NEW JERSEY ADMINISTRATIVE CODE
TITLE 11. DEPARTMENT OF BANKING AND INSURANCE DIVISION OF INSURANCE
CHAPTER 2. INSURANCE GROUP
SUBCHAPTER 17. UNFAIR CLAIMS SETTLEMENT PRACTICES

11:2-17.1 Purpose

N.J.S.A. 17:29B-4(9) and 17B:30-13.1 prohibit insurers from engaging in unfair claims settlement practices. The purpose of this subchapter is to promote the fair and equitable treatment of claimants by defining certain minimum standards for the settlement of claims which, if violated with such frequency as to indicate a general business practice, would constitute unfair claims settlement practices in the business of insurance.

11:2-17.2 Scope

This subchapter applies to all persons and all policies except the following: ocean marine, fidelity and surety, boiler and machinery and workers' compensation. It shall also not apply to commercial property and liability policies for which the annual premium is more than $10,000 and where the claim is made by the commercial insured. This subchapter is not exclusive, and other acts, not herein specified, may also be found to constitute unfair claims settlement practices. This subchapter is not intended to supersede any other rule or regulation.

11:2-17.3 Definitions

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

"After market part" means sheet metal or plastic parts which constitute the exterior of an automobile, including inner and outer panels, manufactured by any manufacturer other than the original manufacturer of the part. Examples of after market parts include, but are not limited to, the following: doors, hoods, fenders, trunk lids, grills and bumper components.

"Catastrophe" means a calamity or other disastrous event that causes widespread losses resulting in excessive claims volume.

"Claimant" means either a first party claimant, a third party claimant, or both and includes such claimant's designated legal representative and includes a member of the claimant's immediate family designated by the claimant.

"Claims settlement" means all the activities of an insurer relating directly or indirectly to the determination of the extent of liabilities due or potentially due under coverages afforded by the policy, and which result in a claim payment or acceptance, compromise or rejection.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"First party claimant" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under an insurance policy or insurance contract arising out of the occurrence of the contingency or less covered by such policy or contract.

"Insurer" means any person, corporation, association, partnership, company, fraternal benefit society, eligible unauthorized surplus lines insurer and any other legal entity engaged as an indemnitor or contractor in the business of insurance. For the purposes of this subchapter, "insurer" shall include any individual, corporation, association, partnership or other legal entity

authorized to represent an insurer with respect to a claim.

"Investigation" means all activities of an insurer related directly or indirectly to the determination of liabilities under coverages afforded by an insurance policy.

"Notification of claim" means any notification, whether in writing or other means acceptable under the terms of an insurance policy or insurance contract, to an insurer or its agent, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

"Pertinent communication" means all correspondence as well as conversations or other forms of communication that are materially related to the handling of a claim.

"Policy" means any contract of insurance and includes, but is not limited to, all policies, contracts, certificates, riders and endorsements which provide insurance coverage.

"Proof of loss" means the necessary documentation required from a claimant to establish entitlement to payment or benefits under a policy.

"Third party claimant" means any individual, corporation, association, partnership or other legal entity asserting a claim against any individual, corporation, association, partnership or other legal entity insured under an insurance policy or insurance contract of an insurer.

"Workers' compensation" includes, but is not limited to, Longshoreman's and Harbor Workers' Compensation.

11:2-17.4 Miscellaneous rules

(a) Every insurer shall distribute copies of this subchapter to every person directly responsible for the handling and settlement of claims subject to this subchapter. Every insurer shall satisfy itself that all such responsible persons are thoroughly conversant with and are complying with this subchapter.

(b) All correspondence to a claimant required of an insurer pursuant to this subchapter shall be written in easy to read and understandable terms. This subsection shall not apply to correspondence to a claimant's legal representative.

11:2-17.5 Misrepresentation of policy provisions

(a) No insurer shall fail to fully disclose to first party claimants all pertinent benefits, coverages or other provisions of an insurance policy or insurance contract under which a claim is presented.

(b) No agent, broker, or insurer shall conceal from first party claimants benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

(c) No insurer shall, except where there is a time limit specified in the policy, make statements, written or otherwise, requiring a claimant to give written notice of loss or proof of loss within a specified time limit and which seek to relieve the company of its obligations if such time limit is not complied with unless the failure to comply with such time limit prejudices the insurer's rights.

(d) No insurer shall request a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment.

(e) No insurer shall issue checks or drafts in partial settlement of a loss or claim using language which releases the insurer or its insured from its total liability.

11:2-17.6 Rules for replying to pertinent communications

(a) All claims must be reported to the designated insurer by a broker no later than three working days following receipt of notification of claim by the broker. For the purposes of this subsection, "broker" shall include a producer of record with respect to any residual market mechanism created by statute.

(b) Every insurer, upon receiving notification of claim shall, within 10 working days, acknowledge receipt of such notice unless payment is made within such period of time. This acknowledgement shall include the address and telephone number of the insurer claims office or authorized claims representative which will handle the claim. Notification given to an agent of an insurer shall be considered notice to the insurer.

(c) Every insurer, upon receiving notification of claim, shall promptly provide first party claimants with necessary claim forms, instructions, and reasonable assistance so that such claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subsection (c) within 10 working days of notification of a claim shall constitute compliance with (b) above.

(d) Every insurer, upon receipt of any inquiry from the Department respecting a claim shall, within 15 working days of receipt of such inquiry, furnish the Department with, based on the information available to the insurer, a complete and accurate written response to the inquiry.

(e) An appropriate reply shall be made within 10 working days on all other pertinent communications from a claimant which reasonably suggest that a response is expected.

11:2-17.7 Rules for prompt investigation and settlement of claims

(a) Every insurer shall commence an investigation on all claims other than auto physical damage within 10 working days of receipt of notification of claim.

(b) The maximum payment period for all personal injury protection (PIP) claims shall be 60 calendar days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same; provided, however, that an insurer may secure a 45-day extension in accordance with N.J.S.A. 39:6A-5.

(c) Unless a clear justification exists, or unless otherwise provided by law, the maximum payment periods for property/liability claims shall be as follows:

1. For all first party claims other than personal injury protection (PIP) and auto physical damage (see N.J.A.C. 11:3-10.5(a)), 30 calendar days from receipt by the insurer of properly executed proofs of loss.

2. For all third party property damage claims, 45 calendar days from receipt by the insurer of notification of claim.

3. For all third party bodily injury claims, 90 calendar days from receipt by the insurer of notification of claim.

(d) Rules for the payment of health insurance claims may be found at N.J.A.C. 11:22-1.

(e) If the insurer is unable to settle the claim within the time periods specified in (c) through (e) above, the insurer must send

the claimant written notice by the end of the payment periods specified in (c) through (e) above. The written notice must state the reasons additional time is needed, and must include the address of the office responsible for handling the claim and the insured's policy number and claim number. This notice shall also include a telephone number which is toll free, or which can be called collect, or which is within the claimant's area code. This number shall provide direct access to the responsible claims office or shall enable the claimant to gain such access at no greater expense than the cost of a telephone call within his or her area code. An updated written notice setting forth the reasons additional time is needed shall be sent within 45 days after the initial notice and within every 45 days thereafter until all elements of the claim are either honored or rejected. The written notifications required under this subsection shall not continue to apply to that aspect of a claim for which the claimant has become represented by an attorney, as evidenced by a letter of representation.

(f) Unless otherwise provided by law, every insurer shall pay any amount finally agreed upon in settlement of all or part of any claim not later than 10 working days from either the receipt of such agreement by the insurer or the date of the performance by the claimant of any conditions set by such agreement, whichever is later.

(g) Where there is a reasonable basis supported by specific information available for review by the Department that the first party claimant has fraudulently caused or contributed to the loss by arson, or other fraudulent schemes, the insurer shall be relieved from the requirements of (c) through (f) above. Provided, however, that the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

(h) Unless otherwise provided by statute or unless otherwise provided by the policy, all life insurance claims shall be paid within a maximum period of 60 calendar days. The payment period is defined as the period between the date proof of loss is received by the insurer and the date of claims settlement.

1. If a claim or a portion of a claim for benefits under a policy requires additional investigation or is denied by the insurer, the insurer shall notify the claimant of such fact in writing within 45 days of due proof of death. The insurer shall also notify the claimant of the reason the claim is being investigated or denied, except in certain cases involving fraud.

2. Any uncontested portion of a claim shall be paid within 60 days of receipt of due proof of death, proof of the interest of the claimant, or any other document or information requested by the insurer under the terms of the policy.

3. The insurer, upon receipt of any document or information requested relating to a claim or portion of a claim under investigation, shall pay the benefits for which the claim is made or deny the claim within 90 days of the receipt of the requested documentation.

4. Payment of a claim or a portion thereof that is not under investigation by the insurer shall be overdue if not remitted to the claimant by the insurer within 60 days following receipt of due proof of death, proof of the interest of the claimant, or any other document or information requested by the insurer.

5. Payment of a claim or a portion of a claim under investigation or denied that becomes eligible for payment shall be overdue if not remitted to the claimant by the insurer within 90 days following receipt of due proof of death, proof of interest of claimant or any other document or information requested by the insurer.

6. Overdue payments shall bear an annual rate of interest equal to the average rate of return of the State of New Jersey Cash

Management Fund, established pursuant to N.J.S.A. 52:18A-90.4, for the preceding fiscal year rounded to the nearest one half percent. Insurers may choose either the Fund's State or Other-than State rates. However, insurers shall not be permitted to change the rate once chosen.

11:2-17.8 Rules for fair and equitable settlements and reasonable explanations applicable to all insurance

(a) No insurer shall deny or offer to compromise a claim because of a policy provision, including any concerning liability, a condition, or an exclusion without providing a specific reference to such language and a statement of the facts which make that language operative.

(b) Any denial or offers of compromise to the claimant shall be confirmed in writing and shall be kept in the appropriate claim file.

(c) In any case where a first party claim is denied or a compromise is offered, the insurer shall notify the first party claimant of any applicable policy provision limiting such claimant's right to sue the insurer.

(d) Insurer shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by law or policy provisions such as Workers' Compensation exclusions, or coordination of benefits provisions.

(e) If a claimant is actively negotiating with an insurer for settlement of a claim, and the claimant's rights may be affected by a statute of limitations or a policy time limit, the insurer shall provide the claimant with written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to claimants 60 calendar days before the date on which such time limit may expire. This rule shall only apply if the insurer is negotiating a claims settlement with a person who is neither an attorney nor represented by an attorney.

(f) No insurer shall make statements which indicate that the rights of a claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the claimant of any applicable law or policy provision.

(g) Unless otherwise provided by law, in any case where there is no dispute as to one or more elements of a claim, payment for such element(s) shall be made notwithstanding the existence of disputes as to other elements of the claim where such payment can be made without prejudice to either party.

(h) An insurer shall not compel claimants to institute litigation to recover amounts due under an insurance policy by offering substantially less than amounts recovered in actions brought by such claimants.

(i) No insurer shall deny payment of a claim when it is reasonably clear that either full or partial benefits are payable.

(j) No claim shall be denied or compromised based on an exclusion, reduction or limitation in a policy unless documentation of facts rendering the exclusion, reduction or limitation operative can be obtained. If such documentation is not made a part of the claim file, the insurer shall place in the claim file a written notation explaining how documentation may be obtained.

(k) With respect to first party claims, insurers shall make claim payments by check or draft with a statement setting forth the coverage under which payment is made and in sufficient detail so that first party claimants can reasonably understand the benefits included within the claim payment. The details should include an explanation of how the benefit payment was calculated. This subsection shall not apply to claims in which the claim payment figure was arrived at through negotiations between the insurer and the first party claimant.

(l) If a first party claimant or a third party claimant not represented by an attorney does not submit sufficient information to establish his or her entitlement to the benefits claimed, then the insurer shall provide the claimant with a general description of the information and documentation needed to establish such entitlement.

11:2-17.9 Rules for fair and equitable settlements applicable to life and health insurance

(a) No insurer shall indicate on a payment draft, check or in any accompanying cover letter that said payment is "final" if additional benefits relating to the claim for which benefits are being paid are payable under the policy.

(b) When it is apparent to the insurer that additional benefits would be payable under a policy upon receipt of additional proofs of loss from the claimant, the insurer shall explain to the claimant in writing or by telephone the additional proofs or information needed to establish entitlement to additional benefits.

(c) No insurer shall undertake any activity that has the effect of coercing the insured to settle a disability claim on a lump sum basis.

(d) No insurer shall pay a claim involving both a covered and noncovered condition on a percentage basis of contributing loss, unless said percentage is reasonable.

(e) Settlement of claims for a fraction of an indemnity period shall be on a pro rata basis unless the policy specifically excludes pro-rata payments.

(f) If it is found that an insured's age is overstated on an individual life or health policy or understated on an annuity, benefits shall be adjusted upward under a policy which contains a misstatement of age provision specified in N.J.S.A. 17B:25-6 and N.J.S.A. 17B:26-18.

(g) No insurer shall request a claimant to sign an agreement which releases the insurer from all future claims under an insurance policy unless no other benefits are payable under it.

(h) Unless otherwise provided by the policy, no insurer may terminate disability benefits based solely on lack of regular medical attendance when the disability has been verified by a physician and can reasonably be expected to continue beyond the date through which benefits have been paid.

(i) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on material misrepresentation by the applicant unless the application is a part of the contract.

(j) No policy shall be rescinded and claim denied for loss incurred during the contestable period based on omission of material information when such information is not specifically requested on the application.

(k) When an application for a life/health policy contains only one medical question or declaration as to general status of the insured's health, such as, "Are you now in good health?", an insurer shall not rescind a policy or deny a claim for loss incurred during the contestable period on the basis of material misrepresentation, if based on the totality of circumstances, the
insured responded to the best of his/her knowledge and belief that the general status of his/her health was satisfactory.

11:2-17.10 Rules for fair and equitable settlements applicable to property and liability insurance

(a) This section, unless otherwise noted in this subchapter, is applicable to claims arising under all property/liability

coverages. This section is organized so that the requirements for all lines of property/liability insurance are found in (a)1 through 6 below; for automobile insurance only, in (a)7 through 13 below; and for other than automobile insurance only, in (a)14 and 15 below. The requirements of this section with respect to motor vehicle claims are in addition to the requirements of N.J.A.C. 11:3-10. In addition to the provisions of this section, the requirements for auto physical damage first party claims found in N.J.A.C. 11:3-10.1 through 10.4 shall also be construed to apply to automobile property damage third party claims from the time that liability becomes reasonably clear. The requirements are as follows:

1. Where liability and damages are reasonably clear, insurers shall not recommend that third party claimants make claim under their own policies solely to avoid paying claims under such insurer's policy.

2. When the amount claimed is reduced because of betterment or depreciation, all information and calculations for such deduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amounts and shall be fair and equitable.

3. Unless the question has been specifically negotiated, the insurer remains liable for hidden damage directly related to the loss giving rise to the claim subject to policy terms, conditions and limits.

4. No insurer shall refuse to grant advance payments on a claim primarily because the claimant has retained an attorney for the purpose of facilitating recovery on his/her behalf.

5. No insurer shall deny a claim for failure to exhibit the property without proof of demand and unfounded refusal by a claimant to do so.

6. Unless the insurer is exercising a right under the policy to repair damaged property, it shall not require as a condition to payment of claims that repairs be made by a particular contractor or repair shop.

7. In all automobile physical damage claims, the first party claimant shall be notified at the time of the insurer's acknowledgement of the claim, or sooner if inquiry is made, whether coverage exists for the rental of an automobile subject to policy terms and conditions.

8. When an insurer acknowledges receipt of an automobile property damage liability claim, or sooner if the claimant inquires, it shall inform the claimant whether and to what extent he or she will be entitled, if the insurer's liability later becomes reasonably clear, to payment for the rental of an automobile or other substitute transportation. Such payment will ordinarily be for the rental of a vehicle comparable to the type of the damaged vehicle (for example, sedan, minivan, sport utility vehicle, etc.) at a reasonable price until the damaged vehicle is repaired or, in the event of a total loss, until the claim is settled. Nothing in this section shall be construed to require that the reimbursement cover costs of a rental vehicle of similar value or "status" to that of the damaged vehicle, but only a comparable type. When an insurer uses the doctrine of comparative negligence to determine its responsibility for the cost of substitute transportation, it shall, as soon as is practicable, advise the claimant of the extent of its liability.

9. An insurer shall provide notice to a claimant three working days prior to the termination of payment for automobile storage charges and place a copy of such notice in a claim file.

10. All after market parts manufactured after October 17, 1988 used in the repair of an automobile where insurance proceeds provide the basis of payment therefor shall carry sufficient permanent identification so as to identify the manufacturer thereof. Such identification shall be accessible after installation to the extent possible.

11. No insurer shall require the use of after market parts in the repair of an automobile unless the after market part is warranted by the manufacturer in a reasonable manner as to duration and coverage and at least equal in like kind and quality to replacement parts available from the original manufacturer of the part in terms of fit, quality and performance. Use of after market parts which have been certified by an independent testing laboratory as being of like kind and quality to the original manufactured part will be deemed to be in compliance with the requirements of this paragraph.

12. Insurers specifying the use of after market parts shall pay for any modifications which may become necessary in making the repair.

13. Where the insurer specifies the use of after market parts, the insurer shall disclose to the claimant, in writing, either on the estimate or on a separate document attached to the estimate, the following information, which shall appear in print no smaller than 10 point type:
THIS ESTIMATE HAS BEEN PREPARED BASED ON THE USE OF AUTOMOBILE PARTS NOT MADE BY THE ORIGINAL MANUFACTURER. PARTS USED IN THE REPAIR OF YOUR VEHICLE BY OTHER THAN THE ORIGINAL MANUFACTURER ARE REQUIRED TO BE AT LEAST EQUAL IN LIKE KIND AND QUALITY IN TERMS OF FIT, QUALITY AND PERFORMANCE TO REPLACEMENT PARTS AVAILABLE FROM THE ORIGINAL MANUFACTURER.

The insurer shall clearly identify on the estimate of such repair all after market parts installed on the vehicle.

14. If the insurer intends to exercise its right to inspect, or cause to be inspected by an independent appraiser, damages prior to repair, it shall have 10 working days following receipt of notification of claim to inspect the claimant's damaged property at a place and time reasonably convenient to the claimant, provided that the claimant has not refused to make the property available for inspection. For third-party property damage claims, this paragraph shall apply once the insured's liability is reasonably clear. This paragraph does not apply to losses caused by a catastrophe.

15. If any loss other than a motor vehicle loss subject to N.J.A.C. 11:3- 10 is to be settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply to the claimant before beginning negotiations a copy of the estimate upon which the settlement is to be based.

i. Such estimate prepared by or for the insurer shall be reasonable, and of an amount which will allow for repairs to be made in accordance with generally accepted standards for safe and proper repairs, subject to policy conditions, such as limits, deductible, depreciation, and prior damage.

ii. If the claimant subsequently claims, based upon a written estimate which he/she obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the company shall review the written estimate and respond to the claimant within 10 working days, and may provide or, if requested, must provide the claimant with the name of the repair shop or contractor that will make the repairs in accordance with generally accepted standards for safe and proper repairs.

11:2-17.11 Written notice by insurers of payment of claims
(a) Upon payment of $5,000 or more in settlement of any third-party liability claim, where the claimant is a natural person, the insurer or its representative (including the insurer's attorney) shall mail to the third-party claimant written notice of payment at the same time payment is made to the third-party claimant's attorney or other representative.

(b) Upon payment of $5,000 or more in settlement of any first-party property claim, the insurer or its representative (including the insurer's attorney) shall mail to the first-party claimant written notice of payment at the same time payment is made to the first-party claimant's public adjuster or other representative.

(c) The written notice referred to in (a) or (b) above shall be mailed to the claimant by regular mail at the claimant's last known address, and shall include at least the following information:
1. The amount of the payment;
2. The party or parties to whom the check is made payable;
3. The party to whom the check was mailed; and
4. The address of the party to whom the check was mailed.

(d) Nothing in (a) or (b) above shall create, or be construed to create, a cause of action for any person or entity, other than the Department, against the insurer or its representative based upon a failure to serve such notice, or the defective service of such notice. Nothing in (a) or (b) above shall establish, or be construed to establish, a defense for any party to any cause of action based upon a failure by the insurer or its representative to serve such notice, or the defective service of such notice.

11:2-17.12 Examinations
(a) Each insurer's claim files are subject to examination and inspection by the Commissioner or by his duly appointed designees pursuant to N.J.S.A. 17:23-4, 17:29B-5, 17B:21-3 and 17B:30-16.

(b) Detailed documentation and/or evidence shall be contained in each claim file in order to permit the Commissioner or his designated examiners or investigators to reconstruct the company's activities relative to the claims settlement. Such documentation shall include but is not necessarily limited to all investigative reports, payment vouchers, transactions, notices, memoranda and work papers. With respect to automobile damage claims, file documentation also shall include the name, address, telephone number and license number of any auto body repair facility that has been utilized by the insurer in the adjustment of the loss or repair of the automobile. All such documentation shall be properly dated and, for investigative reports, notes, memoranda and work papers, the parties preparing such documents shall be identified.

(c) Every insurer shall maintain records of all pertinent communications relating to a claim. The records must identify the date of the communication and the parties, and describe the substance of the communication.

11:2-17.13 Special claims reports
(a) If the Department observes that an insurer's claims settlement practices are not meeting the standards established by statute or by this subchapter, the Department may require such insurer to file periodic reports. Depending on the nature and extent of an insurer's deviations from such standards and with due consideration of the insurer's data capabilities, the

Commissioner in his discretion may require the report to include some or all of the statistics listed below:
1. The total number of claims submitted;
2. The original amount claimed;
3. The classification by line or insurance of each individual claim;
4. The total number of claims denied;
5. The total number of claims paid;
6. The total number of claims compromised;
7. The amount of each settlement;
8. The total number of claims for which lawsuits are instituted against the insurer, the reason for the lawsuit, and the amount of the final adjudication; and
9. An individual listing showing the disposition and other information for each claim.

11:2-17.14 Separability

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

11:2-17.15 Penalties

(a) If, after notice and hearing, the Commissioner finds that a person has violated this subchapter, he shall make his findings in writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to
cease and desist from engaging in such violation. The Commissioner may order payment of a penalty not to exceed $1,000 for each and every violation unless the person knew or reasonably should have known he was in violation of this subchapter, in which case the penalty shall not be more than $5,000 for every violation. The Commissioner shall collect the penalty in the name of the State in a summary proceeding in accordance with "the penalty enforcement law" (N.J.S.A. 2A:58-1 et seq.).

(b) Any person who violates a cease and desist order of the Commissioner under (a) above, after it has become final, and while such order is in effect, shall be liable to a penalty not exceeding $5,000 for each violation, which may be recovered in a civil action. In determining the amount of the penalty the question of whether the violation was willful shall be taken into consideration.

(c) The penalties provided herein shall be in addition to any other penalties authorized by law.