

**Excerpts from the
California Code of Regulations—Title 10
Effective February 2021**

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This Companion is published for the convenience and guidance of the members of the Workers' Compensation Insurance Rating Bureau of California (WCIRB). This Companion does not bear the official approval of the Insurance Commissioner and is not to be considered an official part of the *California Workers' Compensation Uniform Statistical Reporting Plan—1995, Miscellaneous Regulations for the Recording and Reporting of Data—1995, California Workers' Compensation Experience Rating Plan—1995*, or additional regulations approved by the California Department of Insurance. This Companion contains certain sections of the California Code of Regulations, Title 10 that apply to the underwriting and handling of Workers' Compensation Insurance policies insuring liability under the California Workers' Compensation Insurance Act.

Please be advised that the language of some regulations cited in this supplement may be contrary to the current forms filing procedures. Changes to these regulations that would make them consistent with current practice and procedures are under review. The current form filing procedures may be found in the California Workers' Compensation Insurance Forms Manual.

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Article 1. Document Submission and Approval Procedures; Fees
§2207. Form in Which Documents Must be Filed, and Filer's Responsibility for Complying with California Law.

Chapter 5 – Insurance Commissioner
Subchapter 2. – Policy Forms and Other Documents

Article 1. Document Submission and Approval Procedures; Fees

§2207. Form in Which Documents Must be Filed, and Filer's Responsibility for Complying with California Law.

Only those documents submitted in the final form in which they will be issued will be approved or accepted for filing by the Commissioner. The insurer is responsible for conforming its documents to California law before submitting those documents to the Commissioner.

§2211. Form Numbers Required.

Every document submitted pursuant to this Article, except rate schedules and actuarial memoranda, must have a form number in the lower left-hand corner of each page. The form number must be different from any other form number on any document previously filed with or approved by the Commissioner for that insurer. A revised version of a previously filed or approved document which contains any change whatsoever (subject to Section 2202(d) of this Article) is not the same form and its issuance is unlawful unless the revised version is properly submitted and filed or approved with its own unique form number

§2212. Blanks to Be Completed.

All blanks in documents which are not obviously self explanatory shall be filled in with sample material which will indicate the use to be made of the blanks.

§2213. Variable Content.

Variable content in documents submitted to the Commissioner shall be indicated by brackets. The insurer submitting the document shall set forth all variable content either within the brackets or in a separate statement of variability. Complete lists and numerical ranges of variable content or accurate descriptions of the material to be inserted are required. Descriptions that are incomplete or which lack specificity will not be accepted. The Commissioner will charge a separate fee for action on a statement of variability.

§2218. Workers' Compensation Forms and Rates.

(a) Workers' compensation policy forms, endorsement forms, or ancillary agreements that are submitted to the Insurance Commissioner are excluded from the requirements of Sections 2204, 2205, 2216 and 2217 of these regulations. Sections 2250 et seq. govern the submission, approval and use of workers' compensation policy forms, endorsement forms, ancillary agreements, and notices.

(b) Workers' compensation rates shall be filed as provided in Sections 2509.30 et seq. of this chapter.

*Note: Although Section 2218(a) states that workers' compensation form filings are excluded from the requirements of Sections 2216 and 2217, the Commissioner requires insurers to submit a completed Document Submission Form (DSF) with all filings that include Non-Standard Forms.

Article 7. Workers' Compensation Policy Forms
§2250. Definitions.

Article 7. Workers' Compensation Policy Forms

§2250. Definitions.

The following definitions shall apply to this Article.

(a) "Policy form" means a form that an insurer uses to provide workers' compensation insurance coverage to an employer after the form is approved by the Insurance Commissioner.

(b) "Endorsement" or "endorsement form" means a form, agreement or document that amends, adds to, subtracts from, supplements, or revises a policy form and is attached to policy form to be effective.

(c) "Attached" means that a writing is part of the policy of insurance by (1) being physically connected to the policy or (2) including a statement in the writing that it is incorporated by reference into the policy.

(d) "Attachment clause" means a provision in an endorsement or ancillary agreement identifying the policy of insurance and incorporating the endorsement or ancillary agreement by providing blank spaces for the insertion of a policy number, endorsement or ancillary agreement number, endorsement or ancillary agreement effective date, name of policyholder, and if applicable, a countersignature.

(e) "Limiting and restricting endorsement" means an endorsement that excludes from coverage some portion of workers' compensation liability for which the employer is required to secure payment pursuant to the Labor Code that, after approval of the endorsement by the Insurance Commissioner, may be endorsed to a workers' compensation policy.

(f) "Ancillary agreement" means an agreement that is a supplementary writing or contract relating to a policy or endorsement form that adds to, subtracts from, or revises the obligations of either the insured or the insurer regarding any terms of an insurance policy including, but not limited to, dispute resolution agreements, policy premium amounts or rates, expense or tax reimbursement or allocation, deductible amounts, policy duration, cancellation, or claims administration. "Ancillary agreements" do not include:

(1) Limiting and restricting endorsements as defined in Subdivision (e) of this regulation;

(2) Customized limiting and restricting endorsements as defined in Subdivision (g) of this regulation;
or

(3) Agreements specifying only terms described in subdivisions (f)(3)(A) through (f)(3)(F) below, but only if, such terms are disclosed and negotiated contemporaneously with the inception or renewal of the underlying policy, and any revisions or additions to such terms subsequent to the inception or renewal of the policy are mutually agreed upon by the parties:

(A) the method for making payments,

(B) the method for funding deductible amounts or other policy-related charges due under a policy,

(C) the amounts of collateral or security the insured is required to maintain for claims that do not exceed the deductible,

(D) payment due dates,

(E) payment transmittal information, or

(F) the method of selecting a claims administrator, provided that such claims administrator may only administer claims that do not exceed the deductible.

(g) "Customized limiting and restricting endorsement" means an endorsement unique to a specific policy used (1) When the employer's business is conducted in such a manner that it is impossible or impracticable to determine the nature, scope, and extent of employment covered by the insurer, or (2) To prevent the performance of work in such an extremely hazardous manner or under such hazardous conditions as would reflect a reckless disregard by the employer for the welfare of its employees, or (3) To prevent the issuance of an unrestricted policy if it would encourage an operation that is contrary to law or to the rules of a regulatory agency.

Article 7. Workers' Compensation Policy Forms
§2251. Policy Forms; Endorsement Forms; Ancillary Agreements; General Procedures.

(h) "Rating organization" means a workers' compensation rating organization as defined by Insurance Code Section 11750.1(b), and licensed pursuant to Insurance Code Section 11751.1.

(i) "Advisory organization" means a workers' compensation advisory organization as defined by Insurance Code Section 11750.1(e).

(j) "Standard policy form" or "standard endorsement form" means a policy or endorsement form that is submitted to the Insurance Commissioner by a rating organization on behalf of its insurer members for use by any of its insurer members as an insurance policy or endorsement form.

(k) "Non-standard policy form" or "non-standard endorsement form" means a policy form, endorsement form, or ancillary agreement that a rating organization submits to the Insurance Commissioner on behalf of a single insurer member for use as an insurance policy, endorsement, or ancillary agreement.

(l) "Withdrawal of approval" means the Commissioner's notification to an insurer that a policy form, endorsement form, or ancillary agreement that was previously approved will be disapproved and shall not be used.

(m) "Filed" means the date the California Department of Insurance receives a document or electronic transmittal of information, through a Department-approved electronic filing system.

§2251. Policy Forms; Endorsement Forms; Ancillary Agreements; General Procedures.

(a) An insurer shall submit all non-standard policy forms, endorsement forms, or ancillary agreements to the Insurance Commissioner through the rating organization prior to their use as part of a workers' compensation policy. A non-standard policy form, endorsement form, or ancillary agreement, other than a limiting and restricting endorsement or a customized limiting and restricting endorsement, may be used by an insurer if the Insurance Commissioner does not take any action on the form within 30 days after the date of submission to the Insurance Commissioner.

(b) An insurer shall not use policy forms, endorsement forms, or ancillary agreements unless submitted to and approved by the Insurance Commissioner, except as provided in Subdivision (a).

§2252. Limiting and Restricting Coverage.

Sections 2253 through 2269 and 2218 shall govern the policy form, endorsement form, and ancillary agreement submission process and the limitation or restriction of coverage for liability under the workers' compensation laws of the State of California. However, there shall be no limitations or restrictions on the workers' compensation coverage provided on a policy that also provides comprehensive personal liability insurance.

§2253. Endorsements or Ancillary Agreements: Attachment to Insurance Policies.

Every endorsement form or ancillary agreement shall contain an attachment clause, as defined in Section 2250(d), which states it is part of a workers' compensation insurance policy, with blank spaces to be filled in if the endorsement or ancillary agreement is attached to a policy after the policy inception date.

§2254. Submission of Policy Forms, Endorsement Forms, or Ancillary Agreements.

(a) Only a rating organization shall submit policy forms, endorsement forms, or ancillary agreements on behalf of its insurer members. The Insurance Commissioner shall not act upon any policy forms, endorsement forms, or ancillary agreements that are directly submitted by an insurer, and the forms shall not be effective for use.

(b) California Code of Regulations, Title 10, Section 2216 notwithstanding, a rating organization shall transmit policy forms, endorsement forms, or ancillary agreements electronically, unless not technically feasible. The rating organization shall include a copy of the proposed policy form, endorsement form, or

Article 7. Workers' Compensation Policy Forms
§2256. Amendment, Alteration, Variable Text, and Blanks in Policy Forms Endorsement Forms, and Ancillary Agreements.

ancillary agreement and a detailed cover letter that explains the necessity for and purpose of the proposed form.

(c) Standard Policy and Endorsement Forms.

A rating organization may submit a proposed standard policy form, endorsement form, or ancillary agreement to the Insurance Commissioner for approval for use by all members of the rating organization.

(d) Non-standard Policy Forms, Endorsement Forms, or Ancillary Agreements.

(1) An insurer shall file all proposed non-standard policy forms, endorsement forms, or ancillary agreements with a rating organization. The insurer shall include a detailed cover letter explaining the necessity for and purpose of the proposed form and a copy of the proposed form.

(2) An insurer shall cite one or more of the grounds enumerated in Section 2259 of this Article in its cover letter as a basis for use of limiting and restricting endorsements or customized limiting and restricting endorsements.

(3) The rating organization shall review each insurer's filing for compliance with these regulations and California law and shall either:

(A) Submit the entire filing to the Insurance Commissioner if the filing is sufficient and in compliance with these regulations and California law, or

(B) Notify the insurer in writing that the filing is incomplete or not in compliance with these regulations or California law, setting forth the reasons in sufficient detail, and providing the insurer with the following options:

(i) Amend the filing so that it is complete or in compliance and submit it to the Insurance Commissioner, or

(ii) Withdraw the filing without submission to the Insurance Commissioner, or

(iii) Submit the filing with a written explanation to the Insurance Commissioner. The insurer shall identify the reasons why the rating organization determined that the filing is incomplete or does not comply with the regulations or California law, and the insurer shall state why it believes the filing does comply with the regulations or California law.

§2256. Amendment, Alteration, Variable Text, and Blanks in Policy Forms Endorsement Forms, and Ancillary Agreements.

(a) An insurer may not alter or amend a policy form, endorsement form, or ancillary agreement, after it was approved by the Insurance Commissioner other than adding variable text, preprinting or changing officers' signatures, preprinting the insurer's name on a form, or making non-substantive formatting changes.

(b) An insurer may include blank portions on a policy form, endorsement form, or ancillary agreement where variable text, numbers, or data will be inserted. The blank portions shall be clearly identified as having variable text, numbers, or data, or be enclosed with brackets.

(1) An insurer shall fill in any blank portion that is not self-explanatory with sample material which indicates how the blanks will be used, or

(2) An insurer shall include complete lists of variable wording or accurate descriptions of the material to be inserted into submissions containing blanks.

(3) An insurer shall complete approved policy forms, endorsement forms, or ancillary agreements by inserting text, numbers, or data in any of the blank spaces. Insurers may amend or change such inserted provisions without in any way affecting the approval of such policy form, endorsement form, or ancillary agreement.

Article 7. Workers' Compensation Policy Forms
§2257. Use of Policy Forms, Endorsement Forms, and Ancillary Agreements.

§2257. Use of Policy Forms, Endorsement Forms, and Ancillary Agreements.

(a) An insurer may use a standard policy form, or endorsement form, including a standard limiting and restricting endorsement form, after receiving written notice from the rating organization that the form has been reviewed as to form and substance and is ready for use.

(b) An insurer may use a non-standard policy form, endorsement form, or ancillary agreement, other than a limiting and restricting form or a customized limiting and restricting form, after filing it in accordance with Section 2254(d) and receiving approval by the Insurance Commissioner or pursuant to Section 2251(a).

(c) Except for an approved standard policy or endorsement form, an insurer shall not use a limiting and restricting form unless the Insurance Commissioner approves it in writing.

(d) An insurer shall not use any previously-approved policy form, endorsement form, or ancillary agreement following a 30 day period after the Commissioner issues a written notice of the withdrawal of approval of the form to the insurer unless the insurer timely demands a hearing in accordance with this Section. If the insurer timely demands a hearing, the insurer may continue to use the form pending the Commissioner's decision after the conclusion of the hearing. If the Commissioner's decision upholds the withdrawal of approval, the insurer shall not use the form as of the 31st day after the Commissioner's decision.

(1) The Commissioner shall provide written notice of withdrawal of approval to an insurer, specifying the grounds and notifying the insurer that the withdrawal of approval will become effective on the 31st day after the date of the written notice unless the insurer timely files a written demand for a hearing.

(2) An insurer may file a written demand for a hearing within 30 days of the date the Commissioner issues a notice of withdrawal of approval. The written demand shall prominently display the title of the document printed in **bold** or CAPITAL letters as APPEAL OF COMMISSIONER'S WITHDRAWAL OF APPROVAL. The written demand shall identify the insurer's name, the form number(s), and set forth the reason(s) why the form should not be subject to the Commissioner's withdrawal of approval.

(3) Within 30 days from the date the insurer files a timely written demand for a hearing on the notice of withdrawal, the Commissioner may commence a hearing on the notice of withdrawal.

(4) If the Commissioner does not commence a hearing within 30 days of the insurer's written demand for a hearing, the withdrawal of approval shall be deemed ineffective on the 31st day after the insurer's filing of a written demand for a hearing.

§2258. Identification of Forms.

(a) All policy forms, endorsement forms, or ancillary agreements, shall have a unique identifying form number consisting of no more than 11 characters comprised of letters or numbers or a combination of letters and numbers excluding spaces and punctuation, and the month and the year shall be separated from the form number by at least one space.

(b) Non-standard policy forms, endorsement forms, or ancillary agreements: The insurer shall assign a form number to each form and the rating organization shall verify the number as being unique and capable of electronic processing prior to submission to the Insurance Commissioner.

(c) Standard policy forms or endorsement forms: The rating organization shall assign a form number prior to submission to the Insurance Commissioner.

§2259. Grounds and Manner for the Use of Limiting and Restricting Endorsements.

(a) An insurer may use a limiting and restricting endorsement only upon one or more of the following grounds:

(1) To limit insurance coverage for liability for compensation to employees of the specific entity named as the insured in the policy.

Article 7. Workers' Compensation Policy Forms
§2260. Limiting and Restricting Form Specifications.

(2) To exclude an individual who is related to the insured by blood, marriage, adoption or domestic partnership and who is not an employee.

(3) Where the insured seeks by endorsement to negate an "election" under Labor Code Section 4151 to bring under the compensation provisions of the Labor Code persons in his employment who are excluded from the definition of "employee" by Section 3352 and other provisions of Article 2 of Chapter 2 of Part 1 of Division 4 of the Labor Code.

(4) To provide notice to the employer that liability is uninsurable for any of the following: Additional compensation payable to his or her employee due to the employer's serious and willful misconduct pursuant to Insurance Code Section 11661; the illegal employment of a minor under 16 years of age pursuant to Insurance Code Section 11661.5; or the employer's reimbursement to the insurer for the amount of increase in indemnity payments as provided by Labor Code Section 4650(e) pursuant to Insurance Code Section 11661.6.

(5) To exclude only such liability of the employer if the employer affirms in writing to the insurer that other coverage is secured or the entity is lawfully uninsured (e.g., liability of the State and its political subdivisions and institutions).

(6) To exclude an employee who is covered for workers' compensation benefits on a policy also affording comprehensive personal liability insurance.

(7) To exclude liability of an employer for employees who are covered under another employer's workers compensation policy pursuant to an agreement made under Labor Code Section 3602(d).

(8) To exclude liability when the employer's business is conducted in such a manner that it is impossible or impracticable to determine the nature, scope, and extent of employment covered by the insurer without the use of a limiting and restricting endorsement.

(9) To prevent the performance of work in such an extremely hazardous manner or under such hazardous conditions as would reflect a reckless disregard by the employer for the welfare of its employees.

(10) To prevent the issuance of an unrestricted policy if it would serve to encourage an operation that is contrary to law or to the rules of a regulatory agency.

(b) An insurer shall use the customized limiting and restricting endorsement form set forth in Section 2267 only if the limitation and restriction is based upon one or more of the grounds enumerated in subsections (8) through (10) of subdivision (a) of this regulation. An insurer shall submit and obtain approval to use a customized limiting and restricting endorsement in accordance with Sections 2266 and 2267 before attaching it to a policy.

§2260. Limiting and Restricting Form Specifications.

Each limiting and restricting form shall conform to the following specifications:

(a) It shall have **bold** and/or CAPITALIZED text at the top of the form:

"ENDORSEMENT AGREEMENT LIMITING AND RESTRICTING THIS INSURANCE"

(b) The opening statement shall contain the following language:

"The insurance under this policy is limited as follows: It is AGREED that, anything in this policy to the contrary notwithstanding, this policy (or "such insurance as is afforded by the policy by reason of the designation of California in Item 3 of the declarations") DOES NOT INSURE" (or "DOES NOT COVER" or "DOES NOT APPLY TO"),

(c) It shall have a marginal notation prominently displayed and printed in **bold** or CAPITAL letters indicating the character of the limitation or restriction stated in the endorsement.

(d) It shall have in **bold** and/or CAPITALIZED letters the following language:

Article 7. Workers' Compensation Policy Forms
§2266. Submission of the Customized Limiting and Restricting Endorsement.

“FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES, AND OTHER SUBSTANTIAL PENALTIES (Labor Code Section 3710.1, et seq.).”

(e) The words “the insured” may be substituted in any of the approved endorsements for “this employer,” “the insured employer,” “the employer,” or “the named employer.”

§2266. Submission of the Customized Limiting and Restricting Endorsement.

An insurer shall file the customized limiting and restricting endorsement with the rating organization in accordance with Section 2267, along with a detailed cover letter that identifies:

- (a) The policy to which the endorsement will be attached upon approval, and
- (b) The circumstances that justify use of the endorsement.

The rating organization shall submit the endorsement to the Insurance Commissioner for approval or disapproval upon receipt of all required documents and shall forward copies of the endorsement and cover letter to the policyholder and to the Department of Industrial Relations. An insurer shall not use a limiting and restricting endorsement unless it complies with Section 2257(c).

§2267. California Customized Limiting and Restricting Endorsement-Specifications.

Each customized limiting and restricting form shall conform to the following specifications:

- (a) It shall have **bold** and/or CAPITALIZED text at the top of the form:

“CALIFORNIA CUSTOMIZED LIMITING AND RESTRICTING ENDORSEMENT AGREEMENT”

Endorsement Agreement Limiting and Restricting This Insurance

- (b) The opening statement shall contain the following language:

“The insurance under this policy is limited as follows: It is AGREED that, anything in this policy to the contrary notwithstanding, this policy (or “such insurance as is afforded by the policy by reason of the designation of California in Item 3 of the declarations”) DOES NOT INSURE” (or “DOES NOT COVER” or “DOES NOT APPLY TO”).”

Nothing contained in this endorsement agreement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, or limitations of this policy other than as above stated. Nothing elsewhere in this policy shall be held to vary, alter, waive or limit the terms, conditions, agreements or limitations of this endorsement agreement. It is further agreed that “remuneration” when used as a premium basis for such insurance as is afforded by this policy (or “by the policy by reason of the designation of California in Item 3 of the declarations”) shall not include the remuneration of any person excluded from coverage in accordance with the foregoing.

- (c) It shall have a marginal notation prominently displayed and printed in **bold** or CAPITAL letters indicating the character of the limitation or restriction stated in the endorsement.

- (d) It shall have in **bold** and/or CAPITALIZED letters the following language:

FAILURE TO SECURE THE PAYMENT OF FULL COMPENSATION BENEFITS FOR ALL EMPLOYEES AS REQUIRED BY LABOR CODE SECTION 3700 IS A VIOLATION OF LAW AND MAY SUBJECT THE EMPLOYER TO THE IMPOSITION OF A WORK STOP ORDER, LARGE FINES AND OTHER SUBSTANTIAL PENALTIES (Labor Code Section 3710.1, et seq.).

- (e) The words “the insured” may be substituted in any of the approved endorsements for “this employer,” “the insured employer,” “the employer,” or “the named employer.”

§2268. Unlawful Use of Policy Forms, Endorsement Forms, or Ancillary Agreements.

Article 7. Workers' Compensation Policy Forms
§2269. Policy Forms; Endorsement Forms; Ancillary Agreements; Confidentiality.

(a) An insurer shall not use any policy form, endorsement form, or ancillary agreement unless attached to and made a part of the policy. If an insurer attaches a policy or endorsement form that restricts or limits the coverage of the policy, it shall conform in all respects with these rules.

(b) An insurer shall not use a policy form, endorsement form, or ancillary agreement except those filed and approved by the Commissioner in accordance with these regulations.

(c) An insurer shall not use a policy form, endorsement form, or ancillary agreement that does not conform to the regulations set forth in this Article or Insurance Code Sections 11657, 11658 or 11659. An insurer that fails to comply with this regulation is in violation of Insurance Code Sections 11657, 11658 or 11659 and therefore, is in violation of Section 700(c). Such an insurer shall be subject to proceedings pursuant to Sections 701, 704(b) and 1065.1. Each occurrence of a violation to each insured shall constitute a separate and distinct violation for purposes of this regulation.

§2269. Policy Forms; Endorsement Forms; Ancillary Agreements; Confidentiality.

An insurer or a rating organization may submit a written request to prevent public access to a policy form, endorsement form, ancillary agreement, or other related writing that has been submitted to the Insurance Commissioner.

(a) The insurer or the rating organization shall provide the basis upon which each document submitted should be withheld from public access, along with the time period during which each document should be withheld.

(b) The Insurance Commissioner shall base the determination on the nature of the information including, but not limited to, information that is proprietary, privileged, or contains trade secrets.

(c) The Insurance Commissioner shall issue a written decision and send it to the person or entity submitting the request, and it shall be final.

(d) The written request and the Insurance Commissioner's written determination shall be confidential and not open to public inspection.

Article 4. Experience and Reserves
§2318.6. California Workers' Compensation Uniform Statistical Reporting Plan-1995.

Subchapter 3. – Insurers

Article 4. Experience and Reserves

§2318.6. California Workers' Compensation Uniform Statistical Reporting Plan-1995.

EDITORIAL NOTE: Pursuant to the provisions of Government Code Section 11344.6, this regulation is not printed in full herein. The complete regulation may be examined at the offices of the Insurance Commissioner in Oakland, Los Angeles, Sacramento, and San Diego. The complete regulation will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its Oakland, California office.

History: Adoption filed 12-30-94; effective 1-1-95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995.

Article 7. Rates and Rating Systems
§2350. Rules, Classifications and Basic Rates for Workers' Compensation Insurance.

Article 7. Rates and Rating Systems

NOTE: The Insurance Commissioner has approved the manuals named in this Article 7. These manuals are filed but for the present are separately published, not as part of the California Administrative Code. Those manuals not printed herein may be examined at the offices of the Insurance Commissioner in Oakland, Los Angeles, Sacramento and San Diego. The manuals will be published and copies will be made available to the public at nominal cost by the Workers' Compensation Insurance Rating Bureau of California at its Oakland, California, office.

§2350. Rules, Classifications and Basic Rates for Workers' Compensation Insurance.

History: Repealer filed 12/30/94; effective 1-1-95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995.

§2352.1. California Workers' Compensation Retrospective Rating Plan.

History: Repealer filed 12-30-94; effective 1-1-95 with respect to retrospective ratings becoming effective on or after January 1, 1995.

§2353.1. California Workers' Compensation Experience Rating Plan—1995.

History: Adoption filed 12-30-94; effective 1-1-95 with respect to experience ratings with effective dates on or after January 1, 1995.

§2354. Recording and Reporting of Data.

History: Adoption filed 12-30-94; effective 1-1-95 with respect to all new policies with an inception date on or after January 1, 1995 and with respect to renewal policies as of the first normal anniversary date falling on or after January 1, 1995.

Article 9. Workers' Compensation Insurance. Dividends (Refunds) to Policyholders. Regulations Governing Classification of Risks and Premium Rates, Policy and Endorsement Forms.

§2500. Application and Effective Date of Article.

Article 9. Workers' Compensation Insurance. Dividends (Refunds) to Policyholders. Regulations Governing Classification of Risks and Premium Rates, Policy and Endorsement Forms.

§2500. Application and Effective Date of Article.

This article applies to all stock, mutual and reciprocal inter-insurance exchange insurers and to the State Compensation Insurance Fund.

§2501. Purpose.

Compliance with and enforcement of Insurance Code Sections 380, 381, 383, 780, 781, 782, 783, 783.5, 784, 790, 790.01, 790.02, 790.03, 790.035, 790.036, 790.04, 790.05, 790.06, 790.07, 790.08, 790.09, 790.10, 1420, 11630, 11631, 11650, 11651, 11652, 11653, 11654, 11655, 11656, 11656.1, 11656.5, 11656.6, 11656.7, 11656.8, 11656.9, 11657, 11658, 11658.5, 11659, 11660, 11661, 11661.5, 11661.6, 11662, 11730, 11731, 11739, 11751.1 and 12921, and the regulations contained in this article are hereby declared to be necessary in the public interest to protect the rights of injured employees and their dependents, to protect prospective participating workers' compensation policyholders from misrepresentations and unfair practices concerning potential dividends, to prevent certain unfair and coercive practices in the payment of dividends, and to effectuate the purpose of the statutes governing the classification of risks and premium rates and policy and endorsement forms and the filing of such forms for workers' compensation insurance.

§2503. Participating Workers' Compensation Policies - Required Provisions.

(a) Every workers' compensation policy issued on a participating basis shall include a participating provision or endorsement indicating that it is a participating policy. All workers' compensation policy forms, including any participating provisions or endorsements, shall be filed with the Commissioner prior to use.

(b) If a policy is issued on a participating basis, the participating provision or endorsement shall be designated "Participating Provision" and contain the following language:

"Under California Law it is unlawful for an insurer [us] to promise the future payment of dividends under an unexpired workers' compensation policy or to misrepresent the conditions for dividend payment. Dividends are payable only pursuant to conditions determined by the [our] Board of Directors or other governing board [of the Company] following policy expiration. Forfeiture of a right to, reduction in the amount of, or delay in the payment of a policyholder's dividend due to the policyholder's failure to accept renewal of the policy or subsequent policies issued by the same insurer is illegal and constitutes an unfair practice."

(c) A workers' compensation insurer may advise a prospective policyholder, directly or through its agent or an insurance broker or solicitor, of the provisions and factors, or the arrangement thereof, that shall be set forth in the participating provision, provided that such advice or provisions and factors shall not set forth or imply, directly or indirectly, the amount of dividend or percentage of premium which will be paid as dividend, or amount or percentage of premium to be retained by the insurer after payment of dividend.

(d) A participatory provision shall set forth any time schedule during which the insurer intends to consider, compute or pay any dividend, if applicable.

§2504. Representations Regarding Future Payment of Dividends.

No workers' compensation insurer or officer or agent thereof or insurance broker or solicitor shall represent, either orally or in writing, as an inducement either to insure or to continue or to renew insurance, that the insurer has agreed or will agree (a) to pay a specified policyholder's dividend or (b)

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§2505. Policyholder Dividend Statements.

upon a formula, criteria or factors which set forth or can be used to determine the amount of dividend, or percentage of premium to be paid as dividend, or amount or percentage of premium to be retained by the insurer after payment of dividend or (c) to pay a dividend by any plan which is unfairly discriminatory.

§2505. Policyholder Dividend Statements.

(a) Whenever a dividend is paid on a workers' compensation policy, a written form captioned "Policyholder Dividend Statement" shall accompany the dividend paid or, where no dividend is paid, shall be provided in place of a dividend.

(1) The Policyholder Dividend Statement shall identify the policyholder and the insurer, the policy to which the statement applies, and the term of said policy.

(2) The Policyholder Dividend Statement shall present the calculation of the dividend result, and shall provide the policyholder with all essential data provided to compute the dividend result.

(3) When no dividend is paid, the Policyholder Dividend Statement shall state the reason or reasons for non-issuance of a dividend for that participating policy.

(b) In presentation of the calculation of any dividend result based on the individual policyholder's loss experience, the Policyholder Dividend Statement shall show such calculation in columnar form in both actual dollars and percentage of earned premium, and shall present such figures and percentages for the earned premiums, the incurred losses, the Incurred But Not Reported losses (IBNR), if any, the Loss Development Factor (LDF), if any, the insurer retention, if any, and any other factors pertinent to the actual dividend result. Within the context of this paragraph, the INBR losses and the LDF are deemed pertinent factors sufficient to warrant separate identification and disclosure, if applicable.

(c) A Policyholder Dividend Statement prepared in compliance with these sections shall be delivered to the organization or association or the administrator thereof in the event that the insurer will issue a workers' compensation policy insuring an organization or association of employers as a group in compliance with Section 11656.6 of the Insurance Code.

(d) If a policy of insurance is issued, continued or renewed and a Policyholder Dividend Statement is issued in connection therewith by the insurer, a copy of such dividend statement shall be retained by the insurer with a copy of the policy, and shall be available for audit by the Insurance Department. Where the Policyholder Dividend Statement is provided to the policyholder through an agent, broker or solicitor, such agent, broker or solicitor shall also retain a copy of the Policyholder Dividend Statement with a copy of the policy.

(e) Nothing in these regulations prohibits and insurer from issuing dividend statements or payments electronically.

§2506. Sanctions for Unfair Practices or Misrepresentations Regarding Workers' Compensation Dividends.

Any representation as to future dividends, or statements as to prior dividends declared or paid, issued by any insurer, agent, broker, or solicitor to induce a prospective policyholder to accept a policy, or to induce a policyholder to retain or renew a policy, failing to conform to this article shall be deemed an unfair practice or misrepresentation, subject to sanctions set forth in Insurance Code Sections 782, 783, 783.5 and 790.04 et seq.

§2507. Declaration by Board of Directors or Other Governing Board.

No right to a policyholder's dividend under a workers' compensation insurance policy, or to the application or use of any plan, scale, table, formula or schedule to determine whether any dividends shall be paid or allowed or the amount thereof, shall accrue unless and until the Board of Directors or other governing

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§2507.1. Prohibition Against Unfair Discrimination.

body of the insurer shall have determined that the insurer has a surplus from which dividends may lawfully be paid and shall have declared such dividends by resolution adopted after the expiration of the term covered by the policy.

Each declaration of policyholder's dividends for workers' compensation insurance policies by the Board of Directors or other governing board of the insurer shall identify by policy inception or expiration dates the body of policies to which such declaration is applicable and shall specify the dividend plans, scales, tables, formulas or schedules applied or to be applied to determine whether any dividends shall be paid or allowed or the amounts thereof to be allocated to separate policies pursuant to such declaration.

§2507.1. Prohibition Against Unfair Discrimination.

Allocation of dividends shall not be unfairly discriminatory. The dividend plans, scales, tables, formulas or schedules specified in the declaration may provide for allocation of dividends as a flat percentage of premiums or may provide for variations in the amounts of dividends or the percentages of premium paid as dividends based upon loss or expense factors or any other reasonable considerations, such as size, location, hazard, industry or trade classification, which have a probable effect on losses or expenses. Failure to apply in a consistent manner the plans, scales, tables, formulas or schedules adopted and specified in a declaration of dividends shall be prima facie evidence of unfair discrimination.

§2507.2. Prohibition Against Unfair Forfeiture of Dividend for Failure to Renew.

(a) Forfeiture of a right to, reduction in the amount of, or delay in the payment of, a policyholder's dividend due to the policyholder's failure to accept renewal of the policy or subsequent policies offered by the same insurer is coercive and illegal and shall constitute an unfair practice.

(b) This section shall not be deemed to prohibit a reasonable reduction in the amount of a policyholder dividend if:

(1) the policyholder has elected to be considered for policyholder dividends under a plan which utilizes the premium and loss experience of the policyholder for two or more policy years, and

(2) the nature of the adjustment is set forth in the policy or by an endorsement attached to the policy within thirty days after the inception of the first policy year for which such election has been made, and

(3) the policyholder does not remain insured by the same insurer during the complete term of the multi-year dividend plan. In the context of this paragraph, a "reasonable reduction" in the amount of policyholder dividends is defined as and specifically limited to the application of that most favorable dividend plan for which the policyholder then qualifies under the dividend procedures of the insurer unless some alternative dividend plan has been set forth in the policy or an endorsement.

§2508. Group Policies – Reduction or Forfeiture of Member's Right to Distribution of Dividend Funds.

To avoid any coercion or possible misrepresentation of dividends that may be paid to members of organizations or associations of employers insured under group workers' compensation policies, no group policy shall be issued, unless the articles of incorporation, by-laws, agreements of association, or rules and regulations filed pursuant to Insurance Code Section 11656.6 shall provide that (1) any distribution of funds to any member, derived from a dividend, shall not be reduced or forfeited except for reasons set forth in the articles of incorporation, by-laws, agreements of association, or rules and regulations, and (2) no such reduction or forfeiture shall be made effective unless the reasons for such reductions or forfeiture have been made known by written communication to the member prior to inception of his insurance coverage during the policy period for which such dividend adjustment is made.

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Regulations Governing Classification of Risks and Premium Rates, Policy and
Endorsement Forms.**
§2509. False or Deceptive Documents.

§2509. False or Deceptive Documents.

No workers' compensation insurer or officer or agent thereof, or other insurance broker or solicitor shall adopt or cause or permit to be issued, circulated or used any representation, plan, schedule, letter or advertising material of any kind stating or implying that any insurer has acted or will in the future act in any manner at variance with this article.

Article 9.6. Workers' Compensation Rate Filings
§2509.30. Purpose.

Article 9.6. Workers' Compensation Rate Filings

§2509.30. Purpose.

This subchapter is adopted to implement the provisions of Insurance Code Sections 11730 through 11759.1, which, among other matters, govern insurance company filing of workers' compensation insurance rates and rating plans, and to specify the handling of those filings by the Commissioner.

§2509.31. Definitions.

(a) "Actuary" means a member in good standing of the Casualty Actuarial Society or a member in good standing of the American Academy of Actuaries who meets the general qualification standard to present public statements of actuarial opinion.

(b) "Approved pure premium rates" means the pure premium rates prepared and submitted by the designated rating organization and approved by the Commissioner.

(c) "Commissioner" means the Insurance Commissioner of the State of California.

(d) "Deviation" means the insurer's adjustment, upward or downward, of the approved pure premium rates based only on charges in the loss cost per unit of exposure, including loss adjustment expense.

(e) "Pure premium rate modifier" means all the factors, other than deviations, if any, by which an insurer adjusts the approved pure premium rates or its independently developed pure premium rates to arrive at that insurer's filed rates.

(f) "Rating plan" means the rules and numeric values an insurer uses to calculate the premium for an insured.

§2509.32. Insurer's Rate Filing.

(a) Insurance Code Sections 11734 and 11735 require an insurer to file its rates and supplementary rate information at least 30 days before their effective date, unless the Commissioner approves the insurer's request for an earlier date. Insurance Code Section 11658 provides that no insurer shall issue a workers' compensation insurance policy unless the policy is first approved by the Commissioner. Insurers shall file workers' compensation insurance rate filings with the Department of Insurance, Rate Filing Bureau for Workers' Compensation Insurance.

(b) The filing date of a rate filing is the date the Rating Filing Bureau for Workers' Compensation Insurance receives a complete rate filing. The 30-day waiting period described in Insurance Code Section 11734, subdivision (b), and Section 11735, subdivision (a), begins on the filing date.

(c) The Commissioner shall determine whether a rate filing is complete and complies with filing requirements, and the Commissioner may reject a rate filing if the insurer fails to comply with filing requirements or if the filing is incomplete.

(1) If the Commissioner rejects an insurer's rate filing because it is incomplete or otherwise fails to comply with filing requirements, any subsequent rate filing by that insurer shall be given a new filing date on its receipt by the Rate Filing Bureau for Workers' Compensation Insurance.

(2) If a rate filing needs correction of an error or filing of additional information to be complete, the Commissioner shall give the insurer an opportunity to correct the filing. If the insurer corrects the rate filing within 30 days of its original filing date, the insurer may calculate the 30-day waiting period from the original date of the rate filing. If the insurer corrects the rate filing more than 30 days from its original filing date, the Department shall assign a new filing date, which shall be the date the correction or additional information is received by the Rate Filing Bureau for Workers' Compensation Insurance. In that case, the insurer may request of the Commissioner that its rates become effective earlier than the normal 30-day waiting period.

Article 9.6. Workers' Compensation Rate Filings
§2509.33. Disapproval of an Insurer's Rates; Procedure.

(d) Every insurer that makes a rate filing shall complete the Workers' Compensation Insurance Rate Filing Form ("Filing Form") provided by the Department of Insurance. The Filing Form shall be prescribed by the Commissioner. No rate filing shall be complete without a completed Filing Form.

(e) A complete rate filing is one for which the insurer has completed the Filing Form and submitted all necessary attachments and exhibits. Necessary attachments and exhibits are those materials that, together with the Filing Form, are sufficient to enable the Commissioner to determine the rates the insurer would charge its insureds. Unless the Commissioner notifies the insurer within 30 days of the filing date that its rate filing is incomplete, the rate filing will be considered complete.

(f) The insurer shall specify its pure premium rate modifier on the Filing Form.

(g) The insurer may request that any or all of its pure premium rate modifiers and deviations remain on file with the Commissioner and be applicable to subsequent approved pure premium raters. If the insurer makes that request, the following conditions shall apply:

(1) If the insurer chooses to use subsequent approved pure premium rates when they become effective, and has so indicated on the Filing Form, the insurer need file nothing additional with the Department before using those rates. Under that circumstance, the insurer's new rates will be the combination of the new approved pure premium rates and the insurer's previously filed pure premium rate modifications and deviations, if any.

(2) If the insurer chooses to use the subsequent approved pure premium rates but with a different effective date than that specified by the Commissioner, the insurer shall notify the Department of the intended effective date no less than 30 days before their actual use by the insurer, unless the Commissioner approves the insurer's request for an earlier effective date.

(h) If an insurer chooses not to apply any its pure premium rate modifiers and deviations to subsequent approved pure premium rates, it shall so indicate on the Filing Form.

(i) An insurer that wishes to adopt the approved pure premium rates or other filings of the designated rating organization shall specify the rates or other filings it is adopting and, by that reference, may incorporate those rates or other filings into its filing. Every insurer shall adhere to the experience rating plan and uniform statistical reporting plan filed by the designated rating organization and approved by the Commissioner.

(j) An insurer shall accompany each rate filing with a statement of opinion by an actuary regarding whether the filing rates include a reasonable estimate of the insurer's expected losses and expenses for the anticipated risks for the periods the insurer intends to use the filed rates.

(k) If an insurer files a classification system different from the standard classification system developed by the designated rating organization and approved by the Commissioner as part of the uniform statistical reporting plan, the insurer shall explain in detail how its classification system differs from the uniform classification system.

(1) The insurer's classification codes shall be compatible with the classification codes of the uniform classification system.

(2) The insurer shall demonstrate that the data produced by its classification system can be reported consistent with the uniform statistical reporting plan and uniform classification system. The Commissioner will accept in lieu of the insurer's demonstration a written certification from the designated rating organization that data produced by an insurer's classification system can be reported consistent with the uniform statistical reporting plan and the uniform classification system.

§2509.33. Disapproval of an Insurer's Rates; Procedure.

(a) The Commissioner may commence a rate disapproval hearing by serving a notice of hearing on the insurer. The hearing notice shall state which parts of an insurer's rate filings the Commissioner proposes to disapprove and shall specify in reasonable detail the reasons for any proposed disapproval. The

Article 9.6. Workers' Compensation Rate Filings
§2509.34. Disapproval of an Insurer's Rates; Notices to Insured.

hearing notice shall state the date and location of the hearing. A hearing shall be commenced within a reasonable time after issuance of the hearing notice.

(b) The decision of the hearing officer shall be based on the record of the proceedings. The record of the proceedings shall consist of the written pleadings submitted by the parties, any oral testimony, the documentary evidence admitted into evidence by the hearing officer, and if a written transcription of the proceedings is made by a Certified Shorthand Reporter, the written transcription.

(c) A disapproval of a rate filing other than a rejection for incompleteness as specified in section 2509.32, subdivision (c), shall occur only by order of the Commissioner after a hearing. If the Commissioner disapproves a rate, the order shall specify when, within a reasonable time after the decision, the rate shall no longer be used.

(d) All documents admitted as evidence in the hearing shall be open to public inspection.

(e) If after a hearing the Commissioner disapproves an insurer's rate filing, it shall not have any legally effective rates. The Commissioner shall specify interim rates upon the insurer's request.

(f) If the Commissioner rejects an insurer's rate filing because of incompleteness or for failure to comply with filing requirements, its legally effective rates shall be the prior rates in effect for the insurer. "Prior rates" means the rates properly in effect for the insurer at the time of its incomplete filing.

(g) The Commissioner may serve any document concerning a rate disapproval hearing in the manner provided in Section 1013, subdivision (a), of the California Code of Civil Procedure. The address for service on an insurer shall be the address of the insurer's agent for service of process in the State of California.

(h) An insurer may serve any document concerning a rate disapproval hearing as provided in Section 1013, subdivision (a), of the California Code of Civil Procedure. The address for service on the Commissioner shall be his or her address in Oakland.

§2509.34. Disapproval of an Insurer's Rates; Notices to Insured.

Every workers' compensation policy incepting on or after January 1, 1995, shall contain a provision that the premium may be subject to midterm adjustment, for the unexpired term of the policy, pursuant to the Commissioner's power to disapprove rates.

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.40. Scope.

Article 9.7. Workers' Compensation Insurance Procedural Requirements and Standards Applicable to Employers, Insurers, and Rating Organizations in the Initiation of and Response to Requests for Review, Requests for Policyholder Information, and Requests for Reconsideration Provided in Insurance Code Sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), and, Rules of Practice and Procedure for Appeals to the Insurance Commissioner Pursuant to Insurance Codes Sections 11737(f), 11752.6(c), 11753.1(a), 11753.1(b) and 11753.1

§2509.40. Scope.

This article sets forth the procedural requirements and standards applicable to employers, insurers, rating organizations and other persons in the initiation of and response to requests for review, requests for policyholder information, and requests for reconsideration provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), found in Articles 2 and 4 of Chapter 3 of Part 3 of Division 2 of the California Insurance Code, entitled "Regulation of Business of Workers' Compensation Insurance." This article also sets forth the rules of practice and procedure governing appeals to the Insurance Commissioner and proceedings conducted pursuant to Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b). The regulations set forth in this article supersede any previously adopted regulations regarding complaints and appeals to the extent that such previously adopted regulations are inconsistent with these regulations.

§2509.41. Purpose.

- (a) The purpose of this article is to establish a clear and consistent process for the initiation of requests for review, policyholder information, and reconsideration, and the responses thereto, provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).
- (b) The purpose of this article is also to establish a clear and consistent process for the disposition of appeals to the Insurance Commissioner provided in Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).

§2509.42. Definitions.

The following definitions shall apply to this article.

- (a) "Appeal" means a written appeal to the Insurance Commissioner pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).
- (b) "Appellant" means the party filing an appeal pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).
- (c) "Commissioner" means the Insurance Commissioner of the State of California.
- (d) "Complaint and Request for Action" means:
- (1) The written request of an employer or other aggrieved person seeking an insurer's or rating organization's review of the manner in which the rating system has been applied in connection with the insurance afforded or offered, pursuant to subdivision (f) of Insurance Code section 11737.
 - (2) The written request of any employer insured under a workers' compensation insurance policy, served upon a licensed rating organization, for any or all policyholder information relating to the employer, as defined Insurance Code section 11752.6(b).
 - (3) The written request of an employer, insurer or other person seeking reconsideration of a decision, action, or omission to act of a rating organization, pursuant to Insurance Code section 11753.1(a).

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.42. Definitions.

- (4) The written request for reconsideration of an employer, in response to receipt of the notice required by Insurance Code section 11753.1(b) concerning a change in the classification assignment of the employer that results in an increased premium.
- (e) "Day," unless otherwise specified in these regulations, means a calendar day. "Business days", if specified, include all days except Saturdays, Sundays, and any holiday set forth in California Government Code section 6700. The time within which any document may be filed or served shall exclude the first day and include the last day; however, when the last day falls on a Saturday, Sunday or holiday the time computation shall exclude that day and include the next business day.
- (f) "Department" means the California Department of Insurance.
- (g) "Employer" means a person or business entity currently or formerly insured under a workers' compensation insurance policy or a person or business entity seeking such insurance coverage.
- (h) "Filing" means the act of delivery of a pleading to the Department by 4:30 p.m. local time on any due date. Pleadings may be filed by facsimile transmission with the prior approval of the Department. All filed pleadings shall be accompanied by an original declaration of service. An employee of a party, or other representative of a party may sign a declaration of service. A sample declaration of service form can be found in section 2509.78.
- (i) "Hearing" and "Proceeding" mean the hearing provided by Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b), found in Articles 2 and 4 of Chapter 3 of Part 3 of Division 2 of the California Insurance Code, entitled "Regulation of Business of Workers' Compensation Insurance.
- (j) "Hearing Officer" means the Department representative appointed by the Commissioner to preside over the hearing.
- (k) "Party" means the appellant or respondent in an appeal to the Insurance Commissioner and any other person allowed to intervene or participate in the proceeding.
- (l) "Pleading" means any appeal, answer, motion, reply, request, response, evidence, exhibit, brief, request for reconsideration, or other document filed with the Administrative Law Bureau pursuant to this article.
- (m) "Rating Organization" means an entity licensed by the Commissioner pursuant to Insurance Code section 11751. "Designated Rating Organization" means that rating organization designated as the Commissioner's statistical agent pursuant to Insurance Code section 11751.5.
- (n) "Reasonable Time" in relation to a complaint and request for action filed pursuant to Insurance Code sections 11753.1(a) and (b), and Insurance Code Section 11752.6(c) means within thirty (30) days of service of written decision rejecting a request for reconsideration or a request for policyholder information, or, if no timely rejection is served, one hundred and twenty (120) days from the date of service to the rating organization or insurer of the request for reconsideration or the request for policyholder information, unless the time limit for granting or rejecting a request has been extended pursuant to Section 2509.46.
- (o) "Respondent" means an insurer or rating organization that is the subject of an appeal filed pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1(a) and 11753.1(b).
- (p) "Service" in relation to the hearing, means to provide a copy of a document to every other party in the proceeding by personal delivery, first-class mail, registered mail, by mail delivery service, or, with permission of the Commissioner or the hearing officer, by facsimile transmission that is without error. Documents served on insurers or the designated rating organization shall be sent to an office designated for such service pursuant to Section 2509.43(a), below. When a party files a document, the party shall concurrently serve that document on all other parties in the proceeding. All served documents shall be accompanied by a copy of a declaration of service. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the carrier, but any prescribed period of notice and any right or duty to do any act or make any response within any prescribed period or on a date certain after the service of the document served shall be extended for a period of five days.

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.43. Complaints and Requests for Action. Office Designated for Receipt of Complaints and Requests for Action.

(q) "Service" or "Serve" with regard to correspondence and action prior to the filing of an appeal, means to personally deliver a writing, response, decision or notice, or send such documents by first-class mail, registered mail, by mail delivery service or by facsimile transmission that is without error. Documents served on insurers or the designated rating organization shall be sent to an office designated for such service pursuant to Section 2509.43(a), below. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the carrier, but any prescribed period of notice and any right or duty to do any act or make any response within any prescribed period or on a date certain after the service of the document served shall be extended for a period of five days.

§2509.43. Complaints and Requests for Action. Office Designated for Receipt of Complaints and Requests for Action.

(a) Every insurer and rating organization subject to this article shall designate an office within this state for receipt of Complaints and Requests for Action. An insurer or rating organization may designate more than one office to receive Complaints and Requests for Action.

(b) Every insurer and rating organization subject to this article shall provide the address, telephone and facsimile number of a designated office to employers, insurers, insureds, insurance agents and brokers, or other persons inquiring about or making complaints regarding the actions of the insurer or rating organization. A rating organization shall also provide such persons with the telephone number and address of its policyholder ombudsman.

(c) Every insurer subject to this article and any insurance agent or broker through which an employer's insurance was transacted, shall provide the address, telephone and facsimile number of a designated office to employers in the notice required by subdivision (b) of Insurance Code section 11753.1 when the insurer adopts a change in classification that results in an increased premium. The notice required by subdivision (b) of Insurance Code section 11753.1 shall inform the employer of the right to request reconsideration of the classification assignment, and the right to appeal a decision rejecting reconsideration to the Commissioner pursuant to Insurance Code section 11753.1 and these regulations.

(d) Every insurer subject to this article shall include a notice which includes the information set forth in section 2509.77 with each policy of insurance issued or renewed beginning May 23, 1999.

§2509.44. Acknowledgement of Receipt and Notice of Review.

(a) Within thirty (30) days after service of a Complaint and Request for Action, the insurer or rating organization shall serve the applicant with a written acknowledgement of receipt of the Complaint and Request for Action and a notice either granting or denying review of the Complaint and Request for Action. If the insurer or rating organization fails to grant or reject review of the Complaint and Request for Action within thirty (30) days after the request is served, the applicant may proceed in the same manner as if the Complaint and Request for Action had been rejected. Time limitations for an appeal to the Commissioner shall not begin to run until this acknowledgement and notice has been served, unless a decision has been served pursuant to Section 2509.45, below. The acknowledgement shall include the information specified in Section 2509.45(d) and include the following statements:

(1) The insurer or rating organization's failure to grant or reject review of the Complaint and Request for Action within thirty (30) days of service of such Complaint and Request for Action constitutes a rejection of the Complaint and Request for Action.

(2) The insurer or rating organization's failure to grant or reject the Complaint and Request for Action within sixty (60) days after the insurer or rating organization has served the applicant with a notice granting the request for review constitutes a rejection of the Complaint and Request for Action.

(3) An appeal may be taken to the Commissioner from:

(A) a written rejection of review of the Complaint and Request for Action;

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.45. Decision on Complaint and Request for Action; Time for Reconsideration; Notice of Appeal Rights.

(B) a written rejection of the Complaint and Request for Action;

(C) failure of an insurer or rating organization to grant or reject a review of a Complaint and Request for Action or failure to grant or reject a Complaint and Request for Action within the time specified.

(4) Time limitations for an appeal to the Commissioner do not begin to run until this acknowledgement and notice have been served on the applicant, unless a decision on the Complaint and Request for Action has been served on the applicant, in which case an appeal to the commissioner must be filed within 30 days of service of the decision. If an acknowledgement and notice have been served, but no decision has been served within the time limits specified, an appeal may be taken to the Commissioner within 120 days after service of the Complaint and Request for Action on the insurer or rating organization.

(b) Where the acknowledgement concerns a Request for Policyholder Information, the acknowledgement shall also indicate that if the request is rejected in whole or in part, the rating organization is required to provide reasons for any rejection in writing and that an appeal may be taken to the Commissioner from a complete or partial written rejection of the request pursuant to Insurance Code section 11753.1. The rating organization shall serve a copy of a Complaint and Request for Action which concerns a Request for Policyholder Information, and a copy of the acknowledgment of receipt, upon insurers to which the request for policyholder information pertains. The service of these documents satisfies the duty to notify insurers imposed upon rating organizations by subdivision (a) of Insurance Code section 11752.6.

§2509.45. Decision on Complaint and Request for Action; Time for Reconsideration; Notice of Appeal Rights.

(a) Within sixty (60) days after the insurer or rating organization serves the applicant with a notice granting review of the Complaint and Request for Action, the insurer or rating organization shall serve the applicant with a written decision upon the Complaint and Request for Action. The decision shall provide the insurer's or rating organization's evaluation of the Complaint and Request for Action and contain a recitation of the pertinent facts and a determination of the issues presented which grants or rejects in whole or in part the Complaint and Request for Action. The decision shall include a specific statement of the basis for the action taken. If an acknowledgement and notice have not been served pursuant to Section 2509.44, above, the decision shall include the statements required in the acknowledgement and notice. If the insurer or rating organization fails to grant or reject the Complaint and Request for Action within sixty (60) days after the notice granting review was served, the applicant may proceed in the same manner as if the Complaint and Request for Action had been rejected.

(b) An employer, insurer, or other aggrieved person may request reconsideration of a decision of an insurer or the designated rating organization served pursuant to subsection (a) of this section. The request for reconsideration shall be in writing and shall be served within thirty (30) days of service of the decision. The insurer or rating organization shall serve a decision on reconsideration within thirty (30) days of service of the request for reconsideration.

(c) A decision which grants a Request for Policyholder Information, or rejects the request in part, shall be accompanied by such portions of the policyholder information requested that the rating organization has agreed to make available and for which payment has been received.

(d) If review of the Complaint and Request for Action is rejected or the Complaint and Request for Action is rejected, the decision shall include a statement in substantially the following form, in bold:

You have only 30 days from the date this decision was served on you to appeal the decision to the California Insurance Commissioner. See Title 10, California Code of Regulations, section 2509.46.

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§2509.46. Appeals to the Insurance Commissioner; Time Frame for Filing Written Appeal.

Address your appeal to:

ADMINISTRATIVE HEARING BUREAU
 CALIFORNIA DEPARTMENT OF INSURANCE
 1901 HARRISON STREET, 3RD FLOOR MAILROOM
 OAKLAND, CA 94612
 (415) 538-4102

§2509.46. Appeals to the Insurance Commissioner; Time Frame for Filing Written Appeal.

An appeal to the Insurance Commissioner from a written decision of an insurer or rating organization shall be filed within thirty (30) days after service of rejection of review of the Complaint and Request for Action or service of rejection of the Complaint or Request for Action. If an insurer or rating organization fails to serve a written decision, the appeal shall be filed within one hundred and twenty (120) days after service of the Complaint and Request for Action upon the insurer or rating organization. If a request for reconsideration was made pursuant to section 2509.45(b), an appeal shall be filed within thirty (30) days after service of the decision on reconsideration, or if the insurer or designated rating organization fails to serve a written decision on reconsideration, the appeal shall be filed within sixty (60) business days after service of the request for reconsideration. The time to appeal shall not exceed one year after the Complaint and Request for Action was served on the insurer or rating organization. However, the hearing officer may grant further time for the filing of an appeal if he or she determines that the delay was caused by the excusable neglect of the appellant or other circumstances beyond the reasonable control of the appellant.

§2509.47. Form of Appeal and Information Required.

An appeal shall be in writing. It need not be in any particular form, but must include:

- (a) The name, address, telephone number, and fax number of the appellant;
- (b) The name, address, telephone number, and fax number of the appellant's representative, if any;
- (c) Copies of correspondence between the appellant and the insurer and/or rating organization regarding the subject of the appeal, to include: complaints, responses, inquiries, initial decisions, requests for review and action, requests for reconsideration, requests for policyholder information, acknowledgements, notices, and the written decisions of insurers and rating organizations;
- (d) A statement as to why the appellant believes the insurer's or rating organization's decision or action is wrong;
- (e) Any documents which support the appellant's position, which are reasonably available to the appellant at the time of the filing of the appeal, and upon which the appellant intends to rely at the hearing. The documents should be marked consecutively by letter as provided in section 2509.62(c).
- (f) A statement that the appellant has or has not filed a complaint with the Department requesting review of the same transactions, actions or omissions which constitute the subject matter of the appeal. If such a complaint has been previously filed or is pending, the appellant shall provide the Department's assigned file number.

§2509.48. Filing Requirements.

An original and one copy of the appeal must be filed with the Commissioner.

§2509.49. Service of Copy of the Appeal.

The appellant shall serve a copy of the appeal on the office designated by each respondent named in the appeal for receipt of Complaints and Requests for Action, at the same time the appeal is filed with the Commissioner. All served documents shall be accompanied by a copy of a declaration of service. Service by first class mail, registered mail or mail delivery service is complete at the time of deposit with the

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.50. Role of Department of Insurance.

carrier, but any prescribed period of notice and any right of duty to do any act or make any response within any prescribed period or on a date certain after mail service of the document served shall be extended for a period of five days.

§2509.50. Role of Department of Insurance.

The Department of Insurance is not a party to an appeal unless the agency specifically requests to participate in the proceedings. All such requests shall be granted.

§2509.51. Designated Rating Organization.

Whenever an appeal concerns the application of the classification system, uniform experience rating plan, uniform statistical plan or miscellaneous regulations for the recording or reporting of data developed by the designated rating organization, the Commissioner shall transmit a copy of the appeal to the designated rating organization. If the designated rating organization is not otherwise a respondent in the proceeding, the designated rating organization may participate in the proceeding.

§2509.52. Representation.

An appellant may, but need not, be represented in the proceedings before the Commissioner. A representative need not be an attorney.

§2509.53. Pre-Hearing Procedural Provisions; Acknowledgment of Appeal; Assignment of Hearing Officer; Stay of Proceedings; Alternative Dispute Resolution.

(a) The Commissioner shall acknowledge the receipt of an appeal and shall provide the appellant instructions concerning information that must be submitted to the Department.

(b) An appeal shall be considered submitted when sufficient information is received by the Commissioner from the appellant to establish the nature of the complaint and the relief requested and when the appeal has been properly served on all the parties.

(c) Upon submission of an appeal, the Commissioner shall direct the appeal to a hearing officer. The hearing officer shall notify the parties in writing of his or her assignment.

(d) If all parties agree, the hearing officer may refer an appeal for resolution to a neutral mediator for mediation or to a neutral arbitrator for arbitration pursuant to the procedures set forth in Government Code Section 11420.10.

(e) The Commissioner may deny an appeal without a hearing if he or she has information on the subject from which the appeal is taken and he or she believes that a reasonable basis for the appeal does not exist or that the appeal is not made in good faith. The denial shall be in writing and shall set forth the basis for the denial and shall be served on all parties.

§2509.54. Insurer or Rating Organization Response to Appeal.

(a) The insurer or rating organization shall file and serve its response to the appeal within 14 days from the service of the appeal unless the hearing officer grants the insurer or rating organization more time pursuant to a showing of good cause. If the rating organization has joined as a party to the appeal pursuant to Section 2509.51, the rating organization shall file and serve its response within 14 days of service of notice that it has been made a party. The hearing officer may give the rating organization more time pursuant to a showing of good cause. The response shall admit or deny each material allegation in the appeal and raise any defenses or justifications. It shall also set forth any defects in the appeal.

(b) The response must include:

(1) Copies of any correspondence exchanged between the parties concerning the subject matter of the appeal, that were not filed with the appeal;

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§2509.55. Objections to Insurer or Rating Organization's Response.

(2) Copies of any documents in the rating organization's file or the insurer's policyholder file that are relevant to the subject matter of the appeal, that were not filed with the appeal; and

(3) Copies of all statutory, regulatory, or manual provisions the rating organization or insurer relied on in taking its action.

(c) An original and two copies of the insurer's or rating organization's response shall be filed with the Hearing Officer. A copy of the response shall be served on all other parties to the appeal at the same time it is filed with the hearing officer.

§2509.55. Objections to Insurer or Rating Organization's Response.

The appellant shall have 15 days from the date of service of the response to file and serve any reply to the insurer's or rating organization's response to the appeal.

§2509.56. The Hearing – When Held.

The Commissioner shall hold a hearing within 60 days of receipt of a completed appeal, provided however that a hearing may be held later upon agreement of the parties to the appeal. The Commissioner shall give to the parties not less than 10 days written notice of a hearing.

§2509.57. The Hearing – Governing Procedure and Location.

Hearings on appeals shall be conducted pursuant to the procedural provisions of these regulations and those provisions of Chapter 4.5 of Title 2, Division 3, Part 1 of the Government Code, commencing with section 11400 which are mandatory for these regulations, and those optional provisions of Chapter 4.5 specifically adopted herein. The provisions of Chapter 5 (commencing with Government Code section 11500) are not applicable to these proceedings. Hearings shall be conducted in either Los Angeles or Oakland.

(a) The hearing officer may conduct a hearing using informal hearing procedures.

(b) The hearing officer may deny use of the informal hearing procedure, or may convert an informal hearing to a formal hearing after an informal hearing is commenced.

§2509.58. Hearing Officer – Authority.

(a) The hearing officer shall exercise all powers relating to the conduct of the hearing.

(b) The hearing officer may conduct all or part of the proceeding by telephone, television, or other electronic means if each participant in the hearing has an opportunity to participate in and to hear the entire proceeding while it is taking place and to observe exhibits, which shall have been previously received by all parties and by the hearing officer.

(c) The hearing officer shall control the course of the proceedings; rule upon requests for continuances; administer oaths; issue subpoenas; rule on the various motions and objections of the parties; receive evidence, including additional documents; upon notice, hold appropriate conferences before or during hearings; receive offers of proof; hear argument; approve or reject proposed stipulations; and, fix the time and place for the filing of written comment or briefs.

(d) The hearing officer may limit the use of witnesses, testimony, evidence, argument, pleadings, and intervention. However, the parties must be given a reasonable opportunity to be heard, including the opportunity to present and rebut evidence.

(e) The hearing officer shall take any other action necessary or appropriate to the discharge of his or her duties, consistent with the statutory or other authority under which the Commissioner functions. The hearing officer may issue such orders compelling the compliance of the parties and other persons subject to the jurisdiction of the Commissioner as are necessary to the discharge of his or her official duties.

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.59. Discovery.

Article 12 of Chapter 4.5 of the Administrative Procedure Act (commencing with Government Code section 11455.10), is adopted, and is applicable to these proceedings.

(f) The Commissioner shall exercise all authority set forth in this section until a proceeding is assigned to a hearing officer.

§2509.59. Discovery.

Formal discovery by the parties will be permitted by the hearing officer only upon written notice and a showing of good cause.

§2509.60. Subpoenas.

Pursuant to Insurance Code section 12924, subpoenas and subpoenas duces tecum may be issued at the discretion of the hearing officer for the attendance of witnesses and production of documents at the hearing. Any party requesting the issuance of a subpoena must submit a written subpoena request to the hearing officer. The provisions of Article 11 of Chapter 4.5 (commencing with section 11450.05 of the Government Code) are not applicable to these proceedings.

§2509.61. Burden of Proof.

(a) A party has the burden of proof as to each fact the existence or nonexistence of which is essential to the claim for relief or defense that he or she is asserting.

(b) A party claiming that a party has engaged in subterfuge or fraud, or asserting an affirmative defense, has the burden of proof on that issue.

§2509.62. Evidence.

(a) Oral evidence, if taken, shall be taken only on oath or affirmation.

(b) Each party shall have these rights: to present evidence, to argue a case to the hearing officer and to rebut the evidence against the party.

(c) Documentary exhibits shall be legible and reduced to 8-1/2 inches wide and 11 inches long and shall be marked for identification consecutively as follows: appellant's exhibits by letter; respondent's exhibits by number. The moving party shall furnish the original and one copy to the hearing officer, one copy to each party or its representative of record, and one copy for use by a witness, if appropriate. Each page of multi-page exhibits shall be numbered. Copies of exhibits shall be clear and legible. Exhibits introduced at the hearing shall not duplicate the documents filed with the appeal or the response. The parties shall exchange their exhibits with each other five (5) business days prior to the hearing.

(d) The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of evidence over objection in civil actions.

(e) The rules of privilege shall be effective to the extent that they are otherwise required by law to be recognized at the hearing.

(f) The hearing officer has the discretion to exclude evidence if its probative value is substantially outweighed by the probability that its admission will necessitate undue consumption of time.

§2509.63. Order of Proof.

In the absence of a contrary order by the hearing officer, the appellant shall present its evidence first.

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§2509.64. Hearing Reporter.

§2509.64. Hearing Reporter.

The proceedings at the hearing shall be reported by a hearing reporter. However, upon the consent of all the parties, the proceedings may be reported electronically. Parties must make their own arrangements with the reporter if they wish to obtain a copy of the reporter's transcript.

§2509.65. Continuances; Good Cause.

(a) A continuance for any act occurring under this article may be granted by the Commissioner or the hearing officer for good cause shown.

(b) When seeking a continuance, a party shall apply for the continuance within ten (10) business days following the time the party discovered or reasonably should have discovered the event or occurrence which establishes the good cause for the continuance. A continuance may be granted for good cause after the ten (10) business days have lapsed if the party seeking the continuance is not responsible for or has made a good faith effort to prevent the condition or event establishing the good cause.

§2509.66. Additional Evidence or Briefing.

(a) At the hearing, the hearing officer may require the production of further evidence or briefing on any issue. If the hearing officer determines that specific evidence or briefing is necessary as a part of the record, the hearing officer shall set a deadline for filing of the requested evidence or briefing.

(b) Unless ordered by the hearing officer, or upon written motion for good cause shown, no additional evidence shall be introduced after the close of the evidentiary hearing.

§2509.67. Official Notice.

In reaching a decision, official notice may be taken, either before or after submission of the case for decision, of any fact which may be judicially noticed by the courts of this state. The parties shall be informed of the matters to be noticed, and those matters shall be noted in the record, referred to therein, or appended thereto. Each party shall be given a reasonable opportunity on request to refute the officially noticed matters by evidence or by written or oral presentation of authority, the manner of such refutation to be determined by the hearing officer.

§2509.68. Proposal of Stipulations or Settlements.

(a) Parties may stipulate to the resolution of an issue of fact or the applicability of a provision of law material to a proceeding, or may agree to settlement on a mutually acceptable outcome to a proceeding, with or without resolving material issues.

(b) Stipulations shall be filed with the hearing officer, or the Commissioner if a hearing officer has not been designated, for acceptance or rejection.

(c) No evidence of an offer of compromise or settlement made in settlement negotiations is admissible in a hearing, whether as affirmative evidence, by way of impeachment, or for any other purpose.

§2509.69. The Insurance Commissioner's Decision.

(a) Within 60 days after the case is submitted for decision, the hearing office shall prepare and deliver to the Commissioner a proposed decision in a form that may be adopted as the decision in the case. Failure of the hearing officer to deliver a proposed decision within the time required does not prejudice the rights of the Department in the case.

(b) The Commissioner shall issue his or her decision within 60 days of receipt of the proposed decision.

(c) The Commissioner may adopt the proposed decision in its entirety or he may make technical or other minor changes in the proposed decision and adopt it as the decision. Action by the Commissioner under

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.70. Appeals for Correction of Mistake or Clerical Error.

this subsection is limited to a clarifying change or a change of a similar nature that does not affect the factual or legal basis of the proposed decision.

(d) If the proposed decision is not adopted as provided in subsection (c), the Commissioner may decide the case upon the record, including the transcript, or an agreed statement of the parties, with or without taking additional evidence, or may refer the case to the same hearing officer if reasonably available, otherwise to another hearing officer, to take additional evidence. Upon request, a copy of the record shall be made available to the parties, at their cost.

(e) If the case is assigned to a hearing officer, he or she shall prepare a proposed decision as provided in subsection (a) upon the additional evidence and the transcript and other papers which are part of the record of the prior hearing.

(f) The Commissioner shall decide no case provided for in subsection (e) without affording the parties the opportunity to present either oral or written argument before the Commissioner.

(g) The proposed decision shall be deemed adopted by the Commissioner 60 days after delivery by the hearing officer, unless within that time

(1) the Commissioner notifies the parties that the proposed decision is not adopted as provided in subsection (d) and commences proceedings to decide the case upon the record, including the transcript, or

(2) the Commissioner refers the case to the hearing officer to take additional evidence.

(h) If the Commissioner finds that a further delay is required by special circumstances, he or she shall issue an order delaying the decision for no more than 30 days and specifying the reasons therefor.

(i) The final decision of the Commissioner, or the proposed decision that was deemed adopted pursuant to subsection (g) above, shall be a public record and a copy shall be served on each party and his or her representative of record by registered or certified mail.

§2509.70. Appeals for Correction of Mistake or Clerical Error.

(a) Within fifteen (15) days after service of a copy of the decision on a party, but not later than the effective date of the decision, the party may apply to the Commissioner for correction of a mistake or clerical error in the decision, stating the specific ground on which the application is made. Notice of the application shall be given to the other parties to the proceeding. The application is not a prerequisite for seeking judicial review.

(b) The Commissioner may refer the application to the hearing officer who formulated the proposed decision or may delegate his or her authority under this section to one or more persons.

(c) The Commissioner may deny the application, grant the application and modify the decision, or grant the application and set the matter for further proceedings. The application is considered denied if the Commissioner does not dispose of it within fifteen (15) days after it is served on the Commissioner and the other parties.

(d) Nothing in this section precludes the Commissioner, on his or her own motion or on motion of the hearing officer, from modifying the decision to correct a mistake or clerical error. A modification under this subsection shall be made within 30 days after issuance of the decision.

(e) The hearing officer or the Commissioner shall, within fifteen 15 days after correction of a mistake or clerical error in the decision, serve a copy of the correction on each party on which a copy of the decision was previously served.

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.71. Effective Date of Decision.

§2509.71. Effective Date of Decision.

The decision shall become effective 30 days after it is delivered or mailed to the parties unless a reconsideration is ordered within that time, or the Commissioner orders that the decision shall become effective sooner.

§2509.72. Reconsideration.

The Commissioner may order a reconsideration of all or part of the case on his or her own motion or on petition of any party. Petitions for reconsideration must be served on all parties. The power to order a reconsideration shall expire 30 days after service of a decision on the parties, or on the date set by the Commissioner as the effective date of the decision if that date occurs prior to the expiration of the 30-day period or at the termination of a stay of not to exceed 30 days which the Commissioner may grant for the purpose of filing an application for reconsideration.

§2509.73. Contents of Petition.

Petitions for reconsideration shall be based solely upon, and shall set forth specifically, the grounds upon which the decision of the Commissioner allegedly is contrary to law or is erroneous. A petition for reconsideration shall not refer to, or introduce, any evidence which was not part of the record of the evidentiary hearing. Any such evidence nonetheless provided shall be accorded no weight. Copies of documents received in evidence or already part of the record shall be referenced and attached as exhibits.

§2509.74. Response.

A response of other parties to a petition for reconsideration is not required. However, if a response is provided, it must be filed and served within fifteen (15) days of service of the petition for reconsideration.

§2509.75. Hearing on Petition.

The Commissioner may, but is not required to hold a hearing or accept argument on the petition for reconsideration.

§2509.76. Judicial Review.

Judicial review of the Commissioner's final decision may be had by filing a petition for a writ of mandate in accordance with the provisions of section 1094.5 of the Code of Civil Procedure. The right to petition shall not be affected by the failure to seek reconsideration before the Commissioner.

(a) Except as otherwise provided in this section the petition shall be filed within ninety (90) days after the last day on which reconsideration can be ordered.

(b) On request of the petitioner for a record of the proceedings, the complete record of the proceedings, or the parts thereof as are designated by the petitioner in the request, shall be prepared by the Department and shall be delivered to petitioner, within 30 days after the request. The time shall be extended for good cause shown. The petitioner shall pay the fee for the transcript and the cost of preparation of the other portions of the record. The hearing officer shall determine the cost of preparation of other portions of the record. The hearing officer shall determine the cost of preparation of other portions of the record.

(c) The complete record includes the pleadings, all notices and orders issued by the Department, any proposed decision by a hearing officer, the final decision, a transcript of all proceedings, the exhibits admitted or rejected, the written evidence and any other papers in the case.

(d) Where petitioner, within 10 days after the last day on which reconsideration can be ordered, requests the Commissioner or Hearing Officer to prepare all or any part of the record the time within which a petition may be filed shall be extended until 30 days after delivery of the record.

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§2509.77. Forms-Notice of Policyholder Appeal Rights.

(e) The Commissioner may file with the court the original of any document in the record in lieu of a copy thereof.

§2509.77. Forms-Notice of Policyholder Appeal Rights.

The Notice required by subsection 2509.43(d) shall include:

1. Notice of the right to receive policyholder information from the rating organization pursuant to Insurance Code section 11752.6 (Include name, address, phone and fax number.)
2. Notice of the right to contact the rating organization's policyholder ombudsman pursuant to Insurance Code section 11752.6(g) and (h)(1). (Include name, address, phone and fax number.) (The Notice should also include the language required by subdivisions (h)(2) and (h)(3) of section 11752.6)
3. Notice of the right to dispute the actions of the insurer or rating organization pursuant to Insurance Code sections 11737(f) and 11753.1. (Include name, address, phone and fax numbers for office designated for receipt of complaints for both insurer and rating organization.)
4. Notice of the right to appeal to the Insurance Commissioner from the actions of the insurer or rating organization pursuant to the provisions of Insurance Code sections 11737(f), 11752.6(c), 11753.1 and these regulations.
5. Notice of the right to a hearing before the Insurance Commissioner
6. The filing address for all appeals to the Commissioner is:

ADMINISTRATIVE HEARING BUREAU
CALIFORNIA DEPARTMENT OF INSURANCE
1901 HARRISON STREET, 3RD FLOOR MAILROOM
OAKLAND, CA 94612
(415) 538-4102

§2509.78. Forms - Declaration of Service by Mail.

The following form may be used by a party when serving other parties.

Declaration of Service by Mail

In the Matter of

_____ Appellant

vs.

_____ Respondent (Insurer or Rating Organization)

I am over the age of 18 years and not a party to this case. On the _____ day of _____, in the year _____, at _____ (city), _____ (state), I sealed into an envelope and deposited in the United States mail, postage thereon fully prepaid, true copies of the following documents in the above-entitled matter. The original or a true copy of each document served is attached hereto. Said copies were addressed as follows:

_____ Certified/Registered Mail Number (if applicable)

I declare under penalty of perjury that the foregoing is true and correct.

Executed on _____ (month, day), _____ (year) at _____ (city), _____ (state).

Article 9.7. Workers' Compensation Insurance Procedural Requirements
§2509.78. Forms - Declaration of Service by Mail.

_____ (print name) Declarant

Article 9.8. Workers' Compensation Deductible Policies
§2509.80. Definitions.

Article 9.8. Workers' Compensation Deductible Policies

§2509.80. Definitions.

As used in this article:

(a) "Workers' Compensation Deductible Policy" means a policy, or any combination of one or more policies, endorsements or ancillary agreements, in which an insured has agreed with the insurer to be responsible to the insurer for any portion of any workers' compensation claim and, in some cases, the associated loss adjustment expense.

(b) "Workers' Compensation High Deductible Policy" means a Workers' Compensation Deductible Policy in which the portion of any workers' compensation claim and, if applicable, the associated loss adjustment expense, for which the insured agrees to be responsible to the insurer equals or exceeds one hundred thousand dollars (\$100,000.00).

(c) "Insurer" means an insurer admitted in California for the class of workmen's compensation insurance as defined in Insurance Code section 109, and includes the State Compensation Insurance Fund.

(d) "Financial Statements" means the annual statements and quarterly filings required by Insurance Code section 900.

(e) "California Workers' Compensation Claim" means a claim for benefits subject to Chapter 3 of Part 1 of Division 4 of the Labor Code, commencing with Section 3600.

(f) "Open Workers' Compensation Claim" means a California Workers' Compensation Claim under a Workers' Compensation Deductible Policy for which there is any potential future liability.

(g) "Deductible Paid Loss" means the amount of loss paid by the insurer on each workers' compensation claim under a Workers' Compensation Deductible Policy, limited to a maximum value of the policy deductible.

(h) "California Deductible Paid Loss" means the amount of loss paid by the insurer on each California Workers' Compensation Claim under a Workers' Compensation Deductible Policy, limited to a maximum value of the policy deductible.

(i) "Allocated Loss Adjustment Expense" or "ALAE" means the cost of adjusting workers' compensation insurance claims that can be assigned specifically to an individual claim.

(j) "Deductible Incurred Loss" means the estimated final cost of each Open Workers' Compensation Claim, limited to a maximum value of the policy deductible, which pursuant to the terms of the policy may or may not include ALAE, under the Workers' Compensation Deductible Policy in question.

(k) "Aggregate Deductible Incurred Loss" means the estimated final cost, which pursuant to the terms of each policy may or may not include ALAE, of all Open Workers' Compensation Claims, and includes actuarially determined provisions for (1) incurred but not reported claims and (2) a bulk reserve for any shortfall in individual claim cost estimates. In the case of a policy whose terms specify that ALAE is included within the deductible, "Aggregate Deductible Incurred Loss" also includes a reserve for ALAE. "Aggregate Deductible Incurred Loss" includes the deductible portion of all claims that exceed the policy deductible, as well as the full value of all claims within the deductible.

(l) "Deductible Loss Reserves" means the Aggregate Deductible Incurred Loss less any Deductible Paid Loss.

(m) "California Deductible Reserves" means Deductible Loss Reserves for California Workers' Compensation Claims.

(n) "Deductible Ultimate Receivables" means any amounts of Deductible Paid Loss for which the employer has not fully reimbursed the insurer, plus any Deductible Loss Reserves, for the Workers' Compensation Deductible Policy in question.

Article 9.8. Workers' Compensation Deductible Policies
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(o) "California Deductible Ultimate Receivables" means any amounts of California Deductible Paid Loss for which the employer has not fully reimbursed the insurer, plus any California Deductible Reserves, for the Workers' Compensation Deductible Policy in question.

(p) "California Deductible Recoverable" means the California Deductible Ultimate Receivables minus the California Deductible Reserves.

(q) "Qualified United States Financial Institution" means a member of the Federal Reserve System that maintains a public debt rating of at least an A.M. Best Company rating of A-; a Standard & Poor's rating of A-; a Moody's Investors Service rating of A3; or a Fitch Ratings rating of A-.

(r) "Other-Line Coverage" means any and all insurance other than workers' compensation insurance, which the insured under a Worker's Compensation Deductible Policy procures from the Insurer that issues that Workers' Compensation Deductible Policy.

(s) "Other-Line Deductible Plan" means any and all policies of insurance providing Other-Line Coverage under which policy any amount of a claim other than a workers' compensation claim is to be paid first by the Insurer, who is then to be reimbursed by the insured.

(t) "Open Other-Line Claim" means a claim under an Other-Line Deductible Plan for which there is any potential future liability.

(u) "Other-Line Deductible Paid Loss" means the amount of loss paid by the insurer on each claim under an Other-Line Deductible Plan, limited to a maximum value of the policy deductible.

(v) "Other-Line Aggregate Deductible Incurred Loss" means the estimated final cost, which pursuant to the terms of each policy may or may not include ALAE, of all Open Other-Line Claims, and includes actuarially determined provisions for (1) incurred but not reported claims and (2) a bulk reserve for any shortfall in individual claim cost estimates. In the case of a policy whose terms specify that ALAE is included within the deductible, "Other-Line Aggregate Deductible Incurred Loss" also includes a reserve for ALAE. "Other-Line Aggregate Deductible Incurred Loss" includes the deductible portion of all claims that exceed the policy deductible, as well as the full value of all claims within the deductible.

(w) "Other-Line Deductible Loss Reserves" means the Other-Line Aggregate Deductible Incurred Loss less any Other-Line Deductible Paid Loss.

(x) "Other-Line Deductible Plan Ultimate Receivables" means any amounts of Other-Line Deductible Paid Loss for which the employer has not fully reimbursed the insurer, plus any Other-Line Deductible Loss Reserves, for the Other-Line Deductible Plan in question.

(y) "Multiline Deductible Loss Reserves" means the sum of the Deductible Loss Reserves and the Other-Line Deductible Loss Reserves.

(z) "Multiline Deductible Ultimate Receivables" means the sum of the Deductible Ultimate Receivables and the Other-Line Deductible Plan Ultimate Receivables.

(aa) "Multiline Deductible Recoverable" means the Multiline Deductible Ultimate Receivables minus the Multiline Deductible Loss Reserves.

(bb) "Surety" means the insurer issuing a surety bond.

§2509.81. Collateral, Accounting and Credit Risk Requirements.

(a) In order to secure the deductible amount of any Workers' Compensation Deductible Policy, an insurer may collateralize the California Deductible Ultimate Receivables according to the collateral and security requirements specified in subdivision (b)(1) of this Section 2509.81. Another option that may be available to the Insurer is to collateralize the Multiline Deductible Ultimate Receivables according to the collateral and security requirements specified in subdivision (b)(2) of this section.

However, if an Insurer issues a Workers' Compensation High Deductible Policy that insures against a potential California Worker's Compensation Claim, the Insurer shall, for as long as there remain any

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California Deductible Ultimate Receivables under the policy, comply with the provisions of either subdivision (a)(1) or subdivision (a)(2) of this section.

(1) The Insurer shall, for each Workers' Compensation High Deductible Policy that insures against a potential California Worker's Compensation Claim, report on its Financial Statements as required by subdivision (a)(1)(A) or subdivision (a)(1)(B), below:

(A) In the event that the Insurer elects to comply with the requirements of this section by using California-dedicated workers'-compensation-only resources as specified in subdivision (b)(1) of this section, the Insurer shall report any portion of the California Deductible Ultimate Receivables that is not collateralized according to the collateral and security requirements specified in such subdivision (b)(1), as follows:

1. any portion of the California Deductible Recoverable that is not collateralized according to the collateral and security requirements specified in subdivision (b)(1) shall be reported as a non-admitted asset, and
2. any portion of the California Deductible Reserves that is not collateralized according to the collateral and security requirements specified in subdivision (b)(1) shall be reported as a write-in liability on the balance sheet, or

(B) In the event that the Insurer elects to comply with the requirements of this section by using the optional multistate, multiline alternative approach specified in subdivision (b)(2) of this section, the Insurer shall report any portion of the Multiline Deductible Ultimate Receivables that is not collateralized according to the collateral and security requirements specified in such subdivision (b)(2), as follows:

1. any portion of the Multiline Deductible Recoverable that is not collateralized according to the collateral and security requirements specified in subdivision (b)(2) shall be reported as a non-admitted asset, and
2. any portion of the Multiline Deductible Loss Reserves that is not collateralized according to the collateral and security requirements specified in subdivision (b)(2) shall be reported as a write-in liability on the balance sheet; or (2) The Insurer shall satisfy the credit risk requirements set forth in subdivision (c) of this section.

(b) Permissible Forms of Collateral or Security.

(1) California-dedicated workers'-compensation-only resources. In order to satisfy the collateral and security requirements of this subdivision (b)(1) with respect to any Workers' Compensation Deductible Policy, an Insurer must ensure that the employer dedicates and sets aside funds for the exclusive purpose of collateralizing the California Deductible Ultimate Receivables under that policy, in one or a combination of the following forms, in an aggregate amount equal to the California Deductible Ultimate Receivables under the policy:

(A) Assets held by the insurer, as one or a combination of the following:

1. Cash or other lawful money of the United States.
2. Any of the investments described in Article 3 of Part 2 of Division 1 of the Insurance Code, commencing with Section 1170.

(B) All or a separate and distinct portion, not to be used or relied on for any purpose other than to collateralize California Deductible Ultimate Receivables under the Workers' Compensation Deductible Policy in question, of the total amount of the credit available to the Insurer under a clean, unconditional, irrevocable, evergreen letter of credit issued by a Qualified United States Financial Institution.

(C) Assets, in one or more of the forms specified in subdivisions (b)(1)(A)1. or (b)(1)(A)2. of this section, which the Insurer requires by contract with the employer to be held by the employer in a

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fiduciary account for the benefit of the Insurer, in a Qualified United States Financial Institution. In this case the insurer shall require by contract with the employer that:

1. The fiduciary account assets shall be held for the benefit of the Insurer, its assigns, and successors in interest;
2. The fiduciary account shall be subject to examination by the commissioner; and
3. The fiduciary account shall remain open for as long as there are California Deductible Ultimate Receivables under the policy.

(D) A surety bond naming the Insurer as the obligee, provided that:

1. No more than twenty percent (20%) of the California Deductible Ultimate Receivables under the Workers' Compensation Deductible Policy in question are collateralized by means of surety bond;
2. The Surety maintains a company rating of at least an A.M. Best Company rating of A-; a Standard & Poor's rating of A-; a Moody's Investors Service rating of A3; or a Fitch Ratings rating of A-.
3. The Surety is not affiliated with the Insurer issuing the Workers' Compensation Deductible Policy in question; and
4. The surety bond instrument contains, in substance, the following provisions:
 - a. The Surety, and the insured under the Workers' Compensation Deductible Policy in question, shall be jointly and severally bound to the Insurer to pay the Insurer, on demand by the Insurer, the full amount stated on the bond.
 - b. The Surety shall, within a period of no more than ten (10) working days after receiving a written demand for payment by the Insurer, pay the full amount specified by the Insurer in the demand, up to the full amount stated on the bond.
 - c. The Surety's obligation to pay the Insurer the funds specified in the Insurer's written demand, up to the full amount of the bond, shall be unconditional, unqualified and not contingent upon any accounting for the disposition of the bond proceeds by the Insurer after they have been paid by the Surety, or upon the Surety's obtaining a property interest or other security or indemnification, or upon any other circumstance which absent this provision might allow the Surety to avoid timely paying the demand.
 - d. The Surety shall, to the fullest extent permissible by applicable law, waive any right to contest its obligation to pay the full amount of any written demand under the surety bond, up to the full amount stated on the bond, and any right to reimbursement for, restitution of or recovery of funds paid to the Insurer under the bond.
 - e. The surety bond shall be automatically renewable, and the Surety shall not cancel the bond except upon ninety (90) days' written notice to the Insurer.
 - f. If the Surety cancels or non-renews the bond and the Insurer has not, at least thirty (30) days from the effective date of the cancellation or nonrenewal, received from the insured under the Workers' Compensation Deductible Policy in question replacement security that is satisfactory to the Insurer, then the Surety will, upon demand by the Insurer, pay to the Insurer any amounts not previously paid to the Insurer, up to the full amount of the bond.

(2) Optional multistate, multiline alternative approach. In order to satisfy the collateral and security requirements of this subdivision (b)(2) with respect to any Workers' Compensation Deductible Policy that includes coverage for California Workers' Compensation Claims, an Insurer must ensure that the employer dedicates and sets aside funds for the exclusive purpose of collateralizing the Multiline

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Deductible Ultimate Receivables, in one or a combination of the following forms, in an aggregate amount equal to the Multiline Deductible Ultimate Receivables:

(A) Assets held by the insurer, as one or a combination of the following:

1. Cash or other lawful money of the United States.
2. Any of the investments described in Article 3 of Part 2 of Division 1 of the Insurance Code, commencing with Section 1170.

(B) A clean, unconditional, irrevocable, evergreen letter of credit that is issued by a Qualified United States Financial Institution and is not to be used or relied on for any purpose other than to collateralize the Multiline Deductible Ultimate Receivables.

(C) Assets as described in, and satisfying the requirements set forth in, subdivision (b)(1)(C) of this section.

(D) A surety bond naming the Insurer as the obligee and which satisfies the requirements set forth in subdivision (b)(1)(D) of this section.

(c) Credit Risk Requirements.

In order to satisfy the credit risk requirements of this subdivision (c):

(1) The Insurer must maintain at least an A.M. Best Company rating of A-, a Standard and Poor's rating of A-, a Moody's Investors Service rating of A3, or a Fitch Ratings rating of A-, or be a member of a holding company group that maintains such a rating; and

(2) (A) The Insurer must maintain a sum of paid-in capital as defined in Insurance Code section 36, plus surplus as defined in Insurance Code section 700.02, of at least five hundred million dollars (\$500,000,000), or

(B) 1. The Insurer must have entered into an intercompany pooling agreement with its affiliated insurers in the holding company group to which the Insurer belongs, which agreement requires that the loss experience of all the members of the holding company group be 100% pooled, and

2. The holding company group to which the Insurer belongs must maintain a sum of paid-in capital as defined in Insurance Code section 36, plus surplus as defined in Insurance Code section 700.02, of at least five hundred million dollars (\$500,000,000).

§2509.82. Effectiveness.

This article shall apply to Workers' Compensation Deductible Policies issued or renewed on or after January 1, 2019.

Article 21. Workers' Compensation Rating Organization Internet Web Sites
§2593. Authority and Purpose.

Article 21. Workers' Compensation Rating Organization Internet Web Sites

§2593. Authority and Purpose.

The regulations set forth in this article are required to carry out the provisions of Section 11752.75 of Article 3 of Chapter 3 of Part 3 of Division 2 of the Insurance Code. The purpose of these regulations is to provide the standards required to allow a person to submit a query on a rating organization's Internet Web site for workers' compensation insurance coverage information concerning a specified employer on a specified date and to allow for employers to dispute with the rating organization or the employer's insurance company incorrect information displayed on the Internet Web site.

§2593.1. Definitions.

For purposes of this Article:

- (a) "Coverage Information" means the name of the employer, the employer's address or other identifying information, the date specified in the query for coverage information, and the name of the insurer on the date specified in the query for the coverage information.
- (b) "Employer" means the person or entity that is a named insured on the workers' compensation insurance policy for which a query regarding coverage information is being made.
- (c) "FEIN" means Federal employer identification number.
- (d) "Insurer" means a California admitted workers' compensation insurance company that provided workers' compensation coverage to the specified employer on the specified date.
- (e) "Policy" means a workers' compensation insurance policy issued by a California admitted workers' compensation insurance company.
- (f) "Policy Information" means workers' compensation insurance policy data reported by a California admitted insurance company to a rating organization.
- (g) "Query" means an inquiry on the rating organization's insurance coverage Internet Web site regarding workers' compensation coverage information for a specified employer on a specified date.

§2593.2. Employer Query Identifying Information.

A query shall allow for, but is not limited to, the following identifying information on an employer to inquire about the employer's coverage information on a specified date: Name of the employer; Name of the employer and a full or partial address of the employer, including, but not limited to, street name, city, and state; or FEIN.

§2593.3. Web Site Access Restrictions.

- (a) A rating organization may establish protocols, rules, or other limitations and restrictions on its coverage Internet Web site to limit access to information concerning employer workers' compensation insurance coverage so as to allow for only queries for a specified employer on a specified date.
- (b) The coverage Internet Web site shall prohibit the automated retrieval of information and shall give clear notice on the Internet Web site of this prohibition.
- (c) The rating organization shall limit a person's use of the coverage Internet Web site to prevent unlimited or multiple queries of the information that could be used to determine policy inception or expiration dates or policy numbers or used for other purposes for which it was not intended by employing reasonable security or authentication measures to prevent multiple or automated retrieval of employer coverage information while not hindering the public's access to it. Such measures may include limiting the amount of time a person may use the Web site, limiting the number of queries in a single session, employing a challenge-response system, or any other criteria that meets generally accepted industry practices for limiting access to information on a Web site.

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§2593.4. Disclaimers.

(d) The rating organization shall limit query results to identify as best as possible the specified employer being sought and to avoid query results that may list employers related by other criteria, such as employer safety groups or clients of labor contractors and professional employer organizations.

(1) When an employer is being queried for by using the employer's name, only employers with similar names or a portion of that name may be displayed as a result of the query.

(2) When an employer is being queried for by FEIN, only the employer associated with that FEIN may be displayed as a result of the query.

§2593.4. Disclaimers.

(a) The rating organization may provide disclaimers in its coverage Internet Web site regarding the limitations or deficiencies of the coverage information available on the Internet Web site or the policy information it collects from insurers.

(b) In addition to the disclaimers required pursuant to Insurance Code Section 11752.75, the rating organization shall also provide disclaimers regarding the following:

(1) The result of a query is not evidence or verification of workers' compensation insurance coverage, which should be obtained from or verified by the insurer directly.

(2) The results of a query should be confirmed both with the employer and the insurer before it is used for any purpose.

(3) Coverage information may not be available or complete for all employers due to limitations with the policy information, such as similar or duplicate employer names, multiple or alternate locations and addresses for employers, or more than one named insured employer on an insurance policy.

(4) The coverage Internet Web site may only provide coverage information for five years prior to the date of the query.

(5) If employer coverage information is not found on the coverage Internet Web site it may be due to the employer being self-insured, and inquiries concerning self-insured employers should be directed to the California Office of Self Insurance Plans.

§2593.5. Updating Coverage Information.

The rating organization shall post, update, or correct coverage information for an employer on its coverage Internet Web site in a timely manner following the submission of the policy information by insurers. The time to post, update, or correct the information on the web site shall not be more than thirty (30) days from the time the information is received from the insurer.

§2593.6. Disputes.

(a) An employer may dispute the accuracy of its coverage information displayed on a rating organization's Internet Web site by either contacting the insurer who provided the policy information for the coverage period or contacting the rating organization.

(b) If the insurer is contacted by an employer regarding the accuracy of its coverage information displayed on the rating organization's coverage Internet Web site, the insurer shall have thirty (30) days from the date it receives the employer's dispute to review and respond to the employer in writing and, if applicable, to provide corrected policy information to the rating organization. The response to the employer shall include the following:

(1) Whether or not the coverage information is accurate and, if applicable, any corrections that are being made.

(2) The name and contact information of the representative of the insurer who handled the dispute.

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§2593.7. Statistics To Be Maintained by the Rating Organization.

(c) The rating organization shall provide a toll-free telephone number and an email address that shall be conspicuously posted on its coverage Internet Web site for employers to contact the rating organization regarding the accuracy of coverage information displayed on the rating organization's coverage Internet Web site.

(d) If the rating organization is contacted by an employer regarding the accuracy of the coverage information displayed on its coverage Internet Web site, the rating organization shall have thirty (30) days from the date it receives the employer's dispute to confirm with the appropriate insurer that the coverage information displayed correctly reflects the policy information reported and respond to the employer in writing. The response to the employer shall include the following:

- (1) Whether or not the coverage information correctly reflects the policy information reported and, if applicable, what is being corrected.
- (2) The name and contact information of the representative of the insurer who handled the dispute.
- (3) A notice that if the employer continues to believe the coverage information is inaccurate, that the employer should contact the insurer and its representative to determine if any further changes to the policy information are needed.

(e) Only the employer to whom the coverage information pertains may dispute with the insurer or the rating organization the accuracy of the coverage information displayed on the rating organization's coverage Internet Web site. The insurer or the rating organization may take reasonable steps to determine that the person disputing the accuracy of the information on the coverage Internet Web site is the employer, or a representative of the employer, for whom the information pertains.

(f) Only disputes regarding the accuracy of the policy information reported to the rating organization by the insurer and the coverage information displayed on the rating organization's Internet Web site shall be subject to this Article. Any disputes concerning the existence or extent of an insurance contract or the terms of either the contract or its insurance coverage shall not be subject to this Article.

§2593.7. Statistics To Be Maintained by the Rating Organization.

The rating organization shall maintain statistics on usage, user complaints, and employer complaints or disputes to the rating organization or insurers concerning coverage information, along with any resulting correction of the policy or coverage information by the insurer or the rating organization for the coverage Internet Web site, to provide the necessary information to the insurance commissioner to monitor, evaluate, and report on whether the coverage Internet Web site is achieving its intended purpose.