TITLE 365. INSURANCE DEPARTMENT
CHAPTER 25. OTHER LICENSEES
SUBCHAPTER 1. GENERAL PROVISIONS

365:25-1-1. Purpose [REVOKED]

~~The rules in this chapter provide regulations relating to the licensure of agents, adjusters, bail bondsmen, insurance companies, prepaid funeral benefits, viatical and life settlements providers and brokers in the State of Oklahoma.~~

365:25-1-2. Severability [REVOKED]

~~If any provision of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the section and the application of such provisions to the persons or circumstances shall not be affected thereby.~~

SUBCHAPTER 3. PRODUCERS, BROKERS, LIMITED LINES PRODUCERS AND VEHICLE PROTECTION PRODUCT WARRANTORS

365:25-3-1. Insurance producers continuing education

(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education, which an insurance producer must meet and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.

(b) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"CE"** means continuing education.

(2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.

(3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.

(4) **"Credit hour"** means at least fifty (50) minutes classroom instruction unless a correspondence or self-study course.

(5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.

(6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.

(7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance producer.

(8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance producers.

(9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by a producer or producers.

(c) **Exceptions.** The requirements for continuing education in this section shall not apply to:

(1) limited lines producers.

(2) a non-resident producer who resides and is licensed in a state or district having continuing education requirements and the producer meets all the requirements of that state or district to practice therein.
(3) a non-resident producer of a state that does not require continuing education hours may fulfill the requirements of any other state's continuing education requirements and shall be deemed to have complied with this rule upon proof of completion of said hours.

(d) **Continuing education requirements.**

(1) **CE during twenty-four month period.** All licensees shall complete the required hours of continuing education as set forth in 36 O.S. § 1435.29 during each twenty-four month period. The twenty-four month period begins the first day after the license is granted. Ethics shall include, but not be limited to, the study of fiduciary responsibility, commingling of funds, payment and acceptance of commissions, unfair claims practices, policy replacement consideration, and conflicts of interest.
(2) **Certificates of course completion required for license renewal.** If requested by the Insurance Department, each producer shall submit upon each licensing renewal certificate(s) of course completion as approved by the Insurance Department, which verify courses completed during the previous twenty-four month period.
(3) **Credits carried over.** Six (6) credit hours in excess of the minimum twenty-four month period requirement shall carry forward as general hours to the next twenty-four month period. Excess hours may be applied to bring a lapsed license into compliance.
(4) **Legislative updates.** At least two (2) of the continuing education credit hours of instruction completed by licensees each twenty-four month period shall be taken in the following topics:

(A) State legislative updates, or
(B) Federal legislative updates.

(5) ~~**Earthquake insurance education.** Beginning January 1, 2015, each resident insurance producer with a property line of authority shall complete one (1) hour of continuing education credit in the topic of earthquake insurance as part of the continuing education credit hours required each twenty-four month period.~~
~~(6)~~ **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session by including his/her name and license number on roster.
~~(7)~~ (6) **Prerequisite for renewal or reinstatement.** As a prerequisite for licensure renewal or upon reinstatement following a lapse of license, a producer must demonstrate that the education requirements have been reported for the previous renewal cycle.

(e) **Approval of continuing education providers.**

(1) **Information required, fee.** Each provider shall apply for approval from the Commissioner. Each provider, with the exception of public funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations, and Oklahoma state agencies shall submit a provider fee of Two Hundred Dollars ($200.00), and all providers, including public funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma agencies hall provide:

(A) Name, address, and email address of the provider;
(B) Contact person and his or her address and telephone number;

(2) **Renewal fee.** An annual renewal fee of Two Hundred Dollars ($200.00) shall be payable on or before the approval anniversary date of each year by each provider to renew the approval of the provider. A fee of double the annual renewal fee shall be paid if the application for renewal is late or incomplete on the approval anniversary date.

(3) **Reinstatement period.** Providers whose approval has expired may be reinstated pursuant to paragraph 1 of this subsection. The reinstatement period shall be for a period of one (1) year following the expiration of the renewal date. The approval of the provider and any currently active courses shall remain active for the reinstatement period. If the provider and all courses fail to remain active following the reinstatement period, the provider and courses shall not be reinstated and the provider and courses shall be required to be approved pursuant to the provisions of this subsection.

(4) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.

(f) **Courses; approval; records; fee.**

(1) **Timeline for approval.** At least thirty (30) days prior to the use of any course and not less than ten (10) days prior to the Continuing Education Advisory Committee meeting immediately preceding the course date, the provider shall apply for and submit the appropriate course review fee to the Commissioner for course approval. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CE hours awarded for an approved course and the line or lines of insurance for which the course qualifies. The provider shall submit the following at the time of application:

(A) The number of CE hours requested for each course;

(B) Topic outlines which list the summarized topics covered in each course and a copy of any course materials. If a prior approved course has substantially changed, a summarization of those changes;

(C) If a prior approved course has materially changed, a summarization of those changes.

(2) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted. An instructor shall have one of the following qualifications:

(A) Three (3) years of recent experience in the subject area being taught; or

(B) A degree related to the subject area being taught; or

(C) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.

(3) **Written approval required.** All courses shall require written approval by the Commissioner.

(4) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course approval. This withdrawal will not affect any CE hours attained under the course previous to the withdrawal. If a provider provides a CE course after that course has been denied by the Commissioner, the provider may be subject to an administrative action and penalty.

(5) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.
(6) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.
(7) **Content of courses.** Courses must be of a meaningful nature and shall not include the following subjects: motivation, psychology, recruiting, subjects not relating to the insurance license, and any insurance company specific sales techniques or prospecting. However, agency management courses designed to assist producers in becoming more efficient, profitable, and assuring their perpetuation, will be deemed to be in the best interest of the insuring public and thereby subject to approval. Each such agency management course must include the description, the effects the course is designed to accomplish toward the purposes of efficiency, profitability, and/or perpetuation and each course will be reviewed for approval on its own merits.
(8) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance producer a "Certificate of Course Completion" Form.
(9) **List of producers completing course to Commissioner; producer license numbers.** Within ten (10) business days after completion of each course, the provider shall electronically upload a list of all insurance producers who completed the course to the Commissioner's database system. This list shall contain the course number, date of completion and license numbers of all insurance producers completing the course. If the list is not reported within ten (10) business days, a late report fee of Fifty Dollars ($50.00) shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.
(10) **Course records maintained four years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.
(11) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date and instructor's name.
(12) ~~**Course evaluation.** The continuing education provider shall provide written notification to each producer of the opportunity to offer comments on any continuing education class via the Insurance Department website~~.
~~(13)~~ **Course review fee.** A non-refundable course review fee of thirty dollars ($30.00) per course shall be submitted by all continuing education providers at the time the course submission is first submitted for review and upon submission for renewal at expiration with the exception of publicly funded educational institutions, federal agencies, Oklahoma state agencies, non-profit organizations, and not-for-profit organizations.

(g) **Approved Professional Designation Programs.**

(1) **Definitions.**

(A) **Participation.** As used in 36 O.S. § 1435.29(B)(3), participates means successfully completing any part of a course curriculum totaling twenty-four (24) classroom or equivalent classroom hours of an approved professional designation program.
(B) **Approved Professional Designation Program.** As used in 36 O.S. § 1435.29(B)(3), an approved professional designation program means an educational insurance program approved by the Commissioner with a

sponsoring organization that administers curriculum requirements and testing standards for candidates.

(2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:

(A) The program shall have a sponsoring organization;

(B) The program's sponsoring organization shall maintain and govern a code of conduct;

(C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) Each course of the professional designation course curriculum shall be a minimum of twenty-four (24) hours of classroom instruction or equivalent classroom instruction; and

(E) The program shall include an examination requirement that students shall pass before earning the designation.

(3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:

(A) The sponsoring organization's code of conduct;

(B) The sponsoring organization's membership requirements;

(C) The professional designation program's course requirements; and

(D) The professional designation program's examination requirements.

(4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.

(h) **Presumptive Continuing Education Credit Approval.**

(1) **Requirements.** A professional association may receive presumptive approval of the association's continuing education courses by satisfying the following requirements:

(A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;

(B) The association shall maintain and govern a code of member conduct;

(C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma; and

(D) The association shall perpetuate its continuity through the election of officers.

(2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:

(A) The association's mission statement;

(B) The association's code of member conduct;

(C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;

(D) The mailing address and primary contact for the association; and

(E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.

(3) **Notification of approval or disapproval.**

(A) The Commissioner shall notify the association within ninety (90) days from the receipt of submission whether presumptive approval for

continuing education courses was granted. The notification shall indicate the reasons for disapproval.

(B) Submissions to the Commissioner by an association seeking presumptive approval of continuing education courses shall include the course summary, instructor name, course date and location and shall be submitted to the Commissioner at least fifteen (15) business days prior to the presentation of the course.

(C) If the Commissioner receives a report or reports that the content of a continuing education course may violate 365:25-3-1(f)(7) of this section, the Commissioner may review the content and determine if the course should be disapproved for noncompliance. The Commissioner shall notify the association if the course has been disapproved due to non-compliance, and the association shall immediately cease offering the course upon receipt of the notification. The association may then make corrections to a disapproved course to bring the course into compliance with 365:25-3-1(f)(7) of this section and submit the course for approval by the Commissioner in the manner of an original submission for presumptive continuing education course approval.

(D) Should an association receive notification of three (3) disapproved courses within a twenty-four (24) month period, the association's presumptive approval for continuing education courses shall be rescinded for twenty-four (24) months after which time the association may re-apply for presumptive approval.

(4) **Assignment of course number.** The Commissioner shall assign a course number once the presumptive approval for continuing education courses has been granted and shall notify the association of the assigned course number. All future correspondence relating to that course shall reference the assigned course number.

(5) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted.

(6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph (3)(B) of this section during the fourth quarter of the last approval year.

(7) **Agency Management Courses.** Agency management courses shall not be considered for presumptive continuing education approval.

(i) **Self study and distance learning courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed, updated as appropriate, and published annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the producer and revocation of the course approval and or provider status for the provider.

(j) **Repeating courses.** An insurance producer may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the producer may not during the twenty-four month period earn more than the maximum credits designated for the course. A producer may repeat a course after two years have elapsed and receive the maximum credits designated for the course.

(k) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twenty-four-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

(l) **Course approval.** There shall hereby be established by 36 O.S. § 1435.29(B)(1)(b) the Continuing Education Advisory Committee. This committee shall consist of representatives from the Licensing Division, and representatives from the industry as designated by the Commissioner. The committee shall meet at least quarterly and additionally as required. Members of the committee shall serve without pay and shall not be reimbursed for any expenses associated therewith. Prior to the Commissioner's approval or disapproval of a course in 365:25-3-1(f), a continuing education advisory committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted in 365:25-3-1(f) regarding the course or additional information regarding the course, if necessary, the number of CE hours awarded for an approved course and the line or lines of insurance for which the course qualifies. Each course approval shall be valid for a period of not more than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course approval following the review of material changes shall reset the validity period. At the expiration of the validity period, providers shall submit the course for approval by the Commissioner if the provider wants to continue to offer the course for continuing education credit.

(m) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-12. ~~Insurance consultants and~~ surplus lines insurance brokers

~~(a) **Purpose.** The purpose of this section is to require surplus lines brokers and insurance consultants to post bonds with the Insurance Commissioner in the amounts specified.~~

~~(b)~~ (a) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Bond"** means a surety bond in the penal sum as determined in accordance with (d) of this section which shall be obtained in favor of the Commissioner from authorized corporate sureties approved by the Commissioner and conditioned upon the licensee conducting his/its business in accordance with applicable law. Any surety issuing such bond shall notify the Commissioner of any reductions or cancellations in the bond of any licensee. No such bond shall be terminated unless at least thirty (30) days written notice thereof is given by the surety to the licensee and the Commissioner. All surety protection under such bond shall insure to the benefit of any party aggrieved by the acts of the licensee thereunder.

~~(2) **"Commissioner"** means the Insurance Commissioner of the State of Oklahoma.~~

~~(3)~~ (2) **"Gross fee"** means the total of all fees ~~received by any Insurance Consultant~~ derived by offering any advice, counsel, opinion or service with

respect to the benefits, advantages or disadvantages promised under any policy of insurance that could be issued or delivered in this state.

~~(4)~~ (3) **"Gross premium"** means the total of all premiums received by any Surplus Lines Insurance Broker less those reductions permitted by 36 O.S. § 1115.

~~(5) **"Insurance consultant"** means an individual, partnership or corporation who, for a fee, holds himself or itself out to the public as engaged in the business of offering any advice, counsel, opinion or service with respect to the benefits, advantages or disadvantages promised under any policy of insurance that could be issued or delivered in this state.~~

~~(6) **"Person"** means any individual, partnership or corporation or other entity.~~

~~(7) **"Surplus lines insurance broker"** means an individual, partnership or corporation who solicits, negotiates or procures a policy of insurance in an insurance company not licensed to transact business in this state which cannot be procured from insurers licensed to do business in this state. All transactions under such license shall be subject to 36 O.S. §§ 1101 et seq.~~

(4) ~~(8)~~ **"Resident"** means any individual or business entity that either resides in the State of Oklahoma or maintains its principal place of business in the State of Oklahoma.

(c) **Bond required.**

(1) **Surplus lines insurance broker.** No resident shall act as a Surplus Lines Insurance Broker in this state until such person has filed with the Commissioner, and thereafter maintained in force, a bond in an amount prescribed in (d) of this section.

~~(2) **Insurance consultant.** No resident person shall act as an Insurance Consultant in this state until such person has filed with the Commissioner, and thereafter maintained in force, a bond in the amount prescribed in (d) of this section.~~

(2) ~~(3)~~ **Cash in lieu of bond.** In either (1) or (2) of paragraph (c) of this section, cash in lieu of a bond will be considered an acceptable substitute.

(d) **Amount of bond.** The bond required by (c) of this section shall be as follows:

(1) For $1,000,000 and above gross premium or gross fees as applicable - $40,000 bond required;

(2) For $500,000 to $999,999 gross premium or gross fees as applicable - $35,000 bond required;

(3) For $250,000 to $499,999 gross premium or gross fees as applicable - $30,000 bond required;

(4) For $100,000 to $249,999 gross premium or gross fees as applicable - $25,000 bond required;

(5) For $75,000 to $99,999 gross premium or gross fees as applicable - $20,000 bond required;

(6) For $50,000 to 74,999 gross premium or gross fees as applicable - $15,000 bond required;

(7) For $25,000 to $49,999 gross premium or gross fees as applicable - $10,000 bond required;

(8) For all gross premium or gross fees below $25,000 as applicable - $5000 bond required.

~~(e) **Reports required.** Every Insurance Consultant shall, on or before the first day of April of each year, file with the Commissioner a verified statement of all fees received by such consultant as a result of business conducted pursuant to such consultant's license.~~

(e) ~~(f)~~ **Third party administrators.** Pursuant to 36 O.S. § 1448, the amount of bond for a third party administrator must be stipulated by the Insurance Commissioner in an amount that will be sufficient to protect those with which the administrator deals and not less than ten thousand dollars. The bond required by Section 1448 shall be set by the Insurance Commissioner but shall be no less than the following amounts as reported in the annual report of the third party administrator for the immediately preceding calendar year:

(1) For $1,000,000 and above in premiums collected or claims paid, whichever is higher - $40,000 bond required;
(2) For $500,000 to $999,999 in premiums collected or claims paid, whichever is higher - $35,000 bond required;
(3) For $250,000 to $499,999 in premiums collected or claims paid, whichever is higher - $30,000 bond required;
(4) For $100,000 to $249,999 in premiums collected or claims paid, whichever is higher - $25,000 bond required;
(5) For $75,000 to $99,999 in premiums collected or claims paid, whichever is higher - $20,000 bond required;
(6) For $50,000 to 74,999 in premiums collected or claims paid, whichever is higher - $15,000 bond required;
(7) For $49,999 or less in premiums collected or claims paid, whichever is higher - $10,000 bond required.

365:25-3-14. Insurance adjusters continuing education

~~(a) **Purpose.** The purpose of this section is to set forth the requirements for continuing education which an insurance adjuster must meet, and to set forth the requirements for approval by the Insurance Commissioner of a proposed continuing education course.~~
~~(b)~~ (a) **Definitions.** The following words or terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"CE"** means continuing education.
(2) **"Certificate of course completion"** means a document acceptable to the Commissioner which signifies satisfactory completion of the course and reflects hours of credit earned.
(3) **"Continuing Education Advisory Committee"** means the committee established by the Commissioner for the purpose of reviewing and recommending approval or disapproval of continuing education courses.
(4) **"Credit hour"** means at least fifty (50) minutes of classroom instruction, unless a correspondence or self-study course.
(5) **"Instructor"** means a person who presents course materials approved for continuing education credit hours, and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.
(6) **"Instructor Qualification Form"** means a form acceptable to the Commissioner and completed by the instructor which documents qualifications of the instructor.
(7) **"Licensee"** means a natural person who is licensed by the Commissioner as an insurance adjuster.
(8) **"Provider"** means a person, corporation, professional association or its local affiliates, an insurance company or any other entity which is approved by the Commissioner and provides approved continuing education to insurance adjusters.

(9) **"Provider Course Completion Form"** means a form acceptable to the Commissioner and completed by the provider which documents completion of an approved course by an adjuster or adjusters.

~~(c)~~ (b) **Exceptions.** Continuing education requirements shall not apply to non-resident adjusters licensed in a designated home state or resident state that has a continuing education requirement substantially similar to the continuing education requirement in the State of Oklahoma for adjusters.

~~(d)~~ (c) **Continuing education requirements.**

(1) **CE during twenty-four month period.** All licensees shall complete the required hours of continuing education as set forth in Section 6217(B) of Title 36 of the laws of this state during each twenty-four month period. The twenty-four month period begins the first day after the license is granted.

(2) **Certificates of course completion required for license renewal.** If requested by the Insurance Department, each adjuster shall submit upon each licensing renewal a certificate(s) of course completion as approved by the Insurance Department, which verifies courses completed during the previous twenty-four month period.

(3) **Credits carried over.** Six (6) credit hours in excess of the minimum twenty-four month period requirement shall carry forward to the next twenty-four month period as general hours. Excess hours may be applied to bring a lapsed license into compliance.

(4) **Legislative Updates.** At least two (2) of the continuing education credit hours of instruction completed by licensees each twenty-four month period shall be taken in the following topics:

(A) State legislative updates, or

(B) Federal legislative updates.

~~(5) **Earthquake insurance education.** Beginning January 1, 2015, all resident insurance adjuster licensees, or nonresident insurance adjusters who have designated Oklahoma as their home state, with a property line of authority shall complete one (1) hour of continuing education credit in the topic of earthquake insurance as part of the continuing education credit hours required each twenty-four month period.~~

~~(6)~~ (5) **Credits for instructors.** An instructor who is a licensee shall receive the same continuing education credit for presenting approved course materials as a licensee who attends an approved classroom instructional session by including his/her name and license number on roster.

~~(7)~~ (6) **Prerequisite for renewal or reinstatement.** As a prerequisite for license renewal or prior to reinstatement following a lapse of license, an adjuster must demonstrate that the educational requirements have been reported for the previous renewal cycle.

~~(e)~~ (d) **Approval of continuing education providers.**

(1) **Information required.** Each provider shall apply for approval by the Commissioner. Each provider, with the exception of public funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations, and Oklahoma state agencies shall submit a provider fee of Two Hundred Dollars ($200.00), and all providers, including public funded educational institutions, federal agencies, nonprofit organizations, not-for-profit organizations and Oklahoma agencies shall provide:

(A) Name, address, and email address of the provider.

(B) Contact person and his or her address and telephone number(s).

(2) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval of any provider for violation of or non-compliance with any provision of this section.

(3) **Renewal fee.** An annual renewal fee of Two Hundred Dollars ($200.00) shall be payable on or before the approval anniversary date of each year by each provider to renew the approval of the provider. A fee of double the annual renewal fee shall be paid if the application for renewal is late or incomplete on the approval anniversary date.

(4) **Reinstatement period.** Providers whose approval has expired may be reinstated pursuant to paragraph 1 of this subsection. The reinstatement period shall be for a period of one (1) year following the expiration of the renewal date. The approval of the provider and any currently active courses shall remain active for the reinstatement period. If the provider and all courses fail to remain active following the reinstatement period, the provider and courses shall not be reinstated and the provider and courses shall be required to be approved pursuant to the provisions of this subsection.

~~(f)~~ (e) **Courses; approval; records.**

(1) **Timeline for approval.** At least thirty (30) days prior to the use of any course and not less than ten (10) days prior to the Continuing Education Advisory Committee meeting immediately preceding the course date, the provider shall apply for and submit the appropriate course review fee to the Commissioner for course approval. The Commissioner shall grant or deny approval based upon information submitted in this section regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of CE hours awarded for an approved course and the line or lines of insurance for which the course qualifies. The provider shall submit the following at the time of application:

(A) The number of CE hours requested for each course.

(B) Topic outlines which list the summarized topics covered in each course and a copy of any course materials.

(C) If a prior approved course has materially changed, a summarization of those changes.

(2) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted. An instructor shall have one of the following qualifications:

(A) Three (3) years of recent experience in the subject area being taught; or

(B) A degree related to the subject area being taught; or

(C) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.

(3) **Repeated approved course.** At least fourteen (14) days prior to the repetition of an approved course, the Commissioner shall be notified in writing of the repetition, providing course number, name, date, location and instructor's name.

(4) **Written approval required.** All courses shall require written approval by the Commissioner.

(5) **Withheld or withdrawn approval.** The Commissioner may withhold or withdraw approval for any course. This withdrawal will not affect any CE hours attained under the course previous to the withdrawal.

(6) **Minimum of one credit hour.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.
(7) **Continuing education course must be separate from meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.
(8) **Content of courses.** Courses must be of a meaningful nature and shall not include the following subjects: motivation, psychology, recruiting, subjects not relating to the adjuster's license, and insurance company specific sales techniques or prospecting.
(9) **Certificate of Course Completion.** At the completion of each course, the provider shall provide the insurance adjuster a "Certificate of Course Completion" Form.
(10) **List of adjusters completing course to Commissioner.** Within ten (10) business days after completion of each course, the provider shall electronically upload a list of all insurance adjusters who completed the course to the Commissioner's database system. This list shall contain the course number, date of completion and license numbers of all insurance adjusters completing the course. If the list is not reported within ten (10) business days, a late report fee of fifty dollars $50.00 shall be paid to the Insurance Department. Failure to pay the late report fee may result in revocation of provider approval. Continued late filing may also result in loss of approval.
(11) **Course records maintained four (4) years.** Providers shall maintain course records for at least four (4) years. The Commissioner may order an examination of a provider, at the provider's expense, for good cause shown.
(12) **Course review fee.** A non-refundable course review fee of thirty dollars ($30.00) per course shall be submitted by all continuing education providers at the time the course submission is first submitted for review and upon submission for renewal at expiration with the exception of publicly funded educational institutions, federal agencies, Oklahoma state agencies, non-profit organizations, and not-for-profit organizations.
~~(13) **Course evaluation.** The continuing education provider shall provide written notification to each producer of the opportunity to offer comments on any continuing education class via the Insurance Department website.~~

~~(g)~~ (f) **Approved professional designation programs.**
(1) **Definitions.**
(A) **Participation.** As used in 36 O.S. § 6217(C), participates means successfully completing any part of a course curriculum totaling twenty-four (24) classroom or equivalent classroom hours of an approved professional designation program.
(B) **Approved professional designation program.** As used in 36 O.S. § 6217(C), an approved professional designation program means an educational insurance program approved by the Commissioner with a sponsoring organization that administers curriculum requirements and testing standards for candidates.
(2) **Requirements.** A professional designation program shall satisfy the following criteria to receive initial and ongoing approval for the program:
(A) The program shall have a sponsoring organization;
(B) The program's sponsoring organization shall maintain and govern a code of conduct;
(C) The program shall be relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma;

(D) Each course of the professional designation course curriculum shall be a minimum of twenty-four (24) hours of classroom instruction or equivalent classroom instruction; and

(E) The program shall include an examination requirement that students shall pass before earning the designation.

(3) **Submissions.** The sponsoring organization shall submit the following to the Commissioner for its professional designation program to be considered for initial and ongoing approval for the program:

(A) The sponsoring organization's code of conduct;

(B) The sponsoring organization's membership requirements;

(C) The professional designation program's course requirements; and

(D) The professional designation program's examination requirements.

(4) **Submission exemptions.** Professional designation programs recognized by the National Association of Insurance Commissioners (NAIC) for waiver/exemption of pre-licensing education training shall receive initial and continuing approval without submission by the sponsoring organization.

~~(h)~~ (g) **Presumptive continuing education credit approval.**

(1) **Requirements.** A professional association may receive presumptive approval of the association's continuing education courses by satisfying the following requirements:

(A) The association shall have a mission statement that includes a commitment to enhance the professional, educational, or ethical skills of its members;

(B) The association shall maintain and govern a code of member conduct;

(C) The association shall offer educational programs relevant to the sale, solicitation, or negotiation of insurance products in the State of Oklahoma; and

(D) The association shall perpetuate its continuity through the election of officers.

(2) **Submissions.** Each professional association shall submit the following to be considered for initial and ongoing presumptive course approval:

(A) The association's mission statement;

(B) The association's code of member conduct;

(C) The chapter officers, the responsibilities for each officer, and the term of office for each officer;

(D) The mailing address and primary contact for the association; and

(E) The list of continuing education courses approved in Oklahoma and offered by the professional association in the past twenty-four (24) months.

(3) **Notification of approval or disapproval.**

(A) The Commissioner shall notify the association within ninety (90) days from the receipt of submission whether presumptive approval for continuing education courses was granted. The notification shall indicate the reasons for disapproval.

(B) Submissions to the Commissioner by an association seeking presumptive approval of continuing education courses shall include the course summary, instructor name, course date and location and shall be submitted to the Commissioner at least fifteen (15) business days prior to the presentation of the course.

(C) If the Commissioner receives a report or reports that the content of a continuing education course may violate paragraph 365:25-3-1(f)(8) of

this section, the Commissioner may review the content and determine if the course should be disapproved for noncompliance. The Commissioner shall notify the association if the course has been disapproved due to non-compliance, and the association shall immediately cease offering the course upon receipt of the notification. The association may then make corrections to a disapproved course to bring the course into compliance with paragraph 365:25-3-1(f)(8) of this section and submit the course for approval by the Commissioner in the manner of an original submission for presumptive continuing education course approval.

(D) Should an association receive notification of three (3) disapproved courses within a twenty-four (24) month period, the association's presumptive approval for continuing education courses shall be rescinded for twenty-four (24) months after which time the association may re-apply for presumptive approval.

(4) **Assignment of course number.** The Commissioner shall assign a course number once the presumptive approval for continuing education courses has been granted and shall notify the association of the assigned course number. All future correspondence relating to that course shall reference the assigned course number.

(5) **Instructor approval.** Instructors shall be approved by the Commissioner at least fourteen (14) calendar days prior to a presentation of a course. The Commissioner may disapprove any course if instructor approval has not been granted.

(6) **Review.** Course approval shall be reviewed every three (3) years. The association shall re-submit the items required in subparagraph ~~365:25-3-14(H)(3)(B)~~ 365:25-3-14(g)(3)(B) of this section during the fourth quarter of the last approval year.

(7) **Agency management courses.** Agency management courses shall not be considered for presumptive continuing education approval.

~~(i)~~ (h) **Self study and distance learning courses.** The Insurance Commissioner shall determine appropriate guidelines and standards for self-study and distance learning CEC offerings. The guidelines and standards shall include authentication of the registered licensee, technology requirements for course delivery and testing protocols. Guidelines and standards shall be reviewed and updated as appropriate and published on the Commissioner's website annually. Failure to follow the guidelines and standards established by the Commissioner may result in denial of continuing education credit for the adjuster and revocation of the course approval and or provider status for the Provider.

~~(j)~~ (i) **Repeating courses.** An insurance adjuster may repeat a course within the twenty-four month period if the maximum credits designated for the course were not attained in the first attempt. By repeating the course, the adjuster may not during the twenty-four month period earn more than the maximum credits designated for the course. An adjuster may repeat a course after two (2) years have elapsed and receive the maximum credits designated for the course.

~~(k)~~ (j) **Extension of time.** For good cause shown, the Commissioner may grant an extension of time during which the requirements imposed by the act may be completed. The extension shall not exceed twelve (12) months. The extension will not alter the requirements or due date of the succeeding twelve-month period. "Good cause" includes disability, natural disaster, or other extenuating circumstances. Each request for extension of time shall be in writing from the licensee and shall include details and any documentation to support the request. Each request must be received by the Commissioner no less than thirty (30) days before the expiration of the twenty-four month period.

~~(l)~~ (k) **Continuing education advisory committee.**

(1) There shall hereby be established the Continuing Education Advisory Committee. This committee shall consist of representatives from the Licensing Division, and representatives from the industry as designated by the Commissioner. ~~Members of the Advisory Board established by 36 O.S. § 6221 may also serve on the Continuing Education Advisory Committee.~~ The committee shall meet at least quarterly and additionally as required. Members of the committee shall serve without pay and shall not be reimbursed for any expenses associated therewith.

(2) Prior to the Commissioner's approval or disapproval of a course in ~~365:25-3-14(f)~~ OAC 365:25-3-14(e), a continuing education advisory committee will review the course submitted and make its nonbinding recommendation to the Commissioner on granting or denying approval based upon information submitted in ~~365:25-3-14-(f)~~ OAC 365:25-3-14(e) regarding the course or additional information regarding the course, if necessary, the number of CE hours awarded for an approved course and the line or lines of insurance for which the course qualifies. Each course approval shall be valid for a period of not more than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course approval following the review of material changes shall reset the validity period. At the expiration of the validity period, providers shall submit the course for approval by the Commissioner if the provider wants to continue to offer the course for continuing education credit.

~~(m)~~ (l) **Severability provision.** If any provision of this section, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the section, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.

365:25-3-15. Variable product licensing

(a) Producers who wish to sell a variable life product shall have passed successfully the Oklahoma Life Insurance examination and shall provide proof of current FINRA registration with series 6 or 7 and series 63 or 66, or any other exam FINRA deems to be substantially equivalent that is approved by the Commissioner in his or her discretion.

(b) No test shall be required of an applicant for a variable annuity license if:

(1) The applicant provides proof of current FINRA registration with series 6 or 7 and series 63 or 66, or any other exam FINRA deems to be substantially equivalent that is approved by the Commissioner in his or her discretion, and

(2) The applicant shall pay an additional license fee as required by 36 O.S. § ~~1435.23(A)(4)(b)~~ 1435.23(A)(4)(c) with the submission of an application as prescribed by the Insurance Commissioner.

365:25-3-21. Training and education requirements for the sale of annuities

(a) Training and education requirements for producers who sell, solicit or negotiate annuities.

(1) An insurance producer shall not sell, solicit or negotiate the sale of an annuity product in this state unless the insurance producer has adequate knowledge of the product to recommend the annuity and the insurance producer is in compliance with the insurer's standards for product training. An insurance producer may rely on insurer-provided, product-specific training standards and materials to comply with this subsection.

(2) An insurance producer who engages in the sale, solicitation or negotiation of annuity products shall be licensed as a producer with a Life line of Authority and complete a one-time, four (4) hour credit training course as set forth in subsection (b). The course shall be approved by the Insurance Department and provided by an Insurance Department-approved education provider. The continuing education as required by this paragraph shall be applied as a continuing education course under Section 1435.29 of Title 36 of the Oklahoma Statutes.

(3) Insurance producers who currently hold a life insurance line of authority on the effective date of this regulation and who desire to sell annuities shall complete the training requirements of this subsection within twelve (12) months after July 14, 2010.

(4) Individuals who obtain a life insurance line of authority on or after the July 14, 2010 may not engage in the sale, solicitation or negotiation of annuities until the annuity training course required under subsection (a)(2) has been completed.

(b) Training education requirements.

(1) The minimum length of the training required under this subsection shall be sufficient to qualify for at least four (4) CE credit hours, but may be longer.

(2) The training required under this subsection shall include information on the following topics and any other topics approved and specified by the Insurance Commissioner:

(A) the types of annuities and various classifications of annuities,

(B) identification of the parties to an annuity,

(C) how fixed, variable and indexed annuity contract provisions affect consumers,

(D) the application of income taxation of qualified and non-qualified annuities,

(E) the primary uses of annuities, and

(F) appropriate standards of conduct, sales practices, replacement and disclosure requirements.

(3) Providers of courses intended to comply with this subsection shall cover all topics listed in the prescribed outline and shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

(4) Annuity training courses may be conducted and completed by classroom or self-study methods.

(c) Insurer requirements. An insurer shall verify that an insurance producer has completed the annuity training course required under this subsection before allowing the producer to sell an annuity product for that insurer. An insurer may satisfy its responsibility under this subsection by obtaining certificates of completion of the training course or obtaining reports provided by Commissioner-sponsored database systems or vendors or from a reasonably reliable commercial database vendor that has a reporting arrangement with approved insurance education providers.

(d) Training received in other states. The satisfaction of the training requirements of another state that are substantially similar to the provisions of this subsection shall be deemed to satisfy the training requirements of this subsection in this state.

SUBCHAPTER 5. BAIL BONDSMEN
PART 1. CONTINUING EDUCATION

365:25-5-2 Definitions

The following words or terms, when used in this Part shall have the following meaning, unless the context clearly indicates otherwise:

~~"Association" means the Oklahoma Bondsman Association.~~

"CEC" means continuing education credit.

"Certificate of course completion" means a document acceptable to the Commissioner and completed by the ~~Association~~ Course Provider, which signifies satisfactory completion of the course and reflects hours of credit earned.

"Clock hour" means credit hour.

"Course Provider" means a natural person, firm, institution of higher learning, partnership, company, corporation, society, or association offering, sponsoring, or providing courses approved by the Commissioner in eligible continuing education subjects.

"Credit hour" shall consist of at least a fifty (50) minute ~~classroom~~ instructional session unless a correspondence or self-study course.

"Education verification form" means a form acceptable to the Commissioner and completed by the licensee, which documents compliance with the pre-licensing or continuing education requirements.

"Instructor" means a person who presents course materials approved for pre-licensing or continuing education credit hours and who has experience, training, and/or education in the course subject matter and has been approved by the Commissioner.

"Licensee" means a natural person who is licensed by the Commissioner as a bail bondsman.

"Proof of completion" means the certificate of course completion and education verification forms.

365:25-5-4 Application for course approval

(a) ~~**Oklahoma Bondsman Association courses**~~ **Course Provider.** The ~~Oklahoma Bondsman Association~~ Course Provider shall apply for course approval from the Commissioner. The ~~Association~~ Course Provider shall submit a fee to the Insurance Commissioner as set forth in 59 O.S. § 1308.1.

(b) **Information regarding OBA courses.** The ~~Oklahoma Bondsman Association~~ Course Provider shall submit the following information concerning educational courses:

(1) Name, address and qualifications of the instructor;

(2) Contact person, his or her address and telephone number;

(3) The location of the courses or programs, unless it is an individual study or correspondence course;

(4) The number of hours requested for each course;

(5) Topic outlines which list the summarized topics covered in each course and upon request, a copy of any course materials. If a prior approved course has substantially changed, a summarization of those changes.

(c) **Instructor qualifications.** An instructor shall have one of the following qualifications:

(1) Three (3) years of recent experience in the subject area being taught; or

(2) A degree related to the subject area being taught; or

(3) Two (2) years of recent experience in the subject area being taught and twelve (12) hours of college and/or vocational technical school credit hours in the subject area being taught.

(d) **Losing course approval.** The Commissioner may withhold or withdraw approval of any instructor or course for violation of or non-compliance with any provision of this section.

(e) **Course approval expiration.** Each course approval shall be valid for a period of not more than two (2) years, unless the course has a material change. Material changes to courses require course resubmission for overall course review and approval. Course approval following the review of material changes shall reset the validity period. At the expiration of the validity period, providers shall submit the course for approval by the Commissioner if the provider wants to continue to offer the course for continuing education credit.

365:25-5-5 Approval or denial of course; certificate of completion

(a) **Approval required 30 days in advance.** At least thirty (30) days in advance of the presentation of any course, the ~~Association~~ Course Provider shall apply to the Commissioner for course approval. The Commissioner shall grant or deny approval based upon information submitted in 365:25-5-4 regarding each course or additional information regarding the course, if necessary. The Commissioner will assign the number of hours awarded for an approved course.

(b) **Written approval required.** All courses shall require written approval.

(c) **Approval withheld or withdrawn.** The Commissioner may withhold or withdraw approval for any course approval. This withdrawal will not affect any hours attained under the course.

(d) **Minimum one credit hour per course.** Courses submitted for approval must consist of a minimum of one credit hour of course instruction.

(e) **CEC separate component of meetings.** Courses conducted in conjunction with other meetings must have a separate continuing education course component.

(f) **Certificate of Course Completion.** At the completion of each course, whether continuing education or prelicensing, the ~~Association~~ Course Provider shall provide the bondsman with a "Certificate of Course Completion" form, which shall contain the verification of the ~~Association~~ Course Provider that the bondsman completed the course so certified.

(g) ~~OBA~~ **Course Provider supplies Commissioner with list of bondsmen completing course.** At the completion of each course, the ~~Association~~ Course Provider shall provide to the Commissioner a list of all bondsmen who completed the course.

(h) ~~OBA~~ **Course Provider records maintained 4 years**. The ~~Association~~ Course Provider shall maintain course records for at least four (4) years,

365:25-5-6 Proof of completion; video courses

(a) **Correspondence courses.** A bail bondsman who satisfactorily completes an approved course by correspondence and provides proof of satisfactory completion, as specified by the Commissioner, will receive credit for the number of hours assigned by the Commissioner for completion of the course.

(b) **Video courses.** In order for a bail bondsman to receive credit for viewing an approved course presented by electronic recording, the bondsman must view the electronic recording under the supervision of an approved instructor, or under the supervision of an individual approved by the ~~Oklahoma Bondsman Association,~~ Course Provider, and swear by affidavit he has viewed the electronic recording in its entirety. The affidavit must be submitted to the ~~Association~~ Course Provider.

365:25-5-9. Severability provision [REVOKED]

~~If any provision of this Part, or application of such provision to any person or circumstances, shall be held invalid, the remainder of the Part, and the application of such provision to person or circumstances other than those as to which it is held invalid, shall not be affected thereby.~~

PART 5. GENERAL PROVISIONS PERTAINING TO BAIL BONDSMEN

365:25-5-32. Examination fees [REVOKED]

~~A fee of One Hundred Dollars ($100.00) is required before an applicant may take the bail bondsman examination. An additional One Hundred Dollar ($100.00) examination fee is required for each subsequent examination as described in 59 O.S. § 1308.~~

365:25-5-38 Ten Defendant Limit [REVOKED]

~~Pursuant to 59 O.S. §1320, a bondsman is authorized to write bonds on up to ten defendants per year, January 1 through December 31, in each county outside his resident county. For purposes of determining the ten defendants, the bondsman shall consider each date a bond or bonds are written on a defendant as being one of the ten defendants, not withstanding any previous bonds which have been written on that same individual. The ten defendant limit does not apply in counties without a registered bondsman in said county.~~

PART 7. SPECIFIC FINANCIAL CIRCUMSTANCES WARRANTING RELEASE OF PROFESSIONAL DEPOSIT

365:25-5-50. Authority and scope [REVOKED]

~~This regulation is promulgated by the Insurance Commissioner pursuant to Section 1306(A)(5) of Title 59 of the laws of this state to describe the nature and scope of the specific financial circumstances warranting a release of a bail bondsman's professional deposit.~~

SUBCHAPTER 7. COMPANIES
PART 3. REDOMESTICATION

365:25-7-10. Purpose [REVOKED]

~~The purpose of this Part is to set forth the information which must be submitted to the Insurance Commissioner by a company organized under the laws of another state which desires to become a domestic company.~~

365:25-7-11. Application to become domestic insurer, form

An insurer organized under the laws of another state and admitted to do business in this state for the purpose of transacting insurance may make application to the Insurance Commissioner to become a domestic insurer. Such application, which shall be entitled **"Form" R** shall be filed ~~in triplicate~~ electronically, and shall contain information as set out in the items listed below:

(1) **Identity and background of the applicant.**

(A) State the name and address of the applicant seeking to redomesticate.

(B) State the nature of applicant's business operations for the past five years or for such lesser period as such applicant and any predecessors thereof shall have been in existence.

(C) Furnish a chart or listing clearly presenting the identities of the interrelationships among the applicant and all affiliates of the applicant. No affiliate need be identified if its total assets are equal to less than 1/2 of 1% of the total assets of the ultimate controlling person affiliated with the applicant. Also indicate in such chart or listing the following information:

(i) The percentage of ownership of each such person which is owned or controlled by the applicant or by any other such person.
(ii) If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control.
(iii) As to each person specified in such chart or listing, indicate the type of organization (e.g. corporation, trust, partnership);
(I) Describe the business it transacts; and
(II) List the state or other jurisdiction of domicile.
(iv) If court proceedings looking toward a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

(2) **Identity and background of individuals associated with the applicant.** Provide the following with respect to each director and officer of the applicant; each director and officer of applicant's control person or persons; and each owner of 10% or more of the voting securities of the applicant and applicant's control person or persons:

(A) Name and business address;
(B) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;
(C) Material occupations, positions, offices or employments during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required by or registration with any federal, state or municipal government agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith;
(D) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.
(E) Any other information as the Commissioner may deem necessary.

(3) **Future plans of insurer.**

(A) Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.
(B) Provide a three year plan of operation which shall include but not be limited to marketing strategies by state, premium projections by state, information concerning proposed home or regional office locations and employment impact in Oklahoma.

(4) **Regulatory history.**

(A) If any entities listed in 365:25-7-11(1)(c) are required to be licensed by or registered with any federal, state or municipal governmental agency indicate such fact, and indicate the current status of such licensure or registration, and provide an explanation of any surrender, revocation,

suspension or disciplinary proceedings in connection therewith having occurred during the preceding 5 years or which is currently pending.

(B) If the applicant is required to be licensed by or registered with any federal, state or municipal governmental agency indicate such fact, and indicate the current status of such licensure or registration, and provide an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith having occurred during the preceding years or which is currently pending.

(5) **Examination status.** Indicate the following:

(A) Whether the applicant's domiciliary state, or any other state or jurisdiction in which the applicant is transacting the business of insurance, is currently examining the applicant.

(B) Whether the applicant's domiciliary state, or any other state or jurisdiction in which the applicant is transacting the business of insurance has provided notice of intent to examine and if so provide an explanation regarding such proposed examination.

(C) Provide detail as to the nature and type of examination listed in (A) and (B) of this paragraph.

(6) **Rates and reserves.** Indicate the methodologies utilized by the applicant in establishing its insurance rates and reserves. Also, provide the names, addresses, and professional qualifications of the individuals responsible for these functions. Specify if the individuals are outside consultants or employees of the applicant.

(7) **Financial statements and other exhibits.**

(A) Financial statements and exhibits shall 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 following:

(i) Annual and quarterly financial statements of the applicant for the preceding five years.

(ii) Annual financial statements of the person or persons who control the applicant, pursuant to 36 O.S. 1981 Section 1651 (C) for the preceding three fiscal years (or for such lesser period as such person or persons and any predecessors thereof shall have been in existence), and similar information as of a date not earlier than ninety (90) days prior to the filing of the statement. Such financial statements need not be audited; except an audit may be required if the Commissioner determines an audit is necessary.

(C) File as exhibits copies of all proposed tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer or of any ultimate controlling party or parties and (if distributed) of additional soliciting material relating thereto:

(i) any proposed employment consultation, advisory or management contracts concerning the insurer;

(ii) annual reports to the stockholders of the insurer and the ultimate controlling party or parties for the last two fiscal years; and

(iii) any additional documents requested by the Commissioner.

(D) File as exhibits all examination reports, whether financial, organizational, market conduct or otherwise, issued within the past five (5) years by the applicant's domiciliary state, or any other state or jurisdiction in which the applicant transacts the business of insurance.

(E) File as exhibits copies of any documents relating to any final orders or agreements entered into between the applicant or its affiliate and any regulatory body as disclosed in (4) of this section.

(F) And any other information as the Commissioner may deem necessary.

(8) **Cover sheet.** The cover sheet of the Form R shall be as follows:

FORM R

OKLAHOMA REDOMESTICATION APPLICATION

Statement Regarding The Redomestication Of

_____

Name of Insurer

FILED WITH

_____INSURANCE COMMISSIONER~~–newline~~

FOR THE STATE OF OKLAHOMA

Dated:_____, 19__

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

_____

_____

_____

_____

PART 5. OKLAHOMA INSURANCE HOLDING COMPANY SYSTEM REGULATORY ACT

365:25-7-21. Severability provision [REVOKED]

~~If any provision of this Part, or the application thereof to any person or circumstances, is held invalid, such invalidity shall not affect other provisions or applications of this Part which can be given effect without the invalid provision or application, and to that end the provisions of this Part are severable.~~

365:25-7-23. Forms: general requirements

(a) **Forms A, B, C, D, E, and F.** Forms A, B, C, D, E, and F as set forth in Appendices A, B, N, O, Q, and AA of this Chapter, are intended to be guides in the preparation of the statements required by Sections 1633, 1635 and 1636 of the Act. They are not intended to be blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable, or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(b) **Filing statements.** ~~Two (2) complete copies of each statement, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery to the Oklahoma Insurance Department in Oklahoma City, Oklahoma, or by mail addressed to the Insurance Commissioner of the State of Oklahoma, 400 N.E. 50th Street, Oklahoma City, OK 73105.~~ Statements shall be filed

electronically. Third-party verifications sent by the third party may be filed electronically. A copy of a Form B and C shall be filed in each state in which an insurer is authorized to do business, if the Commissioner of that state has notified the insurer of its request in writing, in which case the insurer has thirty (30) days from receipt of the notice to file such form. ~~At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed.~~ Appropriate electronic signatures are permitted. The Commissioner may request a wet signature at his or her discretion. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

(c) **Format of statements.** ~~Statements should be prepared on paper 8 1/2" x 11" in size and preferably bound at the top or the top left hand corner.~~Electronic statements shall meet all technical requirements of the Commissioner. ~~Exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size.~~ All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for reproduction~~photocopying~~. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on ~~photo~~copies. Statements shall be in the English language, and monetary values shall be stated in United States Currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency normally shall be converted into Unites States Currency.

PART 7. COMPANIES IN HAZARDOUS FINANCIAL CONDITION

365:25-7-40. Authority [REVOKED]

~~This part is adopted and promulgated by the Oklahoma Insurance Commissioner pursuant to Section 307.1, 1801, et seq. and Section 1901, et seq., of Title 36 of the Oklahoma Statutes.~~

365:25-7-45. Separability [REVOKED]

~~If any provisions of this part be held invalid, the remainder shall not be affected.~~

PART 11. CREDIT FOR REINSURANCE

365:25-7-65. Credit for reinsurance - Reinsurers maintaining trust funds

(a) Pursuant to Section 5122(E) of the Act, the Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in Section 5123.1(B) of the Act for the payment of the valid claims of its United States domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the Commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the Commissioner to determine the sufficiency of the trust fund.

(b) The following requirements apply to the following categories of assuming insurer:

(1) **Trust fund for a single assuming insurer.** The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by U.S. domiciled

insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in paragraph (2) of this subsection.

(2) **Reduction in required trusteed surplus.** At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of U.S. ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent (30%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers covered by the trust.

(3) **Trust fund for a group including incorporated and individual unincorporated underwriters.**

(A) The trust fund for a group including incorporated and individual unincorporated underwriters shall consist of:

(i) For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, funds in trust in an amount not less than the group's several liabilities attributable to business ceded by U.S. domiciled ceding insurers to any ~~member~~ underwriter of the group;

(ii) For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of this regulation, funds in trust in an amount not less than the ~~group's~~ respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

(iii) In addition to these trusts, the group shall maintain a trusteed surplus of which $100,000,000 shall be held jointly for the benefit of the U.S. domiciled ceding insurers of any member of the group for all the years of account.

(B) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members. The group shall, within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, provide to the Commissioner:

(i) An annual certification by the group's domiciliary regulator of the solvency of each underwriter member of the group; or

(ii) If a certification is unavailable, a financial statement, prepared by independent public ~~accounts~~ accountants, of each underwriter member of the group.

(4) **Trust fund for a group of incorporated insurers under common administration.**

(A) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (calculated and reported in substantially the same manner

as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the National Association of Insurance Commissioners) and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall:

(i) Consist of funds in trust in an amount not less than the assuming insurers' several liabilities attributable to business ceded by United States domiciled ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group;

(ii) Maintain a joint trusteed surplus of which $100,000,000 shall be held jointly for the benefit of United States domiciled ceding insurers of any member of the group; and

(iii) File a properly executed Form AR-1 as evidence of the submission to this state's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination.

(B) Within ninety (90) days after the statements are due to be filed with the group's domiciliary regulator, the group shall file with the Commissioner an annual certification of each underwriter member's solvency by the members' domiciliary regulators and financial statements, prepared by independent public accountants, of each underwriter member.

(c) Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the Commissioner of the state where the trust is domiciled or the Commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the Commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that:

(1) Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied thirty (30) days after entry of the final order of any court of competent jurisdiction in the United States.

(2) Legal title to the assets of the trust shall be vested in the trustee for the benefit of the grantor's United States ceding insurers, their assigns and successors in interest.

(3) The trust shall be subject to examination as determined by the Commissioner.

(4) The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations under reinsurance agreements subject to the trust; and

(5) No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing setting forth the balance in the trust and listing the trust's investments at the preceding year end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

(d) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this section or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the Commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the Commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

(1) The assets shall be distributed by and claims shall be filed with and valued by the Commissioner with regulatory oversight over the trust in accordance with the laws of the state in which the trust is domiciled applicable to the liquidation of domestic insurance companies.

(2) If the Commissioner with regulatory oversight over the trust determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the U.S. beneficiaries of the trust, the Commissioner with regulatory oversight over the trust shall return the assets, or any part thereof, to the trustee for distribution in accordance with the trust agreement.

(3) The grantor shall waive any right otherwise available to it under U.S. law that is inconsistent with this provision.

(e) For purposes of this regulation, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers that are not otherwise secured by acceptable means, and, shall include:

(1) For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance:

(A) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer;

(B) Reserves for losses reported and outstanding;

(C) Reserves for losses incurred but not reported;

(D) Reserves for allocated loss expenses; and

(E) Unearned premiums.

(2) For business ceded by domestic insurers authorized to write life, health and annuity insurance:

(A) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums;

(B) Aggregate reserves for accident and health policies;

(C) Deposit funds and other liabilities without life or disability contingencies; and

(D) Liabilities for policy and contract claims.

(f) Assets deposited in trusts pursuant to 36 O.S. § 5122 and this Section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in 36 O.S. § 5123.1(A), clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in 36 O.S. § 5123.1(A), and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under Paragraphs (1)(E), (3), (6)(B) or (7) of this subsection, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Section 5122 shall be invested only as follows:

(1) Government obligations that are not in default as to principal or interest, that are valid and legally authorized and that are issued, assumed or guaranteed by:

(A) The United States or by any agency or instrumentality of the United States;

(B) A state of the United States;

(C) A territory, possession or other governmental unit of the United States;
(D) An agency or instrumentality of a governmental unit referred to in Subparagraphs (B) and (C) of this paragraph if the obligations shall be by law (statutory ~~of~~ or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or
(E) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(2) Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:
(A) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;
(B) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or
(C) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

(3) Obligations issued, assumed or guaranteed by a solvent non-U.S. institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of U.S. corporations issued in a non-U.S. currency, provided that in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(4) An investment made pursuant to the provisions of Paragraph (1), (2) or (3) of this subsection shall be subject to the following additional limitations:
(A) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;
(B) An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;
(C) The aggregate total investment in mortgage-related securities shall not exceed twenty- five percent (25%) of the assets of the trust; and
(D) Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under Paragraphs (2)(A) and (2)(C) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

(5) As used in this regulation:

(A) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that either:

(i) Represents ownership of one or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under, the notes, certificates or participation), that:

(I) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 U.S.C.~~A.~~ Section 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located; and

(II) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.~~A.~~ Sections 1709 and 1715-b, or, where the notes involve a lien on the manufactured home, by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 U.S.C.~~A.~~ Section 1703; or

(ii) Is secured by one or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of Items (i) (I) and (i)(II) of this subsection.

(B) "Promissory note," when used in connection with a manufactured home, shall also include a loan, advance or credit sale as evidenced by a retail installment sales contract or other instrument.

(6) Equity interests.

(A) Investments in common shares or partnership interests of a solvent U.S. institution are permissible if:

(i) Its obligations and preferred shares, if any, are eligible as investments under this subsection; and

(ii) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the Securities Exchange Act of 1934, 15 U.S.C. §§ 78a to 78kk or otherwise registered pursuant to that Act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the ~~National Association of Securities Dealers, Inc~~ Financial Industry Regulatory Authority, or successor organization. A trust shall not invest in equity interests under this paragraph an amount exceeding one percent (1%) of the assets of the trust even though

the equity interests are not so registered and are not issued by an insurance company;

(B) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development, if:

(i) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC; and

(ii) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development;

(C) An investment in or loan upon any one institution's outstanding equity interests shall not exceed one percent (1%) of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, shall not exceed ten percent (10%) of the assets in the trust;

(7) Obligations issued, assumed or guaranteed by a multinational development bank, provided the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(8) Investment companies.

(A) Securities of an investment company registered pursuant to the Investment Company Act of 1940, 15 U.S.C. § ~~802~~ 80a, are permissible investments if the investment company:

(i) Invests at least ninety percent (90%) of its assets in the types of securities that qualify as an investment under Paragraph (1), (2) or (3) of this subsection or invests in securities that are determined by the Commissioner to be substantively similar tothe types of securities set forth in Paragraph (1), (2) or (3) of this subsection; or

(ii) Invests at least ninety percent (90%) of its assets in the types of equity interests that qualify as an investment under Paragraph (6)(A) of this subsection;

(B) Investments made by a trust in investment companies under this paragraph shall not exceed the following limitations:

(i) An investment in an investment company qualifying under Subparagraph (A)(i) of this paragraph shall not exceed ten percent (10%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall not exceed twenty-five percent (25%) of the assets in the trust; and

(ii) Investments in an investment company qualifying under Subparagraph (A)(ii) of this paragraph shall not exceed five percent (5%) of the assets in the trust and the aggregate amount of investment in qualifying investment companies shall be included when calculating the permissible aggregate value of equity interests pursuant to Paragraph (6)(A) of this subsection;

(9) Letters of Credit.

(A) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Commissioner), to immediately draw down the full amount of the letter of credit and hold

the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(B) The trust agreement shall provide that the trustee shall be liable for its negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

(g) A specific security provided to a ceding insurer by an assuming insurer pursuant to OAC 365:25-7-67 shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section.

365:25-7-66. Credit for reinsurance required by law

Pursuant to Section 5122~~(G)~~ (H) of the Act, the Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 5122(B), (C), (D), (E), ~~or~~ (F), (G) or other appropriate section of the Credit for Reinsurance Act but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means state, district or territory of the United States and any lawful national government.

365:25-7-67. Asset or reduction from liability for reinsurance ceded to an unauthorized assuming insurer not meeting the requirements of 365:25-7-62 through 66 and 365:25-7-73 through 74

(a) Pursuant to Section 5123, the Commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 5122 or other appropriate section of the Credit for Reinsurance Act in an amount not exceeding the liabilities carried by the ceding insurer. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. The security shall be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in Section 5123.1(B) of the Act. This security may be in the form of any of the following:

(1) Cash;

(2) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(3) Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in Section 5123.1(A), effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding ~~company~~ insurer on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(4) Any other form of security acceptable to the Commissioner.

(b) An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to OAC 365:25-7-67~~(a)(1) and (2)~~ shall be allowed only when the requirements of OAC 365:25-7-70 and the applicable portions of Sections 365:25-7-68, 365:25-7-69 or 365:25-7-72 are met.

365:25-7-68. Trust agreements qualified under Section 365:25-7-67

(a) **Definitions.** As used in this section:

(1) "Beneficiary" means the entity for whose sole benefit the trust has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

(2) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

(3) "Obligations," as used in paragraph (b)(11) of this section, means:

(A) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

(B) Reserves for reinsured losses reported and outstanding;

(C) Reserves for reinsured losses incurred but not reported; and

(D) Reserves for allocated reinsured loss expenses and unearned premiums.

(b) **Required conditions.**

(1) The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in Section 5123.1(B) of the Act.

(2) The trust agreement shall create a trust account into which assets shall be deposited.

(3) All assets in the trust account shall be held by the trustee at the trustee's office in the United States.

(4) The trust agreement shall provide that:

(A) The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee;

(B) No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets; (C) It is not subject to any conditions or qualifications outside of the trust agreement; and (D) It shall not contain references to any other agreements or documents except as provided for under ~~paragraph~~ paragraphs (b)(11) ~~or~~ and (b)(12) of this section.

(5) The trust agreement shall be established for the sole benefit of the beneficiary.

(6) The trust agreement shall require the trustee to:

(A) Receive assets and hold all assets in a safe place;

(B) Determine that all assets are in such form that the beneficiary, or the trustee upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

(C) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

(D) Notify the grantor and the beneficiary within ten (10) days, of any deposits to or withdrawals from the trust account;

(E) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

(F) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

(7) The trust agreement shall provide that at least thirty (30) days, but not more than forty-five (45) days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

(8) The trust agreement shall be made subject to and governed by the laws of the state in which the trust is domiciled.

(9) The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee. In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the Commissioner), to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(10) The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith. The failure of the trustee to draw against the letter of credit incircumstances where such draw would be required shall be deemed to be negligence and/or willful misconduct.

(11) Notwithstanding other provisions of this part, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(A) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

(B) To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

(C) Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in Section 5123.1(B) of the Act apart from its general assets, in trust for such uses and purposes specified in subparagraphs

(b)(11)(A) and (B) of this section as may remain executory after such withdrawal and for any period after the termination date.

(12) Notwithstanding other provisions of this regulation, when a trust agreement is established to meet the requirements of Section 365:25-7-67 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

(A) To pay or reimburse the ceding insurer for:

(i) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies, and

(ii) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement;

(B) To pay to the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer; or

(C) Where the ceding insurer has received notification of termination of the trust and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified U.S. financial institution apart from its general assets, in trust for the uses and purposes specified in Subparagraphs (A) and (B) of this paragraph as may remain executory after withdrawal and for any period after the termination date.

(13) Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash in United States dollars, certificates of deposit issued by a United States bank and payable in United States dollars, and investments permitted by Title 36 of the Oklahoma Statutes or any combination of the above, provided investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust shall not exceed five percent (5%) of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities or accident and health risks, then the provisions required by this paragraph must be included in the reinsurance agreement.

(c) **Permitted conditions.**

(1) The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary

receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(2) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends shall be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(3) The trustee may be given authority to invest, and accept substitutions of, any funds in the account, provided that no investment or substitution shall be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in current fair market value to the assets withdrawn and that are consistent with the restrictions in subparagraph (d)(1)(B) of this section.

(4) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets.

(5) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(d) **Additional conditions applicable to reinsurance agreements.**

(1) A reinsurance agreement may contain provisions that:

(A) Require the assuming insurer to enter into a trust agreement and to establish a trust account for the benefit of the ceding insurer, and specifying what the agreement is to cover;

(B) Require the assuming insurer, prior to depositing assets with the trustee, to execute assignments or endorsements in blank, or to transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may whenever necessary negotiate these assets without consent or signature from the assuming insurer or any other entity;

(C) Require that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent; and

(D) Stipulate that the assuming insurer and the ceding insurer agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for the following purposes:

(i) To pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(II) The assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(ii) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) The reinsurance agreement may also contain provisions that:

(A) Give the assuming insurer the right to seek approval from the ceding insurer, which shall not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, provided:

(i) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a current fair market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount, or

(ii) After withdrawal and transfer, the current fair market value of the trust account is no less than 102 percent of the required amount.

(B) Provide for the return of any amount withdrawn in excess of the actual amounts required for (d)(1)(D) of this section, and for interest payments at a rate not in excess of the prime rate of interest on such amounts.

(C) Permit the award by any arbitration panel or court of competent jurisdiction of:

(i) Interest at a rate different from that provided in (d)(2)(B)~~(ii)~~ of this section,

(ii) Court of arbitration costs,

(iii) Attorney's fees, and

(iv) Any other reasonable expenses.

(3) Financial reporting**.** A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this part when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Existing agreements**.** Notwithstanding the effective date of this part, any trust agreement or underlying reinsurance agreement in existence prior to the effective date of this rule will continue to be acceptable until at which time the agreements will have to fully comply with this part for the trust agreement to be acceptable.

(5) Trust agreement beneficiary. The failure of any trust agreement to specifically identify the beneficiary as defined in (a) of this section shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this state.

365:25-7-70. Reinsurance contract

Credit will not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements

of OAC 365:25-7-62, 365:25-7-63, 365:25-7-64, 365:25-7-65, 365:25-7-67, ~~or~~ 365:25-7-73, or 365:25-7-74 or otherwise in compliance with Section 5122 of the Act after the adoption of this part unless the reinsurance agreement:

(1) Includes a proper insolvency clause, which states that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to Section 711 of the Insurance Code; and

(2) Includes a provision pursuant to Section 5122~~(H)~~ of the Act whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel; and

(3) Includes a proper reinsurance intermediary clause, if applicable, which stipulates that the credit risk for the intermediary is carried by the assuming insurer.

365:25-7-72. Letters of credit qualified under 365:25-7-67

(a) The letter of credit must be clean, irrevocable, unconditional and issued or confirmed by a qualified United States institution as defined in Section 5123.1(A) of the Act. The letter of credit shall contain an issue date and expiration date and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit also shall indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in ~~(i)~~(h)(1) of this section. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

(b) The heading of the letter of credit may include a boxed section containing the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" shall provide for a period of no less than thirty (30) days' notice prior to expiration date or nonrenewal.

(e) The letter of credit shall state whether it is subject to and governed by the laws of this state or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

(f) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, then the letter of credit shall

specifically address and provide for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600, or any other successor publication, occur.

(g) If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in (a) of this section, then the following additional requirements shall be met:

(1) The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

(2) The "evergreen clause" shall provide for thirty (30) days' notice prior to expiration date for nonrenewal.

(h) **Reinsurance agreement provisions.**

(1) The reinsurance agreement in conjunction with which the letter of credit is obtained may contain provisions that:

(A) Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover;

(B) Stipulate that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

(i) To pay or reimburse the ceding insurer for:

(I) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

(II) The assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement; and

(III) Any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer;

(ii) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the specific reinsurance remain unliquidated and undischarged ten (10) days prior to the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified U.S. financial institution apart from its general assets, in trust for such uses and purposes specified in (h)(1)(B)(i) of this section as may remain after withdrawal and for any period after the termination date.

(C) All of the provisions of (h)(1) of this section shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

(2) Nothing contained in (h)(1) of this section shall preclude the ceding insurer and assuming insurer from providing for:

(A) An interest payment, at a rate not in excess of the prime rate of interest, on the amounts hold pursuant to (h)(1)(B) of this section; or

(B) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or any amounts that are subsequently determined not to be due.

365:25-7-73. Credit for reinsurance - certified reinsurers

(a) Pursuant to 36 O.S. § 5122(F), the Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the Commissioner. The security shall be in a form consistent with the provisions of Sections 5122(F) and 5123 of the Act and OAC 365:25-7-68, 365:25-7-69 or 365:25-7-72. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

(1) Assuming insurer ratings and security requirements.

(A) Secure - 1: 0% security required

(B) Secure - 2: 10% security required

(C) Secure - 3: 20% security required

(D) Secure - 4: 50% security required

(E) Secure - 5: 75% security required

(F) Vulnerable - 6: 100% security required

(2) Affiliated reinsurance transactions shall receive the same opportunity for reduced security requirements as all other reinsurance transactions.

(3) The Commissioner shall require the certified reinsurer to post one hundred percent (100%), for the benefit of the ceding insurer or its estate, security upon the entry of an order of rehabilitation, liquidation or conservation against the ceding insurer.

(4) In order to facilitate the prompt payment of claims, a certified reinsurer shall not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the Commissioner. The one year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(A) Line 1: Fire

(B) Line 2: Allied Lines

(C) Line 3: Farmowners multiple peril

(D) Line 4: Homeowners multiple peril

(E) Line 5: Commercial multiple peril

(F) Line 9: Inland Marine

(G) Line 12: Earthquake

(H) Line 21: Auto physical damage

(5) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after

the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(6) Nothing in this section shall prohibit the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this section.

(b) The procedure for certification of a reinsurer shall be as follows:

(1) The Commissioner shall post notice on the Oklahoma Insurance Department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The Commissioner may not take final action on the application until at least thirty (30) days after posting the notice required by this paragraph.

(2) The Commissioner shall issue written notice to an assuming insurer that has made application and been approved as a certified reinsurer. Included in such notice shall be the rating assigned the certified reinsurer in accordance with (a) of this section. The Commissioner shall publish a list of all certified reinsurers and their ratings.

(3) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

(A) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a Qualified Jurisdiction, as determined by the Commissioner pursuant to (c) of this section.

(B) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with (b)(4)(H) of this section. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

(C) The assuming insurer must maintain financial strength ratings from two or more rating agencies deemed acceptable by the Commissioner. These ratings shall be based on interactive communication between the rating agency and the assuming insurer and shall not be based solely on publicly available information. These financial strength ratings will be one factor used by the Commissioner in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include the following:

(i) Standard & Poor's;

(ii) Moody's Investors Service;

(iii) Fitch Ratings;

(iv) A.M. Best Company; or

(v) Any other nationally recognized statistical rating organization.

(D) The certified reinsurer must comply with any other requirements reasonably imposed by the Commissioner.

(4) Each certified reinsurer shall be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, the following:

(A) The certified reinsurer's financial strength rating from an acceptable rating agency. The Commissioner shall use the lowest financial strength

rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as follows:

(i) Secure - 1 rating:
(I) A.M. Best Company = A++
(II) Standard & Poor's = AAA
(III) Moody's Investor Service = Aaa
(IV) Fitch Ratings = AAA

(ii)Secure - 2 rating:
(I) A.M. Best Company = A+
(II) Standard & Poor's = AA+, AA, or AA-
(III) Moody's Investor Service = Aa1, Aa2, or Aa3
(IV) Fitch Ratings = AA+, AA, or AA-

(iii) Secure - 3 rating:
(I) A.M. Best Company = A
(II) Standard & Poor's = A+ or A
(III) Moody's Investor Service = A1 or A2
(IV) Fitch Ratings = A+ or A

(iv) Secure - 4 rating:
(I) A.M. Best Company = A-
(II) Standard & Poor's = A-
(III) Moody's Investor Service = A3
(IV) Fitch Ratings = A-

(v) Secure - 5 rating:
(I) A.M. Best Company = B++ or B+
(II) Standard & Poor's = BBB+, BBB, or BBB-
(III) Moody's Investor Service = Baa1, Baa2, or Baa3
(IV) Fitch Ratings = BBB+, BBB, or BBB-

(vi) Vulnerable - 6 rating:
(I) A.M. Best Company = B, B-, C++, C+, C, C-, D, E, or F
(II) Standard & Poor's = BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, or R
(III) Moody's Investor Service = Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, or C
(IV) Fitch Ratings = BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, or DD.

(B) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations;

(C) For certified reinsurers domiciled in the U.S., a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/ casualty reinsurers) or Schedule S (for life and health reinsurers);

(D) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property and casualty reinsurers; attached to this Chapter as Appendix DD) or Form CR-S (for life and health reinsurers; attached to this Chapter as Appendix EE);

(E) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurer's Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are

in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(F) Regulatory actions against the certified reinsurer;

(G) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in (b)(4)(H) of this section;

(H) For certified reinsurers not domiciled in the U.S., audited financial statements ~~(audited U.S. GAAP basis if available; audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the Commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company)~~, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the Commissioner shall consider audited financial statements for the last ~~three (3)~~ two (2) years filed with its non-U.S. jurisdiction supervisor;

(I) The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding;

(J) A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, which involves U.S. ceding insurers. The Commissioner shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement; and

(K) Any other information deemed relevant by the Commissioner.

(5) Based on the analysis conducted under (b)(4)(E) of this section of a certified reinsurer's reputation for prompt payment of claims, the Commissioner may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to U.S. ceding insurers, provided that the Commissioner shall, at a minimum, increase the security the certified reinsurer is required to post by one rating level under (b)(4)(A) of this section if the Commissioner finds that:

(A) more than fifteen percent (15%) of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of ninety (90) days or more which are not in dispute and which exceed $100,000 for each cedent; or

(B) the aggregate amount of reinsurance recoverables on paid losses which are not in dispute that are overdue by ninety (90) days or more exceeds $50,000,000.

(6) The assuming insurer must submit a properly executed Form CR-1 (attached to this Chapter as Appendix CC) as evidence of its submission to the jurisdiction of this state, appointment of the Commissioner as an agent for service of process in this state, and agree to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists enforcement of a final U.S. judgment. The Commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the Commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(7) The certified reinsurer must agree to meet applicable information filing requirements as determined by the Commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under the Oklahoma Open Records Act, 51 O.S.

§ 24A.1, *et seq.*, and shall be withheld from public disclosure. The applicable information filing requirements are as follows:

(A) Notification within ten (10) days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license, or any change in rating by an approved rating agency, including a statement describing such changes and the reasons therefore;

(B) Annually, Form CR-F (attached to this Chapter as Appendix DD) or CR-S (attached to this Chapter as Appendix EE), as applicable;

(C) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in (b)(7)(D) of this section;

(D) Annually, the most recent audited financial statements ~~(audited U.S. GAAP basis if available; audited IFRS basis statements are allowed but must include an audited footnote reconciling equity and net income to a U.S. GAAP basis, or, with the permission of the state insurance Commissioner, audited IFRS statements with reconciliation to U.S. GAAP certified by an officer of the company)~~, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last ~~three (3)~~ two (2) years filed with the certified reinsurer's supervisor;

(E) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers;

(F) A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level; and

(G) Any other information that the Commissioner may reasonably require.

(8) If a certified reinsurer has a change in rating, the procedure shall be as follows:

(A) In the case of a downgrade by a rating agency or other disqualifying circumstance, the Commissioner shall upon written notice assign a new rating to the certified reinsurer in accordance with the requirements of (b)(4)(A) of this section.

(B) The Commissioner shall have the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this section, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the Commissioner to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.

(C) If the rating of a certified reinsurer is upgraded by the Commissioner, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the Commissioner shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the Commissioner, the Commissioner shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.

(D) Upon revocation of the certification of a certified reinsurer by the Commissioner, the assuming insurer shall be required to post security in accordance with OAC 365:25-7-67 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with OAC 365:25-7-65, the

Commissioner may allow additional credit equal to the ceding insurer's *pro rata* share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the Commissioner to be at high risk of uncollectibility.

(c) The procedure for determining if a jurisdiction is a qualified jurisdiction shall be as follows:

(1) If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the Commissioner determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the Commissioner shall publish notice and evidence of such recognition in an appropriate manner. The Commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

(2) In order to determine whether the domiciliary jurisdiction of a non-U.S. assuming insurer is eligible to be recognized as a qualified jurisdiction, the Commissioner shall evaluate the reinsurance supervisory system of the non-U.S. jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-U.S. jurisdiction to reinsurers licensed and domiciled in the U.S. The Commissioner shall determine the appropriate approach for evaluating the qualifications of such jurisdictions, and create and publish a list of jurisdictions whose reinsurers may be approved by the Commissioner as eligible for certification. A qualified jurisdiction shall agree to share information and cooperate with the Commissioner with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the Commissioner, include but are not limited to the following:

(A) The framework under which the assuming insurer is regulated.

(B) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.

(C) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.

(D) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.

(E) The domiciliary regulator's willingness to cooperate with U.S. regulators in general and the Commissioner in particular.

(F) The history of performance by assuming insurers in the domiciliary jurisdiction.

(G) Any documented evidence of substantial problems with the enforcement of final U.S. judgments in the domiciliary jurisdiction. A jurisdiction will not be considered to be a qualified jurisdiction if the Commissioner has determined that it does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(H) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or a successor organization.

(I) Any other matters deemed relevant by the Commissioner.

(3) The Commissioner shall consider the list of qualified jurisdictions published through the NAIC Committee Process in determining qualified jurisdictions. If the Commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the Commissioner shall provide thoroughly documented justification with respect to the criteria provided under (c)(2)(A) through (I) of this section.

(4) U.S. jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program shall be recognized as qualified jurisdictions.

(d) The Commissioner may recognize a reinsurer's certification in another NAIC accredited jurisdiction according to the following:

(1) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the Commissioner has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed Form CR-1 and such additional information as the Commissioner requires. The assuming insurer shall be considered to be a certified reinsurer in this State.

(2) Any change in the certified reinsurer's status or rating in the other jurisdiction shall apply automatically in this State as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the Commissioner of any change in its status or rating within ten (10) days after receiving notice of the change.

(3) The Commissioner may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating in accordance with (b)(8) of this section.

(4) The Commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the Commissioner suspends or revokes the certified reinsurer's certification in accordance with (b)(8) of this section, the certified reinsurer's certification shall remain in good standing in this State for a period of three (3) months, which shall be extended if additional time is necessary to consider the assuming insurer's application for certification in this State.

(e) In addition to the clauses required under OAC 365:25-7-70, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

(f) The Commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

365:25-7-74. Credit for Reinsurance—Reciprocal Jurisdictions

(a) Pursuant to 36 O.S. § 5122(G), the Commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a Reciprocal Jurisdiction, and which meets the other requirements of this regulation.

(b) A "Reciprocal Jurisdiction" is a jurisdiction, as designated by the Commissioner pursuant to Subsection (d), that meets one of the following:

(1) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a "covered

agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

(2) A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

(3) A qualified jurisdiction, as determined by the Commissioner pursuant to 36 O.S. § 5122(F)(3) and OAC 365:25-7-73(c), which is not otherwise described in Paragraph (1) or (2) above and which the Commissioner determines meets all of the following additional requirements:

(A) Provides that an insurer which has its head office or is domiciled in such qualified jurisdiction shall receive credit for reinsurance ceded to a U.S. domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in such qualified jurisdiction;

(B) Does not require a U.S.-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-U.S. jurisdiction or as a condition to allow the ceding insurer to recognize credit for such reinsurance;

(C) Recognizes the U.S. state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in such qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the Commissioner or the Commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction; and

(D) Provides written confirmation by a competent regulatory authority in such qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, shall be provided to the Commissioner in accordance with a memorandum of understanding or similar document between the Commissioner and such qualified jurisdiction, including but not limited to the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

(c) Credit shall be allowed when the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting each of the conditions set forth below.

(1) The assuming insurer must be licensed to transact reinsurance by, and have its head office or be domiciled in, a Reciprocal Jurisdiction.

(2) The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the

Reciprocal Jurisdiction, and confirmed as set forth in Subsection (c)(7) according to the methodology of its domiciliary jurisdiction, in the following amounts:

(A) No less than $250,000,000; or

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters:

(i) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000; and

(ii) A central fund containing a balance of the equivalent of at least $250,000,000

(3) The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

(A) If the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in Subsection (b)(1), the ratio specified in the applicable covered agreement;

(B) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Subsection (b)(2), a risk-based capital (RBC) ratio of three hundred percent (300%) of the authorized control level, calculated in accordance with the formula developed by the NAIC; or

(C) If the assuming insurer is domiciled in a Reciprocal Jurisdiction as defined in Subsection (b)(3), after consultation with the Reciprocal Jurisdiction and considering any recommendations published through the NAIC Committee Process, such solvency or capital ratio as the Commissioner determines to be an effective measure of solvency.

(4) The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (as published on the Department's website), of its agreement to the following:

(A) The assuming insurer must agree to provide prompt written notice and explanation to the Commissioner if it falls below the minimum requirements set forth in Paragraphs (2) or (3) of this subsection, or if any regulatory action is taken against it for serious noncompliance with applicable law.

(B) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the Commissioner as agent for service of process.

(i) The Commissioner may also require that such consent be provided and included in each reinsurance agreement under the Commissioner's jurisdiction.

(ii) Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

(C) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

(D) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

(E) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the Commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of 36 O.S. §§ 5122(F) and 5123 and Sections 365:25-7-68, 365:25-7-69 and 365:25-7-72 of this Regulation. For purposes of this Regulation, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

(F) The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in Paragraph (5) of this subsection.

(5) The assuming insurer or its legal successor must provide, if requested by the Commissioner, on behalf of itself and any legal predecessors, the following documentation to the Commissioner:

(A) For the two (2) years preceding entry into the reinsurance agreement and on an annual basis thereafter, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report;

(B) For the two (2) years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion, if filed with the assuming insurer's supervisor;

(C) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, an updated list of all disputed and overdue reinsurance claims outstanding for ninety (90) days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States; and

(D) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming

insurer to allow for the evaluation of the criteria set forth in Paragraph (6) of this subsection.

(6) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. The lack of prompt payment will be evidenced if any of the following criteria is met:

(A) More than fifteen percent (15%) of the reinsurance recoverables from the
assuming insurer are overdue and in dispute as reported to the Commissioner;

(B) More than fifteen percent (15%) of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverable on paid losses of ninety (90) days or more which are not in dispute and which exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement; or

(C) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by ninety (90) days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

(7) The assuming insurer's supervisory authority must confirm to the Commissioner on an annual basis that the assuming insurer complies with the requirements set forth in Paragraphs (2) and (3) of this subsection.

(8) Nothing in this provision precludes an assuming insurer from providing the Commissioner with information on a voluntary basis.

(d) The Commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

(1) A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The Commissioner's list shall include any Reciprocal Jurisdiction as defined under Section (b)(1) and (2), and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The Commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions as provided by applicable law, regulation, or in accordance with criteria published through the NAIC Committee Process.

(2) The Commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC Committee Process, except that the Commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section (b)(1) and (2). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to 36 O.S. §5122 et seq. or OAC 365, Chapter 25, Part 11.

(e) The Commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this section and to which cessions shall be granted credit in accordance with this section.

(1) If an NAIC accredited jurisdiction has determined that the conditions set forth in Subsection (c) have been met, the Commissioner has the discretion to defer to that jurisdiction's determination, and add such assuming insurer to the list of assuming insurers to which cessions shall be granted credit in accordance with this subsection. The Commissioner may accept financial documentation filed with

another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of Subsection (c).

(2) When requesting that the Commissioner defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly executed Form RJ-1 and additional information as the Commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

(f) If the Commissioner determines that an assuming insurer no longer meets one or more of the requirements under this section, the Commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this section.

(1) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with OAC 365:25-7-67.

(2) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the Commissioner and consistent with the provisions of OAC 365:25-7-67.

(g) Before denying statement credit or imposing a requirement to post security with respect to Subsection (f) of this section or adopting any similar requirement that will have substantially the same regulatory impact as security, the Commissioner shall:

(1) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies one of the conditions listed in Subsection (c) of this section;

(2) Provide the assuming insurer with thirty (30) days from the initial communication to submit a plan to remedy the defect, and ninety (90) days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection;

(3) After the expiration of ninety (90) days or less, as set out in Paragraph (2), if the Commissioner determines that no or insufficient action was taken by the assuming insurer, the Commissioner may impose any of the requirements as set out in this Subsection; and

(4) Provide a written explanation to the assuming insurer of any of the requirements set out in this Subsection.

(h) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

PART 19. ANNUAL FINANCIAL REPORTING

365:25-7-102. Definitions

The following words and terms, when used in this Part 19 of Subchapter 7, shall have the following meaning, unless the context clearly indicated otherwise:

"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, means 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)~~ 365:25-7-113(g) 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" means independent board member as described in O.A.C. ~~365:25-7-113 (c)~~ 365:25-7-113(d).

"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]~~ Article 16A of the Oklahoma Insurance Code, 36 O.S. §§ 1631 et seq., 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)~~ 365:25-7-104(b)(2) – (7) 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)~~ 365:25-7-104(b)(2) –

(7) 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)~~ 365:25-7-104(b)(2) – (7) 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).

365:25-7-106. 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 Article 18 and 19 of the Oklahoma Insurance Code, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(d) [RESERVED]

(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]~~ 36 O.S. § 311A.7, 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) [RESERVED]

(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.

(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)~~ (k)(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.

PART 21. INSURANCE BUSINESS TRANSFERS [NEW]

365:25-7-1. Diagram.

Applicants shall submit a summary diagram indicating the pre-transfer and post-transfer structure of each party of the Insurance Business Transfer, a summary of what portfolio is transferring, a description of any liabilities that are transferring, a high-level capital plan indicating how the parties will meet ongoing capital requirements, and a clear description of any issues or areas of complexity. The summary diagram shall be submitted prior to the nomination of an independent expert.

365:25-7-2. Timeline.

Applicants shall submit a proposed timeline for the transfer. The proposed timeline shall be submitted prior to the nomination of an independent expert.

365:25-7-3. Independent Expert Documentation.

Applicants shall supply documentation in support of its independent expert nomination, including curriculum vitae for the nominated independent expert, a statement signed by the nominated independent expert affirming that he or she is independent and has the capacity to perform the work necessary as part of the Insurance Business Transfer, and a draft letter of engagement including a detailed description of the independent expert's hourly fees and any discounts offered.

365:25-7-4. Notice.

(a) Pursuant to 36 O.S. § 1686(A)(1)(i), the Insurance Business Transfer Plan shall include the form of notice to be provided to policyholders whose policy is part of the subject business. The notice shall include:

(1) The identity of the parties in a way that allows policyholders to readily recognize the parties,

(2) Free telephone contact number and times staffed by the Applicant, and

(3) A clear statement that the policyholder can make objections to the court if the policyholder believes he or she may be adversely affected by the transfer.

(b) The free telephone contact number stated in the notice shall be staffed by a representative of the Applicant at the times specified in the notice.

(c) If the notice asks the policyholder to respond by a certain date, then the notice shall clearly state that the response is not a requirement.

PART 23. TERM AND UNIVERSAL LIFE INSURANCE RESERVE FINANCING [NEW]

365:25-7-130. Authority.

This regulation is adopted and promulgated by the Commissioner pursuant to Section 5124 of Title 36 of the Oklahoma Insurance Code.

365:25-7-131. Purpose and Intent.

The purpose and intent of this regulation is to establish uniform, national standards governing reserve financing arrangements pertaining to life insurance policies containing guaranteed nonlevel gross premiums, guaranteed nonlevel benefits and universal life insurance policies with secondary guarantees; and to ensure that, with respect to each such financing arrangement, funds consisting of Primary Security and Other Security, as defined in 365:25-7-134, are held by or on behalf of ceding insurers in the forms and amounts

required herein. In general, reinsurance ceded for reserve financing purposes has one or more of the following characteristics: some or all of the assets used to secure the reinsurance treaty or to capitalize the reinsurer (1) are issued by the ceding insurer or its affiliates; or (2) are not unconditionally available to satisfy the general account obligations of the ceding insurer; or (3) create a reimbursement, indemnification or other similar obligation on the part of the ceding insurer or any if its affiliates (other than a payment obligation under a derivative contract acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty).

365:25-7-132. Applicability.

This regulation shall apply to reinsurance treaties that cede liabilities pertaining to Covered Policies, as that term is defined in 365:25-7-134, issued by any life insurance company domiciled in this state. This regulation and 365:25-7-60, et seq., shall both apply to such reinsurance treaties; provided, that in the event of a direct conflict between the provisions of this regulation and 365:25-7-60, et seq., the provisions of this regulation shall apply, but only to the extent of the conflict.

365:25-7-133. Exemptions from this Regulation.

This regulation does not apply to the situations described in Subsections a through f below.

(a) Reinsurance of:

(1) Policies that satisfy the criteria for exemption set forth in 365:10-17-5(f) or 365:10-17-5(g); and which are issued before the later of:

(A) The effective date of this regulation, and

(B) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than Jan 1, 2020;

(2) Portions of policies that satisfy the criteria for exemption set forth in OAC 365:10-17-5(e)and which are issued before the later of:

(A) The effective date of this regulation, and

(B) The date on which the ceding insurer begins to apply the provisions of VM-20 to establish the ceded policies' statutory reserves, but in no event later than Jan. 1, 2020;

(3) Any universal life policy that meets all of the following requirements:

(A) Secondary guarantee period, if any, is five (5) years or less;

(B) Specified premium for the secondary guarantee period is not less than the net level reserve premium for the secondary guarantee period based on the Commissioners Standard Ordinary (CSO) valuation tables and valuation interest rate applicable to the issue year of the policy; and

(C) The initial surrender charge is not less than one hundred percent (100%) of the first year annualized specified premium for the secondary guarantee period;

(4) Credit life insurance;

(5) Any variable life insurance policy that provides for life insurance, the amount or duration of which varies according to the investment experience of any separate account or accounts; or

(6) Any group life insurance certificate unless the certificate provides for a stated or implied schedule of maximum gross premiums required in order to continue coverage in force for a period in excess of one year.

(b) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 5122(E) of Title 36; or

(c) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 5122(B), (C), and (D) of Title 36, and that, in addition:

(1) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual, without any departures from NAIC statutory accounting practices and procedures pertaining to the admissibility or valuation of assets or liabilities that increase the assuming insurer's reported surplus and are material enough that they need to be disclosed in the financial statement of the assuming insurer pursuant to Statement of Statutory Accounting Principles No. 1 ("SSAP 1"); and

(2) Is not in a Company Action Level Event, Regulatory Action Level Event, Authorized Control Level Event, or Mandatory Control Level Event as those terms are defined in 36 O.S. § 1522 when its RBC is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation; or

(d) Reinsurance ceded to an assuming insurer that meets the applicable requirements of Section 5122(B), (C), and (D) of Title 36, and that, in addition:

(1) Is not an affiliate, as that term is defined in Section 1631(1) of Title 36, of:

(A) The insurer ceding the business to the assuming insurer; or

(B) Any insurer that directly or indirectly ceded the business to that ceding insurer;

(2) Prepares statutory financial statements in compliance with the NAIC Accounting Practices and Procedures Manual;

(3) Is both:

(A) Licensed or accredited in at least 10 states (including its state of domicile), and

(B) Not licensed in any state as a captive, special purpose vehicle, special purpose financial captive, special purpose life reinsurance company, limited purpose subsidiary, or any other similar licensing regime; and

(4) Is not, or would not be, below 500% of the Authorized Control Level RBC as that term is defined in 36 O.S. § 1522 when its Risk-Based Capital (RBC) is calculated in accordance with the life risk-based capital report including overview and instructions for companies, as the same may be amended by the NAIC from time to time, without deviation, and without recognition of any departures from NAIC statutory accounting practices and procedures pertaining to the admission or valuation of assets or liabilities that increase the assuming insurer's reported surplus; or

(e) Reinsurance ceded to an assuming insurer that meets the requirements of Section 5124(B)(4) of Title 36; or

(f) Reinsurance not otherwise exempt under Subsections A through E if the commissioner, after consulting with the NAIC Financial Analysis Working Group (FAWG) or other group of regulators designated by the NAIC, as applicable, determines under all the facts and circumstances that all of the following apply:

(1) The risks are clearly outside of the intent and purpose of this regulation (as described in Section 2 above);

(2) The risks are included within the scope of this regulation only as a technicality; and

(3) The application of this regulation to those risks is not necessary to provide appropriate protection to policyholders. The commissioner shall publicly disclose any decision made pursuant to this Section 4F to exempt a reinsurance treaty from this regulation, as well as the general basis therefor (including a summary description of the treaty).

365:25-7-134. Definitions.

(a) "Actuarial Method" means the methodology used to determine the Required Level of Primary Security, as described in 365:25-7-135.

(b) "Covered Policies" means the following: Subject to the exemptions described in 365:25-7-133, Covered Policies are those policies, other than Grandfathered Policies, of the following policy types:

(1) Life insurance policies with guaranteed nonlevel gross premiums and/or guaranteed nonlevel benefits, except for flexible premium universal life insurance policies; or,

(2) Flexible premium universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period.

(c) "Grandfathered Policies" means policies of the types described in Subsections b(1) and b(2) above that were:

(1) Issued prior to January 1, 2015; and

(2) Ceded, as of December 31, 2014, as part of a reinsurance treaty that would not have met one of the exemptions set forth in Section 4 had that section then been in effect.

(d) "Non-Covered Policies" means any policy that does not meet the definition of Covered Policies, including Grandfathered Policies.

(e) "Required Level of Primary Security" means the dollar amount determined by applying the Actuarial Method to the risks ceded with respect to Covered Policies, but not more than the total reserve ceded.

(f) "Primary Security" means the following forms of security:

(1) Cash meeting the requirements of Section 5123(1) of Title 36;

(2) Securities listed by the Securities Valuation Office meeting the requirements of Section 5123(2) of Title 36, but excluding any synthetic letter of credit, contingent note, credit-linked note or other similar security that operates in a manner similar to a letter of credit, and excluding any securities issued by the ceding insurer or any of its affiliates; and

(3) For security held in connection with funds-withheld and modified coinsurance reinsurance treaties:

(A) Commercial loans in good standing of CM3 quality and higher;

(B) Policy Loans; and

(C) Derivatives acquired in the normal course and used to support and hedge liabilities pertaining to the actual risks in the policies ceded pursuant to the reinsurance treaty.

(g) "Other Security" means any security acceptable to the commissioner other than security meeting the definition of Primary Security.

(h) "Valuation Manual" means the valuation manual adopted by the NAIC as described in Section 11B(1) of the Standard Valuation Law, with all amendments adopted by the NAIC that are effective for the financial statement date on which credit for reinsurance is claimed.

(i) "VM-20" means "Requirements for Principle-Based Reserves for Life Products," including all relevant definitions, from the Valuation Manual.

365:25-7-135. The Actuarial Method.

(a) **Actuarial Method.** The Actuarial Method to establish the Required Level of Primary Security for each reinsurance treaty subject to this regulation shall be VM-20, applied on a

treaty-by-treaty basis, including all relevant definitions, from the Valuation Manual as then in effect, applied as follows:

(1) For Covered Policies described in 365:25-7-134(b)(1) above, the Actuarial Method is the greater of the Deterministic Reserve or the Net Premium Reserve (NPR) regardless of whether the criteria for exemption testing can be met. However, if the Covered Policies do not meet the requirements of the Stochastic Reserve exclusion test in the Valuation Manual, then the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR. In addition, if such Covered Policies are reinsured in a reinsurance treaty that also contains Covered Policies described in 365:25-7-134(b)(2) above, the ceding insurer may elect to instead use paragraph 2 below as the Actuarial Method for the entire reinsurance agreement. Whether Paragraph 1 or 2 are used, the Actuarial Method must comply with any requirements or restrictions that the Valuation Manual imposes when aggregating these policy types for purposes of principle-based reserve calculations.

(2) For Covered Policies described in 365:25-7-134(b)(2) above, the Actuarial Method is the greatest of the Deterministic Reserve, the Stochastic Reserve, or the NPR regardless of whether the criteria for exemption testing can be met.

(3) Except as provided in Paragraph (4) below, the Actuarial Method is to be applied on a gross basis to all risks with respect to the Covered Policies as originally issued or assumed by the ceding insurer.

(4) If the reinsurance treaty cedes less than one hundred percent (100%) of the risk with respect to the Covered Policies then the Required Level of Primary Security may be reduced as follows:

(A) If a reinsurance treaty cedes only a quota share of some or all of the risks pertaining to the Covered Policies, the Required Level of Primary Security, as well as any adjustment under Subparagraph (C) below, may be reduced to a pro rata portion in accordance with the percentage of the risk ceded;

(B) If the reinsurance treaty in a non-exempt arrangement cedes only the risks pertaining to a secondary guarantee, the Required Level of Primary Security may be reduced by an amount determined by applying the Actuarial Method on a gross basis to all risks, other than risks related to the secondary guarantee, pertaining to the Covered Policies, except that for Covered Policies for which the ceding insurer did not elect to apply the provisions of VM20 to establish statutory reserves, the Required Level of Primary Security may be reduced by the statutory reserve retained by the ceding insurer on those Covered Policies, where the retained reserve of those Covered Policies should be reflective of any reduction pursuant to the cession of mortality risk on a yearly renewable term basis in an exempt arrangement;

(C) If a portion of the Covered Policy risk is ceded to another reinsurer on a yearly renewable term basis in an exempt arrangement, the Required Level of Primary Security may be reduced by the amount resulting by applying the Actuarial Method including the reinsurance section of VM-20 to the portion of the Covered Policy risks ceded in the exempt arrangement, except that for Covered Policies issued prior to Jan 1, 2017, this adjustment is not to exceed cx/ (2 * number of reinsurance premiums per year) where cx is calculated using the same mortality table used in calculating the Net Premium Reserve; and

(D) For any other treaty ceding a portion of risk to a different reinsurer, including but not limited to stop loss, excess of loss and other non-proportional reinsurance treaties, there will be no reduction in the Required Level of Primary Security. It is possible for any combination of Subparagraphs (A), (B), (C), and (D) above to apply. Such adjustments to the Required Level of Primary Security will be done in the sequence that accurately reflects the portion of the risk ceded via the treaty. The ceding insurer should document the rationale and steps taken to accomplish the adjustments to the Required Level of Primary Security due to the cession of less than one hundred percent (100%) of the risk. The Adjustments for other reinsurance will be made only with respect to reinsurance treaties entered into directly by the ceding insurer. The ceding insurer will make no adjustment as a result of a retrocession treaty entered into by the assuming insurers.

(5) In no event will the Required Level of Primary Security resulting from application of the Actuarial Method exceed the amount of statutory reserves ceded.

(6) If the ceding insurer cedes risks with respect to Covered Policies, including any riders, in more than one reinsurance treaty subject to this Regulation, in no event will the aggregate Required Level of Primary Security for those reinsurance treaties be less than the Required Level of Primary Security calculated using the Actuarial Method as if all risks ceded in those treaties were ceded in a single treaty subject to this Regulation;

(7) If a reinsurance treaty subject to this Regulation cedes risk on both Covered and Non-Covered Policies, credit for the ceded reserves shall be determined as follows:

(A) The Actuarial Method shall be used to determine the Required Level of Primary Security for the Covered Policies, and 365:25-7-136 shall be used to determine the reinsurance credit for the Covered Policy reserves; and

(B) Credit for the Non-Covered Policy reserves shall be granted only to the extent that security, in addition to the security held to satisfy the requirements of Subparagraph (a), is held by or on behalf of the ceding insurer in accordance with Sections 5122 and 5123 of Title 36. Any Primary Security used to meet the requirements of this Subparagraph may not be used to satisfy the Required Level of Primary Security for the Covered Policies.

(b) **Valuation used for Purposes of Calculations.**

For the purposes of both calculating the Required Level of Primary Security pursuant to the Actuarial Method and determining the amount of Primary Security and Other Security, as applicable, held by or on behalf of the ceding insurer, the following shall apply:

(1) For assets, including any such assets held in trust, that would be admitted under the NAIC Accounting Practices and Procedures Manual if they were held by the ceding insurer, the valuations are to be determined according to statutory accounting procedures as if such assets were held in the ceding insurer's general account and without taking into consideration the effect of any prescribed or permitted practices; and

(2) For all other assets, the valuations are to be those that were assigned to the assets for the purpose of determining the amount of reserve credit taken. In addition, the asset spread tables and asset default cost tables required by VM-20 shall be included in the Actuarial Method if adopted by the NAIC's Life Actuarial

(A) Task Force no later than the Dec. 31st on or immediately preceding the valuation date for which the Required Level of Primary Security is being

calculated. The tables of asset spreads and asset default costs shall be incorporated into the Actuarial Method in the manner specified in VM-20.

365:25-7-136. Requirements Applicable to Covered Policies to Obtain Credit for Reinsurance; Opportunity for Remediation

(a) **Requirements.** Subject to the exemptions described in 365:25-7-133 and the provisions of 365:25-7-136(b), credit for reinsurance shall be allowed with respect to ceded liabilities pertaining to Covered Policies pursuant to Section 5122 and 5123 of Title 36 if, and only if, in addition to all other requirements imposed by law or regulation, the following requirements are met on a treaty-by-treaty basis:

(1) The ceding insurer's statutory policy reserves with respect to the Covered Policies are established in full and in accordance with the applicable requirements of Sections 1510 and 4061 of Title 36 and related regulations and actuarial guidelines, and credit claimed for any reinsurance treaty subject to this regulation does not exceed the proportionate share of those reserves ceded under the contract; and

(2) The ceding insurer determines the Required Level of Primary Security with respect to each reinsurance treaty subject to this regulation and provides support for its calculation as determined to be acceptable to the commissioner; and

(3) Funds consisting of Primary Security, in an amount at least equal to the Required Level of Primary Security, are held by or on behalf of the ceding insurer, as security under the reinsurance treaty within the meaning of Section 5123 of Title 36, on a funds withheld, trust, or modified coinsurance basis; and

(4) Funds consisting of Other Security, in an amount at least equal to any portion of the statutory reserves as to which Primary Security is not held pursuant to Paragraph (3) above, are held by or on behalf of the ceding insurer as security under the reinsurance treaty within the meaning of Section 5123 of Title 36; and

(5) Any trust used to satisfy the requirements of this section shall comply with all of the conditions and qualifications of 365:25-7-68, except that:

(A) Funds consisting of Primary Security or Other Security held in trust, shall for the purposes identified in 365:25-7-135(b), be valued according to the valuation rules set forth in 365:25-7-135(b), as applicable; and

(B) There are no affiliate investment limitations with respect to any security held in such trust if such security is not needed to satisfy the requirements of 365:25-7-136(a)(3); and

(C) The reinsurance treaty must prohibit withdrawals or substitutions of trust assets that would leave the fair market value of the Primary Security within the trust (when aggregated with Primary Security outside the trust that is held by or on behalf of the ceding insurer in the manner required by 365:25-7-136(a)(3)) below 102% of the level required by 365:25-7-136(a)(3) at the time of the withdrawal or substitution; and

(D) determination of reserve credit under 365:25-7-68(d)(3) shall be determined according to the valuation rules set forth in 365:25-7-135(b), as applicable; and

(6) The reinsurance treaty has been approved by the commissioner.

(b) **Requirements at Inception Date and on an On-going Basis; Remediation**

(1) The requirements of 365:25-7-136(a) must be satisfied as of the date that risks under Covered Policies are ceded (if such date is on or after the effective date of this regulation) and on an ongoing basis thereafter. Under no circumstances shall a ceding insurer take or consent to any action or series of actions that would result in a deficiency under 365:25-7-136(a)(3) or 365:25-7-136(a)(4) with respect to any

reinsurance treaty under which Covered Policies have been ceded, and in the event that a ceding insurer becomes aware at any time that such a deficiency exists, it shall use its best efforts to arrange for the deficiency to be eliminated as expeditiously as possible.

(2) Prior to the due date of each Quarterly or Annual Statement, each life insurance company that has ceded reinsurance within the scope of Section 3 shall perform an analysis, on a treaty-by-treaty basis, to determine, as to each reinsurance treaty under which Covered Policies have been ceded, whether as of the end of the immediately preceding calendar quarter (the valuation date) the requirements of 365:25-7-136(a)(3) and 365:25-7-136(a)(4) were satisfied. The ceding insurer shall establish a liability equal to the excess of the credit for reinsurance taken over the amount of Primary Security actually held pursuant to 365:25-7-136(a)(3), unless either:

(A) The requirements of 365:25-7-136(a)(3) and 365:25-7-136(a)(4) were fully satisfied as of the valuation date as to such reinsurance treaty; or

(B) Any deficiency has been eliminated before the due date of the Quarterly or Annual Statement to which the valuation date relates through the addition of Primary Security and/or Other Security, as the case may be, in such amount and in such form as would have caused the requirements of 365:25-7-136(a)(3) and 365:25-7-136(a)(4) to be fully satisfied as of the valuation date.

(3) Nothing in 365:25-7-136(b)(2) shall be construed to allow a ceding company to maintain any deficiency under 365:25-7-136(a)(3) or 365:25-7-136(a)(4) for any period of time longer than is reasonably necessary to eliminate it.

365:25-7-137. Severability.

If any provision of this regulation is held invalid, the remainder shall not be affected.

365:25-7-138. Prohibition against Avoidance.

No insurer that has Covered Policies as to which this regulation applies (as set forth in 365:25-7-132) shall take any action or series of actions, or enter into any transaction or arrangement or series of transactions or arrangements if the purpose of such action, transaction or arrangement or series thereof is to avoid the requirements of this regulation, or to circumvent its purpose and intent, as set forth in 365:25-7-131.

365:25-7-139. Effective Date.

This regulation shall become effective November 1, 2023, and shall pertain to all Covered Policies in force as of and after that date.

SUBCHAPTER 9. PREPAID FUNERAL BENEFITS

~~**365:25-9-1. Purpose**~~

~~The purpose of this subchapter is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of **"The Act."** The information called for by the regulations of this subchapter is hereby declared to be necessary and appropriate in the public interest.~~

365:25-9-2. Contract approval

No organization shall in any way use any sales Contract without having received prior written approval from the Insurance Commissioner to do so. The ~~original and two~~

~~copies of any such~~ Contract, including any amendments thereto, shall be submitted to the Insurance Commissioner for approval.

365:25-9-3. Forms

(a) General requirements.

(1) Application for prepaid funeral benefits permit form. An application for Prepaid Funeral Benefits shall be submitted to the Insurance Department in the form and manner prescribed by the Insurance Commissioner on the Insurance Department website. The application must be ~~filed with and~~ approved by the Insurance Commissioner before any contracts covered by this act may be marketed. The statutory fee of fifty dollars ($50.00) must accompany this application. An NAIC UCAA Biographical Affidavit must be submitted for each owner(s) of the organization and each designated agent as defined by Section 6126 of the Act.

(2) Bond form requirements. A bond used in connection with ~~"The Act"~~ the Act shall be filed in the form and manner prescribed by the Insurance Commissioner. Any variance from this form must have the prior written approval of the Insurance Commissioner. If any bond required by ~~"The Act"~~ the Act is canceled for any reason, a thirty (30) day written notice must be given by the insurer to the Insurance Commissioner.

(3) Conversion Forms. Applications for Conversion from a trust funded prepaid funeral benefit to an insurance-funded prepaid funeral benefit shall be ~~filed with and~~ approved by the Insurance Commissioner before any contracts covered by ~~"The Act"~~ the Act may be converted. Applications for Conversion shall be submitted to the Insurance Department in the form and manner prescribed by the Insurance Commissioner on the Insurance Department website. Any variance from this form must have prior written approval by the Insurance Commissioner.

(4) Notice of Sale. The seller of a prepaid funeral benefits permit ~~holding funeral home~~ must submit an application to the Insurance Department in the form and manner prescribed by the Insurance Commissioner on the Insurance Department website, at least forty-five (45) days prior to the transfer of ownership. In addition to the notice, the seller must also submit a listing of unrealized prepaid funeral contracts. Insurance funded contracts should be listed independently from trust funded contracts. The listing will, at minimum, reflect the contract holder's name, contract number, contract value, the name of the insurer and the policy's face value (when applicable), and the trust value at the time of notice (when applicable).

(5) Assumption Affidavit. The buyer of a prepaid funeral benefits permit ~~holding funeral home~~ must notify the Commissioner, in the form and manner prescribed by the Insurance Commissioner on the Insurance Department website, of the buyer's intent to purchase thirty (30) days prior to transfer of ownership.

(6) Application for Renewal. The application for renewal of a prepaid funeral benefits permit must be filed with the Commissioner in the form and manner prescribed by the Commissioner on the Insurance Department website, no later than December 31 of each year form in order to renew the permit for the succeeding calendar year. The statutory fee of fifty dollars ($50.00) must accompany the application.

(b) Additional general requirements.

(1) Annual reports.

(A) Annual reports must be filed in accordance with Section 6128 of ~~"The Act"~~ the Act in the manner and form prescribed by the Commissioner on the Insurance Department website. Such reports ~~should~~ shall be submitted in

columnar form in alphabetical order according to the last name of the contract holder. A complete annual report shall be composed of the following items arranged in the order shown below:

(i) PF-1-a
(ii) PF-1-b
(iii) PF-1-c
(iv) PF-1-d
(v) PF-2-a
(vi) PF-2-b
(vii) PF-2-c
(viii) PF-3

(B) Computer print-outs may be submitted in lieu of the reports listed above so long as each legibly provides no less information than shown in the Insurance Commissioner's sample forms. Not less than one page of each annual report form shown above, other than the PF-2-b, shall be submitted. However, where a particular form is not relevant to the operations of a given permitholder, it may be submitted clearly marked, "Not Applicable".

(2) Annual statement of financial condition. An Annual Statement of Financial Condition ~~Reconciliation of Trust Accounts (form PF-3) must~~ shall be filed in accordance with Section 6129 of "The Act" in the manner and form prescribed by the Commissioner on the Insurance Department website.

365:25-9-7. Severability provision [REVOKED]

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

SUBCHAPTER 11. VIATICAL SETTLEMENTS REGULATION

365:25-11-1. Approval of viatical settlement contracts by Commissioner pursuant to 36 O.S. § 4055.5 [REVOKED]

~~Viatical settlement contracts filings pursuant to 36 O.S. § 4055.5 shall be filed with the Rate and Form Compliance Division of the Insurance Department.~~

365:25-11-4.1. Standards for evaluation of reasonable payments for terminally ill insureds

In order to assure that viators receive a reasonable return for viaticating an insurance policy, the return for viaticating a policy shall be no less than the following payouts ~~set out in Appendix W of this chapter~~ for insureds who are terminally ill~~.~~:

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 25 months	60%

365:25-11-6. General rules

(a) Viatical settlement brokers, at the time of their first contact with a prospective viator, shall provide an informational brochure. Such brochure shall use the language and format ~~set out in Appendix U~~ prescribed by the Commissioner on the Insurance Department website.

(b) With respect to policies containing a provision for double or additional indemnity for accidental death, the additional payment shall remain payable to the beneficiary last named by the viator prior to entering into the viatical settlement agreement, or to such other beneficiary, other than the viatical settlement provider, as the viator may thereafter designate, or in the absence of a designation, to the estate of the viator.

I Payment of the proceeds of a viatical settlement pursuant to 4055.9(D) of the Act shall be by means of wire transfer to an account designated by the viator or by certified check or cashier's check.

(d) Payment of the proceeds pursuant to a viatical settlement shall be made in a lump sum except where the viatical settlement provider has purchased an annuity or similar financial instrument issued by a licensed insurance company or bank, or an affiliate of either. Retention of a portion of the proceeds not disclosed or described in the viatical settlement contract by the viatical settlement provider or escrow agent is not permissible without written consent of the viator.

I A viatical settlement provider or broker shall not discriminate in the making or soliciting of viatical settlements on the basis of race, age, sex, national origin, creed, religion, occupation, marital or family status or sexual orientation, or discriminate between viators with dependents and without.

(f) A viatical settlement provider or broker shall not pay or offer to pay any finder's fee, commission or other compensation to any insured's physician, attorney, accountant or other person providing medical, legal or financial planning services to the viator, or to any other person acting as an agent of the viator, other than a viatical settlement broker, with respect to the viatical settlement.

(g) A viatical settlement provider shall not knowingly solicit purchasers who have treated or have been asked to treat the illness of the insured whose coverage would be the subject of the investment.

(h) If a viatical settlement provider enters into a viatical settlement that allows the viator to retain an interest in the policy, the viatical settlement contract shall contain the following provisions;

(1) A provision that the viatical settlement provider will effect the transfer of the amount of the death benefit only to the extent or portion of the amount viaticated. Benefits in excess of the amount viaticated shall be paid directly to the viator's beneficiary by the insurance company;

(2) A provision that the viatical settlement provider will, upon acknowledgment of the perfection of the transfer, either;

(A) Advise the insured, in writing, that the insurance company has confirmed the viator's interest in the policy; or

(B) Send a copy of the instrument sent from the insurance company to the viatical settlement provider that acknowledges the viator's interes' in the policy; and

(3) A provision that apportions the premiums to be paid by the viatical settlement provider and the viator, provided that the contract provides premium payment terms and nonforfeiture options no less favorable, on a proportional basis, than those included in the policy.

(i) In all cases where the insured is a minor child, disclosures to and permission of a parent or legal guardian satisfy the requirements of the Act and this regulation.

365:25-11-9. Insurance company practices

(a) Life insurance companies authorized to do business in this state shall respond to a request for verification of coverage from a viatical settlement provider or a viatical settlement broker within thirty (30) calendar days of the date a request is received, subject to the following conditions:

(1) A current authorization consistent with applicable law, signed by the policy owner or certificate holder, accompanies the request;

(2) In the case of an individual policy or group insurance coverage where details with respect to the certificate holder's coverag' are maintained by the insurer, submission of a verification of coverage for life insurance policies form substantially similar to ~~Appendix V~~ the form and format prescribed by the Commissioner on the Insurance Department website, which has been completed by the viatical settlement provider or the viatical settlement broker in accordance with the instructions on the form.

(b) Nothing in this section shall prohibit a life insurance company and a viatical settlement provider or a viatical settlement broker from using another verification of coverage form that has been mutually agreed upon in writing in advance of submission of the request.

(c) A life insurance company may not charge a fee for responding to a request for information from a viatical settlement provider or viatical settlement broker in compliance with this section in excess of any usual and customary charges to contract holders, certificate holders or insureds for similar services.

(d) The life insurance company may send an acknowledgment of receipt of the request for verification of coverage to the policy owner or certificate holder and, where the policy owner or certificate owner is other than the insured, to the insured. The acknowledgment may contain a general description of any accelerated death benefit that is available under a provision of or rider to the life insurance contract.

(e) A life insurance company shall not require the viator or insured to sign any request for change in a policy or a group certificate from a viatical settlement provider that is the owner or assignee of the insured's insuran'e coverage, unless the viator or insured has ownership, assignment or irrevocable beneficiary rights under the policy. In such a situation, the viatical settlement provider shall provide timely notice to the insured that a settlement transaction on the policy has occurred. Timely notice shall be provided within fifteen (15) calendar days of the change in a policy or group certificate.

SUBCHAPTER 15. CAPTIVE INSURANCE COMPANIES REGULATION

365:25-15-3. Annual Audit

(a) All companies shall have an annual audit by an independent certified public accountant, authorized by the Insurance Commissioner, and shall file such annual audited financial report with the Insurance Commissioner on or before June 30 for the year ending December 31 immediately preceding.

(b) A pure captive insurance company may make written application to file its annual report on a fiscal year basis and, if approved by the Commissioner, shall file such report no later than one hundred eighty (180) days following the close of the fiscal year.

(c) A company that elects to file its annual report on a fiscal year basis shall submit, concurrently with each premium tax return required, a schedule detailing the net direct written premium and assumed premium for the fiscal year in question.

(d) The annual audited financial report shall be considered part of the company's annual 'eport of financial condition except with respect to the date by which it must be filed with the Insurance Commissioner.

(e) The annual audited financial report shall consist of the following:

(1) **Opinion of Independent Certified Public Accountant.**

(A) Financial statements furnished pursuant to this section shall be examined by independent certified public accountants in accordance with generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner.

(B) The opinion of the independent certified public accountant shall cover all years presented.

(C) The opinion shall be addressed to the company on stationery of the accountant showing the address of issuance, shall bear original ~~manual~~ signatures and shall be dated.

(2) **Report of Evaluation of Internal Controls.**

(A) In addition to the annual audit, each company shall furnish the Commissioner with a written report, prepared in accordance with SAS No. 112, or any successor thereto, by the independent certified public accounting firm describing significant deficiencies and material weaknesses in the company's interna' control structure.

(B) The review shall be conducted in accordance with generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner, and the report shall be filed with the Insurance Commissioner.

(C) The company is required to provide a description of remedial actions taken or proposed to correct material weaknesses and, at the Commissioner's discret'on, significant deficiencies, if such actions are not described in the independent certified public accounting firm's repo't.

(3) **Accountant's Letter.**'The independent certified public accountant shall furnish the company, for inclusion on the filing of the annual audited financial report, a letter stating:

(A) That he or she is independent with respect to the company and conforms to the standards of his/her profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and pronouncements of the Financial Accounting Standards Board.

(B) The general background and experience of the staff engaged in audit including the experience in auditing captives or other insurance companies.

(C) That the accountant understands that the audited annual report and his opinions thereon will be filed in compliance with this regulation with the Department, and that the Commissioner will be relying on this information in the monitoring and regulation of the financial position of the company.

(D) That the accountant consents to the requirements of 365:25-15-4(c) of this regulation and that the accountant consents and agrees to make available for review by the Insurance Commissioner, or his appointed agent, the work papers as defined in 365:25-15-4(c).

(E) That the accountant is properly licensed by an appropriate state licensing authority and that he or she is a member in good standing in the American Institute of Certified Public Accountants.

(4) **Financial Statements.** Statements required shall be as follows:

(A) Balance sheet,
(B) Statement of gain or loss from operations,
(C) Statement of changes in financial position,
(D) Statement of changes in capital paid up, gross paid in and contributed surplus and unassigned funds (surplus), and
(E) Notes to financial statements. The notes to financial statements shall be those required by generally accepted accounting principles, or as required by any other comprehensive basis of accounting in use by the company and approved by the Insurance Commissioner, and shall include:

(i) A reconciliation of differences, if any, between the audited financial report and the statement or form filed with the Insurance Commissioner.
(ii) A summary of ownership and relationship of the company and all affiliated corporations or companies insured by the captive.
(iii) A narrative explanation of all material transactions and balances with the company. "Material “ransactions" means sa”es, guarantees, purchases, exchanges, loans or extensions of credit or investments which, based upon an annual aggregate, involve more than five percent (5%) of the insurer's admitte’ assets or twenty-five percent (25%) of the insurer's surplus’as regards policyholders, whichever is less, as of the latest annual financial statement filed with the Commissioner.

(5) **Certification of Loss Reserves and Loss Expense Reserves.**

(A) The annual audit shall include an opinion as to the adequacy of the company's life, h’alth, or annuity reserves, or its loss reserves and loss expense reserves.
(B) Certification shall be in such form as the Insurance Commissioner deems appropriate.

(f) Upon request by the company and for good cause shown, the Commissioner may grant an exemption from the annual audit requirement for any company having direct written and assumed premiums of Two Million Dollars ($2,000,000.00) or less in the preceding year.

365:25-15-12. Acquisition of control of or merger with domestic company [REVOKED]

~~(a) All persons shall comply with Sections 1651-1653 of Title 36 and associated regulations when seeking to acquire control of or merge with a domestic captive insurer, notwithstanding that the Insurance Commissioner may waive or modify the requirements for public notice and hearing when the Insurance Commissioner concludes the public hearing is not necessary due to the limited public interest in the change of control.~~
~~(b) Definitions of terms found in Section 1651 of Title 36 shall apply when a captive insurance company seeks to acquire control of or merge with a domestic company. For purposes of this section, the definition of the term insurer as set out in Section 1651 of Title 36 shall include captive insurance companies.~~

365:25-15-13. Change of business

(a) Except as otherwise provided, any change in the nature of the captive business from that stated in the company's plan of operation filed with the Insurance Commissioner upon application requires prior approval from the Insurance Commissioner.

(b) For purposes of this Section, "nature of the captive business" includes, but is not limited to, nonrecurring transactions such as loans or extensions of credit, reinsurance agreements or modifications thereto, management agreements, service contracts and all cost-sharing arrangements and changes in certificate of incorporation or bylaws.
(c) All business plan changes, both in the nature of the captive business or otherwise, shall be filed with the Insurance Commissioner thirty (30) days in advance of the effective date of the change. The effective date of any business plan change for a captives shall not be prior to approval of the Insurance Commissioner.

365:25-15-14. Prior approval

Requests for the prior approval of the Insurance Commissioner of mergers, consolidations, conversions, mutualizations, redomestications or any other matter for which prior approval is required shall be made on the appropriate ~~forms as set out in this Chapter for use by insurers or on~~ forms as prescribed by the Insurance Commissioner.

365:25-15-25. Confidentiality

Documents, work papers, recorded information, investigatory files, materials, or other information produced by, obtained by, or disclosed to the Commissioner or any other person in the course of licensing, examination, investigation, or analysis by the Commissioner of the financial condition or market conduct of any captive insurance company shall be confidential pursuant to the Oklahoma Captive Insurance Company Act.

SUBCHAPTER 17. CONSUMER PROTECTION IN ANNUITY TRANSACTIONS REGULATION

365:25-17-1. Purpose

(a) The purpose of this regulation is to require producers, as defined in this regulation, to act in the best interest of the consumer when making a ~~set forth standards and procedures for~~ recommendations ~~to consumers that result in a transaction involving~~ of an annuity ~~products~~ and to require insurers to establish and maintain a system to supervise recommendations so that the insurance needs and financial objectives of consumers at the time of the transaction are effectively ~~appropriate~~ addressed.
(b) Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation or to subject a producer to civil liability under the best interest standard of care outlined in 365:25-17-7 or under standards governing the conduct of a fiduciary or fiduciary relationship.

365:25-17-2. Scope

This regulation shall apply to any sale or recommendation of ~~to purchase or exchange~~ an annuity ~~made to a consumer by an insurance producer, or an insurer where no producer is involved, that results in the purchase or exchange recommended~~.

365:25-17-4. Exemptions

Unless otherwise specifically included, this regulation shall not apply to transactions ~~recommendations~~ involving:

(1) Direct response solicitations where there is no recommendation based on information collected from the consumer pursuant to this regulation; ~~or~~
(2) Contracts used to fund:

(A) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(B) A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC), as amended, if established or maintained by an employer;
(C) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC; or
(D) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.;

(3)~~(E)~~ Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(4)~~(F)~~ Formal prepaid funeral contracts.

365:25-17-5. Definitions

The following words and terms, when used in this Subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Annuity" means an ~~fixed annuity or variable~~ annuity that is an insurance product under state law that is individually solicited, whether the product is classified as an individual or group annuity.

"Cash compensation" means any discount, concession, fee, service fee, commission, sales charge, loan, override, or cash benefit received by a producer in connection with the recommendation or sale of an annuity from an insurer, intermediary, or directly from the consumer.

"Consumer profile information" means information that is reasonably appropriate to determine whether a recommendation addresses the consumer's financial situation, insurance needs and financial objectives, including, at a minimum, the following:

(A) Age;
(B) Annual income;
(C) Financial situation and needs, including debts and other obligations;
(D) Financial experience;
(E) Insurance needs;
(F) Financial objectives;
(G) Intended use of the annuity;
(H) Financial time horizon;
(I) Existing assets or financial products, including investment, annuity and insurance holdings;
(J) Liquidity needs;
(K) Liquid net worth;
(L) Risk tolerance, including but not limited to, willingness to accept non-guaranteed elements in the annuity;
(M) Financial resources used to fund the annuity; and
(N) Tax status.

"Continuing education credit" or **"CE credit"** means one continuing education credit as approved pursuant to 36 O.S. § 1435.29 and OAC 365:25-3-1.

"Continuing education provider" or **"CE provider"** means an individual or entity that is approved to offer continuing education courses pursuant to 36 O.S. § 1435.29.

"FINRA" means the Financial Industry Regulatory Authority or a succeeding agency.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

~~**"Insurance producer"** means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.~~

"Intermediary" means an entity contracted directly with an insurer or with another entity contracted with an insurer to facilitate the sale of the insurer's annuities by producers.

"Material conflict of interest" means a financial interest of the producer in the sale of an annuity that a reasonable person would expect to influence the impartiality of a recommendation. "Material conflict of interest" does not include cash compensation or non-cash compensation.

"Non-cash compensation" means any form of compensation that is not cash compensation, including, but not limited to, health insurance, office rent, office support and retirement benefits.

"Non-guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, dividends, non-interest based credits, charges or elements of formulas used to determine any of these, that are subject to company discretion and are not guaranteed at issue. An element is considered non-guaranteed if any of the underlying non-guaranteed elements are used in its calculation.

"Producer" means a person or entity required to be licensed under the laws of this state to sell, solicit, or negotiate insurance, including annuities. For purposes of this regulation, "producer" includes an insurer where no producer is involved.

"Recommendation" means advice provided by a~~n insurance~~ producer~~, or an insurer where no producer is involved,~~ to an individual consumer that was intended to result~~s~~ or does result in a purchase, an~~or~~ exchange, or replacement of an annuity in accordance with that advice. Recommendation does not include general communication to the public, generalized customer services assistance or administrative support, general educational information, and tools, prospectuses, or other product and sales material.

"Replacement" means a transaction in which a new annuity is to be purchased, and it is known or should be known to the proposing producer, or to the proposing insurer whether or not a producer is involved, that by reason of the transaction, an existing annuity or other insurance policy has been or is to be any of the following:

(A) Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated;

(B) Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;

(C) Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;

(D) Reissued with any reduction in cash value; or

(E) Used in a financed purchase.

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

365:25-17-7. Duties of insurers and of insurance producers

(a) **Best Interest Obligations.** A producer, when making a recommendation of an annuity, shall act in the best interest of the consumer under the circumstances known at the time the recommendation is made, without placing the producer's or the insurer's financial interest

ahead of the consumer's interest. A producer has acted in the best interest of the consumer if they have satisfied the following obligations regarding care, disclosure, conflict of interest and documentation:

~~**Suitability required.** In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to his or her investments and other insurance products and as to his or her financial situation and needs.~~

(1) Care Obligation.

(A)The producer, in making a recommendation shall exercise reasonable diligence, care and skill to:

(i) Know the consumer's financial situation, insurance needs, and financial objectives;

(ii) Understand the available recommendation options after making a reasonable inquiry into options available to the producer;

(iii) Have a reasonable basis to believe the recommended option effectively addresses the consumer's financial situation, insurance needs, and financial objectives over the life of the product, as evaluated in light of the consumer profile information; and

(iv) Communicate the basis or bases of the recommendation.

(B) The requirements under subparagraph (a) of this paragraph include making reasonable efforts to obtain consumer profile information from the consumer prior to the recommendation of an annuity.

(C) The requirements under subparagraph (a) of this paragraph require a producer to consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's financial situation, insurance needs, and financial objectives. This does not require analysis or consideration of any products outside the authority and license of the producer or other possible alternative products or strategies available in the market at the time of the recommendation. Producers shall be held to standards applicable to producers with similar authority and licensure.

(D) The requirements under this subsection do not create a fiduciary obligation or relationship and only create a regulatory obligation as established in this regulation.

(E) The consumer profile information, characteristics of the insurer, and product costs, rates, benefits, and features are those factors generally relevant in making a determination whether an annuity effectively addresses the consumer's financial situation, insurance needs, and financial objectives, but the level of importance of each factor under the care obligation of this paragraph may vary depending on the facts and circumstances of a particular case. However, each factor may not be considered in isolation.

(F) The requirements under subparagraph (a) of this paragraph include having a reasonable basis to believe the consumer would benefit from certain features of the annuity, such as annuitization, death or living benefit or other insurance-related features.

(G) The requirements under subparagraph (a) of this paragraph apply to the particular annuity as a whole and the underlying subaccounts to which funds are allocated at the time of purchase or exchange of an annuity, and riders and similar producer enhancements, if any.

(H) The requirements under subparagraph (a) of this paragraph do not mean the annuity with the lowest one-time or multiple occurrence compensation structure shall necessarily be recommended.

(I) The requirements under subparagraph (a) of this paragraph do not mean the producer has ongoing monitoring obligations under the care obligation under this paragraph, although such an obligation may be separately owed under the terms of a fiduciary, consulting, investment advising, or financial planning agreement between the consumer and the producer.

(J) In the case of an exchange or replacement of an annuity, the producer shall consider the whole transaction, which includes taking into consideration whether:

(i) The consumer will incur a surrender charge, be subject to the commencement of a new surrender period, lose existing benefits, such as death, living, or other contractual benefits, or be subject to increased fees, investment advisory fees, or charges for riders and similar product enhancements;

(ii) The replacing product would substantially benefit the consumer in comparison to the replaced product over the life of the product; and

(iii) The consumer has had another annuity exchange or replacement and, in particular, an exchange or replacement within the preceding 60 months.

(K) Nothing in this regulation should be construed to require a producer to obtain any license other than a producer license with the appropriate line of authority to sell, solicit, or negotiate insurance in this state, including but not limited to any securities license, in order to fulfill the duties and obligations contained in this regulation; provided the producer does not give advice or provide services that are otherwise subject to securities laws or engage in any other activity requiring other professional licenses.

(2) Disclosure obligation.

(A) Prior to the recommendation or sale of an annuity, the producer shall prominently disclose to the consumer on a form prescribed by the Commissioner:

(i) A description of the scope and terms of the relationship with the consumer and the role of the producer in the transaction;

(ii) An affirmative statement on whether the producer is licensed and authorized to sell the following products:

(I) Fixed annuities;

(II) Fixed indexed annuities;

(III) Variable annuities;

(IV) Life insurance;

(V) Mutual funds;
(VI) Stocks and bonds; and
(VII) Certificates of deposit;
(iii) An affirmative statement describing the insurers the producer is authorized, contracted, appointed, or otherwise able to sell insurance products for, using the following descriptions:
(I) From one insurer;
(II) From two or more insurers; or
(III) From two or more insurers although primarily contracted with one insurer.
(iv) A description of the sources and types of cash compensation and non-cash compensation to be received by the producer, including whether the producer is to be compensated for the sale of a recommended annuity by commission as part of premium or other remuneration received from the insurer, intermediary, or other producer or by fee as a result of a contract for advice or consulting services; and
(v) A notice of the consumer's right to request additional information regarding cash compensation described in subparagraph (B) of this paragraph;
(B) Upon request of the consumer or the consumer's designated representative, the producer shall disclose:
(i) A reasonable estimate of the amount of cash compensation to be received by the producer, which may be stated as a range of amounts or percentages; and
(ii) Whether the cash compensation is a one-time or multiple occurrence amount, and if a multiple occurrence amount, the frequency and amount of the occurrence, which may be stated as a range of amounts or percentages; and
(C) Prior to or at the time of the recommendation or sale of an annuity, the producer shall have a reasonable basis to believe the consumer has been informed of various features of the annuity, such as the potential surrender period and surrender charge, potential tax penalty if the consumer sells, exchanges, surrenders, or annuitizes the annuity, mortality and expense fees, investment advisory fees, any annual fees, potential charges for and features of riders or other options of the annuity, limitations on interest returns, potential changes in non-guaranteed elements of the annuity, insurance and investment components, and market risk. The requirements of this section are intended to supplement and not replace the disclosure requirements of OAC 365:25-19-1, et seq.
(3) **Conflict of interest obligation.** A producer shall identify and avoid or reasonably manage and disclose material conflicts of interest, including material conflicts of interest related to an ownership interest.
(4) **Documentation obligation.** A producer shall at the time of recommendation or sale:

(A) Make a written record of any recommendation and the basis for the recommendation subject to this regulation,

(B) Obtain a consumer signed statement on a form prescribed by the Commissioner:

(i) A customer's refusal to provide the consumer profile information, if any; and

(ii) A customer's understanding of the ramifications of not providing his or her consumer profile information or providing insufficient consumer profile information; and

(C) Obtain a consumer signed statement on a form prescribed by the Commissioner acknowledging the annuity transaction is not recommended if a customer decides to enter into an annuity transaction that is not based on the producer's recommendation.

(5) **Application of the best interest obligation.** Any requirement applicable to a producer under this subsection shall apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation or sale, regardless of whether the producer has had any direct contact with the consumer. Activities such as providing or delivering marketing or educational materials, product wholesaling or other back office product support, and general supervision of a producer do not, in and of themselves, constitute material control or influence.

~~(b) **Producer required to obtain information from consumer.** Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:~~

~~(1) The consumer's financial status;~~

~~(2) The consumer's tax status;~~

~~(3) The consumer's investment objectives; and~~

~~(4) Such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the consumer.~~

(b)~~(c)~~ **Transactions not based on a recommendation~~Obligation to consumer~~.**

(1) Except as provided under paragraph (2) ~~of this subsection~~, ~~neither an insurance~~ producer~~, nor an insurer where no producer is involved,~~ shall have no ~~any~~ obligation to a consumer under subsection a(1) related to any annuity transaction ~~recommendation~~ if ~~a consumer~~:

(A) No recommendation is made;

(B) A recommendation was made and was later found to have been prepared based on materially inaccurate information provided by the customer;

(C) A customer ~~Refuses~~ refuses to provide relevant consumer profile information and the annuity transaction is not recommended ~~requested by the insurer or insurance producer~~; or

(D)~~(B)~~ A consumer ~~D~~decides to enter into an annuity ~~insurance~~ transaction that is not based on a recommendation ~~of the insurer or insurance~~ producer.~~; or~~

~~(C) Fails to provide complete or accurate information.~~

(2) An insurer's issuance of an annuity ~~or insurance producer's recommendation~~ subject to Paragraph (1) shall be reasonable under all the

circumstances actually known to the insurer ~~or insurance producer~~ at the time ~~of~~ the annuity is issued ~~recommendation~~.

(c)~~(d)~~ **Supervision system ~~to supervise recommendations of insurance producers~~.**

(1) Except as permitted under Subsection B, an insurer may not issue an annuity recommended to a consumer unless there is a reasonable basis to believe that the annuity would effectively address the particular consumer's financial situation, insurance needs, and financial objectives based on the consumer's consumer profile information.

(2) An insurer ~~either~~ shall establish and maintain ~~assure that~~ a supervision system ~~to supervise recommendations~~ that is reasonably designed to achieve the insurer's and its producers' compliance with this regulation, ~~is established and maintained by complying with Paragraphs (3) to (5) of this subsection, or shall establish and maintain such a system,~~ including, but not limited to:

(A) The insurer shall establish and ~~M~~aintaining maintain reasonable ~~written~~ procedures to inform its producers of the requirements of this regulation and shall incorporate the requirements of this regulation into relevant producer training manuals; ~~and~~

(B) The insurer shall establish and maintain standards for producer product training and shall establish and maintain reasonable procedures to require its producers to comply with the requirements of 365:25-17-8 of this regulation;~~Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this regulation.~~

(C) The insurer shall provide product-specific training and training materials which explain all material features of its annuity products to its producers;

(D) The insurer shall establish and maintain procedures for the review of each recommendation prior to issuance of an annuity that are designed to ensure there is a reasonable basis to determine that the recommended annuity would effectively address the particular consumer's financial situation, insurance needs and financial objectives. Such review procedures may apply a screening system for the purpose of identifying selected transactions for additional review and may be accomplished electronically or through other means including, but not limited to, physical review. Such an electronic or other system may be designed to require additional review only of those transactions identified for additional review by the selection criteria;

(E) The insurer shall establish and maintain reasonable procedures to detect recommendations that are not in compliance with subsections a, b, d and e. This may include, but is not limited to, confirmation of the consumer's consumer profile information, systematic customer surveys, producer and consumer interviews, confirmation letters, producer statements or attestations and programs of internal monitoring. Nothing in this subparagraph prevents an insurer from complying with this subparagraph by applying sampling procedures, or by confirming the consumer profile information or other required information under this section after issuance or delivery of the annuity;

(F) The insurer shall establish and maintain reasonable procedures to assess, prior to or upon issuance or delivery of an annuity, whether a producer has provided to the consumer the information required to be provided under this section;

(G) The insurer shall establish and maintain reasonable procedures to identify and address suspicious consumer refusals to provide consumer profile information;

(H) The insurer shall establish and maintain reasonable procedures to identify and eliminate any sales contests, sales quotas, bonuses, and non-cash compensation that are based on the sales of specific annuities within a limited period of time. The requirements of this subparagraph are not intended to prohibit the receipt of health insurance, office rent, office support, retirement benefits or other employee benefits by employees as long as those benefits are not based upon the volume of sales of a specific annuity within a limited period of time; and

(i) The insurer shall annually provide a written report to senior management, including to the senior manager responsible for audit functions, which details a review, with appropriate testing, reasonably designed to determine the effectiveness of the supervision system, the exceptions found, and corrective action taken or recommended, if any.

~~(2) A general agent and independent agency either shall adopt a system established by an insurer to supervise recommendations of its insurance producers that is reasonably designed to achieve compliance with this regulation, or shall establish and maintain such a system, including, but not limited to:~~

~~(A) Maintaining written procedures; and~~

~~(B) Conducting periodic reviews of records that are reasonably designed to assist in detecting and preventing violations of this regulation.~~

(3) (A) Nothing in this subsection restricts an insurer from contracting for performance of a function (including maintenance of procedures) required under this subsection. An insurer is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to OAC 365:25-17-9 of this regulation regardless of whether the insurer contracts for performance of a function and regardless of the insurer's compliance with subparagraph (B) of this paragraph ~~contract with a third party, including a general agent or independent agency, to establish and maintain a system of supervision as required by Paragraph (1) with respect to insurance producers under contract with or employed by the third party~~.

(B) An insurer's supervision system under this subsection shall include supervision of contractual performance under this subsection. This includes, but is not limited to, the following:

(i) Monitoring and, as appropriate, conducting audits to assure that the contracted function is properly performed; and

(ii) Annually obtaining a certification from a senior manager who has responsibility for the contracted function that the manager has a responsible basis to represent, and does represent, that the function is properly performed.

(4) An insurer is not required to include in its system of supervision~~shall make reasonable inquiry to assure that the third party contracting under Paragraph (3) of this subsection is performing the functions required under Paragraph (1) of this subsection and shall take such action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following~~:

(A) A producer's recommendations to consumers of products other than the annuities offered by the insurer~~The insurer annually obtains a certification from a third party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions~~; or ~~and~~

(B) Consideration of or comparison to options available to the producer or compensation relating to those options other than annuities or other products offered by the insurer~~The insurer, based on reasonable selection criteria, periodically selects third parties contracting under Paragraph (3) of this subsection for a review to determine whether the third parties are performing the required functions. The insurer shall perform those procedures to conduct the review that are reasonable under the circumstances~~.

~~(5) An insurer that contracts with a third party pursuant to Paragraph (3) of this subsection and that complies with the requirements to supervise in Paragraph (4) of this subsection shall have fulfilled its responsibilities under Paragraph (1) of this subsection.~~

~~(6) An insurer, general agent or independent agency is not required by Paragraph (1) or (2) of this subsection to:~~

~~(A) Review, or provide for review of, all insurance producer solicited transactions; or~~

~~(B) Include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer, general agent or independent agency.~~

~~(7) A general agent or independent agency contracting with an insurer pursuant to Paragraph (3) of this subsection shall promptly, when requested by the insurer pursuant to Paragraph (4) of this subsection, give a certification as described in Paragraph (4) of this subsection or give a clear statement that it is unable to meet the certification criteria.~~

~~(8) No person may provide a certification under Paragraph (4)(A) of this subsection unless:~~

~~(A) The person is a senior manager with responsibility for the delegated functions; and~~

~~(B) The person has a reasonable basis for making the certification.~~

(d) **Prohibited Practices.** Neither a producer nor an insurer shall dissuade, or attempt to dissuade, a consumer from:

(1) Truthfully responding to an insurer's request for confirmation of the consumer profile information;

(2) Filing a complaint; or

(3) Cooperating with the investigation of a complaint.

(e) **Safe harbor ~~NASD and suitability of variable annuities~~.** ~~Compliance with the National Association of Securities Dealers Conduct Rules pertaining to suitability shall satisfy the requirements under this section for the recommendation of variable annuities. However, nothing in this subsection shall limit the Insurance Commissioner's ability to enforce the provisions of this regulation.~~

(1) Recommendations and sales of annuities made in compliance with comparable standards shall satisfy the requirements under this regulation. This subsection applies to all recommendations and sales of annuities made by financial professionals in compliance with business rules, controls, and procedures that satisfy a comparable standard even if such standard would not otherwise apply to

the product or recommendation at issue. However, nothing in this subsection shall limit the Insurance Commissioner's ability to investigate and enforce the provisions of this regulation.

(2) Nothing in paragraph (1) shall limit the insurer's obligation to comply with 365:25-17-7(c)(1), although the insurer may base its analysis on information received from either the financial professional or the entity supervising the financial professional.

(3) For paragraph (1) to apply, an insurer shall:

(A) Monitor the relevant conduct of the financial professional seeking to rely on paragraph (1) or the entity responsible for supervising the financial professional, such as the financial professional's broker-dealer or an investment adviser registered under federal or state securities laws using information collected in the normal course of an insurer's business; and

(B) Provide to the entity responsible for supervising the financial professional seeking to rely on paragraph (1), such as the financial professional's broker-dealer or investment adviser registered under federal or state securities laws, information and reports that are reasonably appropriate to assist such entity to maintain its supervision system.

(4) For purposes of this subsection, "financial professional" means a producer that is regulated and acting as:

(A) A broker-dealer registered under federal or state securities laws or a registered representative of a broker-dealer;

(B) An investment adviser registered under federal or state securities laws or an investment adviser representative associated with the federal or state registered investment adviser; or

(C) A plan fiduciary under Section 3(21) of the Employee Retirement Income Security Act of 1974 (ERISA) or fiduciary under Section 4975(e)(3) of the Internal Revenue Code (IRC) or any amendments or successor statutes thereto.

(5) For purposes of this subsection, "comparable standards" means:

(A) With respect to broker-dealers and registered representatives of broker-dealers, applicable SEC and FINRA rules pertaining to best interest obligations and supervision of annuity recommendations and sales, including, but not limited to, Regulation Best Interest and any amendments or successor regulations thereto;

(B) With respect to investment advisers registered under federal or state securities laws or investment adviser representatives, the fiduciary duties and all other requirements imposed on such investment advisers or investment adviser representatives by contract or under the Investment Advisers Act of 1940 or applicable state securities law, including but not limited to, the Form ADV and interpretations; and

(C) With respect to plan fiduciaries or fiduciaries, means the duties, obligations, prohibitions, and all other requirements

attendant to such status under ERISA or the IRC and any amendments or successor statutes thereto.

365:25-17-8. Compliance Mitigation; Penalties; Enforcement. ~~of responsibility~~

(a) An insurer is responsible for compliance with this regulation. If a violation occurs, either because of the action or inaction of the insurer or its producer, the ~~The~~ commissioner may order:

(1) An insurer to take reasonably appropriate corrective action for any consumer harmed by a failure to comply with this regulation by the insurer~~'s~~, an entity contracted to perform the insurer's supervisory duties, or by the ~~its insurance~~ producer~~'s, violation of this regulation~~;

(2) ~~An~~ A general agency, independent agency, or the ~~insurance~~ producer to take reasonably appropriate corrective action for any consumer harmed by the ~~insurance~~ producer's violation of this regulation; and

(3) A ~~general agency or independent agency that employs or contracts with an insurance producer to sell, or solicit the sale, of annuities to consumers, to take reasonably a~~ppropriate penalties and sanctions ~~corrective action for any consumer harmed by the insurance producer's violation of this regulation~~.

(b) Any applicable penalty under 36 O.S. §§ 619 and 1435.13 for a violation of ~~Section 365:25-17-7(a), (b), or (c)(2) of~~ this regulation may be reduced or eliminated at the discretion of the Insurance Commissioner if corrective action for the consumer was taken promptly after a violation was discovered or the violation was not part of a pattern or practice.

(c) The authority to enforce compliance with this regulation is vested exclusively with the Insurance Commissioner.

365:25-17-9. Recordkeeping.

(a) Insurers, general agents, independent agencies and ~~insurance~~ producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer, disclosures made to the consumer, including summaries of oral disclosures, and other information used in making the recommendations that were the basis for insurance transactions for five (5) years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of a~~n~~ ~~insurance~~ producer.

(b) Records required to be maintained by this regulation may be maintained in paper, photographic, microprocess, magnetic, mechanical, or electronic media or by any process that accurately reproduces the actual document.

365:25-17-10. Effective Date.

The amendments to this regulation shall take effect six months after the date the regulation is adopted or on November 1, 2023, whichever is later.

SUBCHAPTER 19. ANNUITY DISCLOSURE REGULATION

365:25-19-2. Authority [REVOKED]

~~This regulation is issued based upon the authority granted the Insurance Commissioner under Section 1204 of the Oklahoma Unfair Trade Practices Act, 36 O.S. § 1204.~~

~~365:25-19-8. Separability~~

~~If any provision of this regulation or its application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the regulation and its application to other persons or circumstances shall not be affected.~~

365:25-19-9. Effective Date [REVOKED]

~~This regulation shall become effective January 1, 2007, and shall apply to contracts sold on or after the effective date.~~

SUBCHAPTER 21. REGULATION ON THE USE OF SENIOR-SPECIFIC CERTIFICATIONS AND PROFESSIONAL DESIGNATIONS IN THE SALE OF LIFE INSURANCE AND ANNUITIES

365:25-21-6. Effective Date [REVOKED]

~~This regulation shall become effective July 14, 2009.~~

SUBCHAPTER 23. CEMETARY MERCHANDISE TRUSTS

365:25-23-1. Purpose [REVOKED]

~~The purpose of this subchapter is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the Cemetery Merchandise Trust Act. The information called for by the regulations of this subchapter is hereby declared to be necessary and appropriate in the public interest.~~

365:25-23-3. Contract approval

No organization shall use in any way any sales contract without having received prior written approval from the Insurance Commissioner to do so. The ~~original and two (2) copies of any such~~ contract, including any amendments thereto, shall be submitted to the Insurance Commissioner for approval.

365:25-23-4. Forms

(a) **Application for Cemetery Merchandise Permit.** An application for Cemetery Merchandise Permit shall be made by filing an Application for Cemetery Merchandise Permit Original Application on a form approved by the Commissioner. The application shall be filed with and approved by the Insurance Commissioner before any contracts covered by this act may be marketed.

(b) **Surety bond.** Organizations purchasing a surety bond shall use the Surety Bond Form as approved by the Commissioner. Any variation from this form must have the prior written approval of the Insurance Commissioner.

(c) **Renewal of Cemetery Merchandise Permit.** A renewal of a Cemetery Merchandise Permit shall be made by filing the Renewal of Cemetery Merchandise Permit form as approved by the Commissioner no later than March 15 of each year. Renewals made after March 15 of the year following the year the permit is first issued shall be made by filing the Application for Cemetery Merchandise Permit and paying any fines that may have been imposed with respect to an expired permit in addition to double the renewal fee.

(d) ~~**Cemetery Merchandise Annual Report.** Every holder of a Cemetery Merchandise Permit shall file a Cemetery Merchandise Annual Report on a form approved by the Commissioner on or before March 15 of each year.~~

(e) ~~**Oklahoma Quarterly Report of Cemetery Merchandise.** Every holder of a Cemetery Merchandise Permit that maintains a surety bond shall submit an Oklahoma Quarterly Report of Cemetery Merchandise on a form approved by the Commissioner.~~

~~(f)~~ **Notice of Sale.** Prior to the sale of a cemetery with a cemetery merchandise permit, a permit holder shall first file a Notice of Sale on a form approved by the Commissioner.

365:25-23-6. Surety bond

(a) ~~A permit holder posting a surety bond in lieu of making remittances to a trust fund, shall file a quarterly report no later than the thirtieth day after the close of each quarter. The bond shall be in an amount not less than the minimum funding requirement for cemetery merchandise trusts pursuant to the provisions of 36 O.S. § 7126.~~ If at any time ~~the Quarterly Report shows that~~ the bond posted ~~does not~~ fails to meet the minimum funding requirements, the permit holder shall be notified by the Insurance Department and shall post an additional or amended bond within ten (10) days following notification. The additional or amended bond shall be sufficient in size to satisfy the provisions of 36 O.S. §§ 7126 and 7127.

(b) A bond posted in connection with Cemetery Merchandise Trust Act shall be filed in the form and manner prescribed by the Insurance Commissioner. Any variance from this form must have the prior written approval of the Insurance Commissioner. An insurer shall provide thirty (30) day's written notice to the Insurance Commissioner prior to cancelling any bond required by the Cemetery Merchandise Trust Act.

SUBCHAPTER 27. MILITARY SALES PRACTICES REGULATION

365:25-27-3. Authority [REVOKED]

~~This regulation is issued under the authority of the Oklahoma Unfair Trade Practices Act, 36 O.S. § 1201, et seq.~~

365:25-27-8. Severability [REVOKED]

~~If any provision of these sections or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of these sections are declared to be severable.~~

SUBCHAPTER 29. PHARMACY BENEFIT MANAGERS

365:25-29-1. Purpose [REVOKED]

~~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~~

~~(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 [REVOKED]

~~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 [REVOKED]

~~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. §§ 353.1, 356~~357~~-360 and 36 O.S. §§ 309.1, 404, 6103.2, and 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.~~ A member means a covered individual as defined in Section 357 of Title 59 of the Oklahoma Statutes.

(6) Engaging in the business of insurance means and includes, but is not limited to, any or all of the acts listed in 36 O.S. §§ 105 and 404, and any or all acts of the pharmacy benefits management, effected by mail or otherwise.

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 the Pharmacy Audit Integrity Act, 59 O.S. §§ 356 et seq., 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 thousand (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) 36 O.S. § ~~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 prescriptions ~~medicine~~ via a 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.

(4) For purposes of determining compliance with 36 O.S. § 6961(A) of the act, mileage shall be calculated using distance map and driving directions.

(b) A PBM's retail pharmacy network access shall be monitored for compliance with the 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 36 O.S. § 6961 of the act. Each calendar day in a single zip code where a PBM or Insurer has failed to comply with an applicable provision of 36 O.S. § 6961 shall be deemed an instance of violation.

(1) In conformity with these requirements, each health insurer that utilizes the services of a PBM licensed in this state shall, on a semi-annual basis, complete and submit to the Department its network adequacy audit of the PBMs with which the insurer contracts and/or partners to serve the insurer's members within the State of Oklahoma in a searchable format, in a manner which allows for the data to be organized. A health insurer's Geo Access report shall be submitted in the form and manner prescribed by the Commissioner on the Department website and shall be submitted to the Department every April 30 and October 31 of each calendar year.

(A) A health insurer's GeoAccess report due in April of a calendar year shall cover the time-period of July 1 through December 31 of the immediately preceding calendar year.

(B) A health insurer's GeoAccess report due in October of a calendar year shall cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

(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.~~ PBMs doing business in the State of Oklahoma are required to maintain retail pharmacy network access in conformity with the requirements set forth in 36 O.S. § 6961 of the act. The Department is required by 36 O.S. § 6962 to review and approve retail pharmacy network access for all Oklahoma licensed PBMs. Each calendar day in a single zip code where a PBM has failed to comply with an applicable provision of 36 O.S. § 6961 shall be deemed an instance of violation.

(1) In conformity with these requirements, each PBM licensed in the State shall, on a semi-annual basis, complete and submit to the Department its Oklahoma PBM Semi-Annual Retail Pharmacy Network Access Report in a searchable format, in a manner which allows for the data to be organized. A PBMs Geo Access report shall be in the form and manner prescribed by the Commissioner on the Department website and shall be due every January 31 and July 31 of each calendar year.

(A) A PBM's GeoAccess report due in January of a calendar year shall cover the reporting time-period of July 1 through December 31 of the immediately preceding calendar year.

(B) A PBM's GeoAccess report due in July of a calendar year shall cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

~~(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.~~

365:25-29-9. 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 specific regional or national wholesaler where the drug can be purchased by the dispensing pharmacy at a price ~~equal to or less than~~ below 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~~ the dispensing pharmacy at ~~or~~ a price 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 (including but not limited to any changes or amendments to a provider manual or other document referenced in or by a contract), 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~~ 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; and

(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~~,~~.

(A) In conformity with these responsibilities and before May 1 of each year, every insurer utilizing the services of a PBM licensed in the state shall, on an annual basis, complete and submit an Annual PBM audit report to the Department.

(B) The Annual PBM Audit Report shall be in the manner and form as prescribed by the Commissioner on the Department website.

~~(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 the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, 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 or the Pharmacy Choice Commission may censure a PBM, may suspend or revoke a PBM's license. In addition to or in lieu of any censure, suspension or revocation of a license, the Commissioner or the Pharmacy Choice Commission may assess and levy a civil fine of not less than One Hundred Dollars ($100.00) and not greater than Ten Thousand Dollars ($10,000.00) for each violation of a provision of the Patient's Right to Pharmacy Choice Act, the Pharmacy Audit Integrity Act, Sections 357 through 360 of Title 59 of the Oklahoma Statues, or this Subchapter. ~~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~~ One Hundred Dollars ~~($500.00)~~ ($100.00) no more than ~~Five~~ Ten Thousand Dollars ~~($5,000.00)~~ ($10,000.00) 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.
(c)~~(d)~~ Every health insurer and PBM upon receipt of any inquiry from the Commissioner or the Commissioner's representative shall, within twenty (20) 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 [REVOKED]
~~(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

(1) 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 and Title 59.

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

~~(a)~~ ~~Pursuant to 36 O.S. § 6965, the~~ The Commissioner shall have power and authority to examine and investigate the affairs of every PBM engaged in pharmacy benefits management in the state in order to determine whether it is in compliance with all applicable provisions of Title 15, Title 36 and Title 59 of the Oklahoma Statutes and Title 365 of the Oklahoma Administrative Code and may take disciplinary action to enforce the same. ~~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.~~

365:25:29-16. Transparency requirements and aggregate reporting [NEW]

Each PBM licensed in the state shall, on a quarterly basis submit its Oklahoma Pharmacy Benefit Managers Quarterly Data Report to the Department in a searchable format, in a manner which allows for the data to be organized, in a manner and form that is prescribed by the Commissioner on the Department website.

(1) A PBM Quarterly Report shall be due from each PBM every January 31, April 30, July 31, and October 31 of every calendar year.

(2) Each report shall cover the three months immediately preceding the month in which the report is due and all requested information shall be filled in as and where indicated on the form.

SUBCHAPTER 30. PROFESSIONAL EMPLOYER ORGANIZATIONS

~~**365:25-30-3. Authority**~~

~~This Subchapter is promulgated under the authority granted to the Insurance Commissioner in 40 O.S. § 600.4(J).~~

APPENDIX E. APPLICATION TO WITHDRAW FUNDS DEPOSITED FOR PREPAID FUNERAL EXPENSES [REVOKED]

(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 [REVOKED]

(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 [REVOKED]

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 CERTlFICATlON

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, Stale, 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) [REVOKED]

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 U. INFORMATIONAL BROCHURE TO BE PROVIDED TO A PROSPECTIVE VIATOR AT FIRST CONTACT PURSUANT TO O.A.C. 365:25-11-6(A) [REVOKED]

Selling Your Life Insurance Policy

Understanding Viatical Settlements

Always Check with Your State

Contact your state insurance or securities departments to learn about the issues and risks of viatical settlements if:

- you're considering selling your life insurance policy;
- you're asked to sell your life insurance policy and your health hasn't changed since you bought the policy;
- you're asked to buy a new life insurance policy and immediately sell it for cash.

Buying a Life Insurance Policy?

If you're interested in buying a life insurance policy as an investment, contact your state insurance department before you make a decision.

OKLAHOMA INSURANCE DEPARTMENT

Questions to Ask

- Do I still need life insurance protection?
- If I sell my policy, how do they decide how much cash I get?
- Is this an employer or other group policy? If so, do I need permission to sell it?
- If I sell my policy, who will be the legal owner?
- Do I need the advice of a tax or estate planning advisor before I decide to sell my policy?
- Who will have specific information about me, my family or my health status?
- After I sell my policy, can it be resold by the buyer?

Your state insurance department may have a list of viatical settlement providers and brokers that are licensed to do business in the state. Contact them to make sure yours are on the list.

What is a Viatical Settlement?

A viatical settlement is the sale of a life insurance policy to a third party. The owner (insured) of the life insurance policy sells the policy for an immediate cash benefit.

The buyer (the viatical settlement provider) becomes the new owner of the life insurance policy, pays future premiums, and collects the death benefit when the insured dies.

At one time, most viatical settlements were from people with a life-threatening illness. Now, individuals who are not facing a health crisis may sell their life insurance policies to get cash.

Your state insurance department and the National Association of Insurance Commissioners want you to know the facts before you sell your life insurance policy. This brochure provides some of that information, but it is only a starting point. Consult your own professional financial advisor, attorney, or accountant to help you decide if this is the most suitable arrangement for you.

Consider Your Options

If you're selling your policy to get cash to pay expenses, check all of your options. You may find a way to get more cash from your life insurance policy.

1. Ask your insurance agent or company if you have any cash value in your life insurance policy. You may be able to use some of the cash value to meet your immediate needs and keep your policy in force for your beneficiaries. You may also be able to use the cash value as security for a loan from a financial institution.

2. Find out if your life insurance policy has an accelerated death benefit. An accelerated death benefit typically pays some of the policy's death benefit before the insured dies. It may be a way for you to get cash from a policy without selling it to a third party.

Consumer tips

- Comparison shop. Get quotes from several companies to make sure you have a competitive offer.
- Find out the tax implications. Not all proceeds received from the sale of your life insurance policy are tax free.
- It's important to know that any of your creditors could claim your cash settlement.
- Find out if you will lose any public assistance benefits such as food stamps or Medicaid if you get a cash settlement.
- The buyer of your policy can periodically ask you about your health status. The buyer is required to give you a privacy notice outlining who will get this personal information. Be sure to read it.
- Check all application forms for accuracy, especially your medical history. All questions must be answered truthfully and completely.
- Make sure the viatical settlement provider agrees to put your settlement proceeds into an independent escrow account to protect your funds during the transfer.
- Find out if you have the right to change your mind about the settlement AFTER you get the money. If so, how many days do you have to reconsider and return the money?

APPENDIX V. VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES [REVOKED]

VERIFICATION OF COVERAGE FOR LIFE INSURANCE POLICIES

SUBMITTED TO: _____ NAIC #_____
Name of Insurance Company

POLICY NUMBER: _____

SUBMITTED FROM: _____
Name of Viatical Settlement Broker/Provider

ADDRESS: _____

TELEPHONE NUMBER: _____

CONTACT: _____ TITLE: _____

IF INFORMATION IS CORRECT, INSURER REPRESENTATIVE MAY PLACE A CHECKMARK IN THE BOX. OTHERWISE PROVIDE CORRECTED INFORMATION THROUGHOUT THIS FORM. AN ASTERISK INDICATES INFORMATION THE VIATICAL SETTLEMENT PROVIDER/BROKER MUST PROVIDE.

POLICY OWNER'S AND INSURED'S INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Owner's name	*	
Address	*	
City, state, ZIP code	*	
Tax ID or social security number	*	
Insured's name	*	
Insured's date of birth	*	
Second Insured's name (if applicable)	*	
Second Insured's date of birth (if applicable)	*	

I hereby consent by my signature below to release of information requested by this form by the insurance company to the viatical settlement broker/provider.

_____ _____
Signature of policy owner Date signed

Form VOC

IS THIS POLICY IN FORCE? _____YES _____NO
IF NO, SIGN AND DATE ON PAGE 4 AND RETURN TO THE VIATICAL SETTLEMENT BROKER OR PROVIDER THAT SUBMITTED THE VERIFICATION OF COVERAGE.

POLICY TYPE, RIDERS & OPTIONS:

'____TERM ____WHOLE LIFE ____UNIVERSAL LIFE ____VARIABLE LIFE

If a question is not applicable to the type of policy, write N/A in the column.

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Original issue date	*	
Maturity date of policy		
State of issue	*	
Does the policy have an irrevocable beneficiary?	*	
Is the policy currently assigned?	*	
Was the policy ever converted or reinstated?		
Is the policy in the contestability period?	*	
Is the policy in the suicide period?	*	
Please list all riders and indicate if any are in the contestable or suicide period.	*	

POLICY VALUES

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Policy values as of (insert date)		
Current face amount of policy	*	
Amount of accumulated dividends		
Current face amount of riders		
Amount of any outstanding loans	*	
Amount of outstanding interest on policy loans		
Current net death benefit	*	
Current account value	*	
Current cash surrender value	*	
Is policy participating?	*	
If yes, what is the current dividend option?		

PREMIUM INFORMATION

	This column to be completed by Viatical Settlement Broker/Provider	This column to be used by Insurance Company
Current payment mode	*	
Current modal premium	*	
Date last premium paid	*	
Date next premium due	*	
Current monthly cost of insurance as of (insert date)		
Date of last cost of insurance deduction		

TO BE COMPLETED BY VIATICAL SETTLEMENT BROKER/PROVIDER

The information submitted for verification by the viatical settlement broker/provider is correct and accurate to the best of my knowledge and has been obtained through the policy owner and/or insured.

Signature

Printed Name

TO BE COMPLETED BY INSURANCE COMPANY

The information provided by verification by the insurance company is correct and accurate to the best of my knowledge as of _____(date).

Insurance company: _____NAIC#_____

Printed name: _____Title: _____

Telephone number: _____Fax number: _____

Signature: _____

Please provide information about where the forms listed below should be submitted for processing.

Name: _____Title: _____

Company Name: _____

Mailing Address: _____

City, State, ZIP: _____

Overnight Address: _____

City, State, ZIP: _____

Telephone number: _____Fax number: _____

FORMS REQUEST

Please provide the forms checked below:

- o Absolute Assignment/Change of Ownership/Vertical Assignment
- o Change of Beneficiary
- o Release of Irrevocable Beneficiary (if applicable)
- o Waiver of Premium Claim Form
- o Disability Waiver of Premium Approval Letter
- o Release of Assignment
- o Change of Death Benefit Option Form (if UL)
- o Allocation Change Form (if Variable)
- o Annual Report
- o Current In Force Illustration

APPENDIX W. PAYOUTS FOR INSUREDS WHO ARE TERMINALLY ILL [REVOKED]

Insured's Life Expectancy	Minimum Percentage of Face Value Less Outstanding Loans Received by Viator
Less than 6 months	80%
At least 6 but less than 12 months	70%
At least 12 but less than 18 months	65%
At least 18 but less than 24 months	60%

APPENDIX Z. NOTICE TO EMPLOYEES CONCERNINGQUALIFIED EMPLOYER [REVOKED]

Your employer is a Qualified Employer pursuant to 85A O.S. §202 of the Oklahoma Employee Injury Benefit Act. Your employer does not carry workers' compensation insurance coverage under the Administrative Workers' Compensation Act, and that coverage has terminated or been cancelled. If injured on the job, your benefits are governed by a written benefit plan sponsored by your employer. Contact your employer if you have questions about your benefits, rights, and responsibilities under the benefit plan.

The name title, address, and telephone number of the person you should contact for injury benefit claims administration is:

Name: _____

Title: _____

Address: _____

Phone Number: _____

E-mail: _____

Effective Date: _____