered employee. For purposes of this Section, entering into an agreement with an existing policyholder that has the effect of making its policy a mega deductible workers' compensation policy is considered to be the issuance of a mega deductible workers' compensation policy. (d) An insurer found to be in a financially hazardous condition pursuant to the applicable Sections of Title 36 of the Oklahoma Statutes, or subject to an equivalent regulatory determination in any other state, may not issue or renew a MDWC policy.	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES – Cont**	O.R. 365:15-1-3.2	(e) In addition to the provisions of Title 36 of the Oklahoma Statutes, an insurer issuing MDWC policies may be found to be in hazardous financial condition when one or more of the following conditions are found to exist: (1) the insurer fails to perform a quarterly review of the sufficiency of the collateral maintained by the insurer to secure the policyholder's obligations to reimburse the insurer for claims paid and credit taken against reserves for each policy up to the negotiated deductible amount; (2) the insurer issues a MDWC policy that does not state a specific dollar amount of deductible per claim and, if applicable, in the aggregate; (3) the insurer issues a MDWC policy and fails to include an actuarially supported calculation of the total amounts owed by the policyholder through ultimate loss development; (4) from the inception of the policy through ultimate loss development, the insurer fails to maintain collateral for 100% of the policyholder's liability for each MDWC policy; or (5) the insurer fails to maintain or produce, upon the Department's request, gross and net premium data and first-dollar loss data for each workers' compensation policy with a mega deductible. Such data must be maintained on a quarterly basis in accordance with, or in a substantially similar format as, the Oklahoma Mega Deductible Workers' Compensation Experience Reporting Form created by the Commissioner. (f) Insurers shall provide to the MDWC policyholder, documentation separate from the MDWC policy, explaining the financial responsibility of both the insurer to pay all covered claims and the policyholder's obligation to reimburse the insurer for any deductible amounts paid by the insurer.	

FINANCIAL REQUIREMENTS – **MEGA DEDUCTIBLE WORKERS' COMPENSATION POLICIES – Cont**	Oklahoma Mega Deductible Workers' Compensation Experience Quarterly Reporting Form	(g) The insurer shall report statistics under each MDWC policy to a statistical agency designated by the Commissioner. Statistics shall be reported separately for each insured and each coinsured employer. For statistical and ratemaking purposes, all claims paid by the insurer within the deductible amount shall be reported gross of payments under the deductible. Subject to applicable law, the instructions for statistical reporting shall be as required by that statistical agency. (h) This Section applies to MDWC policies issued, delivered, issued for delivery, or renewed on and after the effective date of this Section.	
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
Administrative Workers' Compensation Act – Compensation Insurance – Contents – Cancellation – Coverage – Insurance Group	85A O.S. 42	Contents of policies – See Statute for requirements	
OKLAHOMA EMPLOYEE INJURY - BENEFIT ACT – **THE OKLAHOMA OPTION**	85 A.O.S. 204 A	A qualified employer may (self-fund or insure benefits payable under the benefit plan, employers' liability) under the Oklahoma Employee Injury Benefit Act, and any other insurable risk related to its status as a qualified employer with any insurance carrier authorized to do business in this state.	
The **Administrative Workers' Compensation Act** – Workplace Medical Plan – Certification - Inspection	85A O.S.64 E	If an employer is not experience-rated when it participates in a certified workplace medical plan, its workers' compensation insurer shall grant a ten-percent premium reduction.	
Postage Requirements	O.R. 365: 15-1-3 (b) (8)	No submissions shall be accepted which arrive at the offices with postage due. No submissions will be returned unless the necessary postage accompanies the same.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
Rating/Advisory Organization	O.R. 365: 15-1-3	Insures may deviate from its rating organization's filings. See regulation for details. NOTE: Please tell us if you are a member or subscriber to a rating organization.	
Unfair Discrimination	36 O.S. 902	Prohibits unfair discrimination.	
Workers' Compensation providers - Obligation to provide Workplace Safety Services - Notice to policyholders	36 O.S. 6701 1/1/15	Insurers shall provide services for its policyholders adequate to implement safety plans for policyholders' operations. Notice that workplace safety services are available to the policyholder from the insurance company must appear in no less than ten (10) point bold type on the front of each workers' compensation insurance or equivalent insurance policy delivered or issued for delivery in this state.	
Appeals of rating classifications	O.R. 365:15-1-24	(a) Any employer engaged in a rating classification dispute reviewed by the NCCI Oklahoma Internal Review Panel may appeal the decision to the Insurance Commissioner by requesting a hearing within thirty (30) days of the date the Panel issues the decision. (b) Upon receipt of a written request, the Commissioner shall either set down the matter for hearing within thirty (30) days from the date of receipt of the request by issuing notice of the hearing to the employer and the insurer or shall issue a written order denying the hearing. (c) The Commissioner shall name the employer and the insurer as parties to the hearing. The Commissioner shall not be a party in an appeal of a rating classification. (d) Procedure for hearings shall be governed by OAC 365:1-7-1 et seq. and the Administrative Procedures Act.	

Withdrawal or Discontinue writing	O.R. 365: 15-1-18	Any insurer desiring to withdraw from the state or discontinue the writing of certain classes of insurance or programs in this state or transferring policyholders between admitted companies within the same insurance holding company system shall give ninety (90) days notice in writing to the Rate and Form Compliance Division of the Insurance Department and shall state in writing its reasons for such action. The ninety (90) days notice is inclusive of, and not in addition to, any other notice requirement per line of business. The insurer shall also provide the following information: (1) The number of policyholders affected; (2) The number of insurance agents affected; (3) The date the insurer will cease writing new business; (4) The date the insurer will start non-renewing insurance policies; (5) The date the insurer will transfer policyholders; (6) Whether the insurer has made arrangements with another insurer to pick up the renewals; if applicable; (7) The lines of insurance on which the insurer plans to concentrate; and (8) Whether the insurer anticipates re-entering the market.	
REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
RATE, RULE, RATING PLAN, FILING REQUIREMENTS			
INDIVIDUAL RISK RATING			
ACTUARIAL CERTIFICATIONS FOR RATES			
ADOPTIONS OF RATE SERVICE ORGANIZATIONS (RSO) FILINGS	36 O.S. 1148	Every member of, or subscriber to, a licensed advisory organization shall adhere to the loss cost filings made on its behalf by such organization within ninety (90) days of the effective date of the loss cost filing.	
Loss Costs	36 O.S. 1148		

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
CONSENT-TO-RATE	36 O.S. 987(E) O.R. 365: 15-7-6 Appendix C	Upon the written consent of the insured in a separate written document, a rate in excess of that determined in accordance with the other provisions of the Property and Casualty Competitive Loss Cost Rating Act may be used on a specific risk. Excess consent rate applications shall be submitted prior to or within a reasonable time after the effective date of the policy and contain the information necessary to establish compliance with the Property and Casualty Competitive Loss Cost Rating Act. The requirements may be satisfied by submitting in duplicate the form furnished by the Insurance Commissioner or its equivalent. (See Appendix C). NCCI Experience Modification exhibit.	
DURATION OF FILINGS	O.R. 365: 15-7-5	Filed rates shall remain in effect until amended or withdrawn by the insurer.	
CREDIT SCORING AND REPORTS			
CATASTROPHE HAZARDS			
CREDIBILITY			
DEFENSE COSTS			
WAIVER OF PREMIUM	O.R. 365: 15-7-23	Insurers may waive additional/return premium. Any return premium shall be returned to the insured upon request. The amount to be waived for both the additional premium and the return premiums shall be shown on a manual rule page manual page and filed with the Commissioner.	
REVIEW REQUIREMENTS	36 O.S. 901.3	In order to be certified by the Insurance Commissioner as complete, a filing shall contain, unless the Commissioner includes as part of the certification a specific finding that a particular item is not necessary and stating the reasons.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
DISCOUNTS	36 O.S. 924.2 (1/1/15) 36 O.S. 924.2 Prior	Any rate, schedule of rates or rating plan for workers' compensation insurance submitted to or filed with the Insurance Commissioner, or fixed by the Board of Managers of CompSource Mutual Insurance Company, and premiums, by whatever name, for workers' compensation for self-insureds except for group self-insured associations shall provide for an appropriate reduction in premium charges, by whatever name, for those eligible insured employers who have successfully participated in the occupational safety and health consultation, education and training program administered by the Commissioner of the Department of Labor pursuant to Section 414 of Title 40 of the Oklahoma Statutes.	
EXPIRATION DATE(S) FOR APPROVED RATES	36 O.S. 987 C	C. Every authorized insurer shall file with the Commissioner, except as to rates for those lines of insurance exempted from the provisions of the Property and Casualty Competitive Loss Cost Rating Act by the Commissioner under subsections E and F of this section and except for those risks designated as special risks under Section 997 of this title, all rates, supplementary rate information and any changes and amendments which it proposes to use. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization as permitted by this title. Such loss cost multiplier filing and expense constant filings made by insurers shall remain in effect until amended or withdrawn by the insurer. Every filing shall state the effective date.	
EFFECTIVE DATE	36 O.S. 987(C)	Every filing shall state the effective date.	
USE AND FILE	36 O.S. 987(A)	In a competitive market, every insurer shall file with the Commissioner all rates and supplementary rate information to be used in this state no later than thirty (30) days after the effective date; provided, that the rates and supplementary rate information need not be filed for commercial risks, which by general custom are not written according to manual rules or rating plans.	
LOSS RATIO STANDARDS			

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
MID-TERM CHANGES			
LOSS COST MULTIPLIERS	36 O.S. 987 C	An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization as permitted by this title. Such loss cost multiplier filing and expense constant filings made by insurers shall remain in effect until amended or withdrawn by the insurer. Every filing shall state the effective date.	
PREMIUM REFUND OR RETENTION	36 O.S. 1241.1	Every policy shall contain a provision relating to process for premium refund if the insured cancels the policy prior to the end of policy period.	
PRICING			
Minimum Premium Rules	36 O.S. 3623.1	A minimum premium charge is considered premium within the definition of this Code, and shall be subject to premium tax as provided in this Code. Minimum premium charge is the smallest acceptable premium for which an insurance company will write a policy. This minimum charge is necessary to cover fixed expenses, other than those expenses defined as fees above, in placing the policy on the books. A minimum premium charge includes, but is not limited to, minimum earned premium and minimum retained premium. An insurance consultant, insurance producer, limited lines producer, managing general agent or surplus lines insurance broker cannot charge a duplicate fee or minimum premium charge.	
Multi-tier	O.R. 365: 15-7-25	Eligibility requirements for each tier must be submitted. The tier eligibility requirements must be specific and mutually exclusive, so that no insured would be eligible for more than one tier. Justification must be provided for the rate differential for each tier.	
Payment Plans	O.R. 365: 15-7-19	Deferred Premium Payment Plans used on policy periods in excess of one year must have a sufficient initial premium paid to cover a short rate cancellation return premium. If the insurance company or other form of association fails to collect the prescribed initial premium then it shall be deemed to have waived application of the short rate cancellation table where such policy is canceled by the insured at the first anniversary date.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
RATE RANGES			
Service Charges	36 O.S. 3623.1	Nothing in this Code shall be construed to prevent an insurer from charging and collecting in this state separate initial membership fees , policy fees and any other fees as defined in subsection C of this section in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax as provided in this Code. An insurer shall fully disclose all fees to its customers. 1. Fees are defined as a flat amount added to the basic premium rate to reflect the cost of establishing the required records, sending premium notices and other related expenses and include, but are not limited to, the following: Installment fees, service charges, financing fees, membership fees, return check fees, policy fees, motor vehicle record fees, inspection fees, late fees, electronic transfer fees, credit score fees and expense load fees. 2. The fee passed on to the consumer must be the actual expense incurred by the insurance company, insurance agency or insurance producer.	
Surcharges			
Other Fees			
RATING PLAN REQUIREMENTS	36 O.S. 987	Must be filed in accordance with Commercial Property and Casualty Competitive Loss Cost Rating Act.	
Expense Modification Plan			
Experience Rating			
Retrospective Rating			
Schedule Rating	O.R. 365: 15-7-29	Maximum debits/credits 25%.	
Small Deductible			
Premiums			
Wrap-up Rating	1. Grand River Dam Authority V. State 2. Independent Insurance Agents of OK, Inc. V. OK Turnpike Authority 3. 61 O.S. 113	Not applicable in Oklahoma.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
RATE/LOSS COST SUPPORTING INFORMATION			
Competition			
Judgment			
Credibility			
Profit Loading			
Single Premium Weighted Loss Cost Multiplier	Bulletin No. PC 2012-03	Insurers will need to provide the number of LCMs to be used by the insurer with the minimum LCM and maximum LCM.	
RETURN ON EQUITY/INVESTMENT INCOME			
SUPPORTING DATA			
TRENDING			
OTHER			
RE-SUBMITTAL OF DISAPPROVED FILING	O.R. 365: 15-7-12	Procedure for re-submittal of disapproved filing.	
Agent Commissions	Bulletin No. PC 2000-03	Multiple agent commission levels are prohibited within one company.	
Forms Filed Separately	O.R. 365: 15-1-21	Policy forms, endorsements, and other forms used shall be filed in compliance with the applicable provisions of Article 36 of the Insurance Code. Said forms shall be filed separately from rates and manual rules.	
Policy Fees	36 O.S. 3623.1	Nothing in this code shall be construed to prevent an insurer from charging and collecting separate initial membership fees and policy fees in addition to premiums for insurance, and such fees shall not be considered premium within the definition of this Code, but shall be subject to premium tax. Fees are defined as a flat amount added to the basic premium rate to reflect the cost of establishing the required records, sending premium notices and other related expenses and include, but are not limited to, the following: Installment fees, service charges, financing fees, membership fees, return check fees, policy fees, motor vehicle record fees, inspection fees, late fees, electronic transfer fees, credit score fees and expense load fees. The fee passed on to the consumer must be the actual expense incurred by the insurance company, insurance agency or insurance producer.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
Flex Filing		NA	
DELIVERY OF POLICY TO INSURED	365: 15-1-3(b)(19) O.R. 365: 15-7-14	In any instance whereby a policy of insurance is effected the insured shall be furnished with either: (A) The original policy; (B) A copy of the original policy or a duplicate policy printed with ten point or larger type; or (C) A certificate including provisions and conditions of the original policy printed with ten point or larger type.	
Filing Fees	O.R. 365: 15-7-3 (b) (2) 36 O.S. 348.1	Rate (or loss cost) and rule filings $100.00 for each individual insurer.	
Postage Requirements	O.R. 365: 15-7-3 (b) (8)	No submissions shall be accepted which arrive at the offices with postage due. No submissions will be returned unless the necessary.	
Group Filings	O.R. 365: 15-7-8	Filings that are made on behalf of more than one insurer shall list the insurer or insurers individually and not by Company group.	
Re-submittal of Disapproved or Rejected Filings	O.R. 365: 15-7-12	All resubmitted filings shall be presented to the Insurance Commissioner in the same manner required by this subchapter for an original filing. In addition the cover letter or filing memorandum addressed to the Insurance Commissioner shall state the full and complete history of the filing, the reason for disapproval, and the factors, that distinguish the resubmittal to warrant reconsideration.	
Retroactive Filings	O.R. 365:15-7-13	Revoked 7/14/2007	
OKLAHOMA EMPLOYEE INJURY - BENEFIT ACT – **THE OKLAHOMA OPTION** – Insurance Coverage	85 A.O.S. 204 B	B. Insurance coverage or surety bond obtained by a qualified employer shall be from an admitted or surplus lines insurer with an AM Best Rating of B+ or better. The Insurance Department has no duty to approve insurance rates charged for this coverage.	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD
Statistical Plans	O.R. 365:15-7-16	Every insurer doing business in this state shall file a statistical plan and any modifications thereto with the Oklahoma Insurance Department. The statistical plan shall record the loss and expenses experience of the insurer and shall provide all data elements necessary to support the rating systems the insurer has filed with the Oklahoma Insurance Department. The experience developed in accordance with an approved statistical plan shall be filed on a yearly basis. An insurer may appoint a registered advisory organization as its agent to report and file its statistical plan and experience. The Insurance Commissioner may approve an advisory organization as a statistical agent to gather, record, compile and report experience in such manner, form and detail as determined by the Insurance Commissioner to be necessary to determine whether rating systems comply with the standards of the Property and Casualty Competitive Loss Cost Rating Act.	