**TITLE 365. INSURANCE DEPARTMENT**
**CHAPTER 25. OTHER LICENSEES**

**365:25-7-90. Authority**
These regulations are promulgated pursuant to the authority granted by Sections 36 O.S. §§ 1534-1541 of the Insurance Law.

**365:25-7-91. Purpose**
The purpose of these regulations is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the Oklahoma Insurance Commissioner to carry out the provisions of 36 O.S. §§ 1534-1541.

**365:25-7-92. Definitions.**
**"Commissioner"** The Insurance Commissioner of the State.
**"Insurance group"** For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined 36 O.S. § 1631.
**"Insurer"** The term "insurer" shall have the same meaning as set forth in 36 O.S. § 103, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.
**"Senior Management"** The term "senior management" shall mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

**365:25-7-93. Filing procedures**
(a) An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by Article 15b of Tile 36 of the Oklahoma Statutes shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described in O.A.C. 365:25-7-94.
(b) The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter "Board") or the appropriate committee thereof.
(c) The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.
(d) For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how

the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(e) Notwithstanding Subsection (a) of this Section, and as outlined in 36 O.S. § 1536, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

(f) An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in O.A.C. 365:25-7-94. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

(g) Each year following the initial filing of the CGAD, the insurer or insurance group shall file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing should so state.

**365:25-7-94. Contents of Corporate Governance Annual Disclosure**

(a) The insurer or insurance group shall be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

(b) The CGAD shall describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following.

(1) The Board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group shall describe and discuss the rationale for the current Board size and structure; and

(2) The duties of the Board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the Board's leadership is structured, including a discussion of the roles of Chief Executive Officer (CEO) and Chairman of the Board within the organization.

(c) The insurer or insurance group shall describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(1) How the qualifications, expertise and experience of each Board member meet the needs of the insurer or insurance group.

(2) How an appropriate amount of independence is maintained on the Board and its significant committees.

(3) The number of meetings held by the Board and its significant committees over the past year as well as information on director attendance.

(4) How the insurer or insurance group identifies, nominates and elects members to the Board and its committees. The discussion should include, for example:

(A)Whether a nomination committee is in place to identify and select individuals for consideration.

(B) Whether term limits are placed on directors.

(C) How the election and re-election processes function.

(D)Whether a Board diversity policy is in place and if so, how it functions.

(5) The processes in place for the Board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any Board or committee training programs that have been put in place).

(d) The insurer or insurance group shall describe the policies and practices for directing Senior Management, including a description of the following factors:

(1) Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

(A) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed.

(B) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(2) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(A) Compliance with laws, rules, and regulations; and

(B) Proactive reporting of any illegal or unethical behavior.

(3)The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description shall include sufficient detail to allow the Commissioner to understand how the organization ensures that compensation programs do not encourage and/or reward excessive risk taking. Elements to be discussed may include, for example:

(A) The Board's role in overseeing management compensation programs and practices.

(B) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(C) How compensation programs are related to both company and individual performance over time;

(D) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(E) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or

otherwise adjusted;

(F) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine whether its risk management objectives are met by incentivizing its employees.

(4) The insurer's or insurance group's plans for CEO and Senior Management succession. (e) The insurer or insurance group shall describe the processes by which the Board, its committees and Senior Management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including a discussion of:

(1) How oversight and management responsibilities are delegated between the Board, its committees and Senior Management;

(2) How the Board is kept informed of the insurer's strategic plans, the associated risks, and steps that Senior Management is taking to monitor and manage those risks;

(3) How reporting responsibilities are organized for each critical risk area. The description should allow the Commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by Senior Management and the Board. This description may include, for example, the following critical risk areas of the insurer:

(A) Risk management processes (An ORSA Summary Report filer may refer to its ORSA Summary Report pursuant to the Risk Management and Own Risk and Solvency Assessment Model Act);

(B) Actuarial function;

(C) Investment decision-making processes; (D)
Reinsurance decision-making processes;

(E) Business strategy/finance decision-making processes; (F)
Compliance function;

(G) Financial reporting/internal auditing; and

(H) Market conduct decision-making processes.

**365:25-7-95. Severability Clause**

If any provision of these regulations, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect other provisions or applications of these regulations which can be given effect without the invalid provision or application, and to that end the provisions of these regulations are severable.

**TITLE 365. INSURANCE DEPARTMENT**
**CHAPTER 25. OTHER LICENSEES**

**365:25-7-100. Authority**

This regulation is promulgated by the commissioner of insurance pursuant to 36 OS §§ 311a.1 through 311a.18 of the Oklahoma Insurance Code.

**365:25-7-101. Purpose and scope**

(a) The purpose of this regulation is to improve the Oklahoma Insurance Department's surveillance of the financial condition of insurers by requiring:

(1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants,

(2) Communication of Internal Control Related Matters Noted in an Audit, and

(3) Management's Report of Internal Control over Financial Reporting.

(b) Every insurer, as defined in O.A.C. 365:25-7-102 shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

(c) Foreign or alien insurers filing the audited financial report in another state, pursuant to that state's requirement for filing of audited financial reports, which has been found by the commissioner to be substantially similar to the requirements herein, are exempt from O.A.C. 365:25-7-103 through O.A.C. 365:25-7-112 of this regulation if:

(1) A copy of the audited financial report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the commissioner in accordance with the filing dates specified in O.A.C. 365:25-7-103, 110, and 111, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

(2) A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the commissioner within the time specified in O.A.C. 365:25-7-109.

(d) Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the report in this state provided the other state has substantially similar reporting requirements and the report is filed with the commissioner of the other state within the time specified.

(e) This regulation shall not prohibit, preclude or in any way limit the commissioner of insurance from ordering or conducting or performing examinations of insurers under the rules and regulations of the Oklahoma Department of Insurance and the practices and procedures of the Oklahoma Department of Insurance.

**365:25-7-102. Definitions**

The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

**"Accountant"** or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

**"Affiliate"** of, or person "affiliated" with, a specific person, is a person that directly, or indirectly

through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

**"Audit committee"** means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers (if applicable), and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to O.A.C. 365:25-7-113(f) for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

**"Audited financial report"** means and includes those items specified in O.A.C. 365:25-7-104 of this regulation.

**"Indemnification"** means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

**"Independent board member"** has the same meaning as described in 365:25-7-113 (c).

**"Insurer"** means a licensed insurer as defined in 36 O.S. § 103. For purposes of the Oklahoma Annual Financial Report Act, insurer includes but is not limited to fraternal benefit societies, health maintenance organizations, multiple employer welfare arrangements, title insurers, and similar organizations licensed by the Insurance Commissioner.

**"Group of insurers"** means those licensed insurers included in the reporting requirements of [insert state law equivalent of the model Insurance Holding Company System Regulatory Act], or a set of insurers as identified by management, for the purpose of assessing the effectiveness of Internal control over financial reporting.

**"Internal audit function"** means a person or persons that provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

**"Internal control over financial reporting"** means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in O.A.C. 365:25-7-104 (b)-(g) of this regulation and includes those policies and procedures that; pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets; provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in O.A.C. 365:25-7-104 (b)-(g) of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in O.A.C. 365:25-7-104 (b)-(g) of this regulation.

**"SEC"** means the United States Securities and Exchange Commission.

**"Section 404"** means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

**"Section 404 Report"** means management's report on “internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant as described in O.A.C. 365:25-7-102.

**"SOX Compliant Entity"** means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the Audit

committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the Internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

**365:25-7-103. General requirements related to filing and extensions for filing of annual audited financial reports and audit committee appointment**

(a) All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report with the commissioner on or before June 1 for the year ended December 31 immediately preceding. The commissioner may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days advance notice to the insurer.

(b) Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for requesting an extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

(c) If an extension is granted in accordance with the provisions in subsection b, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

(d) Every insurer required to file an annual audited financial report pursuant to this regulation shall designate a group of individuals as constituting its audit committee, as defined in O.A.C. 365:25-7-102. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this regulation at the election of the controlling person.

**365:25-7-104. Contents of annual audited financial report**

(a) The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

(b) The annual Audited financial report shall include the following:

(1) Report of independent certified public accountant.

(2) Balance sheet reporting admitted assets, liabilities, capital and surplus.

(3) Statement of operations.

(4) Statement of cash flow.

(5) Statement of changes in capital and surplus.

(6) Notes to financial statements. These notes shall be those required by the appropriate NAIC *Annual Statement Instructions* and the NAIC *Accounting Practices and Procedures Manual*. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to 36 O.S. § 311 of the Oklahoma Insurance Code with a written description of the nature of these differences.

(7) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. (However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted).

**365:25-7-105. Designation of independent certified public accountant**

(a) Each insurer required by this regulation to file an annual audited financial report must within sixty (60) days after becoming subject to the requirement, register with the commissioner in writing the name

and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

(b) The insurer shall obtain a letter from the accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the regulations of the Insurance Department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express his or her opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that Insurance Department, specifying such exceptions as he or she may believe appropriate.

(c) If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the commissioner of this event. The insurer shall also furnish the commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him or her to make reference to the subject matter of the disagreement in connection with his or her opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he or she does not agree; and the insurer shall furnish the responsive letter from the former accountant to the commissioner together with its own.

**365:25-7-106. Qualifications of independent certified public accountant**

(a) The commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(1) Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(2) Has either directly or indirectly entered into an agreement of indemnity or release from liability (collectively referred to as indemnification) with respect to the audit of the insurer.

(b) Except as otherwise provided in this regulation, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the AICPA and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Oklahoma Board of Public Accountancy, or similar code.

(c) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under [cite applicable receivership statute], the mediation or arbitration provisions shall operate at the option of the statutory successor.

(d)

(1) The lead (or coordinating) audit partner (having primary responsibility for the audit) may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the

commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

(A) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(B) Premium volume of the insurer; or

(C) Number of jurisdictions in which the insurer transacts business.

(2) The insurer shall file, with its annual statement filing, the approval for relief from subsection (d)(1) with the states that it is licensed in or doing business in and with the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

(e) The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by, a natural person who:

(1) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Sections 1961 to 1968, or any dishonest conduct or practices under federal or state law;

(2) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or

(3) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

(f) The commissioner of insurance, as provided in Section [insert applicable section] of the insurance code, may, as provided in [insert applicable citation], hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual audited financial report made pursuant to this regulation and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation. (g)

(1) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

(A) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(B) Financial information systems design and implementation;

(C) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(D) Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification (“opinion ") on an insurer's reserves if the following conditions have been met:

(i) Neither the accountant nor the accountant's actuary has performed

any management functions or made any management decisions;
(ii) The insurer has competent personnel (or engages a third party actuary) to estimate the reserves for which management takes responsibility; and
(iii)The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(E) Internal audit outsourcing services;
(F) Management functions or human resources;
(G) Broker or dealer, investment adviser, or investment banking services; (H) Legal services or expert services unrelated to the audit; or
(I) Any other services that the commissioner determines, by regulation, are impermissible.

(2) In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

(h) Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from subsection (g)(1). The insurer shall file with the commissioner a written statement discussing the reasons why the insurer should be exempt from these provisions. If the commissioner finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer, an exemption may be granted.

(i) A qualified independent certified public accountant who performs the audit may engage in other non- audit services, including tax services, that are not described in subsection (g)(1) or that do not conflict with subsection (g)(2), only if the activity is approved in advance by the Audit committee, in accordance with subsection j.

(j) All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to non-audit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity or:

(1) The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;
(2) The services were not recognized by the insurer at the time of the engagement to be non-audit services; and
(3) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(k) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection j. The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(l)

(1) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving

in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

(2) The insurer shall file, with its annual statement filing, the approval for relief from subsection (l)(1) with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic

format acceptable to the NAIC.

**365:25-7-107. Consolidated or combined audits**

(a) An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a pooling or 100 percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

(1) Amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;

(2) Amounts for each insurer subject to this section shall be stated separately;

(3) Noninsurance operations may be shown on the worksheet on a combined or individual basis; (4) Explanations of consolidating and eliminating entries shall be included; and

(5) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual statements of the insurers.

**365:25-7-108. Scope of audit and report of independent certified public accountant**

(a) Financial statements furnished pursuant to O.A.C. 365:25-7-104 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with AU Section 319 of the Professional Standards of the AICPA, *Consideration of Internal Control in a Financial Statement Audit*, the independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to 365:25-7-116, the independent certified public accountant should consider (as that term is defined in Statement on Auditing Standards (SAS) No. 102, *Defining Professional Requirements in Statements on Auditing Standards* or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the *Financial Condition Examiners Handbook* promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

**365:25-7-109. Notification of adverse financial condition**

(a) The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report, in writing, within five (5) business days to the board of directors or its audit committee any determination by the independent certified public

accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the Oklahoma insurance code as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of the report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive the evidence within the required five (5) business day period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five (5) business days.

(b) No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with subsection a.

(c) If the accountant, subsequent to the date of the audited financial report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the commissioner notes the obligation of the accountant to take such action as prescribed in Volume 1, Section AU 561 of the Professional Standards of the AICPA.

**365:25-7-110. Communication of internal control related matters noted in an audit**

(a) In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by Statement on Auditing Standard 60, Communication of Internal Control Related Matters Noted in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the audited financial report discussed in O.A.C. 365:25-7-103(a)) in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

(b) The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.

**365:25-7-111. Accountant's letter of qualifications**

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

(a) That the accountant is independent with respect to the insurer and conforms to the standards of his or her profession as contained in the Code of Professional Ethics and pronouncements of the AICPA and the Rules of Professional Conduct of the Oklahoma Board of Public Accountancy, or similar code;

(b) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as he or she deems appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;

(c) That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this regulation and that the commissioner will be relying on this information in the monitoring and regulation of the financial position of insurers;

(d) That the accountant consents to the requirements of O.A.C. 365:25-7-112 of this regulation

and that the accountant consents and agrees to make available for review by the commissioner, or the commissioner's designee or appointed agent, the workpapers, as defined in O.A.C. 365:25-7-112;
(e) A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and
(f) A representation that the accountant is in compliance with the requirements of 365:25-7-106 of this regulation.

**365:25-7-112. Definition, availability and maintenance of independent certified public accountants work papers**

(a) Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.
(b) Every insurer required to file an audited financial report pursuant to this regulation, shall require the accountant to make available for review by Insurance Department examiners, all work papers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Insurance Department or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Insurance Department has filed a report on examination covering the period of the audit but no longer than seven (7) years from the date of the audit report.
(c) In the conduct of the aforementioned periodic review by the Insurance Department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.

**365:25-7-113. Requirements for audit committees**

(a)This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.
(b) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this regulation. Each accountant shall report directly to the audit committee.
(c) The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's Internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by 365:25-7-114 of this regulation.
(d) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to subsection f and 365:25-7-102(c).

(e) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

(f) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

(g) To exercise the election of the controlling person to designate the audit committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(h)

(1) The audit committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the audit committee in accordance with the requirements of SAS 61, Communication with Audit Committees, or its replacement, including:

(A) All significant accounting policies and material permitted practices;

(B) All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

(C) Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(2) If an insurer is a member of an insurance holding company system, the reports required by subsection (g)(1) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(i) The proportion of independent audit committee members shall meet or exceed the following criteria:

| **Prior Calendar Year Direct Written and Assumed Premiums** | | |
|---|---|---|
| **$0 - $300,000,000** | **Over $300,000,000 - $500,000,000** | **Over $500,000,000** |
| No minimum requirements. See also Note A and B. | Majority (50% or more) of members shall be independent. See also Note A and B. | Supermajority of members (75% or more) shall be independent. See also Note A. |

(j) An insurer with direct written and assumed premium, excluding premiums reinsured with the

Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the commissioner for a waiver from this section's requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from this section with the states that it is licensed in or doing business in and the NAIC. If the nondomestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

**365:25-7-114. Internal audit function requirements**

(a) Exemption – An insurer is exempt from the requirements of this section if:

(1) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000; and

(2) If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $1,000,000,000.

(A) Function – The insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the Audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(B) Independence – In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access

to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(C) Reporting – The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

(D) Additional Requirements – If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

**365:25-7-115. Conduct of insurer in connection with the preparation of required reports and documents**

(a) No director or officer of an insurer shall, directly or indirectly:

(1) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or

(2) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

(b) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(c) For purposes of subsection b of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(1)To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(2) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(3) Not to withdraw an issued report; or

(4) Not to communicate matters to an insurer's audit committee.

**365:25-7-116. Management's report of internal control over financial reporting**

(a) Every insurer required to file an audited financial report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in O.A.C. 365:25-7-102. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under O.A.C. 365:25-7-110. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding.

(b) Notwithstanding the premium threshold in subsection a, the commissioner may require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in (include reference to Corrective Action statute).

(c) An insurer or a group of insurers that is

(1) directly subject to Section 404;

(2) part of a holding company system whose parent is directly subject to Section 404; (3) not directly subject to Section 404 but is a SOX Compliant Entity; or

(4) a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity; may file its or its parent's Section 404 Report and an addendum in satisfaction of this section, O.A.C. 365:25-7-116 "Section 116", requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in O.A.C. 365:25-7-104(b)-(g)) were included in the scope of the Section 404 Report. The addendum shall be a positive

statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in O.A.C. 365:25-7-104(b)-(g)) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 116 report, or (ii) the Section 404 Report and a Section116 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

(d) Management's Report of Internal Control over Financial Reporting shall include:

(1) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(2) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(3) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting; and

(4) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(5) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

(6) A statement regarding the inherent limitations of internal control systems; and

(7) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

(e) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (d) above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(1) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

(2) Management's Report on Internal Control over Financial Reporting, required by subsection (a) above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the State Insurance Department.

**365:25-7-117. Exemptions and effective dates**

(a) Upon written application of any insurer, the commissioner may grant an exemption from compliance with any and all provisions of this regulation if the commissioner finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from

time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing on its application for an exemption. The hearing shall be held in accordance with the regulations of the Oklahoma Department of Insurance pertaining to administrative hearing procedures.

(b) Domestic insurers retaining a certified public accountant on the effective date of this regulation who qualify as independent shall comply with this regulation for the year ending December 31, 2020, and each year thereafter unless the commissioner permits otherwise.

(c) Domestic insurers not retaining a certified public accountant on the effective date of this regulation who qualifies as independent may meet the following schedule for compliance unless the commissioner permits otherwise.

(1) As of December 31, 2020, file with the commissioner an audited financial report

(2) For the year ending December 31, 2020, and each year thereafter, such insurers shall file with the commissioner all reports and communication required by this regulation.

(d) Foreign insurers shall comply with this regulation for the year ending December 31, 2020, and each year thereafter, unless the commissioner permits otherwise.

(e) The requirements of O.A.C. 365:25-7-106(d) shall be in effect for audits of the year beginning
January 1, 2020, and
thereafter.

(f) The requirements of O.A.C. 365:25-7-113 are to be in effect January 1, 2020. An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

(g) The requirements of O.A.C. 365:25-7-116, except for O.A.C. 365:25-7-113 covered above, are effective beginning with the reporting period ending December 31, 2020, and each year thereafter. An insurer or group of insurers that is not required to file a report because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded (but not earlier than December 31, 2020) to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

(h) The requirements of O.A.C. 365:25-7-114 are to be in effect January 1, 2020. If an insurer or group of insurers that is exempt from the O.A.C. 365:25-7-114 requirements no longer qualifies for that exemption, it shall have one year after the year the threshold is exceeded to comply with the requirements of this article.

**365:25-7-118. Canadian and British companies**

(a) In the case of Canadian and British insurers, the annual audited financial report shall be defined as

the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

(b) For such insurers, the letter required in O.A.C. 365:25-7-105(b) shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to O.A.C. 365:25-7-103 and shall affirm that the opinion expressed is in conformity with those requirements.

**365:25-7-119. Severability provision**

(a) If any section or portion of a section of this regulation 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.

## SUBCHAPTER 29. PHARMACY BENEFITS MANAGERS

**365:25-29-1. Purpose**

The purpose of this Subchapter is to:

(1) Set forth the regulations and procedures relating to the licensing and oversight of pharmacy benefits managers under 59 O.S. §§ 357-360, and

(2) Set forth the regulations and procedures relating to the Patient's Right to Pharmacy Choice Act, 36 O.S. §§ 6958-6968.

**365:25-29-2. Scope**

This Subchapter shall apply to all pharmacy benefits managers, which must be licensed pursuant to 59 O.S. § 358(A),and to all health insurers subject to compliance with 36 O.S. § 6958 et seq.

**365:25-29-3. Authority**

This Subchapter is promulgated under the authority granted to the Insurance Commissioner in 59 O.S. § 358(B)and 36 O.S. §§ 6958-6968.

**365:25-29-4. Definitions**

All definitions contained in 59 O.S. §§ 357-360 and 36 O.S. §§ 6958-6968 are applicable to this Subchapter and in addition:

(1) "**Day**" means a calendar day, unless otherwise defined or limited.

(2) The "**act**" means 59 O.S. §§ 357-360 and 36 O.S. §§ 6858-6968.

(3) Pharmacy benefits manager and PBM may be used interchangeably in this Subchapter.

(4) "**Preferred participating pharmacy**" means a pharmacy that is designated as a preferred participating pharmacy in a PBM's retail pharmacy network.

(5) "**Provider**" means an Oklahoma licensed retail pharmacy.

**365:25-29-5. Forms and contents of application for PBM license**

An application for PBM License shall be on a form provided by the Commissioner and shall include:

(1) The identity of the PBM and any company or organization controlling the operation of the PBM, including the name, business address, and contact person for the PBM and the controlling entity. For purposes of this subsection, "control" or "controlling" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of the PBM, whether through the ownership of voting securities, by contract or otherwise, unless, for an individual, the power is the result of an official position with or corporate office held by the person;

(2) The name and address of the corporate officers and directors, members and managers (if an LLC), or names of all partners (if a partnership) of the applicant PBM;

(3) A license fee in the amount of One Thousand Dollars ($1,000.00);

(4) A "Certificate of Incorporation" or comparable organizational document from the domiciliary state of the PBM;

(5) In the case of a PBM domiciled outside the State of Oklahoma, a certificate that the PBM is in good standing in the state of domicile or organization;

(6) A report of the details of any suspension, sanction, penalty or other disciplinary action relating to the PBM and its officers and directors;
(7) The name and address of the agent of record for services of process in Oklahoma;
(8) The number of total covered individuals or lives served under all of the PBM's contracts or agreements in Oklahoma;
(9) The most recently concluded fiscal year-end financial statements for the PBM and its controlling entity, which statements have been audited by an independent certified public accountant (CPA) under U.S. generally accepted accounting principles (GAAP); and
(10) A certificate signed by an Executive Officer of the PBM attesting to the accuracy of the information contained in the filing.

**365:25-29-6. Surety bond**

(a) Prior to the issuance of a pharmacy benefits manager license, the PBM applicant shall file with the Commissioner and thereafter keep in effect, as long as the license remains in effect, a surety bond in an amount determined to be sufficient by the Commissioner. The bond shall be in a form acceptable to the Commissioner and for the purpose of securing conformity with the laws and regulations governing pharmacy benefits managers. The bond shall be for the benefit of parties protected by the provisions of 59 O.S. §§ 357-360 and 36 O.S. §§ 6958-6968.
(b) The surety bond must provide that no party may cancel the bond without first giving thirty (30) days written notice to the principal and the Commissioner.
(c) Absent a finding otherwise, a bond, shall be deemed to be sufficient if it meets the following requirements:

(1) For a PBM with not more than five thousand (5,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of fifty thousand dollars ($50,000.00);
(2) For a PBM with more than five thousand (5,000) but not more than ten thousand (10,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of one hundred thousand dollars ($100,000.00);
(3) For a PBM with more than ten thousand (10,000) but not more than twenty-five (25,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of two hundred fifty thousand dollars ($250,000.00);
(4) For a PBM with more than twenty-five thousand (25,000) but not more than fifty thousand (50,000) annual Oklahoma lives covered, the bond shall have a minimum penal sum of five hundred thousand dollars ($500,000.00);
(5) For a PBM with more than fifty thousand (50,000) but not more than one hundred thousand (100,000) annual Oklahoma lives covered, the bond shall have a minimum penal sum of seven hundred fifty thousand dollars ($750,000.00); and
(6) For a PBM with more than one hundred thousand (100,000) annual Oklahoma covered lives, the bond shall have a minimum penal sum of one million dollars ($1,000,000.00).

**365:25-29-7.1 Retail pharmacy network access -audit**

(a) Standards:

(1) Section 6960 of the act defines "member of a retail pharmacy network" as meaning retail pharmacy providers contracted with a PBM on behalf of a payor in which the pharmacy primarily fills and sells prescription medicine via retail storefront location.

(2) The act draws no distinction between regular or specialty drugs, both being prescription medications, therefore, specialty drugs fall within the contemplation of the act.

(3) Pharmacy benefits managers shall not in any manner on any material, including but not limited to mail and ID cards, include the name of any pharmacy, hospital or other providers unless it specifically lists all pharmacies, hospitals and providers.

(b) A PBM's retail pharmacy network access shall be monitored for compliance with this act by those insurers that utilize the services of such PBM. Health insurers are required to maintain retail pharmacy network access in conformity with the requirements set forth in § 6961 of this act.

(c) Every Insurer that utilizes the services of a PBM shall, as part of the annual general compliance audit required by 365:25-29-9, conduct a network adequacy audit. If the audit reveals the percentage of covered individuals is less than one hundred and five percent (105%) above any of the required percentages in 36 O.S. § 6961 the insurer shall conduct semi-annual network adequacy audits until such time that an audit indicates that the percentage of covered individuals is more than five percent 5% above the required percentage.

(d) The audits must be completed within ninety (90) days of the effective date of 36 O.S. § 6958-6968 and annually each year thereafter. The results of the audits shall be reported to the Commissioner within thirty (30) days of the completion of the audit.

**365:25-29-8. PBM to file certain financial statements with the Commissioner**

(a) Before March 1 of each year, every PBM providing pharmacy benefits management shall submit to the Insurance Commissioner a report of its financial condition verified by the oath of an executive officer. The report shall be prepared using generally accepted accounting principles and consist of a balance sheet, income statement, and statement of cash flows. The report may be supplemented by any additional information required by the Insurance Commissioner.

(b) The Commissioner may extend the time prescribed for filing annual or other reports or exhibits of any kind for good cause shown. However, the Commissioner shall not extend the time for filing annual statements beyond sixty (60) days after the time prescribed by this Section.

**365:25-29-9. Contractual requirements**

(a) Maximum Allowable Cost.

(1) Contracts between a PBM and a provider shall conform to the following requirements:

A. Identify sources of information utilized by the PBM to create and modify the PBM's maximum allowable cost price specific to the pharmacy;

B. The PBM shall provide an electronic process, including but not limited to e-mail, for its pharmacy providers to readily access the MAC list specific to that provider. Upon a provider's written request, a PBM shall furnish its MAC list to the provider in paper form or other agreed format;

C. If a provider is unable to obtain a drug from a regional or national wholesaler at a price equal to or less than the PBM's multisource drug product reimbursement, the PBM shall provide a reasonable appeals procedure; to contest the multisource drug product reimbursement amount;

D. A "reasonable appeals procedure" means a process which permits a provider or a provider's representative to contest a multisource drug product

reimbursement amount based on the provider's contention that the drug is not generally available for purchase by Oklahoma pharmacies in the state at or below the PBM's multisource drug product reimbursement;

E. A provider's appeal shall contain information including but not limited to the date of claim, National Drug Code number, and the identity of the national or regional wholesalers from which the drug was found to be unavailable for purchase by the provider, at or below the PBM's multisource drug product reimbursement;

F. Appeals filed under this subsection shall be presented to the PBM within ten (10) business days following the final adjusted payment date. The PBM must respond to a provider within ten (10) business days following the receipt by the PBM of the notice that the provider is contesting the multisource drug product reimbursement amount;

G. If a provider's appeal is denied, the PBM shall provide the reason for the denial, including the National Drug Code number and the identity of the national or regional wholesalers from whom the drug was generally available for purchase by providers in the state at or below the PBM's multisource drug product reimbursement;

H. If a provider's appeal is found to be justified, the PBM shall make a change in the multisource drug product reimbursement amount, permit the provider to reverse and re-bill the claim in question, and make the multisource drug product reimbursement amount change applicable prospectively for all similarly contracted Oklahoma providers.

(2) A PBM shall permit the submission of either paper or electronic documentation to perfect an appeal. A PBM shall not require the submission of appeals on an individual claim (non-batch) basis or refuse to accept appeals from a provider's designated representative or require procedures that have the effect of obstructing or delaying the appeal process. All multisource drug product reimbursement appeals shall be properly documented.

(3) Before beginning business, and as contracts are amended thereafter, each PBM shall submit to the Insurance Commissioner a certificate signed by an executive officer of the PBM attesting that the Oklahoma provider contracts utilized by such PBM satisfy the requirements of the act.

(b) The relationship between a PBM and an insurer or other payor is controlled by contract whereby the PBM acts on behalf of the payor to facilitate the delivery of prescription medication benefits provided by such payor. Requirements and limitations contained within the act and applicable to such payors must be understood within this payor – contractor relationship.

(c) The act requires or limits certain conduct in the interaction between the PBM and retail pharmacy network providers. Consequently, the Department hereby requires that every insurer utilizing the services of a pharmacy benefit manager shall be responsible, as follows:

(1) for approving all contractual documents utilized by its contracted PBMs and its retail pharmacy network to ensure compliance with the act;

(2) for conducting an annual audit of transactions and practices utilized by its contracted PBMs and members of its retail pharmacy network to ensure compliance with the act; and

(3) any exceptions found shall be reported to the Department pursuant to the Commissioner's examination authority.

**365:25-29-10. Penalty for noncompliance**

(a) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 59 O.S. §§ 357-360 of the Oklahoma Statutes, or this Subchapter as it relates to 59 O.S. §§ 357-360, or upon finding the existence of grounds to refuse the issuance or renewal of such license, the Commissioner may suspend or revoke a PBM's license or assess a civil penalty of not less than Five Hundred Dollars ($500.00) nor more than Five Thousand Dollars ($5,000.00) for each instance of violation, or both. Each day that a pharmacy benefits manager conducts business in the State of Oklahoma without a license shall be deemed to be an instance of violation. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(b) After notice and opportunity for hearing, and upon determining that the PBM has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, or this Subchapter as it relates to 36 O.S. §§ 6958-6968, the Commissioner may suspend or revoke a PBM's license and/or levy fines not to exceed Ten Thousand Dollars ($10,000.00) for each count for which any PBM has violated the provisions of 36 O.S. §§ 6958-6968. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(c) After notice and opportunity for hearing, and upon determining that the health insurer has violated any of the provisions of 36 O.S. §§ 6958-6968 of the Oklahoma Statutes, the Commissioner may suspend or revoke a health insurer's certificate of authority license or assess a civil penalty of not less than Five Hundred Dollars ($500.00) nor more than Five Thousand Dollars ($5,000.00) for each instance of violation, or both. The payment of the penalty may be enforced in the same manner as civil judgments may be enforced.

(d) Every health insurer upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall, within thirty (30) days from the date of inquiry, furnish the Commissioner or the Commissioner's representative with an adequate response to the inquiry.

**365:25-29-11. "Doing pharmacy benefits management business in this state" defined—venue—exceptions**

(a) The venue of any act listed in this Section shall be Oklahoma County.

(b) Any one of the following acts, in this state, effected by mail or otherwise, is defined to be doing pharmacy benefits management business in this state:

(1) The making of or proposing to make, as a PBM, a contract with a covered entity for the provision of pharmacy benefits management services to covered individuals residing in Oklahoma;

(2) The provision of pharmacy benefit management services to covered individuals residing in Oklahoma;

(3) Directly or indirectly acting as an agent for, or otherwise representing or aiding on behalf of another, any person or PBM in:

(A) the solicitation, negotiation, procurement, or effectuation of pharmacy benefits management contracts or services to citizens of this state;

(B) the transaction of matters subsequent to effectuation of a contract providing pharmacy benefits management services and arising out of it; or

(C) any other manner representing or assisting a person in the transaction of the business of pharmacy benefits management to residents in this state.

(c) The provisions of this section do not apply to transactions in this state involving a contract between a covered entity and a PBM not contracted to any provider in this state, that is lawfully solicited, written, and delivered outside of this state, covering only pharmacy benefits provided to individuals or entities not residing or located in this state.

**365-25-29.12. Commissioner's authority – advisory committee**

(a) Pursuant to 36 O.S. § 6966, the Insurance Commissioner shall establish an advisory committee composed of representatives from the following constituent groups:

(1) Oklahoma Pharmacists Association;

(2) Office of the Oklahoma Attorney General;

(3) Consumers; and,

(4) Insurers or PBMs.

(b) The advisory committee shall function in an advisory capacity only. Any investigation or enforcement action in consequence of the act shall be at the sole discretion of the Commissioner.

(c) Nominees for members of the advisory committee as provided in § 6966 (C) shall be representative of the interests of the stakeholders listed above and shall be submitted to the Commissioner for appointment.

(d) Because committee members will be dealing with confidential, proprietary, or competitively sensitive information the Commissioner shall implement the following protections to prevent such information from being viewed or used inappropriately:

(1) Advisory committee members shall avoid conflicts of interest and recuse themselves from being involved in any proceedings where they may have insight into a competitor's pricing or proprietary information. The committee members must also avoid any conduct which could be viewed as a conspiracy to fix prices or otherwise restrict competition.

(2) Committee members shall be required to sign conflict of interest forms that disclose potential conflicts before serving on the committee, and affirmatively recuse themselves when a potential conflict arises. A conflict arises when a committee member has a financial stake in the outcome of a complaint or issue before the committee, or has an existing contract with a PBM, pharmacy, or insurer that is the subject of the committee's review. In addition, committee members shall be required to sign confidentiality commitments that acknowledge the statutory prohibition of any disclosure of confidential information that is available to the committee.

(3) All committee nominations must be supported by a National Association of Insurance Commissioners biographical affidavit and background check.

(e) Meetings of the advisory committee shall be convened by the Commissioner upon ten (10) days prior written notice or waivers thereof. The Commissioner or Commissioner's designee may attend any or all meetings of the committee.

**365:25-29-13. Claims payment**

Payment of claims arising under the terms and conditions of any policy of a medical insurance health benefit plan is the obligation of the insurer that issues such policy. Failure to properly handle such claims is addressed by other provisions of Title 36.

**365:25-29-14. Inquiry/complaint handling process**

(a) Complaints alleging failure by the PBM to comply with the act, shall be made in writing to the Commissioner, supported by evidentiary materials. All complaints must include a completed "PBM Complaint Form" as promulgated by the Commissioner.

(b) All audits of PBMs by health insurers shall include a review of complaints against the PBM to determine compliance with the terms of the contract between the PBM and the complainant.

(c) PBMs must provide the complainant with a written notice as to the final disposition of the complaint.

(d) As part of its response to the Department in connection with every complaint, the PBM must provide a statement to the Department that the complaint was carefully reviewed and could not be resolved under the terms and conditions of the contract.

**365:25-29-15. Examinations of PBMs and health insurers**

(a) Pursuant to 36 O.S. § 6965, the Commissioner may examine PBMs for compliance with the 59 O.S §§ 357-360 and 36 O.S. §§ 6958-6968.

(b) Pursuant to 36 O.S. § 309.1 through 309.7, the Commissioner may examine health insurers for compliance with 36 O.S. §§ 6958-6968.

(c) Any examination permitted under 36 O.S.§ 6965 will follow the examination procedures and requirements applicable to insurers under 36 O.S. §§309.1 through 309.7.

(d) The Commissioner shall not be required to regularly examine a PBM under the same time constraints, as required under 36 O.S. §§ 309.1 through 309.7, applicable to insurers, however, the Commissioner may examine the PBM, pursuant to 36 O.S. § 6965, at any time, in which he or she believes it reasonably necessary to ensure compliance with 59 O.S §§ 357-360 and 36 O.S. §§ 6958-6968 or provisions of this subchapter.

## APPENDIX B. FORM B: OKLAHOMA INSURANCE HOLDING COMPANY SYSTEM REGISTRATION STATEMENT

### FORM B

OKLAHOMA INSURANCE HOLDING COMPANY
SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Commissioner for
the State of Oklahoma.

BY

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

_____
_____
_____
_____
_____
_____

Date: _____, 20_____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____
_____
_____

ITEM 1. **Identity and control of registrant**

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance holding company system; and the method(s) by which control of each Registrant was acquired and is maintained.

ITEM 2. **Organizational chart**

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. No affiliate need be shown if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person within the insurance holding company system unless it has assets valued at or exceeding $250,000. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g., corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. **The ultimate controlling person**

As to the ultimate controlling person in the insurance holding company system furnish the following information:

(a) Name.
(b) Home office address.
(c) Principal executive office address.
(d) The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.
(e) The principal business of the person.
(f) The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.
(g) If court proceedings looking toward a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. **Biographical information.** Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM 5. **Transactions, relationships and agreements**

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(a) loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;
(b) purchases, sales or exchanges of assets;
(c) transactions not in the ordinary course of business;
(d) guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;
(e) all management agreements, service contracts and all cost-sharing arrangements;
(f) reinsurance agreements;
(g) dividends and other distributions to shareholders;
(h) consolidated tax allocation agreements; and
(i) any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Section 1654 of the Act.

Sales, purchases, exchanges, loans or extensions of credit, investments or guarantees involving one-half of 1% or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction; the nature and amount of any payments or transfers of assets between the parties; the identity of all parties to such transaction; and the relationship of the affiliated parties to the Registrant.

ITEM 6. **Litigation or administrative proceedings**

A brief description of any litigation or administrative proceedings of the following types, either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceeding is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate holding company including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. **Statement regarding plan or series of transactions**

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. **Financial statements and exhibits**

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or 365:25-7-23 and 365:25-7-25.

ITEM 9. **Form C required**

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. **Signature and certification**

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 1654 of the Act, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the ____ day of _____, 20____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____,20____, for an on behalf of _____; that
(Name of Company)
(s)he is the _____ of such company and that (s)he is authorized to execute
(Title of Officer)
and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

## APPENDIX D. FIDELITY BOND

Know All Men by These Presents: That we _____, of _____, Oklahoma, as Principal, and _____ a surety company duly authorized to do business in the State of Oklahoma, as Surety, are held and firmly bound unto the State of Oklahoma in the penal sum of $_____, lawful money of the United States, for the payment of which well and truly to be made we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, by these presents.

The condition of the above obligation is such that, whereas, the Principal has applied for a permit from the Insurance Commissioner of the State of Oklahoma, to enter into contracts and receive payments thereon for prepaid funeral services and/or merchandise, in accordance with the terms and provisions of Title 36 Oklahoma Statutes 1981, Section 6121 et seq., and the issuance of such permit is conditional upon the Principal filing a bond in the amount above set forth in the office of such Insurance Commissioner, said bond and the surety thereon to be subject to approval by said Insurance Commissioner.

Now, if the above bounden Principal shall faithfully perform any and all such contracts, and shall faithfully account for and promptly pay over to those entitled thereto and all amounts or sums of money due under the terms of any and all such contracts, according to law, then this obligation shall be void, otherwise to remain in full force and effect.

Provided, however, that the liability of the Surety hereunder may be terminated by giving thirty days written notice thereof, by registered mail, to the Principal and the Insurance Commissioner; and the Surety shall be discharged from all liability for any act or omission of the Principal occurring after the expiration of thirty days from the date of service of such notice.

This obligation shall be effective from noon on _____,
(Month,Day,Year)
to noon on the date of cancellation or termination of this bond, standard time, at the Principal address as to each of said dates.

In witness whereof, the said Principal and Surety above named have subscribed this bond at _____, Oklahoma, this _____ day of _____, 20___.

_____
Principal

By _____

_____
Surety

By _____

## APPENDIX E. APPLICATION TO WITHDRAW FUNDS DEPOSITED FOR PREPAID FUNERAL EXPENSES

(In the event of death and fulfillment of the contract)

Seller And The Authorized Person Selecting Funeral Merchandise And Services For The Beneficiary, _____ Account Number _____, Hereby Certify To The Oklahoma Insurance Commissioner That $_____ Was Available For Use At The Time of Death Of The Beneficiary, Which Was _____, 20____.

**CHECK ONE**

**NON-SPECIFIED CONTRACT ____**

The Above Total Includes 100% Of All Funds Deposited Together With Any And All Interest The Buyer Had Elected To Remain in The Account, And Less Administrative Fees As Seller May Have Deducted.

**GUARANTEED CONTRACT ____**

The Above Total Represents The Total Investment Agreed To By Buyer And Seller And Paid Into The Account In Return For The Funeral Merchandise And Services As Listed Below.

**ITEMIZES MERCHANDISE AND SERVICES BY PRICE**

_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____

The Excess Amount Of $_____ Under This Contract Shall Be Disposed Of (If A Guaranteed Contract, Write NOT APPLICABLE In Above Space)

As Follows: To_____ Address_____

City And State _____ As Was Designated In The Original Contract, To Receive Excess Funds.

We Hereby Certify That All Information Contained Herein Is True And Correct, Regarding This Particular Contract.

| | |
|---|---|
| _____ | _____ |
| AUTHORIZED PERSON | Authorized Person of Funeral Home |
| _____ | _____ |
| | Funeral Home Name (Seal) |
| _____ | _____ |
| | Address |
| _____ | _____ |
| | NOTARY PUBLIC |
| Subscribed And Sworn To Before Me This _____ Day Of _____, 20____. | My Commission Expires: _____ |

**APPENDIX F. BUYERS APPLICATION TO TERMINATE CONTRACT OR WITHDRAW FUNDS PREVIOUSLY DEPOSITED FOR PREPAID FUNERAL BENEFITS UNDER A NON-SPECIFIED OR GUARANTEED CONTRACT**

**(Individual Refund)**

The Undersigned Buyer Requests That $_____ Be Withdrawn From Either a Non-Specified ____ Or A Guaranteed ____ Contract.

If Funds Are Being Withdrawn Under A Guaranteed Price Contract, Buyer Understands And Agrees That Seller Is Relieved Of Responsibility To Furnish Funeral Merchandise And Services At A Guaranteed Price As Was Set Forth In The Original Contract Unless Seller Waves That Option.

Dated This __ Day Of _____, 20___

BUYER SIGNATURE

_____

BUYER'S NAME_____

ADDRESS

_____

_____

_

ACCOUNT NUMBER

_____

**STATEMENT OF SELLER**

The Designated Seller Acknowledges Receipt Of The Above Mentioned Application, And Certifies The Amount Requested To Be Available And On Deposit In A Depository Previously Approved By The Oklahoma Insurance Commissioner.

Seller Approves Buyer's Application And Agrees To Deliver A Copy Of This Application To The Buyer, A Copy To The Oklahoma

Insurance Commissioner, And Agrees To Retain A Copy For A Period Of Time Specified By The Insurance Commissioner.

Dated This __ Day Of _____, 20___

SIGNED

_____

---

Funeral Home Name & Address

**APPENDIX G. ANNUAL REPORT**
**Form PF-1-a** Filed in Accordance with 36 O.S. §6128
FOR PREPAID FUNERAL BENEFITS AND FUNDS

Prepared By

_____
(Name of Funeral Home Director)

_____
(Name of Funeral Home Trust Fund)

FOR THE YEAR ENDING DECEMBER 31, 20____

**QUESTIONNAIRE FOR VERIFICATION:**

| | |
|---|---|
| Were all prepaid funeral contracts signed by all parties involved? | Yes_____ No_____ |
| Were all prepaid funeral withdrawal forms properly signed, notarized and itemized if necessary? | Yes_____ No_____ |
| Do you have current addresses and phone numbers for each buyer? | Yes_____ No_____ |
| Do all contracts carry the name and address of your funeral home? | Yes_____ No_____ |
| Are all prepaid funeral customers notified at least annually of their current account monies and interest accrued to date? | Yes_____ No_____ |

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

IF YOUR ANSWER TO ANY OF THE ABOVE IS NO, PLEASE DESCRIBE IN DETAIL THE REASONS WHY THE QUESTION(S) WERE ANSWERED IN THE NEGATIVE AND WHAT WILL BE DONE TO CORRECT THE SITUATION.

_____
Signature of Director or Manager

_____
Date

**ANNUAL REPORT - 20___**
**Form PF-1-b** CERTIFICATION
DUE MARCH 15, 20___

_____
(Name of Funeral Home)

_____
(Address)

_____
(City, Zip)

The attached information is submitted on behalf of the above funeral home based on its records ending December 31, 20___ covering ALL contracts which have not been discharged as of December 31, 20___.

THIS FORM IS FOR USE ONLY IN REPORTING CONTRACTS FUNDED BY CASH.

(YOU MUST COMPLETE A SEPARATE FORM PF-1-b FOR EACH FINANCIAL INSTITUTION BEING USED BY YOUR FUND.)

_____
(Name of Financial Institution)

_____
(Address)

_____
(City, State, Zip)

## CERTIFICATION

The undersigned states and affirms that he/she has duly executed this annual report for and on behalf of the above funeral home, that he/she is the _____ (Title of Officer) of such organization and that he/she is authorized to execute and file such instrument. He/she further states that he/she is familiar with such instrument and contracts thereof, and that the facts herein set forth are true to the best of his/her knowledge, information and belief.

_____
(Signature)

_____
(Print or type name of Signature)

_____
(Date)

TOTAL OF ALL MONIES HELD PLUS INTEREST: _____

Subscribed and sworn to before me this ____day of _____, 20___.

_____
Notary Public

My Commission Expires:

_____

**APPENDIX H. ANNUAL STATEMENT OF FINANCIAL CONDITION (RECONCILIATION OF TRUST ACCOUNTS)**

Filed in Accordance with 36 O.S. §6129
**Form PF-3**
For the Year 20___

_____
Name of Funeral Home

_____
Address, City, State

1. **BEGINNING BALANCE:** $_____
Sum of all trust as of January 1, 20___. (The amount must agree with prior year's ending balance.)

**ADD:**

2. Total of all new contracts sold, current year. (Please attach a listing of *each* new contract as Schedule 2.) $_____

3. Total of all contracts transferred *into* your Trust Fund, current year. (Please attach a listing of each contract received as Schedule 3.) $_____

4. Total of all deposits to existing contracts. **DO NOT** include interest earned or accrued. (Please attach a listing of each account increased by a deposit as Schedule 4.) $_____

5. Total Interest Earned: $_____

**TOTAL ADDITIONS**

**SUBTRACT:**

6. Total of all contracts withdrawn/ transferred prior to death. (Please attach a listing of each contract withdrawn/transferred as Schedule 6.) $_____

7. Total of all contracts withdrawn due to $_____

death. (Please attach a listing of each contract withdrawn because of death as Schedule 7.)

8. Total Administrative fees charged. $_____

**TOTAL SUBTRACTIONS** $_____

9. **ENDING BALANCE:**
SUM OF **ALL** TRUST AS OF DECEMBER 31, 20___. *$_____

* Please note this amount must agree with trust amount submitted to the State Insurance Department in your Annual Report (Form PF-1-b). Any differences must be explained in *detail* and be supported with appropriate documentation.

I, an Officer of the Trust, do hereby represent that this report is true and accurate:

_____
Officer of Trust

_____
Signature

_____
Name of Funeral Home

The above Reconciliation of Trust Accounts is the representation of management (owners). I have not audited or reviewed the accompanying Trust Accounts and, accordingly, do not express an opinion or any other form of assurance on them:

_____
[Certified] Public Accountant

_____
Address

_____
City, State Zip

**APPENDIX N. FORM C: SUMMARY OF REGISTRATION STATEMENT**

**FORM C**

OKLAHOMA INSURANCE HOLDING COMPANY
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Commissioner for the State of Oklahoma.

BY

_____
Name of Registrant

On Behalf of the Following Insurance Companies

| Name | Address |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Date: _____, 20___

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____
_____
_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific references to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership or holdings of 10 percent of more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction discloses on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 1654 of the Act, the Registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the ____ day of _____, 20____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached summary of registration statement dated _____, 20____, for an on behalf of _____; that (s)he is the
(Name of Company)
_____of such company and that (s)he is authorized
(Title of Officer)
to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

## APPENDIX O. FORM D: PRIOR NOTICE OF A TRANSACTION

**FORM D**

OKLAHOMA INSURANCE HOLDING COMPANY
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Commissioner for
the State of Oklahoma.

BY

_____
Name of Registrant

On Behalf of the Following Insurance Companies

Name Address

_____
_____
_____
_____
_____
_____

Date: _____, 20___

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____
_____
_____

**ITEM 1. Identity of parties to transaction**

Furnish the following information for each of the parties to the transaction:

(a) Name.
(b) Home office address.
(c) Principal executive office address.
(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.
(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.
(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

**ITEM 2. Description of the transaction**

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given under Section 1655(b) of the Act.
(b) A statement of the nature of the transaction.
(c) The proposed effective date of the transaction.

**ITEM 3. Sales, purchases, exchanges, loans, extensions of credit, guarantees or investments**

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee, or investment, whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice, a description of the terms of any securities being received, if any, and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agreements and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than, as of the 31st day of December next preceding:

(a) in the case of non-life insurer's, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or,
(b) in the case of life insurers, 3% of the insurer's admitted assets.

**ITEM 4. Loans or extensions of credit to a non-affiliate**

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of or make investments in any affiliate. Describe the amount and source of duns, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurer's, the lesser of 3% of the insurer's admitted assets or 25% of surplus as regards policyholders or, with respect to life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.

**ITEM 5. Reinsurance**

If the transaction is a reinsurance agreement or modification thereto, as described by Section 1655(b)(3)(ii) of the Act, furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5% of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.

**ITEM 6. Management agreements, service agreements and cost-sharing arrangements**

For management and service agreements, furnish:

(a) a brief description of the managerial responsibilities, or services to be performed.

(b) a brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) a brief description of the purpose of the agreement.

(b) a description of the period of time during which the agreement is to be in effect.

(c) a brief description of each party's expenses or costs covered by the agreement.

(d) a brief description of the accounting basis to be used in calculating each party's costs under the agreement.

**ITEM 7. Signature and certification**

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 1655 of the Act, _____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____on the ____ day of _____, 20____.

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 20____, for an on behalf of _____; that (s)he is the _____
(Name of Applicant) (Title of Officer)
of such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

## APPENDIX Q. FORM E

## PRE-NOTIFICATION FORM REGARDING THE POTENTIAL COMPETITIVE IMPACT OF A PROPOSED MERGER OR ACQUISITION BY A NON-DOMICILIARY INSURER DOING BUSINESS IN THIS STATE OR BY A DOMESTIC INSURER

_____
Name of Applicant

_____
Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of

_____

Dated: _____, 20_____.

Name, title, address and telephone number of person completing this statement:

_____

_____

_____

_____

**ITEM 1. NAME AND ADDRESS**

State the names and addresses of the persons who hereby provide notice of their involvement in a pending acquisition or change in corporate control.

**ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES**

State the names and addresses of the persons affiliated with those listed in Item 1. Describe their affiliations.

**ITEM 3. NATURE AND PURPOSE OF THE PROPOSED MERGER OR ACQUISITION**

State the nature and purpose of the proposed merger or acquisition.

**ITEM 4. NATURE OF BUSINESS**

State the nature of the business performed by each of the persons identified in response to Item 1 and Item 2.

**ITEM 5. MARKET AND MARKET SHARE**

State specifically what market and market share in each relevant insurance market and persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data.

For purposes of this question, market means direct written Insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state.

> **NOTE:** State Insurance Departments may additionally choose to make these calculations using their own data or data provided by the NAIC.

# APPENDIX R. CONVERSION FROM PRE-PAID FUNERAL TRUST TO INSURANCE FUNDED CONTRACTS

_____
Name of Applicant Permit #

_____
Name of Insurer Oklahoma Certificate of Authority #

FILED WITH THE INSURANCE COMMISSIONER FOR
THE STATE OF OKLAHOMA

Dated: _____, 20_____.

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should Be Addressed:

_____
_____
_____
_____

ITEM 1. Copy of Letter from Insurer to Applicant.

Furnish a letter to the applicant from an insurer authorized to do business in Oklahoma evidencing the policy form number and setting out the insurer's agreement to issue insurance policies to convert the prepaid funeral contracts from trust funded benefits to insurance funded benefits.

ITEM 2. Copy of Written Commitment to Commissioner.

Furnish a copy of the written commitment to the Commissioner containing the agreement between or among the insurer, the applicant, and the post-conversion administrator regarding the transfer, receipt, and the application of trust funds upon conversion, which commitment must require a copy of each insurance policy issued be furnished to the owner of the insurance policy and that a copy be made available to the respective prepaid funeral contract purchasers upon request, in the event they are not the owners of the policies.

ITEM 3. Pre-conversion Summary.

Furnish a pre-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of a date within thirty (30) days of the date of application), as well as aggregated totals for each category of information, if appropriate:

(A) individual prepaid funeral benefits contract purchaser's name and/or the owner;
(B) date of execution of pre-converted prepaid funeral contract;
(C) face amount of the contract;
(D) amount paid in and the unpaid balance;
(E) accumulated earnings;
(F) amount due the prepaid funeral contract purchaser upon cancellation and the amount due the application upon death of the prepaid funeral contract owner, assuming death or cancellation were to occur on or about the date of application;
(G) amount retained by the applicant under the Title 36 O.S. §6125; and
(H) whether the pre-converted contract is or was a contract pursuant to Sections 6125(B)(1) or 6125(B)(2).

ITEM 4. Post-conversion Summary.

Furnish a post-conversion summary of the individual prepaid funeral contracts, which must include, at a minimum, the following information (as of the same date of the pre-conversion summary), as well as aggregated totals for each category of information, if appropriate:

(A) annuitant's name;
(B) original prepaid funeral contract amount;
(C) amount paid in and the unpaid balance;
(D) amount applied to the purchase of the insurance policy;
(E) initial cash surrender value and initial death benefit under the insurance policy; and
(F) amount retained by the applicant under the Title 36 O.S. §6125.

ITEM 6. Actuarial Certification.

Furnish an actuarial certification certifying that the reserves to be held by the insurance company with respect to the conversion will be adequate to pay claims as they become due (dated no more than six (6) months prior to the date of the application).

ITEM 8. Form of Assignment.

Furnish a copy of the form of assignment, if any, to be used in assigning insurance policy rights or proceeds to the post-conversion administrator.

ITEM 7. Signature and Certification.

Signature and certification required as follows:

I, _____, being first duly sworn, state that I have read the within and foregoing application and that the answers supplied by me therein are true and correct to the best of my knowledge and belief.

STATE OF )
) ss.
COUNTY OF )

_____ _____
Signature of Applicant Date

_____ _____
Notary Public My Commission Expires