Title 19: Department of Insurance

Part 1: General

Part 1 Chapter 1: (F&C 37-1) Prohibition of "Twisting" Insurance Products

Rule 1.01

The attention of the Insurance Commission of the State of Mississippi has been brought to the fact that certain individuals and other loaning agencies that have insurance agencies or connections with insurance agencies are, in some instances, compelling the borrower to cancel insurance that he has or tenders and to take out new insurance with or through the agency represented, directly or indirectly, by the lender.

After a careful examination of the complaint the Commission is of the opinion that such practice is contrary to the law and an injustice to the borrower in that he should be compelled to cancel his insurance or be denied the right of renewing previous contracts of insurance, provided, the said insurance is with a responsible company that is duly licensed to do business in the State of Mississippi.

Hereafter, no banks, trust companies, loan companies, building and loan associations, individuals, and other loaning agencies, that have an insurance agency or connection therewith shall require, as a condition precedent upon securing a loan, that the borrower shall cancel out insurance and take out new insurance with the lender or with an agency with which the lender is in anywise connected.

Any insurance agent, who directly or indirectly or by subterfuge or artifice, aids, abets or participates in the said practice is guilty of violation of this regulation and is subject to revocation of license.

The acts of any loaning agencies, etc., having a direct or indirect connection with an insurance agency will be deemed the act of the insurance agent or agency with whom they are connected and the agent shall be held strictly accountable for the act of the lender.

Any insurance company, licensed under the laws of Mississippi, who accepts business from the insurance agents with knowledge or under circumstances or conditions that ordinarily amounts to constructive notice that such business is in violation of this said ruling shall likewise be subject to the penalties prescribed by law.

All insurance companies, operating within the State of Mississippi, are requested to acknowledge receipt of this ruling and to immediately notify all of their agents within the State, regarding this matter.

Source: *Miss. Code Ann.* §83-5-1; § 83-5-35 (Rev. 2011)

Part 1 Chapter 2: (LA&H 52-1) Package Policies; Rebates, Prohibitions, Penalty

Rule 2.01

No agent shall use his or her insurance business to promote any other business either directly or indirectly by including policies of insurance with sales of other items, either gratis or at a reduced premium. Any such related transaction shall be considered rebating and any published advertisement along such lines shall be considered prima facie evidence of violation of Section 83-3-121 of Mississippi Code of 1972, Annotated, and any agent found guilty of same shall at a proper hearing before the Commissioner of Insurance of the State of Mississippi be called upon to show cause why his or her license should not be revoked.

Source: *Miss. Code Ann.* § 83-3-121 (Rev. 2011)

Part 1 Chapter 3: (LA&H 53-1) Advertising Restrictions.

Rule 3.01

Within the past few months certain agents have published insurance advertising that has been confusing to the general public. I, therefore, feel that it is incumbent upon me as Insurance Commissioner to advise all Mississippi Agents that any further misleading or confusing advertising, whether intentional or otherwise, will be construed as being against the interest of the insuring public, and any agent affixing his or her signature to such advertising will be called upon to show cause why his or her license should not be revoked.

It is further suggested that any agent or company desiring to advertise, restrict such advertising to the evaluations of his own types of insurance and refrain from criticizing either directly or by implication the insurance sold by his or her competitor.

Source: *Miss. Code Ann.* § 83-5-1; § 83-5-35 (Rev. 2011)

Part 1 Chapter 4: (LA&H 57-1) Promotion of Stock Sales with Insurance Sales**.**

Rule 4.01

Numerous complaints have reached this office recently relative to agents selling or promoting stock sales along with sale of insurance policies. Such a practice is in violation of Section 5639, sub-section (d) of the Mississippi Code of 1942, Annotated.

Recognizing the difficulty of adequately supervising insurance sales as so to prevent joint sales of stock and insurance, it is hereby ordered that no insurance salesman shall be licensed at the same time as a stock salesman for the same company.

Such order is believed to be in the public interest.

Source: *Miss. Code Ann.* §83-5-19 (Rev. 2011)

Part 1 Chapter 5: (F&C 60-1) Cancellation of Insurance as a Result of Agent Non-Payment

Rule 5.01

WHEREAS, it has come to the attention of the Department that an excessive number of insureds are faced with cancellation or rejection of insurance because of unfavorable information reflecting prior cancellation by another company; and

WHEREAS, a substantial number of such prior cancellations are for nonpayment of premium to the company when in fact the premium has been paid in full to the company's agent, and such failure to remit premiums to the company by the agent is no fault of the insured,

IT IS, THEREFORE, the opinion of this Department that the agent failing to pay his company account, thereby jeopardizing the record of his insured who is not at fault, is not qualified to act as an agent under the provision of Section 5723.02 of the MississippiCode of 1942, Annotated.

Any agent who fails to remit a premium collected from an insured to a company, thereby causing a cancellation of said policy for nonpayment of premium, shall be immediately subject to the provisions of Sections 5723-02 and 5723-04 of the Mississippi Code of 1942, Annotated, and a hearing will be called wherein the agent will be asked to show cause why his license should not be revoked in accordance with the provisions of said sections of the statute.

Source: *Miss. Code Ann.* § 83-17-71 (Rev. 2011)

Part 1 Chapter 6: (F&C 60-2) Free Insurance; Prohibition, Penalty

Rule 6.01

We have noted from the newspapers that automobile dealers continue to advertise free insurance in connection with the sale of automobiles. As you are aware, there is no such thing as free insurance in Mississippi and any advertising to the contrary is misleading and a violation of the statute.

It will be appreciated if you will bulletin each of your dealer-agents in Mississippi and instruct them that the next such advertisement appearing in any publication or advertised over the radio or television will result in a hearing for the purpose of revocation of such dealer's license as an insurance agent.

In the event a countersigning agent is used and no licensed agent is listed in the dealership, any insurance company through which insurance is written under such an advertisement will be held strictly accountable for the acceptance of such business.

Source: *Miss. Code Ann.* § 83-3-121 (Rev. 2011)

Part 1 Chapter 7: (F&C 68-1) Manufacturers Output Policy

Rule 7.01

In the past the coverage as captioned above has been treated subject to Section 5834-03(e) of the Mississippi Code of 1942, Annotated and Recompiled and which we quote:

> "If the commission in its discretion shall determine that a filing is impractical or unnecessary as to a kind, class, subdivision or combination of insurance, it may by written order suspend the requirement of filing as to such kind, class, subdivision or combination until otherwise ordered by it. Such order shall be made known to the insurers and rating organization affected thereby."

It is now the desire of this Commission to discontinue the treatment of this coverage as in the past, this to take effect January 1, 1969. After that time, your company should not write this type policy before first having the approval of this Commission as to rate, rule and form.

Your full cooperation in this regard will be appreciated.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Part 1 Chapter 8: (F&C 68-2) Difference in Conditions Insurance.

Rule 8.01

At a recent scheduled meeting of the Mississippi Insurance Commission, the above subject was discussed in detail and we now take this manner of informing you of the procedure to be followed in this state in the future concerning the writing of this coverage.

All licensed companies are hereby advised that "Difference in Conditions" insurance is included in the broad regulatory powers of the Mississippi Insurance Commission. It is the desire of this Commission that the writing of this type coverage cease as of January 1, 1969, or until such time as a filing has been submitted and approved. The Commission is aware of the need for flexibility in rating the various risks and, therefore, asks that a rating formula or, in lieu thereof, a statement, be submitted with the filing concerning the method of rating. The coverage shall be written as an endorsement to the standard fire policy. The Mississippi State Rating Bureau will not audit this part of the overall policy but will mark it "No Jurisdiction". At the same time the daily report is submitted to the Bureau, an individual risk filing should be made with this office for informational purposes only. All filings of this nature have been in the past, and will be in the future, treated as confidential and access will not be made to the public.

Your full cooperation in this regard will be appreciated.

Source: *Miss. Code Ann.* §§83-2-7; 83-5-1 (Rev. 2011)

Part 1 Chapter 9: (F&C 73-1) Use of Investment Income in Ratemaking.

Introduction

The Mississippi Insurance Commission in regular session November 16, 1973, adopted the following rules and regulations to take effect on all rate filings submitted to this Commission and received after December 26, 1973.

Rule 9.01 Section 1

No rating organization, insurer or group of insurers that transact an insurance business in this State shall file with this Commission any rate schedule, or rate revision, which does not reflect, to the extent prescribed hereinbelow, the investment income of each insurer whose experience is incorporated in the filing.

Source: *Miss. Code Ann.* §§ 83-2-3; 83-5-1 (Rev. 2011)

Rule 9.02 Section 2

For the purposes of this Regulation, the rate of investment income shall mean the quotient of (1) the net investment gain or loss as shown on line 9A of the Underwriting and Investment exhibit on Page 4, of the appropriate Annual Statement, divided by (2) the cash and invested assets shown as the sum of items one (1) to seven (7) inclusive, on Page 2 of the appropriate Annual Statement or Annual Statements filed with the Mississippi Insurance Department covering the period of time reflected by the statistical data in such rate filing.

Source: *Miss. Code Ann.* §§ 83-2-3; 83-5-1 (Rev. 2011)

Rule 9.03 Section 3

The amount of investment income allocated to a rate filing shall be determined by multiplying the rate of investment income as determined hereinabove by the sum of (1) reduced by the allowances for acquisition costs, general expense, and taxes in the formula for the premiums which generated the reserve.

Source: *Miss. Code Ann.* §§ 83-2-3; 83-5-1 (Rev. 2011)

Part 1 Chapter 10: (LA&H 76-1) Sale of Trusted Life, Health, and Accident Insurance Group Accounts.

Rule 10.01

WHEREAS, a marked degree of confusion presently exists in this state by reason of the solicitation and sale of trusteed group insurance accounts under the name of various “trusts”, and which are shown to be administered by certain administrators, consultants, trustees, and others,

most of whom do not hold privilege licenses issued by the Mississippi Insurance Department, and;

WHEREAS, there are shown to be many instances wherein such trusteed business is presently being solicited and sold within the State of Mississippi by persons representing insurance companies which are either not licensed in Mississippi or have had their authority to do business in Mississippi suspended or revoked by the Commissioner of Insurance, and further instances where such business is being solicited by agents who have not been issued certificates of authority to represent such insurance companies, and;

WHEREAS, advertisements and brochures soliciting such businesses are being circulated giving prominence to the name of such trusts, administrators, consultants, and others, instead of conducting such business in the proper corporate name of the insurance company underwriting or offering such business, which is violative of Section 83-5-9, Mississippi Code of 1972, and;

WHEREAS, the Mississippi Insurance Department is encountering serious difficulty in answering general inquiries and giving proper assistance to the general public of the State of Mississippi in matters of claims arising under such trusteed account business, it is deemed in the public interest for the Mississippi Insurance Department to promulgate and issue the following regulation:

> On and after this date, it shall be unlawful for any insurance company to solicit, sell or underwrite the sale of any trusteed group insurance account within the State of Mississippi, directly or indirectly, unless and until it shall have previously filed for public record with the Mississippi Insurance Department a detailed summarization of such proposed activities, including all advertising materials, brochures, trust agreements, and sales materials of whatever nature and type, including the name of the administrators, consultants, trustees, supervising general agencies, and others participating therein, which material shall in all instances give prominence to the proper corporate title of the insurance company underwriting such program, and which shall be in addition to submission of all policy contract forms, applications, and related endorsement forms which are made a part of the insurance contract, for our prior review and approval as prescribed by the controlling insurance statutes.

Willful violation of these regulations by an insurance company shall be deemed to be grounds for revocation of the insurance company's privilege license, which shall be in addition to any other penalty provided by statute.

This regulation will be effective as of this date, March 15, 1976.

Source: *Miss. Code Ann.* § 83-5-9 (Rev. 2011)

Part 1 Chapter 11: (79-001) Payment of Premium Checks to Insurance Company**.**

Rule 11.01

WHEREAS, it has been shown that the need and justification exists for the modification of this Department's Order of October 30, 1957 which states that ALL PREMIUM CHECKS SHALL BE MADE PAYABLE EITHER TO THE COMPANY OR TO AN AUTHORIZED STATE AGENCY rather than to the individual agent making the sale; and,

WHEREAS, it is still the practice of some companies and agents in the state to have the insured make his premium check payable to the agent personally or to the unlicensed agency; and,

WHEREAS, some questionable tactics, such as:

A. overcharges on the part of the agent or salesman who have the insured make the premium check payable personally to them or to an unlicensed agency which renders the insurer incapable of ascertaining theamount of premium actually charged and paid;

B. collection of annual premiums by agents and remittance of partial premiums only; and,

C. collection of premiums and failure to submit the application and/or full premium collected and due to the company;

THEREFORE, all licensed agents, insurers, agencies, insurance companies, and supervising general agents are hereby ORDERED to handle premium collections in the following manner:

A. ALL PREMIUM CHECKS SHALL BE MADE PAYABLE TO THE INSURANCE COMPANY WRITING SUCH POLICY OF INSURANCE, AND
B. AUTHORIZED RECEIPTS FROM THE COMPANY OR ITS AGENT WRITING SUCH POLICY OF INSURANCE MUST BE GIVEN AT THE TIME OF RECEIPT OF SUCH PREMIUM CHECK, SUCH RECEIPT MUST BE ON THE COMPANY'S PRINTED FORM COMMONLY USED BY, ON FILE WITH AND APPROVED BY THIS DEPARTMENT, AND MUST CLEARLYSHOW THE NAME AND ADDRESS OF THE COMPANY, THE DATE, NAME OF AGENT, TOTAL PREMIUM COLLECTED AT THE TIME OF THE GIVING OF SUCH RECEIPT AND TYPE OF POLICY TO BE ISSUEDIN CONSIDERATION FOR SUCH PREMIUM. COMPANIES HAVING PRINTED RECEIPTS ALREADY ON HAND MAY USE A RUBBER STAMP UNTIL NEW FORMS ARE PRINTED.

ALL companies are further instructed to incorporate into their receipts in bold type the following:

> "ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY: DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK"

FURTHER, all such companies are instructed to bulletin their individual agents, either through the Home Office or District Regional Office, and inform them of the contents of this Regulation.

Failure to comply with the provisions of this Regulation by any company, agent or agency may result in a formal hearing for suspension or revocation of license.

This regulation will take effect and be in force from and after August 1, 1980.

Promulgated and Adopted, this the 4th Day Of June, 1980.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Part 1 Chapter 12: (81-SIS-3) Proxies, Consents and Authorizations of Domestic Stock Insurers.

Rule 12.01 Statutory Authority

This Regulation is promulgated by the Commissioner of Insurance of the State of Mississippi to implement Sections 83-5-1, 83-5-19 and 83-19-79 through 83-19-97 of the Mississippi Code of 1972, as Amended, and is adopted pursuant to the authority granted to said Commissioner in Sections 83-19-91 and 83-19-97.

Source: *Miss. Code Ann.* § 83-5-1; 83-5-19; 83-19-79 (Rev. 2011)

Rule 12.02 Application of Regulation

A. No domestic stock insurer which has any class of equity securities held of record by three hundred or more persons, or any director, officer, or employee of such insurer, or any other person, shall solicit, or permit the use of his name to solicit, by mail or otherwise, any proxy, consent, or authorization in respect of any such class of equity securities in contravention of this Regulation and Schedules A and B hereto annexed and hereby made a part of this Regulation, provided, however, that this Regulation shall not apply to any insurer if ninety-five percent or more of its equity securities is owned or controlled by a parent or an affiliated insurer and the remaining securities are held of record by less than 500 persons. A domestic stock insurer which files with the Securities and Exchange Commission with respect to any class of securities forms of proxies, consents, and authorizations complying with the requirements of the Securities Exchange Act of 1934, as amended, and the applicable regulations promulgated thereunder, shall be exempt from the provisions of this Regulation with respect to such class of securities.

B. Unless proxies, consents or authorizations in respect of any class of equity securities of a domestic insurer subject to Section 1(a) are solicited by or on behalf of the management of such insurer from the holders of record of such securities in accordance with this Regulation and the Schedules hereto prior to any annual or other meeting of such security holders, such insurer shall file with the Commissioner and transmit to every security holder who is entitled to vote in regard to any matter to be acted upon at the meeting and from whom a proxy is not solicited a written information statement containing the information specified in Schedule C hereto annexed.

Source: *Miss. Code Ann.* § 83-5-1; 83-5-19; 83-19-79 (Rev. 2011)

Rule 12.03 Definitions

The following definitions apply unless the context otherwise requires:

A. Affiliate. An "affiliate" of, or a person affiliated with a specified person is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.
Associate. The term "associate" used to indicate a relationship with any person, means:

1. any corporation or organization (other than the issuer or a majority owned subsidiary of the issuer) of which such person is an officer or partner or is, directly or indirectly, the beneficial owner of 10 percent or more of any class of equity securities,
2. any trust or other estate in which such person has substantial beneficial interest or as to which suchperson serves as trustee or in a similar fiduciary capacity, and
3. any relative or spouse of such person, or any relative of such spouse, who has the same home as such person or who is a director or officer of the issuer or any of its parents or subsidiaries.

B. Beneficial Owner. The term "beneficial owner" includes any person who, directly or indirectly, through any contract, arrangement, understanding, relationship, or otherwise has or shares:

1. voting power including the power to vote, or the power to direct voting of, a security, or
2. investment power which includes the power to dispose of, or to direct the disposition of, such security.

C. Control. The term "control" (including the terms "controlling", "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract, or otherwise.

D. Issuer. The term "issuer" means the issuer of the securities in respect of which a proxy is solicited.

E. Last fiscal year. The term "last fiscal year" of the issuer means the last fiscal year of the issuer ending prior to the date of the meeting for which proxies are to be solicited.

F. Officer. The term "officer" means the president, secretary, treasurer, any vice president in charge of a principal business function (such as sales, administration or finance) and any other person who performs similar policy making functions for the insurer.

G. Commissioner. The term "commissioner" means the Commissioner of Insurance of the State of Mississippi.

H. Parent. A "parent" of a specified person is an affiliate controlling such person directly, or indirectly thorough one or more intermediaries.

I. Person. The term "person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, any unincorporated organization, or a government or political subdivision thereof. As used in this subparagraph, the term "trust" shall include only a trust where the interest or interests of the beneficiary or beneficiaries are evidenced by a security.

J. Proxy statement. The term "proxy statement" means the statement required by Section 5, whether or not contained in a single document.

K. Solicitation.

1. The terms "solicit" and "solicitations" include:

a. any request for a proxy whether or not accompanied by or included in a form of proxy:

b. any request to execute or not to execute, or to revoke, a proxy; or

c. the furnishing of a form of proxy or other communication to security holders under circumstances reasonably calculated to resultin the procurement, withholding or revocation of a proxy.

2. The terms do not apply, however, to the furnishing of a form of proxy to a security holder upon the unsolicited request of such security holder, the performance by the issuer of acts required by Section 9, or the performance by any person of ministerial acts on behalf of a person soliciting a proxy.

Source: *Miss. Code Ann.* § 83-5-1; 83-5-19; 83-19-79 (Rev. 2011)

Rule 12.04 Solicitations to Which Regulation Applies

Section 11 of this Regulation shall apply to every solicitation that is subject to Section 2. Sections 3 through 10 and Section 12 of this Regulation shall apply to every solicitation that is subject to Section 2 except the following:

A. Any solicitation made otherwise than on behalf of the issuer where the total number of persons is not more than ten.

B. Any solicitation by a person in respect of securities carried in his name or in the name of his nominee (otherwise than as voting trustee) or held in his custody, if such person:

1. Receives no commission or remuneration for such solicitation, directly or indirectly, other than reimbursement of reasonable expenses;

2. Furnishes promptly to the person solicited a copy of all soliciting material with respect to the same subject matter or meeting received from all persons who shall furnish copies thereof for such purpose and who shall, if requested, defray the reasonable expenses to be incurred in forwarding such material; and

3. In addition, does no more than impartially instruct the person solicited to forward a proxy to the person, if any, to whom the person solicited desires to give a proxy, or impartially request from the person solicited instructions as to the authority to be conferred by the proxy and state that a proxy will be given if no instructions are received by a certain date.

C. Any solicitation by a person in respect of securities of which it is the beneficial owner.

D. Any solicitation through the medium of a newspaper advertisement which informs security holders of a source from which they may obtain copies of a proxy statement, form of proxy and any other soliciting material and does no more than name the issuer, state the reason for the advertisement and identify the proposal or proposals to be acted upon by security holders.

E. Any solicitation which the Commissioner finds for good cause should be exempt from this Regulation or any part thereof.

Source: *Miss. Code Ann.* § 83-5-1; 83-5-19; 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.05 Information To Be Furnished Security Holders

A. No solicitation subject to this Regulation shall be made unless each person solicited is concurrently furnished or has previously been furnished with a written proxy statement containing the information specified in Schedule A.

B. If the solicitation is made on behalf of the issuer and relates to an annual meeting of security holders at which directors are to be elected, each proxy statement furnished pursuant to paragraph (a) shall be accompanied or preceded by an annual report to security holders as follows:

1. The report shall contain, in comparative columnar form, such financial statements for the last two fiscal years, prepared on a consistent basis, as will in the opinion of the management adequately reflect the financial position of the issuer at the end of each such year and the results of its operations for each such year. Consolidated financial statements of the issuer and its subsidiaries shall be included in the report if they arenecessary to reflect the financial position and

results of operations of the issuer and its subsidiaries, but in such case the individual statements of the issuer may be omitted. TheCommissioner may, upon the request of the issuer, permit the omission of financial statements for the earlier of such two fiscal years upon a showing of good cause therefore.

2. The financial statements for the last two fiscal years required by Subparagraph (b) (1) shall be prepared in a manner acceptable to the Commissioner.

3. The report shall include, in comparative columnar form, a summary of issuer's operations, or the operations of the issuer and its subsidiaries consolidated, or both as appropriate, for each of the last five fiscal years of the issuer (or the life of the issuer and its predecessors, if less).

   Note: subparagraph 7 permits the information required by this subparagraph to be set forth in any form deemed suitable by management.

4. The report shall contain a brief description of the business or businesses done by the issuer and its subsidiaries during the most recent fiscal year which will, in the opinion of management, indicate the general nature and scope of the business of the issuer and its subsidiaries.

5. The report shall identify each of the issuer's directors and officers and shall indicate the principal occupation or employment of each such person and the name and principal business of any organization by which such person is so employed.

6. The report shall identify the principal market in which securities of any class entitled to vote at the meeting are traded, stating the range of bid and asked quotations for each quarterly period during the issuer's two most recent fiscal years, and shall set forth each dividend paid during such two year period.

7. Subject to the foregoing requirements, the report may be in any form deemed suitable by management and the information required by subparagraphs (b) (3) through (b) (6) may be presented in an appendix or other separate section of the report, provided that the attention of security holders is called to such presentation.

8. This paragraph (b) shall not apply, however, to solicitations made on behalf of the management before the financial statements are available if solicitation is being made at the time in opposition to the management and if the management's proxy statement includes an undertaking in bold face type to furnish such annual report to all persons being solicited, at least 20 days before the date of the meeting.

    a. Three copies of the report sent to the security holders pursuant to this Section shall be mailed to the Commissioner solely for his information, not later than the date on which such report was first sent or given to

security holders or the date on which preliminary copies of solicitation material are filed pursuant to Section 8, whichever date is later.

b. If the issuer knows that securities of any class entitled to vote at a meeting with respect to which the issuer intends to solicit proxies, consents or authorizations are held of record by a broker, dealer, bank or voting trustee, or their nominees, the issuer shall require of such record holder at least ten days prior to the record date for the meeting of security holders whether other persons are the beneficial owners of such securities and, if so, the number of copied of the proxy and other soliciting material and, in the case of an annual meeting at which directors are to be elected, the number of copies of the annual report to security holders, necessary to supply such material to beneficial owners. The issuer shall supply such record holder in a timely manner with additional copies in such quantities, assembled in such form and at such place, as the record holder may reasonably request in order to address and send one copy of each to each beneficial owner of securities so held and shall, upon the request of such record holder, pay its reasonable expenses for mailing such material to security holders to whom the material is sent.

Source: *Miss. Code Ann.* §83-5-19; § 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.06 Requirements as To Proxy

A. The form of proxy:

1. shall indicate in bold face type whether or not the proxy is solicited on behalf of the issuers board of directors, and, if not, by whom it is solicited;

2. shall provide a specifically designed blank space for dating the proxy; and,

3. shall identify clearly and impartially each matter or group of related matters intended to be acted upon, whether proposed by the issuer or by security holders. No reference needs to be made to proposals as to which discretionary authority is conferred pursuant to paragraph (c).

B. 1. Means shall be provided in the form of proxy whereby the person solicited is afforded an opportunity to specify by ballot a choice between approval or disapproval of, or abstention with respect to, each matter or group of related matters referred to therein as intended to be acted upon, other than elections to office. A proxy may confer discretionary authority with respect to matters as to which a choice is not so specified provided the form of proxy states in bold face how it is intended to vote the shares represented by the proxy in each such case.

2. A form of proxy which provides for the election of directors and for action on other specified matters shall be prepared so as clearly to provide, by a box or

otherwise, means by which the security holder may withhold authority to vote for any nominee forelection as a director. Any such form of proxy which is executed by the security holder in suchmanner as not to withhold authority to vote for the election of all nominees shall be deemed to grant such authority for all nominees for which a vote is withheld, provided the form of proxy so states in bold face type.

C. A proxy may confer discretionary authority to vote with respect to any of the following matters:

1. Matters which the persons making the solicitation do not know, a reasonable time before the solicitation, are to be presented at the meeting, if a specific statement to that effect is made in the proxy statement or form of proxy;

2. Approval of the minutes of the prior meeting if such approval does not amount to ratification of the action taken at that meeting;

3. The election of any person to any office for which a bona fide nominee is named in the proxy statement and such nominee is unable to serve or for good cause will not serve.

4. Any proposal omitted from the proxy statement and the form of proxy pursuant to Sections 10 or 11.

5. Matters incident to the conduct of the meeting.

D. No proxy shall confer authority to vote for the election of any person to any office for which a bona fide nominee is not named in the proxy statement, or to vote at any annual meeting, other than the next annual meeting (or any adjournment thereof), to be held after the date on which the proxy statement and form of proxy are first sent or given to security holders. A person shall not be deemed to be a bona fide nominee and he shall not be named as such unless he has consented to being named in the proxy statement and to serve if elected.

E. The proxy statement or form of proxy shall provide, subject to reasonable specified conditions, that the securities represented by the proxy will be voted and that where the person solicited specifies by means of a ballot provided pursuant to paragraph (b) a choice with respect to any matter to be acted upon, the securities will be voted in accordance with the specifications so made.

Source: *Miss. Code Ann.* § 85-5-1; 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.07 Presentation of Information in Proxy Statement

A. The information included in the proxy statement shall be clearly presented and the statements made shall be divided into groups according to subject matter and the various groups of statements shall be preceded by appropriate headings.

B. All proxy statements shall disclose, under an appropriate caption, the date by which proposals of security holders intended to be presented at the next annual meeting must be received by the issuer for inclusion in the issuer's proxy statement and form of proxy relating to that meeting, such date to be calculated in accordance with the provisions of Section 10(a). If the date of the next annual meeting is subsequently advanced by more than 30 calendar days or delayed by more than 90 calendar days from the date of the annual meeting to which the proxy statement relates, the issuer shall, in a timely manner, inform security holders must be received, by any means reasonably calculated to so inform them.

Source: *Miss. Code Ann.* § 83-5-19; § 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.08 Material Required To Be Filed

A. Three preliminary copies of the proxy statement and form of proxy and any other soliciting material to be furnished to security holders concurrently therewith (or the information statement pursuant to Schedule C) shall be filed with the Commissioner at least 10 days prior to the date definitive copies of such material are first sent or given to security holders, or such shorter period prior to that date as the Commissioner may authorize upon a showing of good cause therefore.

B. Three preliminary copies of any additional soliciting material relating to the same meeting or subject matter to be furnished to security holders subsequent to the proxy statement shall be filed with the Commissioner at least five days (exclusive of Saturdays, Sundays and holidays) prior to the date copies of such material are first sent or given to security holders, or such shorter period prior to such date as the Commissioner may authorize upon a showing of good cause therefor.

C. Three definitive copies of the proxy statement, form of proxy and all other soliciting material (or the information statement) in the form in which such material is furnished to security holders, shall be filed with, or mailed for filing to, the Commissioner no later than the date such material is first sent or given to any security holder.

D. Copies of replies to inquiries from security holders requesting further information and copies of communications which do no more than request that forms of proxy theretofore solicited be signed and returned need not be filed pursuant to this Section.

E. Notwithstanding the provisions of paragraphs (a) and (b) of this Section and of paragraph (e) of Section 13, copies of soliciting material in the form of speeches, press releases and radio or television scripts may, but need not, be filed with the Commissioner prior to use or publication. Three definitive copies, however, shall be filed with or mailed for filing to the Commissioner as required by paragraph (c) not later than the date such material is

used or published. The provisions of paragraph (a) and (b) of this Section and of paragraph (e) of Section 13 shall apply, however, to any reprints or reproductions of all or any part of such material.

F. Where any proxy statement, form of proxy or other material filed pursuant to this Regulation is amended or revised, one of the copies of such amended or revised material filed pursuant to this Regulation shall be marked to indicate clearly and precisely the changes effected therein.

Source: *Miss. Code Ann.* §85-5-19; 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.09: Mailing Communications For Security Holders

If the management of the issuer has made or intends to make any solicitation subject to this Regulation, the issuer shall perform such of the following acts as may be duly requested in writing with respect to the same subject matter or meeting by any security holder who is, or security holders who are, entitled to vote at least one percent of the votes entitled to be voted on such matter and who shall defray the reasonable expenses to be incurred by the issuer in the performance of the act or acts requested.

A. The issuer shall mail or otherwise furnish to such security holder, as promptly as practicable after the receipt of such request:

1. A statement of the approximate number of record owners and, to the extent known to the issuer, the approximate number of beneficial owners of any class of securities, any of whom have been or are to be solicited on behalf of the management, or any group of whom the security holder shall designate:

2. An estimate of the cost of mailing a specified proxy statement, form of proxy or other communication to such owner.

B. 1. Copies of any proxy statement form of proxy or other communication furnished by the security holder shall be mailed by the issuer to such of the security owners specified in subparagraph (a) (1) as the security holder shall designate.

2. Such material furnished by the security holder shall be mailed with reasonable promptness after receipt of the material to be mailed, envelopes or other containers therefore, and postage or payment for postage. The issuer need not, however, mail any such material prior to the first day on which solicitation is made on behalf of the issuer.

3. The issuer shall not be responsible for such proxy statement, form of proxy or other communication.

C. In lieu of performing the acts specified above, the issuer may, at its option, furnish promptly to such security holder a reasonably current list of the names and addresses of

such of the record owners and, to the extent known to the issuer, the beneficial owners as the security holder shall designate and a scheduled of the handling and mailing costs if such schedule has been supplied to the issuer.

Source: *Miss. Code Ann.* §83-19-93; § 83-19-97 (Rev. 2011)

Rule 12.10 Proposals of Security Holders

A. If any holder or holders of the securities of an issuer (hereafter referred to as the "proponent") notifies the issuer in writing not less than 90 days before the issuer's annual meeting of his intention to present a lawful proposal for action at a forthcoming meeting of the issuer's security holders and at the time of such notice the proponent is entitled to vote at least one percent of the votes entitled to be voted on such proposal, the issuer shall set forth the proposal in its proxy statement and identify it in its form of proxy and provide for the specification of approval or disapproval of such proposal. The proxy statement shall also include the name and address of the proponent.

B. If the issuer opposed any proposal received from a proponent, it shall also, at the request of the proponent, include in its proxy statement a statement of the proponent of not more than 500 words in support of the proposal.

C. The issuer may omit proposal and any statement in support thereof from its proxy statement and form of proxy under any of the following circumstances:

    1. The proponent has submitted more than one proposal in connection with a particular meeting.

    2. The proposal is more than 500 words in length.

    3. The proposal of the supporting statement is contrary to any Section of this Regulation or the schedules hereto, including Section 11, which prohibits false or misleading statements in proxy soliciting materials.

    4. The proposal relates to the enforcement of a personal claim or the redness of a personal grievance against the issuer, its management, or any other person.

    5. The proposal deals with a matter not significantly related to the issuer's business; a matter beyond the issuer's power to effectuate; a matter relating to the conduct of the ordinary business operations of the issuer; or an election to office.

    6. The proposal is counter to a proposal to be submitted by the issuer at the meeting; the proposal relates to specific amounts of cash or stock dividends.

    7. The proposal is subsequently duplicative of a proposal previously submitted to the issuer by another proponent, which proposal will be included in the management's proxy material for the meeting.

8. Substantially the same proposal has previously been submitted to security holders in the issuer's proxy statement and form of proxy relating to any annual or special meeting of security holders held within the preceding five calendar years, and received less than five percent of the total number of votes cast in respect thereof at the time of its most recentsubmission.

D. If the issuer intends to omit any proposal from its proxy statement and/or forms of proxy, it shall notify the proponent in writing of its intention at least ten days before the issuer's preliminary proxy material is filed pursuant to Section 8(a).

Source: *Miss. Code. Ann.*§83-19-97 (Rev. 2011)

Rule 12.11: False or Misleading Statements

No proxy statement, form of proxy, notice of meeting, information statement, or other communication, written or oral, subject to this Regulation shall contain any statement which, at the time and in the light of the circumstances under which it is made, is false or misleading with respect to any material fact, or which omits to state any material fact necessary in order to make the statements therein not false or misleading or necessary to correct any statement in any earlier communication with respect to the same meeting or subject matter which has become false or misleading.

Source: *Miss. Code Ann.* §83-19-97; 85-5-35 (Rev. 2011)

Rule 12.12 Prohibition of Certain Solicitations

No person making a solicitation which is subject to this Regulation shall solicit any undated or postdated proxy or any proxy which provides that it shall be deemed to be dated as of any date subsequent to the date on which it is signed by the security holder.

Source: *Miss. Code Ann.*§83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.13 Special Provisions Applicable To Election Contests

A. Solicitations to Which This Section Applies. This Section applies to any solicitation subject to this Regulation by any person or group for the purpose of opposing a solicitation subject to this Regulation by any other person or group with respect to the election or removal of directors at any annual or special meeting of security holders.

B. Participant or Participant in a Solicitation.

1. For the purpose of this Section the terms "participant" and "participant in a solicitation" include: the issuer; any director of the issuer, and any nominee for whose election as a director proxies are solicited; any other person, acting alone

or with one or more other persons, committees or groups, in organizing, directing or financing the solicitation.

2. For the purpose of this Section the terms "participant" and "participant in a solicitation" do not include:

    a. a bank, broker or dealer who, in the ordinary course of business, lends money or executes orders for the purchase or sale of securities and who is not otherwise a participant;
    b. any person or organization retained or employed by a participant to solicit security holders or any person who merely transmits proxy solicitating material or performs ministerial of clerical duties;
    c. any person employed in the capacity of attorney, accountant, or advertising, public relations or financial adviser, and whose activities are limited to the performance of his duties in the course of such employment;
    d. any person regularly employed as an officer or employee of the issuer or any of its subsidiaries or affiliates who is not otherwise a participant; or any officer or director of: or,
    e. any person regularly employed by any other participant, if such officer, director or employee is not otherwise a participant.

C. Filing of Information Required by Schedule B.

1. No solicitation subject to this Section shall be made by any other person other than the issuer unless at least five business days prior thereto, or such shorter period as the Commissioner may authorize upon a showing of good cause therefore, there has been filed with the Commissioner by or on behalf of each participant in such solicitation, a statement in duplicate containing the information specified by Schedule B and a copy of any material proposed to be distributed to security holders in furtherance of such solicitation.

2. Within seven business days after a solicitation subject to this Section is made by the issuer, or such longer period as the Commissioner may authorize upon a showing of good cause therefore, there shall be filed with the Commissioner by or on behalf of each participant in such solicitation other than the issuer, a statement in duplicate containingthe information specified by Schedule B.

3. If any solicitation on behalf of the issuer or any other person has been made, or if proxy material is ready for distribution, prior to a solicitation subject to this Section in opposition thereto, a statement in duplicate containing the information specified in Schedule B shall be filed with the Commissioner by or on behalf of each participant in such prior solicitation, other than the issuer, as soon as reasonably practicable after the commencement of the solicitation in opposition thereto.

4. If, subsequent to the filing of the statements required by paragraphs (a), (b), and (c) of this Section additional persons become participants in a solicitation subject to this Section, there shall be filed with the Commissioner by or on behalf of each such person, a statement in duplicate containing the information specified by Schedule B, within three business days after such person becomes a participant, or such longer period as the Commissioner may authorize upon a showing a good cause therefor.

5. If any material change occurs in the facts reported in any statement filed by or on behalf of any participant, an appropriate amendment to such statement shall be filed promptly with the Commissioner.

6. Each statement and amendment thereto filed pursuant to this paragraph shall be part of the public files of the Commissioner.

D. Solicitations Prior to Furnishing Required Written Proxy Statement.

Notwithstanding the provisions of Section 5(a), a solicitation subject to this Section may be made prior to furnishing security holders a written proxy statement containing the information specified in Schedule A with respect to such solicitation, provided that:

1. The statements required by paragraph (c) are filed by or on behalf of each participant insuch solicitation.

2. No form of proxy is furnished to security holders prior to the time the written proxy statement required by Section 5(a) is furnished to such persons: provided, however, that this paragraph (b) shall not apply where a proxy statement then meeting the requirements of Schedule A has been furnished to security holders.

3. At least the information specified in subparagraph (2) and (3) of the statements required by paragraph (c) to be filed by each participant, or an appropriate summary thereof, are included in each communication sent or given to security holders in connection with the solicitation.

4. A written proxy statement containing the information specified in Schedule A withrespect to a solicitation is sent or given security holders at the earliest practicably date.

E. Solicitations Prior to Furnishing Required Written Proxy Statement—FilingRequirements.

Three copies of any soliciting material proposed to be sent or given to security holders prior to the furnishing of the written proxy statement required by Section 5(a) shall be file with the Commissioner in preliminary form at least seven business days prior to the date definitive copies of such material are first sent or given to such persons, or such shorter period as the Commissioner may authorize upon a showing of good cause therefor.

F. Notwithstanding the provisions of Section 5(b), two copies of any portion of the annual report referred to in Section 5(b) which comments upon or refers to any solicitation subject to this Section, or to any participant in any such solicitation, other than the solicitation by the management, shall be filed with the Commissioner as proxy material subject to this Regulation. Such portion of the report shall be filed with the Commissioner, in preliminary form, at least seven business days prior to the date copies of the report are first sent or given to security holders.

Source: *Miss. Code Ann.* § 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.14 Solicitations and Materials Complying With NAIC Model Regulation and Schedules

Notwithstanding the foregoing Sections, the Commissioner may permit the solicitation of proxies, consents, or authorizations, provided that the manner of solicitation and the form of the proxy, proxy statement and other documents used in such solicitation comply with the National Association of Insurance Commissioner's Model Regulation and the Schedules thereto.

Source: *Miss. Code Ann.* § 83-19-97 (Rev. 2011)

Rule 12.15 Severability

If any provision of any Section of the Regulation or the application thereof to any insurer or circumstances is held invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application and to this end the provisions of this Regulation are declared to be severable.

Source: *Miss. Code Ann.* § 83-19-97 (Rev. 2011)

Rule 12.16 Effective Date

This Regulation shall be in full force and in effect on and after _____, 1981. Promulgated and adopted, This the ____ day of _____, 1981.

Source: *Miss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Rule 12.17 Schedule A: Miscellaneous

A. Revocability of Proxy

State whether or not the person giving the proxy has the power to revoke it. If the right of revocation before the proxy is exercised is limited or is subject to compliance with any formal procedure, briefly describe such limitation or procedure.

B. Dissenters' Rights of Appraisal

Outline briefly any rights of appraisal or similar rights of dissenters with respect to any matter to be acted upon and indicate any statutory procedure required to be followed by dissenting security holders in order to perfect such rights. Where such rights may be exercised only within a limited time after the date of adoption of a proposal, the filing of a charter amendment or other similar act, state whether the person solicited will be notified of such date.

C. Persons Making the Solicitation

1. Solicitations Not Subject to Section 13

a. If the solicitation is made by the issuer, so state. Give the name of any director of the issuer who has informed the issuer in writing that he intends to oppose any action intended to be taken by the issuer and indicate the action which he intends to oppose.

b. If the solicitation is made otherwise than by the issuer, so state and give the names of the persons by whom and on whose behalf it is made.

c. If the solicitation is to be made otherwise than by the use of the mails, describe the methods to be employed. If the solicitation is to be made by specially engaged employees or paid solicitors, state

i. the material features of any contract or agreement for such solicitation and identify the parties, and
ii. the cost or anticipated cost thereof.

d. State the names of the persons by whom the cost of solicitation has been or will be borne, directly or indirectly.

2. Solicitations Subject to Section 13

a. State by whom the solicitation is made and describes the methods employed and to be employed to solicit security holders.

b. If regular employees of the issuer or any other participant in a solicitation have been or are to be employed to solicit security holders, describe the class or classes of employees to be so employed, and the manner and nature of their employment for such purpose.

c. If specially engaged employees, representatives or other persons have been or are to be employed to solicit security holders, state;

i. the material features of any contract or arrangement for such solicitation and identify the parties,

ii. the cost or anticipated cost thereof; and
iii. the approximate number of such employees or employees of any other person (naming such other person) who will solicit security holders.

d. State the total amount estimated to be spent and the total expenditures to date for or in connection with the solicitation of security holders.

e. State by whom the cost of the solicitation will be borne. If reimbursement will be sought from the issuer, state whether the question of such reimbursement will be submitted to a vote of security holders.

f. If any such solicitation is terminated pursuant to a settlement between the issuer and any other participant in such solicitation, describe the terms of such settlement, including the cost or anticipated cost thereof to the issuer.

D. Interest of Certain Persons in Matters to be Acted Upon

1. Solicitations Not Subject to Section 13. Describe briefly any substantial interest, direct or indirect, of each of the following persons in any matter to be acted upon, other than elections to office:

a. If the solicitation is made on behalf of the issuer, each current director or officer of the issuer.

b. If the solicitation is made otherwise than on behalf of the issuer, any person who would be a participant in a solicitation (except the issuer, or an officer, director, or nominee of the issuer).

c. Each nominee for election as a director of the issuer.

d. Each associate of the foregoing persons.

2. Solicitations Subject to Section 13.

a. Describe briefly any substantial interest, direct or indirect, of each participant (except the issuer) in any matter to be acted upon at the meeting, and include with respect to each participant the information or an adequate summary thereof, required by Items (2)(a), (2)(b), 3, 4(b), 4(c) of Schedule B.

E. Voting Securities and Principal Holders Thereof

1. State as to each class of voting securities of the issuer entitled to be voted at the meeting, the number of shares outstanding and the number of votes to which each class is entitled.

2. Give the date as of which the record of security holders entitled to vote at the meetingwill be determined. If the right to vote is not limited to security holders of record on that date, indicate the conditions under which other security holders may be entitled to votes.

3. If action is to be taken with respect to the election of directors and if the persons solicited have cumulative voting rights:

    a. make a statement that they have such rights,
    b. describe such rights,
    c. state the conditions precedent to the exercise thereof; and,
    d. if discretionary authority to cumulative votes is solicited, so indicate.

4. Furnish the following information as of the most recent practicable date, in substantially the tabular form indicated, with respect to: any person or group of persons who is known to be the beneficial owner of more than five percent of any class of securities; and, all directors and nominees, naming them, and directors and officers of the issuer as a group, without naming them.

(1)	(2)	(3)	(4)
Title of Class	Name of Beneficial Owner	Amount and Nature Of Beneficial Ownership	Percent of Class

5. If, to the knowledge of the persons on whose behalf the solicitation is made, a change in control of the issuer has occurred since the beginning of its last fiscal year, state the name of the person(s) who acquired control, the amount and the source of the consideration used by such person or persons, the basis of the control, the date and a description of the transaction(s) which resulted in the change of control and the percentage of voting securities of the issuer now beneficially owned directly or indirectly by the person(s) who acquired control; and the identity of the person(s) from whom control was assumed. Describe any arrangements which may at a subsequent date result in a change of control of the issuer.

F. Directors and Executive Officers

If action is to be taken with respect to election of directors, furnish the following information, in tabular form to the extent practicable, with respect to each person nominated for election as a director and each person whose term of office will continue after the meeting. However, if the solicitation is made on behalf of person other than the issuer, the information required need be furnished only as to nominees of the persons making the solicitation.

1. Identification of directors and officers. List the names and ages of all directors and officers of the issuer, and all persons nominated or chosen to become directors or officers; indicate all positions and offices with the issuer held by each such person; state his term of office as director and/or officer and period(s) during which he has served as such; briefly describe any arrangement or understanding between him and any other person or persons (naming such person(s)) pursuant to which he was or is to be selected as a director, officer, or nominee.

   The information regarding officers need not be furnished in proxy or information statements provided that such information is furnished in a separate item in the issuer's annual report to stockholders.

2. Family relationships. State the nature of any family relationship not more remote than first cousin between any director, officer, or person nominated or chosen by the issuer to become a director or officer and also any such family relationship between any such person and any officer or director of any of the issuer's parents, subsidiaries or other affiliates.

3. Business experience. State the principal occupations and employment during the past five years of each director and each person nominated or chose to become a director or officer and the name and principal business of any corporation or other organization in which such occupations and employment were carried on.

4. Directorships. Indicate other directorships held by each director or person nominated or chosen to become a director.

5. Involvement in certain legal proceedings. Describe any legal proceedings which have occurred during the past five years or which are pending which are material to an evaluation of the ability or integrity of any director, or person nominated to become a director or officer of the issuer.

6. Describe any of the following relationships which exist:

   a. If the nominee or director is, or has within the last two full fiscal years been, an officer, director or employee of, or owns, or has within the last two full fiscal years owned,directly or indirectly, in excess of a 1 percent equity interest in any firm, corporation, or other business or professional entity:

      i. which has made payments to the issuer or its subsidiaries during the issuer's last full fiscal year in an aggregate amount in excess of 1 percent of the issuer's total consolidated gross revenues for its last full fiscal year;

ii. to which the issuer or its subsidiaries were indebted at any time during the issuer's last fiscal year in an aggregate amount in excess of 1 percent of the issuer's total consolidated assets at the end of such fiscal year;

iii. to which the issuer or its subsidiaries have made payments during such entity's last fiscal year or to which the issuer or its subsidiaries propose to make payments during such entity's current fiscal year in excess of 1 percent of such entity's consolidated gross revenues for its last full fiscal year;

iv. in order to determine whether payments made or proposed to be made exceed 1 percent of the consolidated gross revenues of any entity other than the issuer for such entity's last full fiscal year, it is appropriate to rely on information provided by the nominee or director;

v. in calculating payments for property and services, the following may be excluded: payments where the rates or charges involved in the transaction are determined by competitive bids, or the transaction involves the rending of services as a public utility at rates or charges fixed in conformity with law or governmental authority; or,payments which arise solely from the ownership of securities of the issuer and no extra or special benefit not shared on a pro rata basis by all holders of the class of securities is received;

vi. In calculating indebtedness for purposes of subparagraph (ii) above, debt securities which have been publicly offered, admitted to trading on a national securities exchange, or quoted on the automated quotation system of a registered securities association may be excluded.

b. The nominee or director is a member or employee of, or is associated with, a law firm which the issuer has retained in the last two full fiscal years or proposes to retain in the current fiscal year where fees paid or anticipated to be paid by the issuer are material to either the law firm, the issuer, or both.

c. The nominee or director is a director, partner, officer or employee of any investment banking firm which has performed services for the issuer other than as a participating underwriter in a syndicate in the last two full fiscal years or which the issuer proposes to have perform services in the current year; or

d. The nominee or director is a control person of the issuer (other than solely as a director of the issuer).

7. State whether or not the issuer has standing audit, nominating, and compensation committees of the Board of Directors, or committees performing similar functions. If the issuer has such committees, however designated, identify each committee member, state the number of committee meetings held by each such committee during the last fiscal year and describe briefly the functions performed by such committees.

   If the issuer has a nominating or similar committee, state whether the committee will consider nominees recommended by shareholders and, if so, describe the procedures to be followed by shareholders in submitting such recommendations.

8. State the total number of meetings of the board of directors (including regularly scheduled and special meetings) which were held during the last full fiscal year. Name each incumbent director who during the last full fiscal year attended fewer than 75 percent of the aggregate the total number of meetings of the board of directors (held during the period for which he has been a director) and the total number of meetings held by all committees of the board on which he served (during the periods that he served).

9. If a director has resigned or declined to stand for re-election to the board of directors since the date of the last annual meeting of shareholders because of a disagreement with the issuer on any matter relating to the issuer's operations, policies or practices and if the director has furnished the issuer with a letter describing such disagreement and requesting that the matter be disclosed, the issuer shall state the date of resignation or declination to stand for re-election and summarize the director's description of the disagreement.

   If the issuer believes that the description provided by the director is incorrect or incomplete, it may include a brief statement presenting its views of the disagreement.

10. With respect to those classes of voting stock which participated in the election of directors at the most recent meeting at which directors were elected:

    a. State the percentage of shares present at the meeting and voting or withholding authority to vote in the election of directors; and disclose in tabular format the percentage of total shares cast for and withheld from the for or, where applicable, cast against, each nominee, which respectively, were voted for and withheld from the vote for, or voted against, such nominee. When groups of classes or series of classes vote together in the election of a director or directors, they shall be treated as a single class for the purpose of the preceding sentence.

    b. Instructions.

i. Calculate the percentage of shares present at the meeting and voting withholding authority to vote in the election of directors, referred to in paragraph j(1), by dividing the total shares cast for and withheld from the vote for or, where applicable, voted against, the director in respect of whom the highest aggregate number of shares was cast by the total number of shares outstanding which were eligible to vote as of the record date for the meeting.

ii. No information need be given in response to item 6(j) unless, with respect to any class of voting stock (or group of classes which voted together), 5% or more of the total shares cast for and withheld from the vote for or, where applicable, cast against any nominee were withheld from the vote for or cast against such nominee.

iii. If an issuer elects less than the entire board of directors annually, disclosure is required as to all directors if 5% or more of the total shares cast for and withheld from, the vote for, or, where applicable, cast against any incumbent director were withheld from, or cast against the vote for such director at the meeting at which he was most recently elected.

iv. No information need be given in response to item 6(j) if the issuer has previously furnished to its security holders a report of the results of the most recent meeting of security holders at which directors were elected which includes:

1. a description of each matter voted upon at the meeting and a statement of the percentage of the shares voting which were voted for and against each such matter; and

2. the information which would be called for by this item 6(j).

3. If an issuer has previously furnished such results to its security holders, this fact should be set forth in a letter accompanying the filing of preliminary proxy materials with the Commissioner.

G. Remuneration of Directors and Officers

Furnish the following information if action is to be taken with regard to: the election of directors; any bonus, profit sharing or other remuneration plan, contract, or arrangement in which any director, nominee for election as a director, or officer of the issuer will participate; any pension or retirement plan in which any such person will participate; or, the granting or extension to any such person of any options, warrants or rights to purchase any securities, other than warrants or rights issued to security holders as such,

on a pro rata basis. If the solicitation is made on behalf of persons other than the issuer, the information required need be furnished only as to nominees of the persons making the solicitation and associates of such nominees.

1. Current remuneration. Furnish the information required in the table below, in substantially the tabular form specified, concerning all remuneration of the following persons and groups for services in all capacities to the issuer and its subsidiaries during the issuer's last fiscal year, or, in specified instances, certain prior fiscal years:

    a. Five officers or directors. Each of the five most highly compensated officers or directors of the issuer as to whom the total remuneration required to be disclosed in Columns C1 and C2 below, would exceed $50,000, naming each such person; and

    b. All officers and directors. All officers and directors of the issuer as a group, stating the number of persons in the group without naming them.

    c. Specified Tabular Format:

(A)	(B)	(C)	(D)	(C1)	(C2)
Name of Individual or Number of person in group	Capacities in which served	Cash and cash-equivalent forms of remuneration	Aggregate of contingent forms of remuneration	Salaries, fees, directors' fees, commissions and bonuses	Securities or property, insurance benefits or reimbursement, personal benefits

    d. information to be Included: Columns C-1, C-2, and D of the table should contain with respect to each person or group of persons specified in subparagraphs (1)(a) and (2)(b) of paragraph G a dollar amount which reflects the total of all items of remuneration described in the heading to that column including, but not necessarily limited to, those items set forth in the subparagraphs of that column.
        i. COLUMN C:Include all Cash and Cash Equivalent Forms of Remuneration received during the fiscal year and all such amounts accrued during the fiscal year which, with reasonable certainty, will be distributed or vested in the future.
        ii. COLUMN C-1: Salaries, Bonuses, Fees, and Commissions:
            (a) All cash remuneration distributed or accrued in the form of salaries, commissions, bonuses and fees for service rendered.
            (b) Compensation earned for services performed in the latest fiscal year even if it is deferred for future payment.

(c) Payments received in the latest fiscal year but earned in prior years which were deferred until the latest year, if such amounts were not shown in an earlier proxy statement or annual report to stockholders.

iii. COLUMN C-2: Securities, Property, Insurance Benefits or reimbursement, Personal Benefits (Perquisites):

(a) Spread between the acquisition price, if any, and fair market price of securities or property acquired under any contract, plan or arrangements.

(b) Cost of any life insurance premiums, health insurance premiums and medical reimbursement plans, Premiums for nondiscriminatory plans generally available to all salaried employees are excluded.

(c) Personal benefits (perquisites) not directly related to job performance, excluding benefits provided on a nondiscriminatory basis, valued on the basis of cost to the issuer of providing such benefits.

(1) If unreasonable effort or expense is required to determine the amounts of personal benefits, they may be omitted if their aggregate value does not exceed $10,000 for each other.

(2) If the amount of personal benefits exceeds 10% of the amount of total remuneration or $25,000, whichever is less, the amount and a brief description of the benefits must be disclosed in a footnote.

(d) Vested company contributions to thrift, profit sharing, pension, stack purchase and similar plans.

iv. COLUMN D: Include all contingent forms of remuneration the distribution, vesting, and measurement of which is subject to future events. Report only amounts relating to the latest fiscal year, not amounts accrued in previous periods.

(a) Amount expensed for financial reporting purposes representing nonvested contributions, payments, or accruals under any pension or retirement plans annuities, employment contracts, deferred compensation plans including IRS qualified plans, unless the amount for the individual cannot be separated in which case a footnote is required indicating the percentage which contributions to the plan bear to participants total remuneration.

(b) The amount expensed for financial reporting purpose under any incentive compensation plans (long-term income plans), such as stock appreciation rights, stock options, performance share plans, where payout is based on objective standards or stock value.

(1) In subsequent years, if the corporation credits compensation expense for financial reporting purposes as a result of a decline in the value of contingent compensation, Column D may be reduced by a corresponding amount. A footnote explaining such action should be included.

(c) The amount expensed for financial reporting purposes for any nonvested contribution payment or accrual to stock purchase plans, profit sharing, and thrift plans whether or not they are qualified under the Internal Revenue Code.

(d) Transactions with Third Parties. Item 7(a), among other things, includes transactions between the issuer and a third party when the primary purpose of the transactions is to furnish remuneration to the persons specified in Item 7(a). Other transactions between the issuer and third parties in which person specified in Item 7(a) have an interest, or may realize a benefit, generally are addressed by other disclosure requirements concerning the interest of management and others in certain transactions. Item 7(a) does not require disclosure of remuneration paid to a partnership in which any officer or director was a partner; any such transactions should be disclosed pursuant to these other disclosure requirements, and not as a note to the remuneration table presented pursuant to Item 7(a).

(e) Other Permitted Disclosure. The issuer may provide additional disclosure through a footnote to the table, through additional columns, or otherwise, describing the components of aggregate remuneration in such greater detail as is possible.

2. Proposed remuneration.

a. Briefly describe all remuneration payments proposed to be made in the future, pursuant to any existing plan or arrangement to the persons and groups specified in Item 7(a). As to defined benefit or actuarial plans with respect to which amounts are not included in the table, include a separate table showing the estimated annual benefits payable upon retirement to persons in specified remuneration and years-of-service classifications.

b. Information need not be furnished with respect to any group life, health, hospitalization, or medical reimbursement plans which do not discriminate in favor of officers or directors of the issuer and which are available generally to all salaried employees.

3 Remuneration of directors. Describe any standard or special arrangements, stating amounts, by which directors of the issuer are compensated for services as a director.

4. Options, warrants, or rights.

   a. Furnish the information required by the following table as to all options to purchase securities from the issuer or its subsidiaries which were granted to or exercised by the persons and groups specified in Item 7(a) since the beginning of the issuer's last fiscal year, and as to all options held by such persons as of the latest practicable date:

   b. The following tabulation shows as to certain directors and officers and as to all directors and officers as a group:
      i. the amount of options granted since the beginning of the issuer's last full fiscal year,
      ii. the amount of shares acquired since that date through the exercise of options,
      iii. the amount of shares of the same class sold during such period and
      iv. the amount of shares subject to all unexercised options held as of the most recentpracticable date.

Title of securities	Name	Name	Name	All directors and officers as a group
Granted—19---to date:				
Number of shares				
Average per share option price	$	$	$	$
Exercised—19—to date:				
Number of Shares				
Aggregate option price of options exercised	$	$	$	$
Sales—19—to date:				
Number of Shares				***
Unexercised at 19--:				
Number of Shares				
Average per share option price	$	$	$	$
In addition, during the period employees were granted option for…..shares at an average price per share of $.....				

***Sales by directors and officers who exercised options during the period 19—to date.

5. Instructions

a. All figures should be adjusted, where applicable, in accordance with the terms of the options to reflect stock splits and to give effect to share dividends.

b. Other tabular presentations are acceptable if they include the necessary data. Tabular presentation may not be needed if only a very few options have been granted.

c. Market value

i. Where the total market value on the granting dates of the securities called for by all options granted during the period specified does not exceed $10,000 for any officer ordirector named in answer to Item 7(a), or $40,000 for all officers and directors as a group, this Item need not be answered with respect to options granted to such person or group.

ii. Where the total market value on the dates of purchase of all securities purchased through the exercise of options during the period specified does not exceed $10,000 for any such person or $40,000 for such group, this Item need not be answered with respect to options exercised by such person or group.

iii. Where the total market value as of the latest practicable date of the securities called for by all options held at such time does not exceed $10,000 for any such person or $40,000 for such group, this Item need not be answered with respect to options held as of the specified date by such person or group.

d. The term “option” as used in this paragraph includes all options, warrants or rights, other than those issued to security holders as such on a pro rata basis. Where the average price per share iscalled for, the weighted average price per share shall be given.

e. The extension, re-granting or material amendment of options shall be deemed the granting of options within the meaning of this paragraph.

f. If the options relate to more than one class of securities, the information shall be given separately for each such class.

6. Indebtedness of management.

a. State as to each of the following persons who was indebted to the issuer or its subsidiaries at any time since the beginning of the last fiscal year of the registrant, the largest aggregate amount of indebtedness outstanding at any time during such period, the nature of the indebtedness outstanding and the transaction in which it was incurred, the amount thereof outstanding as

of the largest practicable date, and the rate of interest paid or charged thereon:

i. Each director or officer of the issuer;

ii. Each nominee for election as a director; and

iii. Each associate of any such director, officer or nominee.

b. This subparagraph (e) does not apply to: (a) any person whose aggregate indebtedness did not exceed $10,000 or 1 percent of the issuer's total assets, whichever is less, at any time during the period specified or (b) indebtedness under an insurance policy.

7. Transactions with management.

a. Describe briefly any transaction since the beginning of the issuer's last fiscal year or any presently proposed transactions, to which the issuer or any of its subsidiaries was or is to be a party, in which any of the following persons had or is to have a direct or indirect material interest, naming such person and stating his relationship to the issuer, the nature of his interest in the transaction and, where practicable, the amount of such interest.

i. Any director or officer of the issuer;

ii. Any nominee for election as a director;

iii. Any security holder who is known to the issuer to own of record or beneficially more than ten percent of any class of issuer's voting securities; and

iv. Any relative or spouse of any of the foregoing persons, or any relative of such spouse, who has the same home as such person who is a director or officer of any parent or subsidiary of the issuer.

b. Also, describe briefly any material legal proceedings to which any such person is a party adverse to the issuer or any of its subsidiaries or has a material interest adverse to the issuer or any of its subsidiaries.

c. No information need be given in response to this Item 7(f) as to any remuneration or other transaction reported in response to Item 7(a), (b), (c), (d), (e), or as to any transaction with respect to which information may be omitted pursuant to these Items.

d. No information need be given in answer to this Item 7(f) as to any transaction where:

   i. The rates or charger involved in the transaction are determined by competitive bids, or at rates or charges fixed in conformity with law or governmental authority;

   ii. The transaction involves services as a bank depository of funds, transfer agent, registrar, trustee under a trust indenture, or similar services;

   iii. The amount involved in the transaction or series of similar transaction, including all periodic installments in the case of any lease or other agreement providing for periodic payments or installments, does not exceed $40,000; or

   iv. The interest of the specified person arises solely from the ownership of securities of the issuer and the specified person receives no extra or special benefit not shared on a pro rata basis by all holders of securities of the class.

e. It should be noted that this item calls for disclosure of indirect, as well as direct, material interests in transactions. A person who has a position or relationship with a firm, corporation, or other entity, which engages in a transaction with the issuer or its subsidiaries may have an indirect interest in such transaction by reason of such position or relationship. However, a person shall be deemed not to have a material indirect interestin a transaction within the meaning of this Item 7(f) where:

   i. The interest arises onlyfrom such person's position as a director of another corporation or organization (other than a partnership) which is a party to the transaction, or
   ii. from both such position and ownership;

   iii. The interest arises only from such person's position as a limited partner in a partnership in which he and all other persons specified in Item 7(f) had an interest percent; or

   iv. The interest of such person arises solely from the holding of an equity interest (including a limited partnership interest but excluding a general partnership interest) or a creditor interest in another person which is a party to the transaction with the issuer or any of its subsidiaries and the transaction is notmaterial to such other person

8 Instructions.

a. In describing any transaction involving the purchase of sale of assets by or to the issuer or any of its subsidiaries, otherwise than in the ordinary course of business, state the cost of the assets to the purchaser and, if acquired by the seller within two years prior to the transaction, the cost thereof to the seller. Indicate the principle followed in determining the issuer's purchase or sale price and the name of the person making such determination.

b. Information shall be furnished in answer to this Item with respect to transactions not excluded above which involve remuneration from the issuer or its subsidiaries, directly or indirectly, to any of the specified persons for services in any capacity unless the interest of such persons for services in any capacity unless the interest of such persons arises solely from the ownership individually and in the aggregate of less than 10% of any class of equity securities of another corporation furnishing the services to the issuer or itssubsidiaries.

9 Transactions with pension or similar plans.

a. Describe briefly any transactions since the beginning of the issuer's last fiscal year, or any presently proposed transactions, to which any pension, savings or similar plan provided by the issuer, or any of its parents or subsidiaries was or is to be a party, in which any of the persons specified in Item 7(f) or the issuer or any of its subsidiaries had or is to have a direct or indirect material interest naming such person and stating hisrelationship to the issuer, the nature of his interest in the transaction and, where practicable, the amount of such interest.

b. No information need be given in answer to paragraph (g) with respect to:

i. payments to the plan, or payments to beneficiaries, pursuant to the terms of the plan;

ii. payment of remuneration for services not in excess of 5 percent of the aggregate remuneration received by the specified person during the issuer's last fiscal year from the issuer and its subsidiaries; or

iii. any interest of the issuer or any of its subsidiaries which arises solelyfrom its general interest in the success of the plan.

10. Instructions.

a. Subparagraph to Item 7(f) shall apply to this Item 7(g).

b. Without limiting the general meaning of the term “transaction”, there shall be included in answer to this item any remuneration received or any loans received or outstanding during this period, or proposed to be received.

H. Matters Related to Accounting

If the solicitation is made on behalf of the issuer and relates to an annual meetingof security holders at which directors are to be elected, or financial statements are included, furnish the following information:

1. If the issuer’s financial statements are not certified by independent public or certified accountants, so state.

2. If the Board of Directors has no audit or similar committee, so state.

3. If the issuer’s financial statements are certified by independent public or certified accountants, so state and provide the following information:

   a. The name of the principal accountant selected or being recommended to shareholders for election, approval or ratification for the current year. If no accountant has been elected or recommended, so state and briefly describe the reason therefor.

   b. The name of the principal accountant for the fiscal year most recently completed if different from the accountant selected or recommended for the current year or if no accountant has been elected or recommended for the current year.

   c. If a change or changes in accountants have taken place since the date of the proxy statement for the most recent annual meeting of shareholders, so state, and if in connection with such change(s) a material disagreement in connection with financial disclosure between the accountant and issuer has occurred, the disagreement shall be described. Prior to filing the preliminary proxy materials with the Commissioner which contains or amends such description, the issuer shall furnish the description of the disagreement to any accountant with whom the disagreement has occurred. If that accountant believes that the description of the disagreement is incorrect or incomplete, he may include a brief statement, not to exceed 200 words, in the proxy statement presenting his view of the disagreement. This statement shall be submitted to the issuer within ten business days of the date the accountant receives the issuer’s description.

   d. The proxy statement shall indicate whether or not representatives of the principal accountants for the current year and for the most recently completed fiscal year are expected to be present at the stockholders’ meeting with the opportunity to make a statement if they desire to do so and whether or not

such representatives are expected to be available to respond to appropriate questions.

e. If any change in accountants has taken place since the date of the proxy statement for the most recent annual meeting of shareholders, state whether such change was recommended or approved by:

i. Any audit or similar committee of the Board of Directors, if the issuer has such a committee; or

ii. The Board of Directors, if the issuer has no such committee.

iii. For the fiscal year most recently completed, describe each professional service provided by the principal accountant and state the percentage relationship which the aggregate of the fees for all non-audit services bear to the audit fees, and, except as provided below, state the percentage relationship which the fee for each non-audit service bears to the audit fees. Indicate whether, before each professional service provided by the principal accountant was rendered, it was approved by, and the possible effect on the independence of the accountant was considered by, (1) any audit or similar committee of the Board of Directors and, (2) for any service not approved by an audit or similar committee, the Board of Directors.

4. Instructions.

a. For the purposes of this subsection, all fees for services provided in connection with the audit function (e.g. reviews of quarterly reports) may be computed as part of the audit fees. Indicate which services are reflected in the audit fees computation.

b. If the fee for any non-audit service is less than 3 percent of the audit fees, the percentage relationship need not to be disclosed.

c. Each service should be specifically described. Broad general categories such as “tax matters” or “management advisory services” are not sufficiently specific.

d. Describe the circumstances and give details of any services provided by the issuer’s independent accountant during the latest fiscal year that were furnished at rates or terms that were not customary.

e. Describe any existing direct or indirect understanding or agreement that places a limit on current or future years’ audit fees, including fee arrangements that provide fixed limits on fees that are not subject to reconsideration if

unexpected issues involving accounting or auditing are encountered. Disclosure of fee estimates is not required.

I. Bonus, Profit Sharing and Other Remuneration Plans: Pension and Retirement Plans

If action is to be taken with respect to any bonus, profit sharing or other remuneration plan or any pension or retirement plan, furnish the following information.

1. Describe briefly the material features of the plan, identify each class of persons who will participate therein, indicate the approximate number of persons in each such class and state the basis of such participation.

2. Furnish such information, in addition to that required by this item and Item 7, as may be necessary to describe adequately the provisions already made pursuant to all bonus, profit sharing, pension retirement, stock option, stock purchase, deferred compensation, or other remuneration or incentive plans, now in effect or in effect within the past five years, for each director or officer named in answer to Item 7(a) who may participate in the plan to be acted upon; all present directors and officers of the issuer as a group, if any director or officer may participate in the plan, and all employees, if employees may participate in the plan.

3. If the plan to be acted upon can be amended otherwise than by a vote of stockholders, to increase the cost thereof to the issuer or to alter the allocation of the benefits as between the directors and officers on the one hand and employees on the other, state the nature of the amendments which can be so made.

4. With regard to any bonus, profit sharing or other remuneration plan, on which action is to be taken, furnish the following information.

   a. State separately the amounts which would have been distributable under the plan during the last fiscal year of the issuer (1) to directors and officers and (2) to employees if the plan had been in effect.

   b. State the name and position with the issuer of each person specified in Item 7(a), who will participate in the plan and the amount which each such person would have received under the plan for the last fiscal year of the issuer if the plan had been in effect.

5. With regard to any pension or retirement plan on which action is to be taken, furnish the following information:

   a. State the approximate total amount necessary to fund the plan with respect to past services, the period over which such amount is to be paid and the estimated annual payments necessary to pay the total amount over such period, the estimated annual payment to be made with respect to current

services and the amount of such annual payments to be made for the benefit of directors and employees.

b. State the name and position with the issuer of each person specified in Item 7(a) who will be entitled to participate in the plan, the amount which would have been paid or set aside by the issuer and its subsidiaries for the benefit of such person for the last fiscal year of the issuer if the plan had been in effect, and the amount of the annual benefits estimated to be payable to such person in the event of retirement at normal retirement date.

6. Instructions.

a. If action is to be taken with respect to the amendment or modification of an existing plan, the item shall be answered with respect to the plan as proposed to be amended or modified and shall indicate any material differences from existing plan.

b. The following instructions shall apply to paragraph (b):

i. Information need only be given with respect to benefits received or set aside within the past five years.

ii. Information need not be included as to payments made for, or benefits to be received from, group life or accident insurance, group hospitalization or similar group payments or benefits.

iii. If action is to be taken with respect to any plan in which directors or officers may participate, the information called for by Item 7(d) and shall be furnished for the last five fiscal years of the issuer and any period subsequent to the end of the latest such fiscal year, in aggregate amounts for the entire period for each such person and group. If any named person, or any other director or officer, purchased securities through the exercise of options during such period, state the aggregate amount of securities of that class sold during the period by such named person and by such named person and such other directors and officers as a group. The information called for by this Instruction is in lieu of the information since the beginning of the issuer's last fiscal year called for by Item 7(d). If employees may participate in the plan to be acted upon, state the aggregate amount of securities called for by all options or options granted to employees during the five-year period and, if the options were other than "restricted" or "qualified" stock options or options granted pursuant to an "employee stock purchase plan", as the quoted terms are defined in section 422 through 424 of the Internal Revenue Code, state that fact and the weighted average option price per share. The information called for by this instruction may be furnished in the form of the table set forth in Item 7(d).

c. If the plan to be acted upon is set forth in a written document, three copies thereof shall be filed with the Commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

d. The information called for by subparagraph (e)(1)(c) or (e)(2)(b) of this Item 7 need not be given as to payments made on an actuarial basis pursuant to any group pension plan which provides for fixed benefits in the event of retirement at a specified age or after a specified number of year of service.

J. Options, Warrants, or Rights

If action is to be taken with respect to the granting or extension of any options to purchase securities of the issuer or any subsidiary, furnish the following information:

1. State the title and amount of securities called for or to be called for by such options; the prices, expiration dates and other material conditions upon which the options may be exercised; the consideration received or to be received by the issuer or subsidiary for the granting or extension of the options; the market value of the securities called for or to be called for by the options as of the latest practicable date; and in the case of options, the Federal income tax consequences of the issuance and exercise of such option tothe recipient and to the issuer.

2. State separately the amount of options received by the following persons, naming each such person: each director or officer named in answer to Item 7(a); each nominee for election as a director of the issuer; each associate of such directors, officers, or nominees; and each other person who received by all directors and officers of the issuer as a group, without naming them.

3. Furnish such information, in addition to that required by this item and Item 7, as may be necessary to describe adequately the provision already made pursuant to all bonus, profit sharing pension, retirement, stock option, stock purchase, deferred compensation, or other remuneration or incentive plans, now in effect or in effect within the past five years, for each director or officer named in answer to Item 7(a) who may participate in the plan to be acted upon; all present directors and officers of the issuer as a group, if any director or officer may participate in the plan, and all employees, if employees may participate in the plan.

4. Instructions.

a. For the purpose of this paragraph J, the term option includes any option, warrant or right.

b. Paragraphs (2) and (3) do not apply to warrants or rights to be issued to security holders as such on a pro rata basis.

c. Instruction 6 to paragraph Ishall also apply to paragraph (3) of this item.

d. If the options described in answer to this item are issued pursuant to a plan which is set forth in a written document, three copies thereof shall be filed with the Commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

K. Authorization of Issuance of Securities Otherwise than for Exchange

If action is to be taken with respect to the authorization or issuance of any securities otherwise than for exchange for outstanding securities of the issuer, furnish the following information:

1. State the title and amount of securities to be authorized or issued.

2. If the securities are other than additional shares of common stock of a class outstanding, furnish a brief summary of the following, if applicable: dividend, voting, liquidation, preemptive, and conversion rights, redemption and sinking fund provisions, interest rate and date of maturity.

3. Describe briefly the transaction in which the securities are to be issued, including a statement as to the nature and approximate amount of consideration received or to be received by the issuer, and the approximate amount devoted to each purpose, as far as is determinable, for which the net proceeds have been or are to be used. If it is impracticable to describe the transaction in which the securities are to e issued, state the reason, indicate the purpose of the authorization of the securities, and state whether further authorization for the issuance of the securities by a vote of security holders will be solicited prior to such issuance.

4. If the securities are to be issued otherwise than in a general public offering for cash, state the reasons for the proposed authorization or issuance and the general effect thereof upon the rights of existing security holders.

L. Modification or Exchange of Securities

If action is to be taken with respect to the modification of any class of securities of the issuer, or the issuance or authorization for the issuance of securities of the issuer in exchange for outstanding securities of the issuer, furnish the following information:

1. If outstanding securities are to be modified, state the title and amount thereof. If securities are to be issued in exchange for outstanding securities, state the title amount of securities to be so issued, the title and amount of outstanding securities to be exchanged therefor and the basis of the exchange.

2. Describe any material differences between the outstanding securities and the modified or new securities.

3. State the reasons for the proposed modification or exchange and the general effect thereof upon the rights of existing security holders.

4. Furnish a brief statement as to arrears in dividends or as to defaults in principal or interest in respect to the outstanding securities which are to be modified or exchanged and such other information as may be appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

5. Outline briefly nay other material features of the proposed modification or exchange. If the plan of the proposed action is set forth in a written document, file copies thereof with the Commissioner at the time the preliminary proxy material is filed.

M. Mergers, Consolidations, Acquisitions, and Similar Matters

Furnish the following information if action is to be taken with respect to any plan for the merger or consolidation of the issuer into or with any other person or of any other person into or with the issuer, the acquisition by the issuer or any of its security holders of securities of another issuer, the acquisition by the issuer of any other going business or of the assets thereof, the sale or other transfer of all or any substantial part of the assets of the issuer, or the liquidation or dissolution of the issuer:

1. Outline briefly the material features of the plan. State the reasons therefor and the general effect thereof upon the rights of existing security holders. If the plan is set forth in a written document, file three copies thereof with the Commissioner at the time preliminary copies of the proxy statement and form of proxy are filed.

2. Furnish the following information as to the issuer and each person which is to be merged into the issuer or into or with which the issuer is to be merged or consolidated or the business or assets or to be acquired or which is the issuer of securities to be acquired by the issuer in exchange for all or a substantial part of its assets or to be acquired by security holders of the issuer. What is required is information essential to an investor’s appraisal of the action proposed to be taken.

    a. Describe briefly the business of such person.

    b. State the location and describe the general character of the plants and other important physical properties of such person. The description is to be given from an economic and business standpoint, as distinguished from a legal standpoint. Portfolio or investment assets of an issuer need not be enclosed.

    c. Furnish a brief statement as to dividends in arrears or defaults in principal or interest in respect of any securities of the issuer or of such person, and as to the effect of the plan thereon and such other information as may be appropriate in the particular case to disclose adequately the nature and effect of the proposed action.

d. Furnish tabulation in columnar form showing the existing and the pro forma capitalization.

e. Furnish in columnar form for each of the last five fiscal years an historical summary of earnings and show per share amounts of net earnings, dividends declared for each year and book value per share at the end of the latest period.

f. Furnish in columnar form for each of the last five fiscal years a combined pro forma summary of earnings, as appropriate in the circumstances, indicating the aggregate and per-share earnings for each such year and the pro forma book value per share at the end of the latest period. If the transaction establishes a new basis of accounting for assets of any of the persons included therein, the pro forma summary of earnings shall be furnished only for the most recent fiscal year and interim period and shall reflect appropriate pro forma adjustments resulting from such new basis of accounting.

g. To the extent material for the exercise of prudent judgment in regard to the matter to be acted upon, furnish the historical and pro forma earnings data specified in (5) and (6) above for interim periods of the current and prior fiscal years, if available.

3. Instructions.

a. Subparagraph (b) of this Item 13 shall not apply if the plan described in answer to paragraph (a) involves only the issuer and one or more of its totally-held subsidiaries.

b. As to each class of securities of the issuer, or of any person specified in paragraph (b), which is admitted to dealing on a national securities exchange or with respect to which a market otherwise exists, and which will be materially affected by the plan, state the high and low sale prices (or, in the absence of trading in a particular period, the range of the bid and asked prices) for each quarterly period within two years. This information may be omitted if the plan involves merely the liquidation or dissolution of the issuer.

N. Financial Statements

1. If action is to be taken with respect to any matter specified in Item 11, 12, 13 above, furnish financial statements of the issuer and its subsidiaries complying with the requirements of Section 4(b)(1), (2) and (3) of the Regulation including schedules of supplementary profit and loss information. Such statements may be omitted with respect to a plan described in answer to Item 13 if the plan involves only the issuer and one or more of its totally-held subsidiaries.

2. If action is to be taken with respect to any matter specified in Item 13(b) furnish for each person specified therein, other than the issuer, financial statements complying with the requirements of Section 4(b)(1), (2) and (3) of the Regulation.

3. The Commissioner may, upon the request of the issuer, permit the omission of any of the statements herein required where such statements are not necessary for the exercise of prudent judgment in regard to any matter to be acted upon, or may permit the filing in substitution therefor of appropriate statements of comparable character. The Commissioner may also require the filing of other statements in addition to, or in substitution for, the statements herein required in any case where such statements for an adequate presentation of the financial statements are required, or whose statements are otherwise material for the exercise of prudent judgment in regard to any matter to be acted upon. In the usual case, financial statements are deemed material to the exercise of prudent judgment where the matter to be acted upon is the authorization or issuance of a material amount of senior securities, but are not deemed material where the matter to be acted upon is the authorization or issuance of common stock, otherwise than in an exchange, merger or consolidation, acquisition or similar transaction.

4. The proxy statement may incorporate by reference any financial statements contained in an annual report sent to security holders with respect to the same meeting as that to which the proxy statement relates, provided such financial statements substantially meet the requirements of this Item.

O. Acquisition or Disposition of Property.

If action is to be taken with respect to the acquisition or disposition of any property, furnish the following information:

1. Describe briefly the general character and location of the property.

2. State the nature and amount of consideration to be paid or received by the issuer or any subsidiary. To the extent practicably, outline briefly the facts bearing upon the question of the fairness of the consideration.

3. State the name and address of the transferor or transferee as the case may be, and the nature of any material relationship of such person to the issuer or an affiliate of the issuer.

4. Outline briefly any other material features of the contract or transaction.

P. Restatement of Accounts

If action is to be taken with respect to the restatement of any asset, capital, or surplus account of the issuer, furnishes the following information:

1. State the nature of the restatement and the date as of which it is to be effective.

2. Outline briefly the reasons for the restatement and for the selection of the particular effective date.

3. State the name and amount of each account (including any reserve accounts) affected by the restatement and the effect of the restatement thereon. Tabular presentationof the amounts shall be made when appropriate, particularly in the case of recapitalization.

4. To the extent practicable, state whether and the extent, if any, to which the restatement will, as of the date thereof, alter the amount available for distribution to the holders of equity securities.

Q. Action with Respect to Reports

If action is to be taken with respect to any report of the issuer or of its directors, officers or committees or any minutes of its stockholders, furnish the following information:

1. State whether or not such action is to constitute approval or disapproval of any of the matters referred to in such reports or minutes.

2. Identify each of such matters which it is intended will be approved or disapproved and furnish the information required by the appropriate item or items of this Schedule with respect to each such matter.

R. Matters Not Required to be Submitted

If action is to be taken with respect to any matter which is not required to be submitted to a vote of security holders, state the nature of such matter, the reasons for submitting it to a vote of security holder and what action is intended to be taken by the management in the event of a negative vote on the matter by the security holders.

S. Amendment of Charter, Bylaws of Other Documents

If action is to be taken with respect to any amendment of the issuer's charter, bylaws or other documents as to which information is not required above, state briefly the reasons for and general effect of such amendment.

Instruction: Where the matter to be acted upon is the classification of directors, state whether vacancies which occur during the year may be filled by the board of directors to serve only until the next annual meeting or may be so filled for the remainder of the full term.

T. Other Proposed Action

`If action is to be taken with respect to any matter not specifically referred to above, describe briefly the substance of each matter in substantially the same degree of detail as is required by Items 5 to 19, inclusive, above.

U. Vote Required for Approval

As to each matter which is to be submitted to a vote of security holders, other than elections to office or the selection or approval of auditors, state the vote required for its approval.

Source: *Miss. Code Ann.* § 83-19-97 (Rev. 2011)

Rule 12.18 Schedule B: Information to Be Included In Statements Filed By Or On Behalf Of a Participant (Other Than the Issuer) In a Proxy Solicitation inan Election Contest

A. Issuer

State the name and address of the Issuer.

B. Identity and Background

1. State the following:

a. Your name and business address.

b. Your present principal occupation or employment and the name, principal business and address of any corporation or other organization in which such employment is carried on.

2. State the following:

a. Your residence address.

b. Information as to all material occupations, positions, offices or employments during the last ten years, giving starting and ending dates of each and the name, principal business and address of any business corporation or other business organization in which each such occupation, position, office or employment was carried on.

3. State whether or not you are or have been a participant in any other proxy contest involving this company or other companies within the past ten years. If so, identify the principals, the subject matter and your relationship to the parties and the outcome.

4. State whether or not, during the past ten years, you have been convicted in a criminal proceeding (excluding traffic violations or similar misdemeanors) and, if

so, give dates, nature of conviction, name and location of court, and penalty imposed or other disposition of the case. A negative answer to this sub-item need not be included in the proxy statement or other proxy soliciting material.

C. Interest in Securities of the Issuer

1. State the amount of each class of securities of the issuer which you own beneficially, directly or indirectly.

2. State the amount of each class of securities of the issuer which you own of record but not beneficially.

3. State with respect to all securities of the issuer purchased or sold within the past two years, the dates on which they were purchased or sold and the amount purchased or sold on each such date.

4. If any part of the purchase price or market value of any of the securities specified in paragraph (c) is represented by funds borrowed or otherwise obtained for the purpose of acquiring or holding such securities, so state and indicate the amount of the indebtedness as of the latest practicable date. If such funds were borrowed or obtained otherwise than pursuant to a margin account or bank loan in the regular course of business of a bank, broker or dealer, briefly describe the transaction, and state the names of the parties.

5. State whether or not you are a party to any contracts, arrangements or understandings with any person with respect to any securities of the issuer including but not limited to joint ventures, loan or option arrangements, puts or calls guarantees against losses or guarantees or profits, division of losses or profits, or the giving or withholding of proxies. If so, name the persons with whom such contracts, arrangements, or understandings exist and give the details thereof.

6. State the amount of securities of the issuer owned beneficially directly or indirectly, by each of your associates and the name and address of each such associate.

7. (g) State the amount of each class of securities of any parent, subsidiary or affiliate of the issuer which you own beneficially directly or indirectly.

D. Further Matters.

1. Describe the time and circumstances under which you became a participant in the solicitation and state the nature and extent of your activities or proposed activities as a participant.

2. Describe briefly, and where practicable state the approximate amount of, any material interest, direct or indirect, of yourself and of each of your associates in any material transactions since the beginning of the company's last fiscal year, or in any material

proposed transactions, to which the company or any of its subsidiaries or affiliates was or is to be a party.

3. State whether or not you or any of your associates have any arrangement or understanding with any person:

    a. With respect to any future employment by the issuer or its subsidiaries or affiliates; or

    b. With respect to any future transactions to which the issuer or any of its subsidiaries or affiliates will or may be a party.

If so, describe such arrangement or understanding and state the names of the parties thereto.

E. Signature

The statement shall be dated and signed in the following manner:

I certify that the statements made in this statement are true, complete, and correct, to the best of my knowledge and belief.

_____ _____

(Date) (Signature of participant or authorized representative)

Source: *Miss. Code Ann.* § 83-19-91; § 83-19-97 (Rev. 2011)

Rule 12.19 Schedule C: Information Required In Information Statement

Note. Where any item other than Item 5, calls for information with respect to any matter to be acted upon at the meeting, such item need be answered only with respect to proposals to be made by the issuer.

A. Information Required by Items of Schedule 14A

Furnish the information called for by all of the items of Schedule A of the Regulation Regarding Proxies, Consents and Authorization (other than Items 1, 3, and 4 thereof) which would be applicable to any matter to be acted upon at the meeting if proxies were to be solicited in connection with the meeting.

B. Statement That Proxies Are Not Solicited

The following statement shall be set forth on the first page of the information statement in bold face type:

WE ARE NOT ASKING YOU FOR A PROXY AND YOU ARE REQUESTED NOT TO SEND US A PROXY.

C. Date, Time and Place of Meeting

State the date, time and place of the meeting of security holders, unless such information is otherwise disclosed in material furnished to security holders with the information statement.

D. Interest of Certain Persons in or Opposition to Matters to be ActedUpon.

1. Describe briefly any substantial interest, direct or indirect, by security holdings or otherwise, of each of the following persons in any matter to be acted upon, other than elections to office:

    a. Each person who has been a director or officer of the issuer at any time since the beginning of the last fiscal year.

    b. Each nominee for election as a director of the issuer.

    c. Each associate of the foregoing persons.

2. Give the names of any director of the issuer who has informed the management in writing that he intends to oppose any action to be taken by the management at the meeting and indicate the action which he intends to oppose.

E. Proposals by Security Holders

If any security holder entitled to vote at the meeting has, not less than 90 days before the issuer's annual meeting, submitted to the issuer a proposal which is accompanied by notice of his intention to present the proposal for action at the meeting, make a statement to that effect, identify the proposal and indicate the disposition proposed to be made of the proposal by the management at the meeting.

Source: *Miss. Code Ann.* § 83-19-97 (Rev. 2011)

Part 1 Chapter 13: (83-1) Public Records Act as Same Is Interpreted By the Mississippi Insurance Department.

Rule 13.01: Purpose and Application

This regulation contains the rules and procedures to be followed by the Mississippi Insurance Department in implementing the Public Records Act of 1983, Miss. Code Ann. 25-61-1, et seq.

Employees of the Mississippi Insurance Department may, however, continue to furnish to the public, informally and without compliance with these procedures, information and records which

they customarily furnish in the regular performance of their duties prior to the enactment of the Public Records Act of 1983, Miss. Code Ann. 25-61-1 et seq., (hereinafter "Act").

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.02: Statement of Policy

The policy of the Mississippi Insurance Department is one of full and responsible disclosure of its identifiable records consistent with the provisions of the Public Records Act of 1983, Miss. Code Ann. 25-61-1 et seq. All records not exempt from disclosure will be made available. Moreover, records exempt from mandatory disclosure will be made available as a matter of discretion when disclosure is not prohibited by law or is not against the public interest.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.03: Public Records

A. Personnel

1. A Freedom of Information Officer will be responsible for the processing of all official requests for information/records pertaining to the Mississippi Insurance Department and its separate divisions including the offices of the Fire Marshal and the Liquefied Compressed Gas Sector.

2. A Freedom of Information Liaison Officer, located in the office of the Mississippi Insurance Department or its divisions, will be designated from each division of said Department. The duty of this position will be to assist the Freedom of Information Officer in the enforcement of the Mississippi Public Records Act of 1983.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.04: Request for Records

A. A request for a record of the Mississippi Insurance Department may be made orally or in writing and shall be directed to said agency either by mail at the usual mailing address, P.O. Box 79, Jackson, MS 39205 or in person at the offices of the Mississippi Insurance Department 10th Floor, Woolfolk State Office Building, Jackson, MS 39201. Although oral requests may be honored, a requestor may be asked to submit in writing a request for records not customarily made available. Any written request for records covered by these regulations shall be deemed to be a request for records pursuant to the Act whether or not the Act is mentioned in the request. When a request is made in writing, both the envelope and the letter should clearly indicate that the subject is a Freedom of Information Request.

B. A request should reasonably describe the desired record. Where possible, specific information regarding the dates, files, titles, file designation, etc., should be supplied.

C. Where the information supplied by the requestor is not sufficient to permit the identification and location of the record by the Mississippi Insurance Department without an unreasonable amount of effort, the requestor will be contacted and asked to supply the necessary information. Every reasonable effort shall be made by the agency to assist in the identification and location of requested records.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.05: Time Limitations

A. Pursuant to the time frames established by Miss. Code Ann. § 25-43-1.106, the Mississippi Insurance Department shall determine whether to comply with or to deny the request and shall dispatch such determination to the requestor.

B. If no determination has been dispatched at the end of the statutory time period, the requestor may deem his request denied, and exercise a right of appeal in accordance with Section 13.09 of this regulation. When no determination can be dispatched within the applicable time limit, the Mississippi Insurance Department shall nevertheless continue to process the request; on expiration of the time limit the agency shall inform the requestor of the reason for the delay, of the date on which a determination may be expected, and of his right to treat the delay as a denial and of the appeal rights provided by the Act. The agency may ask the requestor to forego until a determination is made.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.06: Exemptions

A. A requested record shall not be withheld from inspection or copying unless it comes within one of the classes of records exempted by the Public Records Act of 1983, Miss. Code Ann. 25-61-1 et seq.

B. The classes of records authorized to be exempted from disclosure are those which concern matters are:

1. Records furnished to public bodies by third parties which contain trade secrets or confidential commercial or financial information until notice to said parties has been given, but such record shall be released within a reasonable period of time unless said third party shall have obtained a court order protecting such records as confidential.

2. Any public record held to be exempt from disclosure which contain confidential or privileged or exempt material by a state or federal court decision, constitutional provision or statute;

3. Records in the possession of a public body, which are developed among judges and among judges and their aides;

4. Records in the possession of a public body, which are developed among juries concerning judicial decisions;

5. Personnel records and applications for employment in the possession of a public body, except those which may be released to the person who made the application or with the prior written consent of the person who made the application;

6. Test questions and answers in a public body which are used in employment examinations;

7. Letters of recommendation in the possession of a public body respecting any application of employment;

8. Records in the possession of a public body, which represent and constitute the work product of any attorney, representing a public body and which are related to litigation made by or against such public body or in anticipation of prospective litigation, including all communications between such attorney made in the course of an attorney/client relationship;

9. Records in the possession of a public body which would disclose information about a person's tax payment or status;

10. Appraisal information in the possession of a public body, which would concern the sale or purchase of real or personal property for public purposes prior to public announcement of the purchase or sale, where the release of such records would have a detrimental effect on such sale or purchase;

11. Test questions and answers in the possession of a public body which are to be used in future academic examinations;

12. Letters of recommendation in the possession of a public body respecting admission to any educational agency or institution;

13. Records in the possession of a public body which are not otherwise protected by law, that:

    a. are compiled in the process of detecting and investigating any unlawful activity or alleged unlawful activity, the disclosure of which would harm such investigation;

    b. would reveal the identity of informants;

    c. would prematurely release information that would impede the public body's enforcement, investigative or detection efforts in such proceedings;

d. would disclose investigatory techniques;

e. would deprive a person of a right to a fair trial or an impartial adjudication;

f. would endanger the life or safety of a public official or law enforcement personnel; or

g. are matters pertaining to quality control or peer review activities;

h. applications for licensure in the possession of a public body except that which may be released to the person who made the application or with the prior written consent of the person who made the application;

i. test questions in the possessions of a public body that are to be used in the future license examinations;

j. commercial and financial information of a proprietary nature to be submitted to a public body by a firm, business, partnership, association, corporation, individual or other like entity; provided, however, that nothing herein shall be considered to deny access to such information submitted to a regulatory agency by a public utility that is related to the establishment of, or changes in, rates regulated by such agency.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.07: Responses to Request

A. When a requested record has been identified and is available, the Mississippi Insurance Department shall notify the requestor as to where and when the record is available for inspection or copies will be available if applicable. The notification shall also advise a requestor of any applicable fees. Generally, oral requests for information not exempt from the provisions of the Act shall be acted upon and the information made available for inspection and/or copying during regular office hours to any person upon such request; provided, however, a requestor may be asked to submit in writing a request for records not customarily made available or where time or personnel restraints make it impossible to comply with such oral requests during the working day such request is made.

B. A response denying a written request for record shall be in writing and shall include:

1. The identity of each person responsible for the denial;

2. A reference to the specific exemption or exemptions authorizing the withholding of the record with a brief explanation of how each exemption applies to the record withheld. Where more than one record has been requested and is being withheld, the foregoing shall be provided for each record withheld; and

3. A statement of the appeal rights provided by the Act.

C. If a requested record cannot be located from the information supplied or is known to have been destroyed or otherwise disposed of, the requestor shall be so notified.

D. The Mississippi Insurance Department reserves the right to disseminate information by one of two methods:

1.By distributing copies of the requested materials to the requestor, or

2. By giving the requestor access to the material.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.08: Fees

A. Charges for services rendered in response to information requests shall be as follows:

1. Searching for records, per quarter hour, or any part thereof, by clerical personnel….. $1.50

2. Non-routine searching, per quarter hour, or any part thereof, by supervisory personnel…. $4.00

3. Copies made by electrostatic, scanner, or Xerox copy machines……$0.50 per copy (Miss. Code Ann. § 83-5-77). Pages printed on front and back side shall be considered as two pages for copy charge purposes.

4. Copies made by an outside service…… Actual Charge

5. Mailing and Postage Costs…….. Actual cost

6. When a response to a request requires services of material for which no fee has been established, the actual cost of such services or material to the Mississippi Insurance Department may be charged, but only if the requestor has been notified of and pays such costs before they are incurred.

7. Where an extensive number of documents are identified and collected response to a request and the requestor has not indicated in advance his willingness to pay fees as are anticipated for copies of the document, the agency shall inform the requestor that the documents are available for inspection and for subsequent copying at the established rate.

8. A charge of $20.00 shall be made for each seal certifying true copies of agency records in accordance with Miss. Code Ann. § 83-5-77.

9. Search costs may be imposed even if the requested records cannot be located. No fees shall be charged for examination and review by the Mississippi Insurance Department to determine whether a record is subject to disclosure.

10. Fees must be paid in full prior to issuance of requested copied.

11. Remittances shall be in form either of a personal check or bank draft drawn on a bank in the United States, a postal money order, or cash. Remittance shall be made payable to the order of the Mississippi Insurance Department of Commissioner of Insurance and mailed or otherwise delivered to the head of the Mississippi Insurance Department. The agency will not assume responsibility for cash which is lost in the mail.

12. A receipt for fees paid will be given only upon request. No refund will be made for services rendered.

13. The Mississippi Insurance Department may waive all or part of any fee when it is deemed to be either in the agency's interest or in the interest of the public.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2011)

Rule 13.09: Review of Denials

A. When a request for records has been denied in whole or in part by the Mississippi Insurance Department, the requestor may appeal the denial to the Commissioner of Insurance or may seek immediate judicial review of the denial in the Chancery Court.

B. An appeal to the Commissioner of Insurance shall be in writing, and shall include a statement of the circumstances, reasons or arguments advanced in support of disclosure, and a copy of any written denial issued.

C. Unless the Commissioner of Insurance otherwise directs, the Freedom of Information Officer shall act on behalf of the Commissioner of Insurance on all appeals under this section, except that in the case of initial denial by the Freedom of Information Officer, the Commissioner of Insurance or his designee shall act on the appeal.

D. A written determination with respect to an appeal shall be made within ten (10) days of the filing of the appeal. If the records or any divisible part thereof are found to have been improperly withheld, the Commissioner of Insurance shall order the Mississippi Insurance Department to make them available. If the agency continues to withhold the record, the requestor may seek enforcement of the order in the Chancery Court.

E. A denial in whole or in part of a request on appeal shall set forth the exemption relied on, a brief explanation consistent with the purpose of the exemption of how the exemption applies to the records withheld, and the reasons for asserting it. The denial shall also inform the requestor of the right of judicial review.

F. If no determination has been dispatched at the end of the statutory time period, the requestor may deem his request denied, and exercise his right to judicial review of the denial.

Source: *Miss. Code Ann.* § 25-43-1.101, et seq.; §83-5-73 (Rev. 2011)

Rule 13.10: Records Maintained by Agencies

A. The Mississippi Insurance Department shall make and maintain records pertaining to each request for information, including copies of correspondence. The material shall be filed by individual request.

B. The Mississippi Insurance Department shall maintain a file, open to the public, which shall contain copies of all letters of denial. Such denials shall be preserved in a denial file for a period of not less than three (3) years from the date such denials are made. Said denial file shall be made available for inspection and/or copying during regular office hours to any person upon written request.

C. Where the release of the identity of the requestor or other identifying details related to the request would constitute a clearly unwarranted invasion of personal privacy, the Mississippi Insurance Department shall delete the identifying details from the copies of the documents maintained in the public file.

D. The Mississippi Insurance Department shall also maintain records permitting annual reporting of the following:

1. Total number of requests made to the agency;

2. The total number of requests granted and denied, in whole or in part;

3. The number of times each exemption was invoked as the basis for nondisclosure;

4. The names and titles or positions of each person responsible for the denial of records and the number of instances each person was involved in a denial; and

5. The amount of fees collected and the amount of fees for duplication and search waived by the agency.

Source: *Miss. Code Ann.* § 25-61-5; § 27-101-1 (Rev. 2011)

Rule 13.11: Effective Date

The Effective Date of this Regulation is thirty (30) days from and after its adoption and filing with the Secretary of State's Office.

Source: *Miss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Part 1 Chapter 14: **(**87-101) Unfair Trade Practices-Discrimination on the Basis of Blindness or Partial Blindness.

Rule 14.01 Authority and Purpose

This Regulation is promulgated by the Commissioner of Insurance of the State of Mississippi to implement Section 83-5-5, 83-5-29, 83-5-31, 83-5-33, 83-5-35(g), and 83- 5-45 of the Mississippi Code of 1972, Annotated and Amended, and is promulgated with an effective date of thirty (30) days after promulgation and filing with the Office of the Secretary of State upon compliance with the applicable statutes.

The purpose of this regulation is to state that individuals who are blind or partially blind, do not, for that reason, constitute a class. Therefore, individuals who are blind orpartially blind will not, solely on that basis, be unfairly discriminated against in the amount of premium, policy fees or rates charged for any contract of life, accident or health insurance or in benefits payable thereunder, or in any of the terms or conditions of such contract, or of life annuity or in the dividends or other benefits payable thereon or in any other of the terms and conditions of such contracts or in any manner whatsoever.

Source: *Miss. Code Ann.* § 83-5-35; § 83-63-5 (Rev. 2011)

Rule 14.02 Definitions

A. For the purpose of this regulation, "contract" shall mean "insurance policy" or "insurance contract" as defined in Section 83-5-5 and as specifically provided for in Chapter 7 and 9 of Title 83 of the Mississippi Code of 1972.

B. "Person" shall mean "person" as defined in Section 83-5-31(a) of the Mississippi Code of 1972.

Source: *Miss. Code Ann.* § 83-5-5; § 83-5-31 (Rev. 2011)

Rule 14.03 Applicability and Scope

This regulation shall apply to all contracts delivered or issued for delivery in this state by a person on or after the effective date of this regulation and to all existing group contracts which are amended or renewed on or after the effective date of this regulation.

Nothing contained in this regulation shall be construed to prohibit discrimination between individuals of the same class who do not have equal expectation of life or who have expected risk of loss different than that of other individuals of the same class.

Source: *Miss. Code Ann.* § 83-5-1; § 83-5-13 (Rev. 2011)

Rule 14.04 For the purposes of Section 83-5-35 (g)(1)(2) of the Code, individuals shall not be considered to be of the same class solely because such individuals are blind or partially blind.

Source: *Miss. Code Ann.* § 83-5-35 (Rev. 2011)

Rule 14.05 Unfairly Discriminatory Acts or Practices

The following are hereby indentified as acts or practices which constitute unfair discrimination between individuals of the same class: Refusing to insure, or refusing to continue to insure, or limited the amount, extent or kind coverage available to an individual, or charging an individual a different rate for the same coverage solely because of blindness or partial blindness.

Source: *Miss. Code Ann.* § 83-5-35 (Rev. 2011)

Part 1 Chapter 15: Rules of Practice and Procedure before the Mississippi Insurance Department and State Fire Marshal's Office.

Rule 15.01 Statutory Authority
Rule 15.02 Purposes
Rule 15.03 Applicability
Rule 15.04 Definitions
Rule 15.05 General Matters; Matters Pertaining to all Proceedings
Rule 15.06 Licensing of Producers
Rule 15.07 Licensing of Insurers
Rule 15.08 Notice
Rule 15.09 Hearing and Adjudication
Rule 15.10 Orders
Rule 15.11 Rules and Rulemaking
Rule 15.12 Declaratory Opinions
Rule 15.13 Effective Date

Rule 15.01 Statutory Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the requirements of *Miss. Code Ann. §*25-43-5 an in accordance with the Mississippi Administrative Procedures Law. Some provisions of this Regulation are promulgated pursuant to the requirements of *Miss. Code Ann. §*25-61-5.

Source: *Miss. Code Ann.* § 25-61-5; § 83-5-1 (Rev. 2022)

Rule 15.02 Purposes

*Miss. Code Ann. §*25-43-5, the "Administrative Procedures Law", requires each agency of state government to adopt as a rule a description of its organization, stating the general course and

method of its operations and the methods whereby the public may obtain information or make submissions or requests, and adopt rules of practice setting forth the nature and requirements of all formal and informal procedures available, including all requirements respecting the filing of applications for any license and the licensing procedure employed by the agency and the method whereby persons desiring notice pending applications may obtain such notice and request an opportunity to be heard.

The purpose of this Regulation is to comply with the requirements of the Administrative Procedures Law. Some provisions of the Regulation also comply with the requirements of *Miss. Code Ann. §*25-61-5 of the Mississippi Public Records Act of 1983, as amended.

Source: *Miss. Code Ann.* § 25-61-5 (Rev. 2021) § 83-5-1 (Rev. 2022)

Rule 15.03 Applicability

This Regulation shall be of general applicability and shall apply in all cases except to the extent a statute of the State of Mississippi provides otherwise.

Source: *Miss. Code Ann.* § 25-61-5 (Rev. 2021)

Rule 15.04 Definitions

A. Department – The Insurance Department of the State of Mississippi.

B. State Fire Marshal's Office – a division of the Department that is tasked with coordinating and assisting Mississippi fire and law enforcement services in order to protect life and property from fire and related perils.

C. Commissioner – The Insurance Commissioner and State Fire Marshal of the State of Mississippi.

D. Person – Any individual, partnership, corporation, association, reciprocal, exchange, inter-insurer, fraternal benefit society, insurer, company, society, syndicate, business trust, or any public or private organization of any character.

E. Party – Any person named or admitted as a party, or properly seeking and entitled as of right to be admitted as a party, in any Department proceeding.

F. Rule – Any Department statement of general applicability and effect that implements, interprets, or prescribes law or policy, or describes the organization, procedure, or practice of the Department.

G. Rule-Making – The process for the formulation, amendment, or repeal of a rule.

H. Order – The final disposition of the Department in any matter other than rule-making in which the Department is required by law to make its determination and, unless otherwise provided in law, after notice and hearing.

I. Adjudication – A ruling or judgment on a matter that is under the jurisdiction of the Department of Insurance.

J. Hearing – A proceeding for consideration or presentation of evidence, facts and matters for adjudication and decision regarding a matter that is under the jurisdiction of the Department of Insurance.

K. License – Any Department permit, certificate, approval, registration or similar form of permission or record required by law, except a charter, an insurance producer's certificate of authority. For the purposes of this regulation, a license shall also include any permit, certificate of compliance or license issued by the State Fire Marshal's Office.

L. Licensing – The Departmental process respecting the grant, denial, renewal, revocation, suspension, probation, withdrawal, or amendment of a license.

M. Application – The request for authority for an action or an issuance by the Commissioner or the Department.

N. Charter – The corporate charter of any corporation formed under the laws of Mississippi for the purpose of becoming an Insurer.

O. Certificate Of Authority – When used with respect to an insurance producer, a certificate issued by the Commissioner pursuant to *Miss. Code Ann*. Section 83-17-5. When used with respect to a foreign insurer, a certificate issued by the Commissioner pursuant to *Miss. Code Ann.* §83-21-1.

P. Insurance – A contract of insurance as defined in *Miss. Code Ann.* §83-5-5.

Q. Insurer – A "company" or "insurance company" as defined in *Miss. Code Ann*. §83-5-5.

R. Examination – A test, whether oral, written, or both, to determine the capacity of an applicant to be an insurance producer, broker, solicitor or adjuster.

S. Insurance Code – Mississippi Code Annotated, Title 83.

T. Certificate Of Compliance – A certificate issued by the Commissioner in his role as State Fire Marshal that a person or entity has met all necessary requirements and is in acting in accordance with any statute, rule or regulation under the jurisdiction of the State Fire Marshal.

U. Website – The Department hosts a public website wherein Department information, notices, bulletins and regulations, among other documents and information, are posted. The Department's website address is www.mid.ms.gov .

Source: *Miss. Code Ann.* §§ 83-5-1, et seq. (Rev. 2022)

Rule 15.05 General Matters.

A. Description of Department –The Insurance Department generally regulates all insurance companies and their agents doing business in the State of Mississippi. The Department's responsibilities include, but are not limited, to the following: granting or withholding of charters, issuing certificates of authority; issuing licenses; approving policies, proxies, and advertising material; conducting hearings on rates; and any other matters affecting the regulation of the insurance industry in this state; administering and collecting surplus lines premium taxes; receiving and examining reports and financial statements from all insurance companies authorized to do business in this state; and preparing annual reports of the Insurance Commissioner.

The Commissioner has the further responsibility for the promulgation of rules and regulations concerning the activities of insurance companies and insurance producers engaged in the business of insurance in this State. The Department is composed of several divisions that deal directly with the public including, but not limited to:

- Producer Licensing;
- Financial and Market Regulation;
- Life and Health Actuarial;
- Consumer Services;
- Investigations and Consumer Protection; Property and Casualty Rating;
- Legal.

The Insurance Department of the State of Mississippi also houses the State Fire Marshal's Office. The Commissioner of Insurance is by virtue of his office the State Fire Marshal and conducts investigations into all fires of a suspicious nature; ensures compliance with the Mississippi Fire Prevention Code, provides fire safety education, and regulates manufactured housing, liquefied compressed gas, electronic alarms, pyrotechnics and elevators/escalators.

B. Office and Hours -The Office of the Department is located at Suite 1001, 501 N. West Street, Woolfolk State Office Building, in Jackson, Mississippi. The office shall be open during business hours each day, Saturday, Sunday, and holidays excepted. The mailing address of the Department is P. O. Box 79, Jackson, Mississippi 39205, and its telephone number is (601) 359-3569.

C. Custody Of Records – The Commissioner shall have custody of the Seal and records of the Department including the transcripts of testimony and exhibits with all papers and requests filed in proceedings, the minutes of all actions taken by the Department and all of

its findings, determinations, reports, opinions, orders, rules, regulations, and approved forms.

D. Public Records – Except as limited by *Miss. Code Ann. §§*25-61-9 and 25-61-11, and any other applicable statutory restriction, all public records of the Department are available to the public and may be inspected or copied at the office of the Department.

   a. Records Request - A public records request may be made by using the Department's online public records request system, which can be found at the Department's website: www.mid.ms.gov , or it may be made by written request or by telephone. If a request is made verbally, the requestor may be asked to also submit a written request.

   b. Copies of Records - Copies may be requested and shall be made under the supervision of Department personnel. Records may also be provided by e-mail or by providing scanned copies on a compact disc. The Department may not be able to produce the records in any other type of requested format, such as an electronic format. The Department shall prepare an invoice pursuant to the Public Access Information Fee Schedule located on the Department's website. The fees shall be collected by the Department in advance of complying with the request pursuant to *Miss. Code Ann.* §25-61-7.

   c. Production Schedule - Pursuant to *Miss. Code Ann*. §25-61-5, the Public Records Request will be fulfilled within seven (7) working days of the submission of the request. After seven (7) working days, MID will either produce the requested documents, will request an additional seven (7) working days, or another date that is mutually agreed upon by the parties .Denials by the Department for a request for access to or copies of public records shall be in writing and shall contain a statement of the specific reasons for the denial. Some information produced may contain publicly identifiable information or exempted information that is not subject to disclosure. MID will redact that information before producing the public documents as provided in *Miss. Code Ann*. §§25-61-9 and 25-61-11.

E. Computation Of Time – In computing the time period within which an act must be performed, the first day shall be excluded and the last day shall be included, but if the last day shall fall on a Saturday, Sunday or a legal holiday, then the next business day shall be construed as the last day.

Source: *Miss. Code Ann.* § 25-61-1, et seq. (Rev. 2021); 83-5-1 (Rev. 2022)

Rule 15.06 Licensing of Insurance Producers:

A. License Required - All insurance producers and business entities must be properly licensed before engaging in the business of insurance in this state. All applicants must have complied with the licensing laws prior to receiving a license to engage in the business of insurance in the State of Mississippi.

B. Major Lines of Authority -Insurance producer licenses are issued in the following major lines of authority:

1. Life
2. Accident and Health
3. Property
4. Casualty
5. Variable Life and Variable Annuity, and
6. Personal Lines

C. Limited Lines of Authority - Limited lines producer licenses are issued in the following limited lines of authority:

1. Industrial Fire
2. Surety
3. Title
4. Trip Accident and Baggage
5. Industrial Life and Accident & Health
6. Car Rental
7. Crop Insurance
8. Travel; and
9. Storage

D. Initial and Renewal Applications - License applications and renewal applications shall be made through the Department's online licensing portal, which may be found at the Department's website; www.mid.ms.gov .

E. Licensure Period – An insurance producer's license will continue until such time as the licensure period elapses without timely renewal, or an administrative action is taken by the Department resulting in the revocation of the insurance producer's license.

F. Continuation of License during Proceeding - When an insurance producer has made a timely and sufficient application for renewal of a license, certificate of authority, with reference to any activity of a continuing nature, the license, certificate of authority does not expire until the administrative action is completed. When a renewal application is denied or an administrative hearing is set to review the licensure status of an insurance producer, or the terms of a certificate of authority are limited, then the license or certificate of authority expires upon the issuance of an Administrative Order by the Commissioner

Source: *Miss. Code Ann.* §§ 27-15-87 and 27-15-91 (Rev. 2021); 83-17-1, et seq.; 83-17-55, et seq.; 83-17-217 (Rev. 2022)

Rule 15.07 Licensing of Insurers

A. Authority and Control – The Department has the sole authority and control over the issuance, grant, denial, refusal, suspension, revocation, expiration, termination, continuance, and renewal of licenses and certificates of authority for all insurers.

B. License Forfeited – Upon the revocation or forfeiture of a license or certificate of authority, said license shall be considered forfeited and no longer valid.

C. Notice and Hearing– Notice and hearing in accordance with this Regulation are required before the suspension or revocation of a license or certificate of authority. Suspension, refusal or revocation of a license or certificate of authority must be for certain statutory causes.

D. License Expiration– The license of an insurer is of a continuing nature, and shall only expire upon the suspension, revocation or forfeiture of an insurer's license. When administrative action is taken to suspend or revoke an insurer's license or certificate of authority, then the license or certificate of authority expires the last day for review of any Department Order or at a later date if so fixed by a court.

E. Domestic Insurers— Domestic insurers may become licensed and obtain a certificate of authority by complying with all statutory requirements, including but not limited to those of Title 83, Chapter 19 of the Code of Mississippi, completing and filing with the Department all necessary forms and providing any other information required by the Department. Copies of such forms and instructions regarding required information may be obtained at the Department's website; www.mid.ms.gov .

F. Foreign Insurers— Foreign insurers may become licensed and obtain a certificate of authority by complying with all statutory requirements, including but not limited to those of Title, 83, Chapter 21 of the Code of Mississippi, and completing and filing with the Department all necessary forms and providing any other information required by the Department. Copies of such forms and instructions regarding required information may be obtained at the Department's website; www.mid.ms.gov .

G. Non-Admitted And Alien Insurers – Insurers may be considered for placement on the Department's eligible list of non-admitted insurers by complying with all statutory requirements, including but not limited to *Miss. Code Ann*. §83-21-17, and completing and filing with the Department all necessary forms and providing any other information required by the Department. Copies of such forms and instructions regarding required information may be obtained at the Department's website; www.mid.ms.gov .

~~H.~~ Annual Filings – Admitted insurers must annually complete and file with the Department all necessary forms and any other information required by the Department. Copies of such forms and instructions regarding required information may be obtained at the Department's website; www.mid.ms.gov.

Source: *Miss. Code Ann.* § 83-19-1, et seq.; § 83-21-1, et seq. (Rev. 2022)

Rule 15.08 Administrative Hearings

A. Notices issued by the Department - Notices shall be effective only when in writing, signed by the Commissioner, his designee, or his attorney.

    1. Every notice shall state its effective date.

    2. Every notice shall concisely state;

        a. Its intent and purpose;

        b. The grounds on which it is based; and

        c. The provisions of the statutes pursuant to which action is taken or proposed to be taken; but failure to so designate all applicable provisions shall not deprive the Commissioner of the right to rely thereon.

    3. A notice may be given by service upon or delivery to the person to be notified or by mailing it, postage prepaid, addressed to such person at his home or at his principal place of business as last on record in the Department, or by electronic delivery with a delivery receipt, if an electronic mail address has been provided.

B. Notice of Hearing – Prior to any hearing regarding an administrative action the Department may be taking against any licensee under the jurisdiction of the Department, the Department shall provide the following notice.

    1. Notice of at least twenty (20) days before hearing unless a different time period is specified by law.

    2. Notice shall include a statement of the terms or substance of the intended action or a description of the subjects and issues involved, and the time, the place and the manner in which interested persons may present their views thereon.

C. Hearing - In every case of adjudication in cases of a denial, revocation or suspension of any license or certificate of authority, and in cases of rule-making, where rules must be made after a hearing, and in all cases where required by the Insurance Code, a hearing shall be conducted either in-person, or by telephone or videoconference.

D. Right to Counsel – Any person appearing before the Department or any of its representatives shall have the right to be retain their own counsel for representation during the administrative process.

E. Exhibits and Evidence: The parties shall communicate and pre-file documentary evidence and/or exhibits with the Commissioner or the Hearing Officer, if one has been designated, not less than three (3) days prior to the hearing date.

1. Parties shall file exhibits electronically when possible.

2. Absent good cause, exhibits that are not pre-filed will not be admitted into the record.

F. Presentation of Evidence– Opportunity shall be afforded all parties to respond and present evidence and argument on all issues involved.

G. Settlement- Nothing in these rules shall prohibit informal disposition by stipulation, settlement, or consent order.

H. Default – If, after proper notice and service, a person fails to appear before the Department for an administrative hearing, a default may be entered against that person, and a final order may be entered by the Commissioner.

I. Record – The record shall include:

1. All pleadings, motions, and intermediate rulings;

2. All evidence received or considered, including on request of any party a transcript of all proceedings or any part;

3. A statement of matters officially noticed;

4. Offers of proof, objections and rulings;

5. Proposed findings and exceptions; and,

6. A final order entered into the matter.

J. Findings of Fact – Findings of fact shall be based exclusively on the evidence received or on matters officially noticed by the Commissioner through his personal knowledge and expertise.

K. Relevant Materials - The Commissioner or his designee has the authority to exclude data or materials deemed to be improper or irrelevant. Formal rules of evidence shall not apply.

L. Court Reporter - The Department does not provide a court reporter for administrative hearings; the Department will make and preserve a record of an administrative hearing through the use of audio or video recording. A party wishing to have a court reporter present for an administrative hearing will need to make their own arrangements to retain a court reporter.

M. Service of Process - Parties shall be served either personally or by mail, postage prepaid, addressed to such person at his home or at his principal place of business as last on record in the Department, or by electronic delivery with a delivery receipt, if an electronic mail address has been provided, with a copy of any notice of hearing, decision or order.

N. Impartiality – Every member of the Department present shall conduct himself in an impartial manner and the presiding official may withdraw if he deems himself disqualified. Any party may file an affidavit of personal bias or disqualification, which shall be ruled upon by the Department, may be granted if it is timely and sufficient, and filed in good faith.

O. Power and Duties of Presiding Official – The presiding officer of the hearing shall be either the Commissioner or his designee, and shall have the power to:

1. Maintain order;

2. Rule on all questions arising during the course of the hearing;

3. Permit discovery by deposition or otherwise;

4. Hold conferences for the settlement or simplification of the issues;

5. Make or recommend findings;

6. Generally, regulate and guide the course of the proceedings.

P. Burden of Proof – the proponent of a rule or order shall have the burden of proof.

Q. Evidence –The Commissioner or his designee has the authority to exclude data or materials deemed to be improper or irrelevant. Irrelevant, immaterial, and unduly repetitious evidence shall be excluded. Any other evidence, oral or documentary, not privileged, may be received if it is a type commonly relied upon by reasonably prudent men in the conduct of their affairs. The Formal Rules of Evidence shall not apply.

R. Objections – Objections to the introductions of evidence may be made and shall be noted of record.

S. Evidence may be Written – When a hearing can be so expedited (and the interests of the parties will not be prejudiced) any part of the evidence may be received in written form.

T. Cross-Examination – Parties shall have the right to conduct such cross-examination as may be required for a full, true disclosure of the facts.

U. Official Notice – Official notice may be taken of judicially cognizable facts and of generally recognized technical or scientific facts peculiarly within the Department's specialized knowledge. Parties shall be notified of material so noticed (including any staff

memoranda or data). Parties shall be afforded a reasonable opportunity to show the contrary.

V. Continuation of License during Proceeding - When an insurance producer_has made a timely and sufficient application for renewal of a license or certificate of authority, with reference to any activity of a continuing nature, the license or certificate of authority does not expire until the administrative action is completed. When a renewal application is denied or an administrative hearing is set to review the licensure status of an insurance producer, or the terms of a certificate of authority are limited, then the license or certificate of authority expires upon the issuance of an Administrative Order by the Commissioner.

Source: *Miss. Code Ann.* § 25-43-1.106 (Rev. 2021) and § 83-18-21 (Rev. 2022)

Rule 15.09: Administrative Orders

A. Notice and Hearing – Unless otherwise provided in statutory law, any administrative action of the Commissioner shall only be made after notice and hearing to the respondent.

B. Written Orders – Orders of the Commissioner shall be effective only when in writing.

C. Order Formulated Upon Adjudication – There shall be an order formulated upon each adjudication made by the Department or the Commissioner, or his deputy or employee.

D. Effective Date – Each order shall contain its effective date and shall concisely state its intent or purpose and the grounds and pertinent provision of law on which it is based.

E. Publication of Order– An order may be given by service upon or delivery to the person ordered by mail, postage prepaid, addressed to the person at his home or at his principal place of business as last of record in the Department, or by electronic delivery with a delivery receipt, if an electronic mail address has been provided. Furthermore, the Commissioner has the discretion to post said Order on the Department's website.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2022)

Rule 15.10. Bulletins.

The Department may issue Bulletins, which are considered guidance and explanatory in nature, without notice and hearing, and without public participation. Upon adoption of a Bulletin by the Commissioner, the a copy of the Bulletin shall be placed on the Department website, and electronically mailed to all persons who may have made timely request of the Commissioner for notice of adoption of any rule.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2022)

Rule 15.11 Regulations.

A. The Department shall comply with the Mississippi Administrative Procedures Act, *Miss. Code Ann.* §§25-43-1, et. seq., in the establishment the rules and regulations of the Department.

B. Notice– Prior to adoption, amendment or repeal of any regulation, the Department shall give the following notice.

    1. Notice of at least twenty-five (25) days of the intended action is required

    2. Notice shall include a statement of the terms or substance of the intended action or a description of the subjects and issues involved, and the time, the place and the manner in which interested persons may present their views thereon.

    3. Notice shall be filed with the office of the Secretary of State of the State of Mississippi, placed on the Department website, and electronically mailed to all persons who may have made timely request of the Commissioner for advance notice of rule-making proceedings.

    4. Notice may be published in such newspapers of general daily circulation and in such insurance publications as selected by the Department.

C. Emergency Regulations –If the Commissioner finds that an imminent peril to the public health, safety or welfare require adoption of a rule upon fewer than twenty-five (25) days notice and states in writing its reasons for that finding, the Commissioner may proceed without prior notice of hearing or upon an abbreviated notice and hearing that it finds practicable to adopt an emergency rule, pursuant to the provisions provided in *Miss. Code Ann.*, §25-43-3.108.

D. Written Comments – Written comments will be accepted on all proposed regulations, except for emergency or temporary regulations. The Department's website will provide interested parties with the information on when and how a written comment may be submitted regarding the adoption of the proposed regulation.

E. Oral Hearing - If an oral hearing is held regarding the adoption of a regulation, the following provision, in addition to any statutory requirements, shall apply:

    1. The time and place of the public hearing shall be posted on the Department's website.

    2. The public hearing shall be presided over by the Commissioner or his designee.

    3. The Commissioner or his designee shall determine all procedural questions not governed by the Administrative Procedures Act, may limit the number of witnesses and to impose such time and presentation limitations as deemed reasonable. Any public hearing held will be a non-adversary, fact-finding

proceeding, and any rule action taken need not be based exclusively on the record of such hearing.

4. Any person interested may attend the hearing, with or without counsel. Any hearing participant may introduce oral testimony through such witnesses as the presiding representative shall permit.

5. The obtaining and use of witnesses is the responsibility of the parties attending the hearing. All witnesses shall be present on their own volition, but any person appearing as a witness may be questioned by any hearing participant and the presiding representative.

6. The Commissioner or his designee have the authority to exclude data or materials deemed to be improper or irrelevant. Formal rules of evidence shall not apply.

F. Written and Oral Comments - All timely written and/or oral comments will be considered before taking any final rule action. All rule actions proposed pursuant to this regulation shall be effective upon the Department's provision of the final version of the rule or statement of repeal thereof to the office of the Secretary of State. However, no rule shall become effective prior to the time limits imposed by the Administrative Procedures Act. Any party having timely commented adversely to the proposed rule action may seek review of the final rule action in a court of proper jurisdiction.

G. Post-Adoption Actions - Any person aggrieved by any act of the Commissioner with regard to the adoption, amendment or repeal of any rule, may file a petition for review of an adverse ruling within five (5) days after receipt of notice thereof in the case of those interested persons who have made timely requests of the Insurance Department for advance notice of the Insurance Department's rule-making procedure and ten (10) days for all other interested persons.

Source: *Miss. Code Ann.* § 25-43-3.101, et seq. (Rev. 2021)

Rule 15.12 Declaratory Opinions

Pursuant to *Miss. Code. Ann.* §25-43-2.103, any person with a substantial interest in the subject matter may make a written request of an agency for a declaratory opinion as to the applicability to specified circumstances of a statute, rule or order within the primary jurisdiction of the agency.

A. Request for a Declaratory Order—Any request for a declaratory opinion must be made in writing and shall be directed to the Department's Legal Division. Such petition shall be promptly considered and a prompt disposition shall be made.

B. Response - The Department shall provide a written response to the request for a declaratory opinion to the requesting party within forty-five days of receipt of said

request, providing either a declaratory opinion, an agreement to issue an opinion within ninety days, or decline to issue a declaratory opinion.

Source: *Miss. Code Ann.* §§25-43-2.103; (Rev. 2021) 83-5-1 (Rev. 2022)

Rule 15.13: Effective Date

This Regulation shall become effective thirty (30) days after filing with the Office of the Secretary of State.

Source: *Miss. Code Ann.* § 25-43-3.106 (Rev. 2021)

Part 1 Chapter 16: (88-105) Advertisements of Medicare Supplement Insurance with Interpretative Guidelines

Introduction.The Commissioner of Insurance of the State of Mississippi does hereby promulgate and adopt the following regulation in pursuance of and under the authority of Miss. Code Ann. Sections 83-5-29 et seq., 83-9-101 et seq., 25-43-1 et seq., Mississippi Insurance Department Regulation Number 88-101, and other applicable provisions of the Mississippi Insurance Laws.

Rule 16.01: Purpose

The purpose of these rules is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance; to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance agents and companies.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.02: Applicability

A. These rules shall apply to any "advertisement" of Medicare supplement insurance as that term is defined herein, unless otherwise specified in these rules, which the insurer knows or reasonably should know is intended for presentation, distribution, or dissemination in this State when such presentation, distribution, or dissemination is made either directly or indirectly by or on behalf of an insurer, agent, broker, producer or solicitor, as those terms are defined in the Insurance Code of this State.

B. Every insurer shall establish and at all times maintain a system of control over the content, form and method of dissemination of all of its Medicare supplement insurance advertisements. All such advertisements, regardless of by whom written, created, designed or presented, shall be the responsibility of the insurers benefiting directly or indirectly from their dissemination.

C. Advertising materials which are reproduced in quantity shall be identified by form numbers or other identifying means. Such identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

Source: *Miss. Code Ann.* § 83-9-102; § 83-9-103 (Rev. 2011)

Rule 16.03: Definitions

A. An advertisement for the purpose of these rules shall include:

1. printed and published material, audio visual material and descriptive literature used by or on behalf of an insurer in direct mail, newspapers,magazines, radio scripts, TV scripts, billboards and similar displays;

2. descriptive literature and sales aids of all kinds issued by an insurer,agent, producer, broker or solicitor for presentation to members of the insurance-buying public; including, but not limited to, circulars,leaflets, booklets, depictions, illustrations, form letters and leadgenerating devices of all kinds as herein defined; and

3. prepared sales talks, presentations and material for use by agents, brokers, producers and solicitors whether prepared by the insurer or the agents, broker, producer or solicitor.

B. The definition of "advertisement" includes advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.

C. The definition of "advertisement" does not include:

1. material to be used solely for the training and education of an insurer's employees, agents or brokers;

2. material used in house by insurers

3. communications within an insurer's own organization not intended for dissemination to the public;

4. individual communications of a personal nature with current policyholders other than material urging such policyholders to increase or expand coverage;

5. correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract;

6. court approved material ordered by a court to be disseminated to policyholders; or

7. a general announcement for a group or blanket policyholder to eligible individuals on an employment or membership list that a contract or program has been written or arrange; provided, the announcement must clearly indicate that it is preliminary to the issuance of a booklet.

D. “Medicare Supplement Insurance” means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

E. “Certificate” means, for the purposes of these Rules, any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this State.

F. “Insurer” for the purpose of these rules shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an “insurer” in the Insurance Code of this State and is engaged in the advertisement of itself, or Medicare supplement insurance.

G. “Exception” for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

H. Reduction” for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

I. “Limitation” for the purpose of these rules shall mean any provision which restricts coverage under the policy other an exception or a reduction.

J. “Institutional Advertisement” for the purpose of these rules shall mean an advertisement having as its sole purpose the promotion of the reader’s, viewer’s or listener’s interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

K. “Invitation to Inquire” for the purpose of these rules shall mean an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance which is limited to a brief description of coverage, and which shall contain a provision in the following or substantially similar form:

> “This policy has [exclusions] [limitations] [reductions of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable].”

L. “Invitation to Contract” for the purpose of these rules shall mean an advertisement which is neither an institutional advertisement nor an invitation to inquire.

M. "Person" for the purpose of these rules shall mean any natural person, association,organization, partnership, trust group, discretionary group, corporation or any other entity.

N. "Medicare" means "The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and popularly known as the "Health Insurance of the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

O. "Lead-Generating Device," for the purpose of these rules, shall mean any communication directed to the public which, regardless of form, content or statedpurpose; is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

Source: *Miss. Code Ann.* § 83-9-101; § 93-9-103 (Rev. 2011)

Rule 16.04 Method of Disclosure of Required Information

All information required to be disclosed by these rules shall be set out conspicuously and in close conjunction with the statements to which such information relates or under appropriate captions of such prominence that it shall not be minimized, rendered obscure or presented in an ambiguous manner or fashion or intermingled with the context of the advertisement so as to be confusing or misleading.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.05 Form and Content of Advertisements

A. The format and content of a Medicare supplement insurance advertisement shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.

B. Advertisements shall be truthful and not misleading in fact or in implication. Words or phrases whose meanings are clear only by implication or by the consumer's familiarity with insurance terminology shall not be used.

C. An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words… Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health

benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

D. No insurer, agent, broker, producer, solicitor or other person shall solicit a resident of this State for the purchase of Medicare supplement insurance in connection with or as the result of the use of any advertisement by such person or any other person, where the advertisement:

1. Contains any misleading representations or misrepresentations, or is otherwise untrue, deceptive or misleading with regard to the information imparted, the status, character or representative capacity of such person or the true purpose of the advertisement; or

2. Otherwise violates the provisions of these rules.

E. No insurer, agent, broker, solicitor or other person shall solicit residents of this State for the purchase of Medicare supplement insurance through the use of a true or fictitious name which is deceptive or misleading with regard to the status, character, or proprietary or representative capacity of such person or the true purpose of the advertisement.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.06 Advertisements of Benefits, Losses Covered or Premiums Payable

A. Deceptive Words, Phrases or Illustrations Prohibited

1. No advertisement shall omit information or use words, phrases, statements, references or illustrations if the omission of such information or use of such words, phrases, statements, references or illustrations has the capacity, tendency or effect of misleading or deceiving purchasers or prospective purchasers as to the nature or extent of any policy benefit payable, loss covered or premium payable. The fact that the policy offered is made available to a prospective insured for inspection prior to consummation of the sale or an offer is made to refund the premium if the purchaser is not satisfied, does not remedy misleading statements.

2. No advertisement shall contain or use words or phrases such as “all,” “full,” “complete,” “comprehensive,” “unlimited,” “up to,” “as high as,” “this policy will help fill some of the gaps that Medicare and your present insurance leave out,” “this policy pays all that Medicare doesn’t” or similar words and phrases, in a manner which exaggerates any benefit beyond the terms of the policy.

3. An advertisement which also is an invitation to join an association, trust or discretionary group must solicit insurance coverage on a separate and distinct application which requires separate signatures for each application. The separate and distinct application required for an advertisement which is also an invitation to join an association, trust or discretionary groups need not be on a separate

document or contained in a separate mailing. The insurance program must be represented so as not to mislead or deceive the prospective members that they are purchasing insurance as well as applying for membership, if that is the case.

4. An advertisement shall not contain descriptions of policy limitations, exceptions or reductions, worded in a positive manner to imply that it is a benefit, such a describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after 6 months." Words and phrases used in an advertisement to desire such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

5. An advertisement of Medicare supplement insurance sold by direct response shall not state or imply that "because no insurance agent will call and no commissions will be paid to 'agents' that it is a low cost plan" or use other similar words or phrases because the cost of advertising and servicing such policies is a substantial cost in marketing by direct response.

B. Exceptions, Reductions and Limitations

1. An advertisement which is an invitation to contract shall disclose those exceptions, reductions and limitations affecting the basic provisions of the policy.

2. When a policy contains a waiting, elimination, probationary or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such a loss, an advertisement which is subject to the requirements of the preceding paragraph shall disclose the existence of such periods.

3. An advertisement shall not use the words "only," "just," "merely," "minimum," or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

C. Preexisting Conditions

1. An advertisement which is an invitation to contract shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy. The use of the term "preexisting condition" without an appropriate definition or description shall not be used.

2. When a Medicare supplement insurance policy does not cover losses resulting from preexisting conditions, no advertisement of the policy shall state or imply that the applicant's physical condition or medical history will not affect the

issuance of the policy or payment of a claim thereunder. This rule prohibits the use of the phrase "no medical examination required" and phrases of similar import, but does not prohibit explaining "automatic issue." If an insurer requires a medical examination for a specified policy, the advertisement shall disclose that a medical examination is required.

3. When an advertisement contains an application form to be completed by the applicant and returned by mail, such application form shall contain a question or statement which reflects the preexisting condition provisions of the policy immediately preceding the blank space for the applicant's signature. For example, such an application form shall contain a question or statement substantially as follows:

   Do you understand that this policy will not pay benefits during the first six (6) months after the issue date for a disease or physical condition for which medical advice was given or treatment was recommended by or received from a physician with six (6) months before the policy issue date? YES

   Or substantially the following statement:

   I understand that the policy applied for will not pay benefits for any loss incurred during the first six (6) months after the issue date due to a disease or physical condition for which I received medical advice or for which treatment was recommended by or received from a physician within six (6) months before the issue date.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.07 Necessity for Disclosing Policy Provisions Relating to Renewability, Cancellability and Termination

An advertisement which is an invitation to contract shall disclose the provisions relating to renewability, cancellability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons, in a manner which shall not minimize or render obscure the qualifying conditions.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.08 Testimonials or Endorsements by Third Parties

A. Testimonials and endorsements used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial or endorsement, makes as its own all of the statement contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules. When a testimonial or endorsement is used more than one year after it was originally given, a confirmation must be obtained.

B. A person shall be deemed a “spokesperson” if the person making the testimonial or endorsement:

1. Has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee or otherwise; or

2. Has been formed by the insurer, is owned or controlled by the insurer, itsemployees, or the person or persons who own or control the insurer; or

3. Has any person in a policy-making position who is affiliated with the insurer in any of the above described capacities; or

4. Is in any way directly or indirectly compensated for making a testimonial or endorsement.

C. The fact of a financial interest or the propriety or representative capacity of a spokesperson shall be disclosed in an advertisement and shall be accomplished in the introductory portion of the testimonial or endorsement in the same form and with equalprominence thereto. If a spokesperson is directly or indirectly compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: “Paid Endorsement”. The requirement of thisdisclosure may be fulfilled by use of the phrase “Paid Endorsement” or words of similar import in a type style and size at least equal to that used for the spokesperson’s name or the body of the testimonial or endorsement; whichever is larger. In the case of television or radio advertising, the required disclosure must be accomplished in the introductory portion of the advertisement and must be given prominence.

D. The disclosure requirements of this rule shall not apply where the sole financial interest or compensation of a spokesperson, for all testimonials or endorsements made on behalf of the insurer, consist of the payment of union “scale” wages required by unionrules, and if the payment is actually for such “scale” for TV or radioperformances.

E. An advertisement shall not state or imply that an insurer or a Medicare supplement insurance policy has been approved or endorsed by any individual, group of individuals, society, association or other organizations, unless such is the fact, and unless any proprietary relationship between an organization and the insurer is disclosed. If the entity making the endorsement or testimonial has been formed by the insurer or is owned or controlled by the insurer or the person or persons who own or control the insurer, such fact shall be disclosed in the advertisement. If the insurer or an officer of the insurer formed or controls the association, or holds any policy-making position in the association, that fact must be disclosed.

F. When a testimonial refers to benefits received under a Medicare supplement insurance policy, the specific claim data, including claim number, date of loss, and other pertinent information shall be retained by the insurer for inspection for a period of four years or

until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials which do not correctly reflect the presentpractices of the insurer or which are not applicable to the policy or benefit being advertised is not permissible.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.09 Use of Statistics

A. An advertisement relating to the dollar amounts of claims paid, the number of persons insured, or similar statistical information relating to any insurer or policy shall not use irrelevant facts, and shall not be used unless it accurately reflects all of the relevant facts. Such an advertisement shall not imply that such statistics are derived from a policy advertised unless such is the fact, and when applicable to other policies or plans shall specifically so state.

    1. An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, it must be stated clearly that the data do not relate to the policy being advertised.

    2. An advertisement using statistics which describe an insurer, such as corporate structure, financial standing, age, product lines or relative position in the insurance business, may be irrelevant and, if used at all, must be used with extreme caution because of the potential for misleading the public. As a specific example, an advertisement for Medicare supplement insurance which refers to the amount of life insurance which the company has in force or the amounts paid out in life insurance benefits is not permissible unless the advertisement clearly indicates the amount paid out for each line of insurance.

B. An advertisement shall not represent or imply that claim settlements by the insurer are "liberal" or "generous" or use words of similar import, or state or imply that claim settlements are or will be beyond the actual terms of the contract. An unusual amount paid for a unique claim for the policy advertised is misleading and shall not be used.

C. The source of any statistics used in an advertisement shall be identified in such advertisement.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.10 Disparaging comparisons and Statements

An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of non-comparable policies of other insurers, and shall not disparage competitors, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance.

A. An advertisement shall not contain statements such as “no red tape” or “here is all you do to receive benefits.”

B. Advertisements which state or imply that competing insurance coverages customarily contain certain exceptions, reductions or limitations not contained in the advertised policies are unacceptable unless such exceptions, reductions, or limitations are contained in a substantial majority of such competing coverages.

C. Advertisements which state or imply that an insurer’s premiums are lower or that its loss ratios are higher because its organizational structure differs from that of competing insurers are unacceptable.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.11 Jurisdictional Licensing and Status of Insurer

A. An advertisement which is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

B. An advertisement shall not create the impression directly or indirectly that the insurer,its financial condition or status; or the payment of its claims; or the merits, desirability or advisability of its policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this State or the United States Government.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.12 Identity of Insurer

A. The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be state in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which with or without disclosing the name of the actual insurer would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.

B. No advertisement shall use any combination of words, symbols or physical materials which by their content, phraseology, shape, color or other characteristics are so similar to combination of words, symbols or physical materials used by agencies of the federal government or of this State, or otherwise appear to be of such nature that it tends to confuse or mislead prospective insureds into believing that the solicitation is in some manner connected with an agency of the municipal, state or federal government.

C. Advertisements, envelopes or stationary which employs words, letters, initials, symbols or other devices which are so similar to those used by governmental agencies or other insurers are not permitted if they may lead the public to believe:

1. that the advertised coverages are somehow provided by or are endorsed by such governmental agencies or such other insurers;

2. that the advertiser is the same as, is connected with or is endorsed by such governmental agencies or such other insurers.

D. No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

E. No advertisement in the form of envelopes or stationary of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any agent who may call upon the consumer in response to the advertisement is connected with a governmental agency, such as the Social Security Administration.

F. No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, said word is qualified by language differentiating it from Medicare. Such an advertisement, however shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

G. No advertisement shall be used that fails to include the disclaimer to the effect of "Not connected with or endorsed by the U.S. Government or the federal Medicare program."

H. No advertisement may imply that the reader may lose a right or privilege or benefit under federal, state or local law if he fails to respond to the advertisement.

I. The use of letter, initials, or symbols of the corporate name or trademark that would have the tendency or capacity to mislead or deceive the public as to the true identity of the insurer is prohibited unless the true, correct and complete name of the insurer is in close conjunction and in the same size type as the letter, initials or symbols of the corporate name or trademark.

J. The use of the name of an agency or "_____ Underwriters" or "_____ Plan" in type, size and location so as to have the capacity and tendency to mislead or deceive as to the true identity of the insurer is prohibited.

K. The use of an address so as to mislead or deceive as to true identity of the insurer, its locations or licensing status is prohibited.

L. No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

M. All advertisements used by agents, producers, brokers or solicitors of an insurer must have prior written approval of the insurer before they may be used.

N. An agent who makes contact with a customer, as a result of acquiring that consumer's name from a lead generating device must disclose such fact in the initial contact with the consumer.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.13 Group or Quasi-Group Implications

A. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and as such enjoy special rates or underwriting privileges, unless such is the fact.

B. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their occupational status entitles them to reduced rates on a group or other basis when , in fact, the policy being advertised is sold only on an individual basis at regular rates.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.14: Introductory, Initial or Special Offers

A. Offers

1. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such is the fact. An advertisement shall not contain phrases describing an enrollment period as "special,""limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

2. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this State unless there has been a lapse of not less than (6) months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which theapplicant must mail the application, which shall be not less than ten days and not more than forty days from the date that such enrollment period is advertised

for the first time. This rule applies to all advertising media, i.e., mail, newspapers, radio, television, magazines and periodicals, by any one insurer. It is not applicable to solicitation of employees or members of a particular group or association which otherwise would be eligible under specific provisions of the Insurance Code for group, blanket or franchise insurance. The phrase "any one insurer" includes all the affiliated companies of a group of insurance companies under common management or control.

3. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless such is the fact.

4. The phrase "a particular insurance product" in Paragraph (2) of this section means an insurance policy which provides substantially different benefits than those contained in any other policy. Different terms of renewability; an increase or decrease in the dollar amounts of benefits; an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product being offered as a different product eligible for concurrent or overlapping enrollment.

B. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term "juxtaposition" means side by side or immediately above or below.

C. Special awards, such as a "safe driver's award" shall not be used in connectionwith advertisements of Medicare supplement insurance.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.15 Statements About an Insurer

An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of the insurer in the insurance business. An advertisement shall not contain a recommendation by any commercial rating system unless it clearly indicated the purpose of the recommendation and the limitations of the scope and extent of the recommendation.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.16 Enforcement Procedures

A. Advertising File: Each insurer shall maintain at its home or principal office a complete file containing every printed, published or prepared advertisement of its individual policies and typical printed, published or prepared advertisements of its blanket, franchise and group policies hereafter disseminated in this or any other state, whether or not licensed in such other state, with a notation attached to each such advertisement which advertised. Such file shall be available for inspection by this Department. All such advertisements shall be maintained in said file for a period of either four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time.

B. Certificate of Compliance: Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these rules must file with this Department, with its Annual Statement, a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this State as implemented and interpreted by these rules.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Rule 16.17 Severability Provision

If any section or portion of a section of these rules, or the applicability thereof to any person or circumstance is held invalid by a court, the remainder of the rules, or the applicability of such provision to other persons or circumstances, shall not be affected thereby.

Source: *Miss. Code Ann.* § 83-9-115 (Rev. 2011)

Rule 16.18 Filing Requirements for Advertising

Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Commissioner of Insurance of this State for review and approval by the Commissioner.

This regulation shall become effective thirty (30) days after its adoption and filing with the Mississippi Secretary of State's Office, as required by law.

Source: *Miss. Code Ann.* § 83-9-103; § 83-9-110 (Rev. 2011)

Rule 16.19 Appendix: Interpretive Guidelines

A. Guideline 1

Disclosure is one of the principal objectives of the rules and this section states specifically that the rules shall assure truthful and adequate disclosure of all material and relevant information. The rules specifically prohibit some previous advertising techniques.

B. Guideline 2

These rules apply to any "advertisement" as that term is defined in Section 3, Subsections A, H, I and J unless otherwise specified in the rules. These rules apply to group, blanket and individual Medicare supplement insurance advertisements. Certain distinctions, however, are applicable to these categories. Among them is the level of conversance with insurance, a factor which is covered by Section 5A of the rules.

C. Guideline 3-A

The scope of the term "advertisement" extends to the use of all media for communications to the general public, to the use of all media for communications to specific members of the general public, and to use of all media for communications by agents, brokers, producers and solicitors.

D. Guideline 3-I

A "brief description of coverage" in an invitation to inquire may consist of an explanation of Medicare benefits, minimum benefits, standards for Medicare supplement policies, and the manner in which the advertised Medicare supplement insurance policy supplements the benefits of Medicare and meets or exceeds the minimum benefit requirements. An invitation to inquire shall not refer to cost or the maximum dollar amount of benefits payable.

As with all Medicare supplement insurance advertisements, an invitation to inquire must not:

1. Employ devices which are designed to create undue anxiety in the minds of the elderly or excite fear of dependence upon relatives or charity;

2. Exaggerate the gaps in Medicare coverage;

3. Exaggerate the value of the benefits available under the advertised policy;

4. Otherwise violate the provisions of these rules.

E. Guideline 4

The rule permits the use of either of the following alternative methods of disclosure:

1. The first alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions conspicuously and in close conjunctions with the statements to which such information relates. This may be accomplished by disclosure in the description of the related benefits or in a paragraph set out in close conjunction with the description of policy benefits.

2. The second alternative provides for the disclosure of exceptions, limitations, reductions and other restrictions not in conjunction with the provisions describing policy benefits but under appropriate captions of such prominence that the information shall not be minimized, rendered obscure or otherwise made to appear unimportant. The phrase "under appropriate captions" means that the title must be accurately descriptive of the captioned material. Appropriate captions include the following: "Exceptions," "Exclusions," "Conditions Not Covered," and "Exceptions and Reductions." The use of captions such as, or similar to, the following are not acceptable because they do not provide adequate notice of the significance of the material: "Extent of Coverage," "Only these Exclusions," or "Minimum Limitations."

In considering whether an advertisement complies with the disclosure requirements of this rule, the rule must be applied in conjunction with the form and content standards contained in Section 5.

F. Guideline 5-A

The rule must be applied in conjunction with Section 1 and 4 of the rules. The rule refers specifically to "format and content" of the advertisement and the "overall" impression created by the advertisement. This involves factors such as, but not limited to, the size, color and prominence of type used to describe benefits. The word "format" means the arrangement of the text and the captions.

The rule requires distinctly different advertisements for publication in newspapers or magazines of general circulation, as compared to scholarly, technical or business journals and newspapers. Where an advertisement consists of more than one piece of material, each piece of material must, independent of all other pieces of material, conform to the disclosure requirements of this rule.

G. Guideline 5-B

The rule prohibits the use of incomplete statements and words or phrases which have the tendency or capacity to mislead or deceive because of the reader's unfamiliarity with insurance terminology.

Therefore, words, phrases and illustrations used in an advertisement must be clear and unambiguous if the advertisement uses insurance terminology, sufficient description of a word, phrase or illustration shall be provided by definition or description in the context of

the advertisement. As implied in Guideline 5-A, distinctly different levels of comprehension to the subscribers of various publications may be anticipated.

H. Guideline 6-A(1)

The rule prohibits the use of incomplete statements and words or phrases which create deception by omission or commission. The following examples are illustrations of the prohibitions created by the rule:

1. An advertisement which describes any benefits that vary by age must disclose the fact.

2. An advertisement that uses a phrase such as "no age limit" must disclose that premiums may vary by age or that benefits may vary by age if such is the case.

3. Advertisements, applications, requests for additional information and similar materials are unacceptable if they state or imply that the recipient has been individually selected to be offered insurance, or has had his eligibility for such insurance individually determined in advance, when in fact the advertisement is directed to all persons in a group or to all persons whose names appear on a mailing list.

4. Advertisements for group or franchise group plans which provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless such is the fact.

5. It is unacceptable to use terms such as "enroll" or "join" with reference to a group or blanket insurance coverage when such is not the case.

6. An advertisement, which states or implies immediate coverage is provided, is unacceptable unless suitable administrative procedures exist so that the policy is issued within fifteen working days after the application is received by the insurer.

7. Applications, request forms for additional information, and similar related materials are unacceptable if they resemble paper currency, bonds or stock certificates; or use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised is connected with a governmental agency, such as the Social Security Administration or the Department of Health and Human Services.

8. An advertisement which uses the word "plan" without identifying it as a Medicare supplement insurance policy is not permissible.

9. An advertisement which implies in any manner that the prospective insured may realize a profit from obtaining Medicare supplement insurance is not permissible.

10. An advertisement which fails to disclose any waiting or elimination periods is unacceptable.

11. Examples of benefits payable under a policy shall not disclose only maximum benefits unless such maximum benefits are paid for loss from common or probable illnesses or accidents, rather than exceptional or rare illnesses or accidents or periods of confinement for such exceptional or rare accidents or illnesses.

12. When a range of benefit levels is set forth in an advertisement, it must bemade clear that the insured will receive only the benefit level written or printed in the policy selected and issued.

13. Advertisements for policies whose premiums are modest because of their limited amount of benefits shall not describe premiums as "low," "low-cost," "budget" or use qualifying words of similar import. This rule also prohibits the use of words such as "only" and "just" in conjunction with statements of premium amounts when used to imply a bargain.

14. An advertisement which exaggerates the effects of statutorily mandated benefits or required policy provisions or which implies that such provisions are unique to the advertised policy is unacceptable. For example, the phrase, "Money Back Guarantee," is an exaggerated description of the thirty-day right to examine the policy and is not acceptable.

15. An advertisement which implies that a common type of policy or a combination of common benefits is "new," "unique," "a bonus," "a breakthrough," or is otherwise unusual is unacceptable. Also, the addition of a novel method of premium payment to an otherwise common plan of insurance does not render it "new."

16. An advertisement may not omit the word "covered" when referring to benefits payable under its policy. Continued reference to "covered" is not necessarily where this fact has been prominently disclosed in the advertisement.

17. An advertisement must state that benefits payable under the policy are based upon Medicare eligible expenses, if such is the case.

18. An advertisement which fails to disclose that the definition of "hospital" does not include a nursing home, convalescent home or extended care facility, as the case may be, is unacceptable.

19. A television, radio, mail or newspaper advertisement or lead generating device which is designed to produce leads either by use of a coupon, a request to write or to call the company, or a subsequent advertisement prior to contact must include

information disclosing that an insurance agent may contact the applicant if such is the fact.

20. Advertisements for policies designed to supplement Medicare shall not employ devices which are designed to create undue anxiety in the minds of the elderly. Such phrases as "here is where most people over 65 learn about the gaps in Medicare," or "Medicare is great, but . . ." or which otherwise exaggerate the gaps in Medicare coverage are unacceptable. Phrases or devices which unduly excite fear of dependence upon relatives or charity are unacceptable. Phrases or devices which imply that long sicknesses or hospital stays are common among the elderly are unacceptable.

21. An advertisement which is an invitation to contract implying that the coverage is supplemental to Medicare, if it does not explain the manner in which it is supplemental to Medicare coverage, is not acceptable.

22. An advertisement which is an invitation to contract for Medicare supplement insurance is unacceptable if the advertisement:

    a. Fails to disclose in clear language which of the Medicare benefits the policy is not designed to supplement or if it otherwise implies that Medicare provides only those benefits which the policy is designed to supplement;

    b. Describes the in-patient hospital coverage of Medicare as "Medicare hospital," or "Medicare Part A" when the policy does not supplement the non-hospital or the psychiatric hospital benefits of Medicare Part A;

    c. Fails to describe clearly the operation of the Part or Parts of Medicare which the policy is designed to supplement; or

    d. Describes those Medicare benefits not supplemented by the policy in such a way as to minimize their importance relative to the Medicare benefits which are supplemented.

23. Advertisements which indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population, or that particular segments of the population are acceptable risks, when such distinctions are not maintained in the issuance of policies, are not acceptable.

24. Any advertisement which contains statements such as "anyone can apply" or "anyone can join" other than with respect to a guaranteed issue policy for which administrative procedures exist to assure that the policy is issued within a reasonable period of time after the application is received by the insurer is unacceptable.

25. Any advertisement which uses any phrase or term such as "here is all you do to apply," "simply" or "merely" to refer to the act of applying for a policy which is not a guaranteed issue policy is unacceptable unless it refers to the fact that the application is subject to acceptance or approval by the insurer.

26. Advertisements which state or imply that premiums will not be changed in the future are not acceptable unless the advertised policies so provide.

27. An advertisement which does not require the premium to accompany the application must not overemphasize that fact and must make the effective date of that coverage clear.

28. An advertisement which is an invitation to contract which fails to disclose the amount of any deductible and/or the percentage of any co-insurance factor is not acceptable.

I. Guideline 6-A (2)

The rule recognizes that certain words and phrases in advertising may have a tendency to mislead the public as to the extent of benefits under an advertised policy. Consequently, such terms (and those specified in the rules do not represent a comprehensive list but only examples) must be used with caution to avoid any tendency to exaggerate benefits and must not be used unless the statement is literally true in every instance. The use of the following phrases based on such terms or having the same effect must be similarly restricted: "pays hospital, surgical, etc. bills," "pays dollars to offset the cost of medical care," "safeguards your standard of living," "pays full coverage," "pays complete coverage," or "pays for financial needs." Other phrases may or may not be acceptable depending upon the nature of the coverage being advertised.

The rule also prohibits words or phrases which exaggerate the effect of benefit payment on the insured's general well-being, such as "worry-free savings plan," "guaranteed savings," "financial peace of mind," and "you will never have to worry about hospital bills again."

Advertisements which are an invitation to contract for policies designed to supplement Medicare benefits are unacceptable if they fail to disclose that no hospital confinement benefits will be payable for that portion of a Medicare benefit period for which Medicare pays all hospital confinement expenses (currently sixty days) other than the initial deductible if the policy so provides. The length of said period must be stated in days.

J. Guideline 6-A(4)

Explanations must not minimize nor describe restrictive provisions in a positive manner. Negative features must be accurately set forth. Any limitation on benefits precluding preexisting conditions must also be restated under a caption concerning exclusions or limitations, notwithstanding that the preexisting condition exclusion has been disclosed

elsewhere in the advertisement. (See Guideline 6-C for additional comments on preexisting conditions.

K. Guideline 6-A(5)

The rule should be applied in conjunction with Section 10. Phrases such as “we cut cost to the bone” or “we deal direct with you so our costs are lower” shall not be used.

L. Guideline 6-B(1)

An advertisement which is an invitation to contract as defined in Section 3J must recite the exceptions, reductions and limitations as required by the rule and in a manner consistent with Section 4.

If an exception, reduction or limitation is important enough to use in a policy, it is sufficient important that its existence in the policy should be referred to in the advertisement regardless of whether it may also be the subject matter of a provision of the Uniform Individual Accident and Sickness Policy Provision Law.

Some advertisements disclose exceptions, reductions and limitations as required, but the advertisement is so lengthy that it obscures the disclosure. Where the length of an advertisement has this effect, special emphasis must be given by changing the format to show the restrictions in a manner which does not minimize, render obscure or otherwise make them appear unimportant.

M. Guideline 6-C(1)

The rule implements the objective of Section 6A(4)(a) by requiring in negative terms a description of the effect of a preexisting condition exclusion because such an exclusion is a restriction on coverage. The subdivision also prohibits the use of the phrase “preexisting condition” without an appropriate definition or description of the term and prohibits stating a reduction in the statutory time limit as an affirmative benefit. The words “appropriate definition or description” mean that the term “preexisting condition” must be defined as it is used by the company’s claims department.

N. Guideline 6-C(2)

The phrase “no health questions” or words of similar import shall not be used if the policy excludes preexisting conditions. Use of a phrase as “guaranteed issue,” or “automatic issues,” if the policy excludes preexisting conditions for a certain period, must be accompanied by a statement disclosing that fact in a manner which does not minimize, render obscure or otherwise make it appear unimportant and is otherwise consistent with Section 4.

O. Guideline 6-C(3)

Some states require approval of the application even when the application is not attached to the policy when issued. The rule does not change such a requirement. The text of this guideline should be modified to reflect the rule applicable in the particular state.
Guideline 7

P. Guideline 7

Advertisements of cancellable Medicare supplement policies must state that the contract is cancellable or renewable at the option of the company as the case may be. With respect to noncancellable policies and guaranteed renewable policies, the policy provisions, with respect to renewability, must be set forth and defined where appropriate.

The rule also requires a statement of the qualifying conditions which constitute limitations on the permanent nature of the coverage. These customarily fall into three categories: age limits, reservation of a right to increase premiums, and the establishment of aggregate limits. For example, "noncancellable and guaranteed renewable" does not fulfill the requirements of the rule if the policy contains a terminal age _____." If a guaranteed renewable policy reserves the right to increase premiums, the statement must be expanded into language similar to "guaranteed renewable to age _____" but the company reserves the right to increase premium rates on a class basis." If the contract contains an aggregate limit after which no further benefits are payable, the above statement must be amplified with the phrase "subject to a maximum aggregate amount of $50,000" or similar language. A Medicare supplement insurance policy may have one or more of the three basic limitations and an advertisement must describe each of those which the policy contains. Over fifty percent of new individual policy issues are guaranteed renewable; therefore, the fact that a policy is guaranteed renewable shall not be exaggerated.

An advertisement for a Medicare supplement insurance policy which provides for age step-rated premium rates based upon the policy year or the insured's attained age must disclose such rate increases and the times or ages at which such premium increases.

Q. Guideline 8-A

The rule must be applied in conjunction with Section 9 and requires that all such statements must be genuine and not fictitious. Under the rule, the manufacturing, substantive editing or "doctoring up" of a testimonial is clearly prohibited as being false and misleading to the insurance-buying public. However, language which would be unacceptable under these rules must be edited out of a testimonial.

R. Guideline 8-C

The rule requires that either approval or endorsement of a policy by an individual, group or individuals, society, association or other organization be factual and that any proprietary relationship between the sponsoring or endorsing organization and the insurer be disclosed. For example, if the dividend under an association group case is payable to

the association, disclosure of that fact is required. Also, if the insurer or an officer of the insurer formed or controls the association, that fact must be disclosed. This guideline also applies to Section 8E.

S. Guideline 9-A

An advertisement shall specifically indentify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, it must be stated clearly that the data does not relate to the policy being advertised.

An advertisement which states the dollar amount of claims paid must also indicate the period over which such claims have been paid.

If the term "loss ratio" is used, it shall be properly explained in the context of the advertisement and, unless the state has issued a regulation otherwise defining the term, it shall be calculated on the basis of premiums earned to losses incurred and shall not be on a yearly run-off basis.

T. Guideline 9-C

The rule does not require that statistics for this State be used since statistics as hospital charges and average stays may vary from state to state. When nationwide statistics are used, such fact should be noted, unless the statistics on the particular point are substantially the same in a state to which the advertisement is directed. Statistics may only be used if they are current and credible.

U. Guideline 10

The rule prohibits disparaging, unfair or incomplete comparisons of policies or benefits which would have a tendency to decline or mislead the public. The rule does not preclude the use of comparisons by health maintenance organizations, prepaid health plans and other direct service organizations which describe the difference between their prepaid health benefits coverage and indemnity insurance coverage.

V. Guideline 11-A

The rule prohibits advertisements which imply that an insurer is licensed beyond the limits of those jurisdictions where it is actually licensed. An advertisement which contains testimonials from persons who reside in a state in which the insurer is not licensed or which refers to claims of persons residing in states which the insurer is not licensed implies licensing in those states; and, therefore, is in violation of this rule unless the advertisement states that the insurer is not licensed in those states.

W. Guideline 11-B

Although the rule permits a reference to an insurer being licensed in a state where the advertisement appears, it does not allow exaggeration of the fact of such licensing nor does it permit the suggestion that competing insurers may not be so licensed because, in most states, an insurer must be licensed in the state to which it directs its advertising.

Terms such as "official" or words of similar import, used to describe any policy or application form are not permissible because of the potential for deceiving or misleading the public. This guideline also applies to Section 11C.

X. Guideline 14-A(1)

The rule prohibits advertising representing that a product is offered or an introductory, initial or special offer basis or otherwise which (a) will not be available later; or (b) is available only to certain Individuals, unless such is the fact. This rule prohibits the repetitive use of such advertisements. Where an insurer used enrollment periods as the usual method of advertising these policies, the rule prohibits describing an enrollment period as a special opportunity or offer for the applicant.

Y. Guideline 14-A(2)

The rule restricts the repetitive use of enrollment periods. The requirements of reasonable closing dates and waiting periods between enrollment periods were adopted to eliminate the abuses which formerly existed. This rule does not limit just the use of enrollment periods. It requires that a particular insurance product offered in an enrollment period through any advertising media, including the prepared presentations of agents, cannot be offered again in the State until six (6) months from the close of the enrollment period. Thus, an insurer must choose whether to use enrollment periods or open enrollment for a product. (See Section 14A (4) for the definition of "a particular insurance product.")

The rule does not prohibit multiple advertising during an enrollment period through any and all media published or transmitted within this State as long as the enrollment periods advertisements have the same expiration date.

The rule does not prohibit the solicitation of members of a group or association for the same product even though there has not been a lapse of six (6) months since the close of a preceding enrollment period which was open to the general public for the same product.

The rule does not require separation by six (6) months of enrollment periods for the same insurance product in this State if the advertising material is directed by an admitted insurer to persons by direct mail on the basis that a common relationship exists with an entity. Examples of such would be a bank and its depositors, a department store to its charge account customers, or an oil company to its credit card holders, and more than one of such organizations is sponsoring such insurance product at different times if providing such insurance under such a rule does not apply to one specific sponsor to the same persons in this State on the basis of their status as customers of that one specific entity only.

Z. Guideline 14-A(4)

The rule defines the meaning of "a particular insurance product" in Section 14A(2) and prohibits advertising of products having minor variations such as different periods or different amounts of daily hospital indemnity benefits, in a succession of enrollment periods.

AA. Guideline 15

The rule is closely related to the requirements of Section 9 concerning the use of statistics. The rule prohibits insurers which have been organized for only a brief period of time advertising that they are "old" and also prohibits emphasizing the size and magnitude of the insurer. Also, the occupations of the persons comprising the insurer's board of directors or the public's familiarity with their names or reputations is irrelevant and must not be emphasized. The preponderance of a particular occupation or profession among the board of directors an insurer does not justify the advertisement of a plan of insurance offered to the general public as insurance designed or recommended by members of that occupation or profession. For example, it is unacceptable for an insurance company to advertise a policy offered to the general public as "the physicians' policy" or "the doctors' plan" simply because there is a preponderance of physicians or doctors on the board of directors of the insurer. The rule prohibits the use of recommendation of a commercial rating system unless the purpose, meaning and limitations of the recommendation are clearly indicated.

BB. Guideline 16

The text of Subsection A is identical to the text of the first paragraph of the Enforcement Section of previous drafts of the rules except the last sentence of the subsection has been revised to require that the advertising file be maintained either for a period of four years (rather than three as previously) or until the next regular examination of the insurer, whichever is the longer period of time.

CC. Guideline 18

The rule is attached as an example of the text of a rule may be used at the option of the Commissioner in a state which reviews advertisements prior to use. The NAIC takes no position here on the question of whether direct response advertising should be subject to prior review by the Commissioner.

Source: *Miss. Code Ann.* § 83-9-103 (Rev. 2011)

Part 1 Chapter 17: **(**89-101) Guidelines To Be Followed When Lending Institutions Enter Into Agreements with Insurance Companies To Lease Space in Retail Areas.

Rule 17.01 Purpose:

The purpose of this regulation is to identify prohibited activities, which, when take in conjunction with another specific existing relationship, such as a lease, between a lending institution and/or insurance companies, agents, agencies or representatives of same, would violate statutory provisions contained in *Miss. Code Ann*. Sections 83-5-29 through 83-5-51, 83-17-7, as Amended, and 83-17-227 through 83-17-231 (1972).

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.02 Authority:

This regulation is issued pursuant to the authority vested in the Commissioner of Insurance of the State of Mississippi under *Miss. Code Ann*. Sections 83-5-29 through 83-5-51, 83-17-7, as Amended, 83-17-231 and other applicable provisions of the Mississippi Insurance Laws and is being adopted in accordance with the provisions of *Miss. Code Ann*. Chapter 43, Title 25 and Mississippi Insurance Department Regulation Number 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.03 Definitions:

For the purposes of this regulation, unless the context otherwise requires:

A. "Agent" means an "insurance agent" as defined in *Miss. Code Ann.* Sections 83-17-1, 83-17-101 and 83-17-203 (1972).

B. "Insurance Company" means any company which is subject to the jurisdiction of the Mississippi Insurance Department under *Miss. Code Ann*. Title 83 (1972).

C. "Lending Institution" means any bank or savings and loan association as defined in *Miss. Code Ann*. Section 83-17-227 (1972).

D. "Insurance" means all kinds of insurance as set forth in *Miss. Code Ann.* Title 83 (1972), with the exception of credit life and credit health and accident insurance as defined under *Miss. Code Ann.* Section 83-17-227 (e) (1972).

E. "Retail Area" means all open space within the financial institution building where the normal business of banking is conducted, but is not limited to loan and discount transaction stations, savings stations, cash debit and credit stations and installment and finance payment stations.

F. "Leased Area" means that specific location where the agent will conduct business, display advertisements and promote insurance related activities as identified in the leasing agreement.

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.04 Relationships:

No insurance company, agent, agency or representative of same, shall enter into any contract, lease or other agreement with a lending institution which results in:

A. any activity reasonably leading a person to believe that his credit-worthiness, or that extension of credit or renewal thereof, is conditioned upon the purchase of insurance through a particular insurance company, agent, agency or representative of same:

B. the lending institution or its employees, either directly or indirectly, soliciting insurance for or acting on behalf of an insurance company, agent, agency or representative of same, in the sale or negotiation of insurance.

The dollar amount of rent paid by an insurance company, agent, agency or representative of same, to a lending institution shall be on a strict square footage basis, and shall not be based on a percentage of premium income.

Any compensation, rental fee and/or expense reimbursement paid by the insurance company, agent, agency or representative of same, to the lending institution or its employees must be commercially reasonable considering all material and relevant circumstances and must meet the requirements of all applicable law.

No insurance company, agent, agency or representative of same, may enter into any agreement which requires a lending institution or its employees to provide support services which are prohibited by applicable law. By way of illustration and not limitation, the following support services are specifically prohibited: adjustment and payment of losses; amendment of insurance contracts to keep coverages current; collection of premiums; issuance of policies, certificates and other documents; return of unearned premiums; payment of cash values; and transmittal of applications for insurance contract.

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.05 Physical Facilities:

The direct or indirect solicitation or transaction of insurance business by an insurance company, agent, agency or representative of same, shall be restricted to the leased area. Accordingly, any insurance company, agent, agency or representative of same, entering into any contract, lease or other agreement with a lending institution shall abide by the following:

A. All signs displayed in connection with the operation of the insurance company, agent, agency or representative of same shall have no indication of any relationship with the lending institution. A sign with the following disclaimer must appear at or directly adjacent to the Leased Area:

"Insurance is offered by (name of Insurance Company, agency or agent). The (name of the Lending Institution) is neither an insurance company nor agency, and the insurance products offered are not FDIC/FSLIC insured."

Other signs may appear in the general banking area directing interested customers to the designated insurance area. The Commissioner of Insurance may order the removal of any signs or other promotional or advertising materials, the location, size, color or content of which violate the provisions of this regulation.

B. The leased area by an insurance company, agent, agency or representative of same must be situated and individually identified from the other retail area of the lending institution who are conducting normal banking activities from express or implied intimidation or interference with the customers' free choice regarding the purchase of insurance.

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.06 Advertising:

Any advertisement, promotional material, sales literature or public announcement of insurance products must be filed with the Mississippi Insurance Department at least thirty (30) days prior to distribution or announcement. If, within thirty (30) days after filing, the Commissioner notifies the insurance company in writing that such filing is disapproved, stating the reason therefor, it will be unlawful for the insurance company to use the filing. Otherwise, the insurance company will be allowed to use any such filing not disapproved within thirty (30) days after filing. Each insurance company shall be responsible for the compliance with this requirement by its agents, agencies and the lending institution which is a party to the lease agreement.

Any use of the name of the lending institution by an insurance company, agent, agency or representative of same in promoting, announcing or advertising its insurance products, other than strictly as an address referencing the location of the insurance company, agent, agency or representative of same, is prohibited. Further, the use of the name of the lending institution in identifying the address of the insurance company, agent, agency or representative of same, cannot be made in such a manner as to indicate any other relationship with the lending institution to the insurance product being advertised. Advertising and sale literature, taken as a whole, shall not be misleading or deceptive such as to cause a reader to reasonably conclude that the insurance product is endorsed or offered by the lending institution.

No insurance company, agent, agency or representative of same shall use a lending institution's logo in any advertisement, promotional material, sales literature or public announcement of insurance products.

Source: *Miss. Code Ann.* § 83-5-29 et seq. (Rev. 2011)

Rule 17.07 Severability:

If any provision of any section of this regulation or the application thereof to any circumstance or insurance company, agent, agency or representative of same, nor any other person or entity, is held invalid, such invalidity shall not affect any other provision of that section or application of the regulation which can be given effect without the invalid provision or application, and to this end the provisions of this regulation are declared to be severable.

This regulation shall become effective thirty (30) days after its adoption and filing with the Mississippi Secretary of State's Office, as required by law.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-5-29 to 83-5-51 (Rev. 2011)

Part 1 Chapter 18: (89-105) Regulation of Corporation Allocations With Respect to Credit Insurers and Certain Insurance Holding Companies and Bank Deposits.

Rule 18.01: Statutory Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to authority granted by Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(4) and Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 29 and in accordance with the Mississippi Administrative Procedures Law.

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 47 states that "nothing in this Chapter shall be construed to relieve any person from compliance with any other applicable law of this State."

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 29 grants to the Commissioner authority to "issue any regulations that he deems necessary to effectuate the purposes of this chapter (the credit insurance chapter of the Mississippi Code Annotated).

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(4) provides that: the Commissioner "is hereby vested with full authority as provided by Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 29 to regulate, reduce and/or adjust experience refunds or corporate allocations in accordance with the provisions of paragraphs (c) and (d) of subsection (3) of this section." This Regulation is promulgated by the Commissioner pursuant to his full authority to regulate corporation allocations, and payments to agents in connection with the sale of credit insurance.

Source: *Miss. Code Ann.* § 83-53-25; § 83-53-29 (Rev. 2011)

Rule 18.02: Purposes

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(1) provides that "no one shall pay, accrue, credit or otherwise allow, either directly or indirectly, any compensation to any creditor, person, partnership, corporation, association or other entity in connection with any policy, certificate or other contract of credit life insurance or credit disability insurance which

exceeds forty-five percent (45%) of the premium rates approved for such policy, certificate or contract."

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(2) defines "compensation" as including, but not limited to, all of the following:

A. Commission, fees, and expense allowances;

B. The fair market value of all equipment, calculators, goods and service;

C. The fair market value of benefits such as travel, vacations or other rewards of any kind; and,

D. All other accruals, payments and other compensation or expenditures in any form whatsoever.

Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(3) establishes certain limited exceptions to the definition of "compensation" set out in Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(2).

The Commissioner has determined that not all payments being made under the guise of Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(2) and (3) are permitted pursuant to those sections.

The Commissioner has also determined that the use of compensating balances or the deposit of monies into non-interest bearing accounts with creditors in connection with a credit life and/or credit disability insurance program, either directly or indirectly, is in violation of Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 35(d) and Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25(2) and (3).

The purpose of this Regulation is to regulate certain activities and methods under which the credit insurance business within the State of Mississippi is written and to eliminate certain devices and plans designed to avoid or render ineffective the provisions of Title 83, Chapter 53, Section 1 through 47, Mississippi Code of 1972, Annotated and other pertinent statutes. The specific purposes of this Regulation are to regulate corporate allocations with respect to stock or other equity interests in credit insurers or credit insurance holding companies and their affiliates and to regulate compensating balances or other low or non-interest bearing accounts on deposit with creditors, thereby prohibiting methods and devices designed to avoid or render ineffective the provisions of Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 25 and Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 27 relating to the payment of compensation with respect to credit insurance.

Source: *Miss. Code Ann.* § 83-53-29 (Rev. 2011)

Rule 18.03: Definitions

Terms used herein shall be defined as follows:

A. "Creditor" shall mean a creditor as defined in Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 3(2)(d), any person or entity licensed as an agent to write credit insurance and any person, partnership, corporation, association or other entity affiliated in any manner with or related to a creditor, including an affiliation arising by virtue of being designated by a creditor as a holder of stock which will benefit in any manner, directly or indirectly, from credit insurance written by the creditor.

B. "Credit insurance" shall mean credit life insurance as defined in Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 3(2) (b) and credit disability insurance as defined in Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 3(2)(c).

C. "Insurer" shall have the same meaning as defined in Mississippi Code of 1972, Annotated, Title 83, Chapter 53, Section 3(2) (g).

D. "Credit insurance holding company" shall be defined as any corporation or other legal entity which controls an insurer engaged in the business of writing credit insurance. "Control" shall have the same meaning as defined in Mississippi Code of 1972, Annotated, Title 83, Chapter 6, Section 1(c).

E. "Corporate allocation" shall mean the apportionment of any part of the assets, income, earnings, profits or losses of any corporation, insurer or other legal entity with respect to any class or series of stock, or other equity interest, in an insurer or credit insurance holding company.

F. "Compensating balances" and/or "special deposit accounts" shall mean the deposit of premiums or money to the account of the insurer with a creditor through which the insurer writes credit insurance, when such account is either non-interest bearing or at a rate less than that which is usually paid on similar accounts or is controlled by the creditor.

Source: Miss. Code Ann. §§ 83-53-3; 83-53-29; 83-6-1(c) (Rev. 2011)

Rule 18.04: Applicability

This Regulation shall apply to all insurers engaged in the business of writing credit insurance and the shareholders thereof, all credit insurance holding companies and the shareholders thereof, and all creditors.

Source: *Miss. Code Ann.* §§83-53-1; 83-5-3 (Rev. 2011)

Rule 18.05: Regulation of Corporate Allocations, Dividends and Distributions

A. Insurers engaged in credit insurance operations and credit insurance holding companies affiliated in any way with any such insurer, may make corporate allocations for or to the

benefit of any class or series of stock or other equity interest in such insurer or credit insurance holding company which is issued to a creditor writing credit insurance business with the insurer. Permitted corporate allocations are only those with respect to common stock or other equivalent equity interests of surplus which remains after all corporate allocations to preferred stockholders; preferred stock if such corporate allocations provide a fixed or variable rate of return which is reasonably related to the investment by the creditor and the risk associated with the investment; or common or preferred stock which represents the actual consideration paid by a creditor for such interest or surplus arising from credit insurance business written by the creditor.

B. Insurers and credit insurance holding companies with more than one class or series of stock may make corporate allocations or dividends only in accordance with specific and express provisions set forth in the articles of association, articles of incorporation, bylaws or resolutions of the insurer or credit insurance holding company. Each insurer and credit insurance holding company must file copies of its articles, bylaws, and resolutions in the office of the Commissioner of Insurance of the State of Mississippi.

C. Insurers and credit insurance holding companies may pay dividends on or make distributions with respect to its shares of stock or other equity interests, including payments to redeem or purchase shares of stock or other equity interests, to any creditor only form corporate allocations made in accordance with this regulation to the benefit of the class or series of stock or other equity interest with respect to which the payment or distribution is made.

D. No insurer or credit insurance holding company shall make a distribution of capital and/or paid-in surplus with respect to any class or series of stock or other equity interest to any creditor, whether as a partial or complete distribution of the capital and/or paid-in surplus attributable to such stock or other equity interest, without notification to the creditor that the payment source of such distribution is the capital and/or paid-in surplus attributable to such stock or other equity interest along with an explanation of the effect of the distribution on the capital and/or paid-in surplus attributable to such stock or other equity interest.

E. No insurer or credit insurance holding company may recapitalize or reorganize its capital structure for the purpose of making available for dividends or distributions to creditors with respect to any class or series of its stock or other equity interest any of the capital and/or surplus which has been previously allocated to another class or series of its stock or other equity interest without prior approval of the Commissioner of Insurance.

F. No insurer shall make a dividend, either in cash or stock certificates, except from its actual net surplus computed as required by law in its annual statements. No such dividend may be paid unless and until the insurer has filed with the Commissioner the annual statement of the insurer for the year(s) in which such surplus was earned.

G. Dividends or distributions to be paid to stockholders, once declared by the board of directors of an insurer or credit insurance holding company, are charged directly to

unassigned surplus and must be carried as a liability of such insurer or credit insurance holding company until paid. An approval or ratification of corporate allocations by the board of directors of an insurer or credit insurance holding company shall not constitute a dividend or distribution.

H. The Commissioner of Insurance hereby reserves the right, after notice and hearing, to declare corporate allocation or dividend methods or other equity interest programs, other than those which conform to the requirements of this Regulation and statutes of the State of Mississippi, to be in violation of in Mississippi Code of 1972, Annotated, Title 83, Chapter 53,Section 25, and to order and require appropriate remedial action, including, but not limited to, rescission of the sale of such stock or other equity interest and penalties and fines provided in the statutes of the State of Mississippi.

Source: *Miss. Code Ann.* § 83-53-25 (Rev. 2011)

Rule 18.06: Prohibition on Compensating Balances or Other Special Deposit Accounts

Compensating balances and special deposit accounts by an insurer with a creditor through which the insurer issues credit insurance are to be considered in violation of Title 83, Chapter 53, Section 25(1) of the in Mississippi Code of 1972, Annotated. This prohibition applies regardless of whether premiums are due the insurer on the single premium basis or on the monthly premium outstanding balance basis. Nothing herein shall prevent an insurer from making deposits in financial institutions in the normal course of business.

Source: *Miss. Code Ann.* § 83-53-25 (Rev. 2011)

Rule 18.07: Severability

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

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 18.08: Effective Date

This Regulation shall become effective April 1, 1990.

Source: *Miss. Code Ann.* § 25-43-3.113 (2010)

Part 1 Chapter 19: **(92-102)** Life and Health Reinsurance Agreements**.**

Rule 19.01: Authority

This Regulation is adopted and promulgated by the Commissioner of Insurance pursuant to *Miss. Code Ann*. §§ 83-1-29, 83-1-165, 83-5-1, 83-6-31 and 83-19-157, and in accordance with the provisions of Miss. Code Ann. Chapter 43, Title 25, and Mississippi Insurance Department Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §§ 83-1-29; 83-1-165; 83-5-1; 83-6-31;83-19-157 (Rev. 2011)

Rule 19.02: Preamble

A. The Mississippi Insurance Department recognizes that licensed insurers routinely enter into reinsurance agreements that yield legitimate relief to the ceding insurer from strain to surplus.

B. However, it is improper for a licensed insurer, in the capacity of ceding insurer, to enter into reinsurance agreements for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business being reinsured. In substance or effect, the expected potential liability to the ceding insurer remains basically unchanged by the reinsurance transaction, notwithstanding certain risk elements in the reinsurance agreement, such as catastrophic mortalityor extraordinary survival. The terms of such agreements referred to herein and described in Section 4 violate:

    1. Sections 83-5-35(e), 83-5-55 and 83-5-69 relating to financial statements which do not properly reflect the financial condition of the ceding insurer;

    2. Sections 83-19-151, 83-19-153 and 83-19-155 relating to reinsurance reserve credits, thus resulting in a ceding insurer improperly reducing liabilities or establishing assets for reinsurance ceded; and

    3. Sections 83-1-29, 83-1-155(1)(a), 83-5-17 and 83-23-1 relating to creating a situation that may be hazardous to policyholders and the people of this State.

Source: *Miss. Code Ann.* § 83-1-29; § 83-5-35; § 83-19-151 (Rev. 2011)

Rule 19.03: Scope

This regulation shall apply to all domestic life and accident and health insurers and to all other licensed life and accident and health insurers which are not subject to a substantially similar regulation in their domiciliary state. This regulation shall also similarly apply to licensed property and casualty insurers with respect to their accident and health business. This regulation shall not apply to assumption reinsurance, yearly renewable term reinsurance or certain non-proportional reinsurance such as stop loss or catastrophe reinsurance.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 19.04: Accounting Requirements

A. No insurer subject to this regulation shall, for reinsurance ceded, reduce any liability or establish any asset in any financial statement filed with the Department if, by the terms of the reinsurance agreement, in substance or effect, any of the following conditions exist:

1. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period, are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured, unless a liability is established for the present value of the shortfall (using assumptions equal to the applicable statutory reserve basis on the business reinsured). Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the company at the time the business is reinsured;

2. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets.

3. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negative experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

4. The ceding insurer must, at specific points in time scheduled in the agreement, terminate or automatically recapture all or part of the reinsurance ceded;

5. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

6. The treaty does not transfer all of the significant risk inherent in the business being reinsured. The following table identifies for a representative sampling of products or type of business, the risks which are considered to be significant. For products not specifically included, the risks determined to be significant shall be consistent with this table.

   Risk categories:

   a. Morbidity

   b. Mortality

   c. Lapse

      This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

   d. Credit Quality (C1)

      This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

   e. Reinvestment (C3)

      This is the risk that interest rates will fall and funds reinvested (coupon payment or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

   f. Disintermediation (C3)

      This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

      + - Significant 0- Insignificant

      RISK CATEGORY

      a b c d e f

Health Insurance - other than LTC/LTD*
+ 0 + 0 0 0

Health Insurance - LTC/LTD*
+ 0 + + + 0

Immediate Annuities
0 + 0 + + 0

Single Premium Deferred Annuities
0 0 + + + +

Flexible Premium Deferred Annuities
0 0 + + + +

Guaranteed Interest Contracts
0 0 0 + + +

Other Annuity Deposit Business
0 0 + + + +

Single Premium Whole Life
0 + + + + +

Traditional Non-Par Permanent
0 + + + + +

Traditional Non-Par Term
0 + + 0 0 0

Traditional Par Permanent
0 + + + + +

Traditional Par Term
0 + + 0 0 0

Adjustable Premium Permanent
0 + + + + +

Indeterminate Premium Permanent
0 + + + + +

Universal Life Flexible Premium
0 + + + + +

Universal Life Fixed Premium

0 + + + + +

Universal Life Fixed Premium
0 + + + + +
dump-in premiums allowed

*LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance

7. (a) The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in Paragraph (7) (b)) either transfer the underlying assets to the reinsurer or legally segregate such assets in a trust or escrow account or otherwise establish a mechanism satisfactory to the commissioner which legally segregates, by contract or contract provision, the underlying assets.

(b) Notwithstanding the requirements of Paragraph (7)(a), the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment or disintermediation risk may be held by the ceding company without segregation of such assets:

i. Health Insurance - LTC/LTD

ii. Traditional Non-Par Permanent

iii. Traditional Par Permanent

iv. Adjustable Premium Permanent

v. Indeterminate Premium Permanent

vi. Universal Life Fixed Premium
    a. (no dump-in premiums allowed)

The associated formula for determining the reserve interest rate adjustment must use a formula which reflects the ceding company's investment earnings and incorporates all realized and unrealized gains and losses reflected in the statutory statement. The following is an acceptable formula:

Rate = 2 (I + CG)
X + Y - I - CG

Where: I is the net investment income (Exhibit 2, Line 16, Column 7)

CG is capital gains less capital losses (Exhibit 4, Line 10, Column 6)

X is the current year cash and invested assets (Page 2, Line 10A, Column 1) plus investment income due and accrued (Page 2, Line 16, Column 1) less borrowed money (Page 3, Line 22, Column 1)

Y is the same as X but for the prior year

8. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within ninety (90) days of the settlement date.

9. The ceding insurer is required to make representations or warranties not reasonably related to the business being reinsured.

10. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured.

11. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

B. Notwithstanding Subsection A, an insurer subject to this regulation may, with the prior approval of the commissioner, take such reserve credit or establish such asset as the commissioner may deem consistent with the Insurance Law, Rules or Regulations, including actuarial interpretations or standards adopted by the Department.

C. 1. Agreements entered into after the effective date of this regulation which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the commissioner within thirty (30) days from its date of execution. Each filing shall include data detailing the financial impact of the transaction. The ceding insurer's actuary who signs the financial statement actuarial opinion with respect to valuation of reserves shall consider this regulation and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with this department. The actuary should maintain adequate documentation and be prepared upon request to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this regulation.

2. Any increase in surplus net of federal income tax resulting from arrangements described in Subsection C(1) shall be identified separately on the insurer's statutory financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

   {For example, on the last day of calendar year N, company XYZ pays a $20 million initial commission and expense allowance to company ABC for reinsuring an existing block of business. Assuming a 34% tax rate, the net increase in surplus at inception is $13.2 million ($20 million - $6.8 million) which is reported on the "Aggregate write-ins for gains and losses in surplus" line in the Capital and Surplus account. $6.8 million (34% of $20 million) is reported as income on the "Commissions and expense allowances on reinsurance ceded" line of the Summary of Operations.

   At the end of the year N+1 the business has earned $4 million. ABC has paid $.5 million in profit and risk charges in arrears for the year and has received a $1 million experience refund. Company ABC's annual statement would report $1.65 million (66% of ($4 million - $1 million - $.5 million) up to a maximum of $13.2 million) on the "Commissions and expense allowance on reinsurance ceded" line of the Summary of Operations, and -$1.65 million on the "Aggregate write-ins for gains and losses in surplus" line of the Capital and Surplus account. The experience refund would be reported separately as a miscellaneous income item in the Summary of Operations.}

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 19.05 Written Agreements

A. No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department, unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the "as of date" of the financial statement.

B. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding ninety (90) days from the execution date of the letter of intent, in order for credit to be granted for the reinsurance ceded.

C. The reinsurance agreement shall contain provisions which provide that:

1. The agreement shall constitute the entire agreement between the parties with respect to the business being reinsured thereunder and that there are no understandings between the parties other than as expressed in the agreement; and

2. Any change or modification to the agreement shall be null and void unless made by amendment to the agreement and signed by both parties.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 19.06 Existing Agreements

Insurers subject to this regulation shall reduce to zero by December 31, 1996 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the effective date of this regulation which, under the provisions of this regulation would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this regulation.

Source: *Miss. Code Ann.* § 83-5-35 (Rev. 2011)

Rule 19.07 Effective Date

This regulation shall become effective December 31, 1996 and after filing with the office of the Secretary of State.

Source: *Miss. Code Ann.* § 25-43-3.106 (Rev. 2010)

Part 1 Chapter 20: Insurance Holding Company Regulation with Reporting Forms and Instructions.

Rule 20.01 Authority

This regulation is adopted and promulgated pursuant to the authority granted by *Miss. Code Ann*. Section 83-6-31 (1972), and in accordance with the provisions of Miss Code Ann. Chapter 43, Title 25, and the Mississippi Insurance Department Regulation 19 Miss. Admin. Code, Part 1, Chapter 15, said regulation being the "Rules of Practice and Procedure before the Mississippi Insurance Department".

Source: *Miss. Code Ann.* § 83-6-31 (Rev. 2011)

Rule 20.02 Purpose

The purpose of this regulation is to set forth rules and procedural requirements which the Commissioner deems necessary to carry out the provisions of the Insurance Holding Company System Regulatory Act, *Miss. Code Ann*. Section 83-6-1 et seq. (Supp. 2013), hereinafter

referred to as "the Act". The information called for by this regulation is hereby declared to be necessary and appropriate in the public interest and for the protection of the policyholders in this State.

Source: *Miss. Code Ann.* § 83-6-31 (Rev. 2011)

Rule 20.03 Severability Clause

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

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 20.04 Forms - General Requirements

A. Forms A, B, C, D, E and F are intended to be guides in the preparation of the statements required by Sections 83-6-24, 83-6-5, 83-6-21, and 83-6-24 of the Act. They are not intended to be blank forms which are to be filled in. These statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

B. One (1) complete copy of each statement including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to: Insurance Commissioner of the State of Mississippi, Attention: Commissioner. The copy shall be manually signed in the manner prescribed on the form. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of such power of attorney or other authority shall also be filed with the statement.

C. If an applicant requests a hearing on a consolidated bases under Section 83-6-24(4)(d) of the Act, in addition to filing the Form A with the commissioner, the applicant shall file a copy of Form A with the National Association of Insurance Commissioners (NAIC) in electronic form.

D. Statements should be prepared electronically. Statements shall be easily readable and suitable for review and reproduction. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and

any monetary value shown in a foreign currency normally shall be converted into United States currency.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-21; 83-6-24; 83-6-31 (Supp. 2013)

Rule 20.05 Forms - Incorporation by Reference, Summaries and Omissions

A. Information required by any item of Form A, Form B, Form C, Form D, Form E or Form F may be incorporated by reference in answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in answer or partial answer to any item of Form A, Form B, Form C, Form D, Form E or Form F provided such document or paper is filed as an exhibit to the statement. Excerpts of documents may be filed as exhibits if the documents are extensive. Documents currently on file with the Commissioner which were filed within three years need not be attached as exhibits. References to information contained in exhibits or in documents already on file shall clearly identify the material and shall specifically indicate that such material is to be incorporated by reference in answer to the item. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

B. Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference. In any case where two or more documents required to be filed as exhibits are substantially identical in all material respects except as to the parties thereto, the dates of execution, or other details, a copy of only one of such documents need be filed with a schedule identifying the omitted documents and setting forth the material details in which such documents differ from the documents a copy of which is filed.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-21; 83-6-24; 83-6-31 (Supp. 2013)

Rule 20.06 Forms - Information Unknown or Unavailable and Extension of Time to Furnish

If it is impractical to furnish any required information, document or report at the time it is required to be filed, there may be filed with the Commissioner as a separate document a statement:

A. Identifying the information, document or report in question;

B. Stating why the filing thereof at the time required is impractical; and,

C. Requesting an extension of time for filing the information, document or report to a specified date. The request for extension shall be deemed granted unless the Commissioner within 60 days after receipt thereof enters an order denying the request.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-21; 83-6-24 (Supp. 2013)

Rule 20.07 Forms - Additional Information and Exhibits

In addition to the information expressly required to be included in Form A, Form B, Form C, Form D, Form E and Form F, there shall be added such further material information, if any, as may be necessary to make the information contained therein not misleading. The person filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Forms A, B, C, D, E or F shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change and not the date of the original filing.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-21; 83-6-24; 83-6-31 (Supp. 2013)

Rule 20.08 Definitions

A. "Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

B. "Ultimate controlling person" means that person which is not controlled by any other person.

C. Unless the context otherwise requires, other terms found in those regulations and in Section 83-6-1 of the Act are used as defined in the Act. Other nomenclature or terminology is according to the Industry Code or industry usage if not defined by the Code.

Source: *Miss. Code Ann.* §§ 83-6-1; 83-6-31 (Supp. 2013)

Rule 20.09 Subsidiaries of Domestic Insurers

The authority to invest in subsidiaries under Section 83-6-2(2) of the Act is in addition to any authority to invest in subsidiaries which may be contained in any other provision of the Insurance Code.

Source: *Miss. Code Ann.* § 83-6-2 (Supp. 2013)

Rule 20.10 Acquisition of Control - Statement Filing (Form A)

A person required to file a statement pursuant to Section 83-6-24 of the Act shall furnish the required information on Form A, hereby made a part of this regulation. Such person shall also furnish the required information on Form E, hereby made a part of this regulation and described in Rule 20.14 of this regulation.

Source: *Miss. Code Ann.* § 83-6-24; 83-6-31 (Supp. 2013)

Rule 20.11 Amendments to Form A

The applicant shall promptly advise the Commissioner of any changes in the information so furnished on Form A arising subsequent to the date upon which such information was furnished but prior to the Commissioner's disposition of the application.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 20.12 Acquisition

If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of Section 83-6-24 of the Act, the name of the domestic insurer on the cover page should be indicated as follows:

"ABC Insurance Company, a subsidiary of XYZ Holding Company".

Where a Section 83-6-24 insurer is being acquired, references to "the insurer" contained in Form A shall refer to both the domestic subsidiary insurer and the person being acquired.

Source: *Miss. Code Ann.* §§ 83-6-24; 83-6-31 (Supp. 2013)

Rule 20.13 Pre-Acquisition Notification

If a domestic insurer, including any person controlling domestic insurer, is proposing a merger or acquisition pursuant to Section 83-6-24(1) of the Act, that person shall file a pre-acquisition notification form, Form E, which was developed pursuant to Section 83-6-24 of the Act.

Additionally, if a non-domiciliary insurer licensed to do business in this state is proposing a merger or acquisition pursuant to Section 83-6-24 of the Act, that person shall file a pre-acquisition notification form, Form E. No pre-acquisition notification form need be filed if the acquisition is beyond the scope of Subsection 2(b) of Section 4, Senate Bill 2298, 2017 Regular Legislative Session.

In addition to the information required by Form E, the commissioner may wish to require an expert opinion as to the competitive impact of the proposed acquisition.

Source: *Miss. Code Ann.* § 83-6-24 (Rev. 2011); Senate Bill 2298, 2017 Regular Legislative Session

Rule 20.14 Annual Registration of Insurers - Statement Filing (Form B)

An insurer required to file a registration statement pursuant to Section 83-6-5 of the Act shall file such statement on an annual basis and shall furnish the required information on Form B, hereby made a part of this regulation.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-31 (Supp. 2013)

Rule 20.15 Summary of Registration - Statement Filing (Form C)

An insurer required to file an annual registration statement pursuant to Section 83-6-3 is also required to furnish information required on Form C, hereby made a part of these regulations. An insurer shall file a copy of Form C in each state in which the insurer is authorized to do business, if requested by the Commissioner of that state.

Source: *Miss. Code Ann.* §§ 83-6-3 (Supp. 2013)

Rule 20.16 Amendments to Form B

A. An amendment to Form B shall be filed within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement.

B. Amendments shall be filed in the Form B format with only those items which are being amended reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert Year)" and shall indicate the date of the change and not the date of the original filings.

Source*: Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 20.17 Alternative and Consolidated Registration

A. Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register under Section 83-6-3 of the Act. A registration statement may include information not required by the Act regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this State. In lieu of filing a registration statement on Form B, the authorized insurer may file a copy of the registration statement or similar report which it is required to file in its State of domicile, provided:

1. the statement or report contains substantially similar information required to be furnished on Form B; and

2. the filing insurer is the principal insurance company in the insurance holding company system.

B. The question of whether the filing insurer is the principal insurance company in the insurance holding company system is a question of fact and an insurer filing a registration statement or report in lieu of Form B on behalf of an affiliated insurer, shall set forth a brief statement of facts which will substantiate the filing insurer's claim that it, in fact, is the principal insurer in the insurance holding company system.

C. With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under paragraph (a) above.

D. Any insurer may take advantage of the provisions of Section 83-6-13 of the Act without obtaining the prior approval of the Commissioner. The Commissioner, however, reserves the right to require individual filings if he deems such filings necessary in the interest of clarity, ease of administration or the public good.

Source: *Miss. Code Ann.* §§ 83-6-13; 83-6-31 (Rev. 2011)

Rule 20.18 Disclaimers and Termination of Registration

A. A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

1. the number of authorized, issued and outstanding voting securities of the subject;

2. with respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

3. all material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person;

4. A statement explaining why such person should not be considered to control the subject.

B. A request for termination of registration shall be deemed to have been granted unless the Commissioner, within 30 days after he receives the request, notifies the registrant otherwise.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 20.19 Transactions Subject to Prior Notice - Notice Filing (Form D)

A. An insurer required to give notice of a proposed transaction pursuant to Section 83-6-21 of the Act shall furnish the required information on Form D, hereby made a part of this regulation.

B. Agreements for cost sharing services and management services shall at a minimum and as applicable:

1. Identify the person providing services and the nature of such services;

2. Set forth the methods to allocate costs;

3. Require timely settlement, not less frequently than on a quarterly basis, and compliance with the requirements in the Accounting Practices and Procedures Manual.

4. Prohibit advancement of funds by the insurer to the affiliate except to pay for services defined in the agreement;

5. State that the insurer will maintain oversight for functions provided to the insurer by the affiliate and that the insurer will monitor services annually for quality assurance;

6. Define Books and records of the insurer to include all books and records developed or maintained under or related to the agreement;

7. Specify that all books and records of the insurer are and remain the property of the insurer and are subject to control of the insurer;

8. State that all funds and invested assets of the insurer are the exclusive property of the insurer, held for the benefit of the insurer and are subject to the control of the insurer;

9. Include standards for termination of the agreement with and without cause;

10. Include provisions for indemnification of the insurer in the event of gross negligence or willful misconduct on the part of the affiliate providing the services;

11. Specify that, if the insurer is placed in receivership or seized by the commissioner under the Insurer Rehabilitation and Liquidation Act, Section 83-34-1, et seq. (Supp. 2013).

    i. All of the rights of the insurer under the agreement extend to the receiver or commissioner; and

    ii. All books and records will immediately be made available to the receiver or the commissioner, and shall be turned over to the receiver or

commissioner immediately upon the receiver or the commissioner's request;

12. Specify that the affiliate has no automatic right to terminate the agreement if the insurer is placed in receivership pursuant to the Insurer Rehabilitation and Liquidation Act, Section 83-34-1, et seq. (Supp. 2013); and,

13. Specify that the affiliate will continue to maintain any systems, programs, or other infrastructure notwithstanding a seizure by the commissioner under Section the Insurer Rehabilitation and Liquidation Act, Section 83-34-1, et seq. (Supp. 2013), and will make them available to the receiver, for so long as the affiliate continues to receive timely payment for services rendered.

Source: *Miss. Code Ann.* §§ 83-6-21; 83-6-31 (Supp. 2013)

Rule 20.20 Enterprise Risk Report

The ultimate controlling person of an insurer required to file an enterprise risk report pursuant to Section 83-6-5(5) of the Act shall furnish the required information on Form F, hereby made a part of these regulations.

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-31 (Supp. 2013)

Rule 20.21 Extraordinary Dividends and Other Distributions

A. Requests for approval of extraordinary dividends or any other extraordinary distribution to shareholders shall include the following:

1. The amount of the proposed dividend;

2. The date established for payment of the dividend;

3. A statement as to whether the dividend is to be in cash or other property and, if in property, a description thereof, its cost, and its fair market value together with an explanation of the basis for valuation;

4. A copy of the calculations determining that the proposed dividend is extraordinary. The work paper shall include the following information:

i. The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurers own securities) paid within the period of twelve (12) consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year.

ii. Surplus as regards policyholders (total capital and surplus) as of the 31st day of December next preceding;

iii. If the insurer is a life insurer, the net gain from operations for the 12-month period ending the 31st day of December next preceding;

iv. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding and the two preceding 12-months periods; and

v. If the insurer is not a life insurer, the dividends paid to stockholders excluding distributions of the insurer's own securities in the preceding two calendar years.

5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted; and

6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs.

B. Subject to Section 83-6-25, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof, including the same information required by Subsection A(4).

Source: *Miss. Code Ann.* §§ 83-6-5; 83-6-31 (Supp. 2013)

Rule 20.22 Adequacy of Surplus

The factors set forth in Section 83-6-23 of the Act are not intended to be an exhaustive list. In determining the adequacy and reasonableness of an insurer's surplus no single factor is necessarily controlling. The Commissioner, instead, will consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner will consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner will consider the individual subsidiary and may discount or disallow its valuation to the extent that the individual investments so warrant.

Source: *Miss. Code Ann.* § 83-6-23 (Rev. 2011)

Rule 20.23 Effective date

This Regulation, as amended, shall be effective on and after July 1, 2017.

Source: *Miss. Code Ann.* §§ 25-43-3.112; 83-5-1 (Rev. 2011)

Rule 20.25 Form A - Statement Regarding the Acquisition of Control of or Merger with a Domestic Insurer

FORM A

STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____
Name of Domestic Insurer

BY

_____
Name of Acquiring Person (Applicant)

Filed with the Insurance Department of

_____
(State of domicile of insurer being acquired)

Dated: _____, 20 _____

Name, Title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement should be Addressed:

_____
_____
_____
_____

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

A. State the name and address of the applicant seeking to acquire control over the insurer.

B. If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

C. Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the

applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (e.g. corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

On the biographical affidavit, include a third party background check, and state the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10% or more of the voting securities of the applicant if the applicant is not an individual.

A. Name and business address;

B. Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

C. Material occupations, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

D. Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty imposed or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

A. Describe the nature, source and amount of funds or other considerations used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

B. Explain the criteria used in determining the nature and amount of such consideration.

C. If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was arrived at.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS, OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASERS OF VOTING SECURITIES

Describe any purchases of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

A. Financial statements, exhibits, and three-year financial projections of insurer(s) shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

B. The financial statements shall include the annual financial statements of the persons identified in Item 2(c) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

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

C. File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or Regulation Sections 4 and 6.

ITEM 13. AGREEMENT REQUIREMENTS FOR ENTERPRISE RISK MANAGEMENT

Applicant agrees to provide, to the best of its knowledge and belief, the information required by Form F within fifteen (15) days after the end of the month in which the acquisition of control occurs.

ITEM 14. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 83-6-24 of the Act _____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ of _____ 20_____.

(SEAL)_____
Name of applicant

Attest: BY_____
(Name) (Title)

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated

_____, 20_____, for and on behalf of _____

_____ ; that (s)he is the
(Name of applicant)

_____of such company and that (s)he is an
(Title of Officer)

authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Source: *Miss. Code Ann.* § 83-6-23 (Rev. 2011)

Rule 20.26: Form B - Insurance Holding Company System Annual Registration Statement

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

BY

_____
(Name of Registrant)

On Behalf of Following Insurance Companies:

Name Address

_____
_____
_____
_____

Date: _____, 20_____

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

_____
_____
_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

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

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to

each person specified in such chart or listing indicate the type of organization (e.g.,- corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

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

A. Name.

B. Home office address.

C. Principal executive office address.

D. The organizational structure of the person, i.e., corporation, partnership, individual, trust, etc.

E. The principal business of the person.

F. The name and address of any person who holds or owns 10% or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

G. If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations. If the ultimate controlling person is an individual, furnish the individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations.

ITEM 5. TRANSACTIONS AND AGREEMENTS

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

A. Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates:

B. Purchases, sales or exchanges of assets;

C. Transactions not in the ordinary course of business;

D. Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

E. All management agreements, service contracts and all cost-sharing arrangements;

F. Reinsurance agreements;

G. Dividends and other distributions to shareholders;

H. Consolidated tax allocation agreements; and

I. Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material for purposes of Sections 83-6-3 through 83-6-19 of the Act.

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

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

ITEM 6. LITIGATION OR ADMINSTATIVE PROCEEDINGS

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

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

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

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

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

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

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

B. If the ultimate controlling person is a corporation, an organization, a limited liability company, or other legal entity, the financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

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

   Other than with respect to the foregoing, such financial statements shall be filed in a standard form and format adopted by the National Association of Insurance Commissioners, unless an alternative form is accepted by the Commissioner. Documentation and financial statements filed with the Securities and Exchange Commission or audited GAAP financial statements shall be deemed to be an appropriate form and format.

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

   Any ultimate controlling person who is an individual may file personal financial statements that are reviewed rather than audited by an independent public accountant. The review shall be conducted in accordance with standards for review of personal financial statements published in the *Personal Financial Statements Guide* by the

American Institute of Certified Public Accountants. Personal financial statements shall be accompanies by the independent public accountant's Standard Review Report stating that the accountant is not aware of any material modifications that should be made to the financial statements in order for the statements to be in conformity with generally accepted accounting principles.

C. Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person; and any additional documents or papers required by Form B or Regulation Sections 20.04 and 20.06.

ITEM 9. FORM C REQUIRED

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

ITEM 10: SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of Section 83-6-5, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20_____.

(SEAL)_____
Name of Registrant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____; that (s)he is the
(Name of company)

_____ of such company and that (s)he is authorized to execute
(Title of Officer)

and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Source: *Miss. Code Ann.* § 83-6-5 (Rev. 2011)

Rule 20.27 Form C - Summary of Registration Statement

FORM C
SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of _____

BY

_____
(Name of Registrant)

On Behalf of Following Insurance Companies

Name Address

_____
_____
_____
_____

Date: _____, 20_____

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

_____
_____
_____

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

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

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

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

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

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

Pursuant to the requirements of Section 83-6-3, Registrant has caused this annual registration statement to be duly signed on its behalf of the City of _____ and State of _____ on the _____ day of _____, 20_____.

(SEAL)_____
Name of Applicant

BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of _____; that (s)he is the
(Name of applicant)

_____ such company and that (s)he is authorized to execute
(Title of Officer)

and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Source: *Miss. Code Ann.* § 83-6-3 (Rev. 2011)

Rule 20.28 Form D - Prior Notice of a Transaction

FORM D
PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of _____

BY

_____
(Name of Registrant)

On Behalf of Following Insurance Companies

Name Address

_____
_____
_____
_____

Date: _____, 20_____

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

_____
_____
_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

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

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, i.e. corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the

transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

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

(a) A statement as to whether notice is being given under Section 83-6-21 (2)(a)(b)(c)(d) (e) (f) or (g) of the Act.

(b) A statement of the nature of the transaction.

(c) A statement of how the transaction meets the "fair and reasonable" standard of Section 83-6-21(1)(a); and

(d) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR INVESTMENTS

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

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

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

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than, (a) in the case of non-life insurer's, the lesser of 3% of the insurer's admitted assets or 25%

of surplus as regards policyholders or, (b) in the case of life insurers, 3% of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

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

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

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described by Section 83-6-21(2)(c) of the Act, or a reinsurance pooling agreement or modification thereto as described by Section 83-6-21(c), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

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

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS.

For management agreements and services agreements, furnish:

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

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

For cost-sharing arrangements, furnish:

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

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

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

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

(e) a brief statement as to the effect of the transaction upon the insurer's policyholder surplus;

(f) A statement regarding the cost allocation methods that specifies whether proposed charges are based on "cost or market". If market based, rationale for using market instead of cost, including justification for the company's determination that amounts are fair and reasonable; and

(g) A statement regarding compliance with the *NAIC Accounting Practices and Procedure Manual* regarding expense allocation.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE: _____

Pursuant to the requirements of Section 83-6-21 of the Act, _____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 20____.

(SEAL)_____
Name of Applicant
BY_____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 20_____, for and on behalf of

_____; that (s)he is the
(Name of Applicant)

_____ of such company and that (s)he is authorized to
(Title of Officer)

execute and file such statement. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

Source: *Miss. Code Ann.* § 83-6-21 (Rev. 2011)

Rule 20.29: Form E – Pre-Acquisition Notification Form

FORM E

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

_____
Name of Applicant

_____
Name of Other Person
Involved in Merger or
Acquisition

Filed with the Insurance Department of

_____

Dated:_____, 20_____

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

_____

_____

_____

_____

ITEM 1. NAME AND ADDRESS

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

ITEM 2. NAME AND ADDRESSES OF AFFILIATED COMPANIES

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

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

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

ITEM 4. NATURE OF BUSINESS

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

ITEM 5. MARKET AND MARKET SHARE

State specifically what market and market share in each relevant insurance market the persons identified in Item 1 and Item 2 currently enjoy in this state. Provide historical market and market share data for each person identified in Item 1 and Item 2 for the past five years and identify the source of such data. Provide a determination as to whether the proposed acquisition or merger, if consummated, would violate the competitive standards of the state as stated in Section 4 of Senate Bill 2298, 2017 Regular Legislative Session. If the proposed acquisition or merger would violate competitive standards, provide justification of why the acquisition or merger would not substantially lessen competition or create a monopoly in the state.

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

Miss. Code Ann. § 83-6-24 (Supp. 2013); Senate Bill 2298, 2017 Regular Legislative Session

Rule 20.30: Form F – Enterprise Risk Report

FORM F

ENTERPRISE RISK REPORT

Filed with the Insurance Department of the State of _____

By

_____
Name of Registrant/Applicant

On Behalf of/Related to Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____, 20_____

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

_____

_____

_____

ITEM 1. ENTERPRISE RISK

The Registrant/Applicant, to the best of its knowledge and belief, shall provide information regarding the following areas that could produce enterprise risk as defined in Miss. Code Ann. § 83-6-5(5), provided such information is not disclosed in the Insurance Holding Company System Annual Registration Statement filed on behalf of itself or another insurer for which it is the ultimate controlling person:

- Any material developments regarding strategy, internal audit findings, compliance or risk management affecting the insurance holding company system;

- Acquisition or disposal of insurance entities and reallocating of existing financial or insurance entities within the insurance holding company system;

- Any changes of shareholders of the insurance holding company system exceeding ten percent (10%) or more of voting securities;

- Developments in various investigations, regulatory activities or litigation that may have a significant bearing or impact on the insurance holding company system;

- Business plan of the insurance holding company system and summarized strategies for next 12 months;

- Identification of material concerns of the insurance holding company system raised by supervisory college, if any, in last year;

- Identification of insurance holding company system capital resources and material distribution patterns;

- Identification of any negative movement or discussions with rating agencies which may have caused, or may cause, potential negative movement in the credit ratings and individual insurer financial strength ratings assessment of the insurance holding company system (including both the rating score and outlook);

- Information on corporate or parental guarantees throughout the holding company and the expected source of liquidity should such guarantees be called upon; and

- Identification of any material activity or development of the insurance holding company system that, in the opinion of senior management, could adversely affect the insurance holding company system.

The Registrant/Applicant may attach the appropriate form most recently filed with the U.S. Securities and Exchange Commission, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the form provides responsive information. If the Registrant/Applicant is not domiciled in the U.S., it may attach its most recent public audited financial statement filed in its country of domicile, provided the Registrant/Applicant includes specific references to those areas listed in Item 1 for which the financial statement provides responsive information.

ITEM 2: OBLIGATION TO REPORT

If the Registrant/Applicant has not disclosed any information pursuant to Item 1, the Registrant/Applicant shall include a statement affirming that, to the best of its knowledge and belief, it has not identified enterprise risk subject to disclosure pursuant to Item 1.

Miss. Code Ann. § 83-6-5 (Supp. 2013)

Part 1 Chapter 21: (94-104) Prescribing Form of Certificate of Contribution for Certain Assessments Paid to Mississippi Life and Health Insurance Guaranty Association and Approving

Rule 21.01 Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by *Miss. Code Ann.* §§ 83-5-1 and 83-23-217 (Rev. 1991), and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §§83-5-1; 83-23-217 (Rev. 2011)

Rule 21.02 Purpose

The purpose of this Regulation is to prescribe the form of the certificate of contribution to be issued by the Mississippi Life and Health Insurance Guaranty Association to each member insurer paying a Class B assessment to the Mississippi Life and Health Insurance Guaranty Association and to approve the form and amount and period of time that a certificate of contribution may be shown as an admitted asset by the member insurer in its statutory financial statement.

Source: *Miss. Code Ann.* § 83-23-203 (Rev. 2011)

Rule 21.03 Definitions

A. "Class B assessment" shall mean assessments by the Mississippi Life and Health Insurance Guaranty Association made to the extent necessary to carry out the powers and duties of the Mississippi Life and Health Insurance Guaranty Association under Miss. Code Ann. § 83-23-215 (Rev. 1991), with regard to an impaired or insolvent insurer.

B. "Impaired insurer" shall have the same meaning as defined in Miss. Code Ann.§83-9-209 (Rev. 1991).

C. "Insolvent insurer" shall have the same meaning as defined in Miss. Code Ann.§83-9-209 (Rev. 1991).

D. "Member insurer" shall have the same meaning as defined in Mississippi Code Annotated Section 83-9-209.

Source: *Miss. Code Ann.* § 83-23-215 (Rev. 2011)

Rule 21.04: Form of Certificate of Contribution

The Mississippi Life and Health Insurance Guaranty Association shall issue to each member insurer paying a Class B assessment to the Mississippi Life and Health Insurance Guaranty

Association a certificate of contribution for the amount of the assessment so paid. Such certificate of contribution shall be in substantially the form attached hereto as Appendix A, which is hereby made a part of this Regulation.

Source: *Miss. Code Ann.* § 83-23-211 (Rev. 2011)

Rule 21.05: Financial Statement Treatment of Certificate of Contribution

A certificate of contribution may be shown by a member insurer in its statutory financial statement as an admitted asset in such form and for such amount, if any, and period of time as the commissioner may by order approve, provided, that a member insurer shall in any event at its option have the right to show a certificate of contribution as an admitted asset at percentages of the amount assessed and paid for calendar years as follows:

A. One hundred percent (100%) for the calendar year of issuance of thecertificate of contribution;

B. Eighty percent (80%) for the first calendar year after the year of issuance of the certificate of contribution;

C. Sixty percent (60%) for the second calendar year after the year of issuance of the certificate of contribution;

D. Forty percent (40%) for the third calendar year after the year of issuance of the certificate of contribution;

E. Twenty percent (20%) for the fourth calendar year after the year of issuance of the certificate of contribution; and

F. Zero percent (0%) for the fifth calendar year after the year of issuance of the certificate of contribution and thereafter.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 21.06: Severability

If any provision of any section of this Regulation or the application thereof to any circumstance or person or entity is held invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effectwithout the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 21.07: Effective Date

This Regulation shall become effective December 31, 1994.

Source: *Miss. Code Ann.* § 25-43-3.106 (Rev. 2010)

Part 1 Chapter 22: Credit for Reinsurance.

Rule 22.01: Authority

This Regulation is promulgated to the authority granted by *Miss. Code Ann*. § 83- 19-157.

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.02: Purpose

The purpose of this regulation is to set forth rules and procedural requirements which the commissioner deems necessary to carry out the provisions of law on Credit for Reinsurance, *Miss. Code Ann.* § 83-19-151 ("the Act"). The actions and information required by this regulation are hereby declared to be necessary and appropriate in the public interest and for the protection of the ceding insurers in this state.

Source: *Miss. Code Ann.* § 83-19-151 (Rev. 2011)

Rule 22.03: Severability

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

Source: *Miss. Code Ann.* § 83-5-1; § 83-19-151 (Rev. 2011)

Rule 22.04: Credit for Reinsurance - Reinsurer Licensed in this State

Pursuant to *Miss. Code Ann*. § 83-19-151(a), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to assuming insurers which were licensed in this state as of the date on which statutory financial statement credit for reinsurance is claimed.

Source: *Miss. Code Ann.* § 83-19-151(a) (Rev. 2011)

Rule 22.05: Credit for Reinsurance - Accredited Reinsurers

A. Pursuant to *Miss. Code Ann.* § 83-19-151(b), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which is accredited as a reinsurer in this state as of the date on which statutory financial statement credit for reinsurance is claimed. An accredited reinsurer must:

1. File a properly executed Form AR-1 (attached as an exhibit to this regulation) as evidence of its submission to this state's jurisdiction and to this state's authority to examine its books and records, and

2. File with the commissioner a certified copy of a letter or a certificate of authority or of compliance as evidence that is licensed to transact insurance or reinsurance in at least one state, or, in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state; and

3. File annually with the commissioner a copy of its annual statement filed with the insurance department of its state or domicile or, in the case of an alien assuming insurer, with the state through which it is entered and in which it is licensed to transact insurance or reinsurance, and a copy of its most recent audited financial statement; and

4. Maintain a surplus as regards policyholders in an amount not less than $20,000,000, or obtain the affirmative approval of the commissioner upon a finding that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers.

B. If the commissioner determines that the assuming insurer has failed to meet or maintain any of these qualifications, he may upon written notice and opportunity for hearing, suspend or revoke the accreditation. Credit shall not be allowed a domestic ceding insurer under this section if the assuming insurer's accreditation has been revoked by the commissioner, or if the reinsurance was ceded while the assuming insurer's accreditation was under suspension by the commissioner.

Source: *Miss. Code Ann.* § 83-19-151 (Rev. 2011)

Rule 22.06: Credit for Reinsurance - Reinsurer Domiciled in Another State

A. Pursuant to *Miss. Code Ann.* § 83-19-151(c) the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer as of any date on which statutory financial statement credit for reinsurance is claimed:

1. Is domiciled and licensed in (or, in the case of a United States branch of an alien assuming insurer, is entered through) a state which employs standards regarding credit for substantially similar to those applicable under the Act and this regulation

2. Maintains a surplus as regards policyholders in an amount not less than $20,000,000; and

3. Files a properly executed Form AR-1 with the commissioner as evidence of its submission to this state's authority to examine its books and records.

B. The provisions of this section relating to surplus as regards policyholders shall not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system. As used in this section, "substantially similar" standards means credit for reinsurance standards which the commissioner determines equal or exceed the standards of the Act and this regulation.

Source: *Miss. Code Ann.* § 83-19-151(c) (Rev. 2011)

Rule 22.07: Credit for Reinsurance - Reinsurers Maintaining Trust Funds

A. Pursuant to *Miss. Code Ann.* § 83-19-151(d), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer which, as of any date on which statutory financial statement credit for reinsurance is claimed, and thereafter for so long as credit for reinsurance is claimed, maintains a trust fund in an amount prescribed below in a qualified United States financial institution as defined in *Miss. Code Ann.* § 83-19-155(b), for the payment of the valid claims of its United States domiciled ceding insurers, their assigns and successors in interest. The assuming insurer shall report annually to the commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers, to enable the commissioner to determine the sufficiency of the trust fund.

B. The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States domiciled insurers, and in addition, the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in paragraph (2) of this subsection.

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

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

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

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

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

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

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

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

4. (a) The trust fund for a group of incorporated insurers under common administration, whose members possess aggregate policyholders surplus of $10,000,000,000 (calculated and reported in substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC) and which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation, shall:

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

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

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

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

C. (1) Credit for reinsurance shall not be granted unless the form of the trust and any amendments to the trust have been approved by either the commissioner of the state where the trust is domiciled or the commissioner of another state who, pursuant to the terms of the trust instrument, has accepted responsibility for regulatory oversight of the trust. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that:

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

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

(c) The trust shall be subject to examination as determined by the commissioner.

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

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

(2) (a) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by this subsection or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws

of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight over the trust or other designated receiver all of the assets of the trust fund.

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

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

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

D. For purposes of this section, the term "liabilities" shall mean the assuming insurer's gross liabilities attributable to reinsurance ceded by U.S. domiciled insurers excluding liabilities that are otherwise secured by acceptable means, and, shall include:

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

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

(b) Reserves for losses reported and outstanding;

(c) Reserves for losses incurred but not reported;

(d) Reserves for allocated loss expenses; and

(e) Unearned premiums.

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

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

(b) Aggregate reserves for accident and health policies;

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

(d) Liabilities for policy and contract claims.

E. Assets deposited in trusts established pursuant to Section 83-19-151 and this section shall be valued according to their current fair market value and shall consist only of cash in U.S. dollars, certificates of deposit issued by a U.S. financial institution as defined in Section 83-19-155(a), clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified U.S. financial institution, as defined in Section 83-19-155(a), and investments of the type specified in this subsection, but investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust shall not exceed five percent (5%) of total investments. No more than twenty percent (20%) of the total of the investments in the trust may be foreign investments authorized under Paragraphs (1)(e), (3), (6)(b) or (7) of this subsection, and no more than ten percent (10%) of the total of the investments in the trust may be securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in U.S. dollars and representing rights conferred by a foreign security shall be classified as a foreign investment denominated in a foreign currency. The assets of a trust established to satisfy the requirements of Section 83-19-151 shall be invested only as follows:

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

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

(b) A state of the United States;

(c) A territory, possession or other governmental unit of the United States;

(d) An agency or instrumentality of a governmental unit referred to in Subparagraphs (b) and (c) of this paragraph if the obligations shall be by law (statutory ~~of~~ or otherwise) payable, as to both principal and interest, from taxes levied or by law required to be levied or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but shall not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements; or

(e) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC;

(2) Obligations that are issued in the United States, or that are dollar denominated and issued in a non-U.S. market, by a solvent U.S. institution (other than an insurance

company) or that are assumed or guaranteed by a solvent U.S. institution (other than an insurance company) and that are not in default as to principal or interest if the obligations:

(a) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated, are similar in structure and other material respects to other obligations of the same institution that are so rated;

(b) Are insured by at least one authorized insurer (other than the investing insurer or a parent, subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance, are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC; or

(c) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC;

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

(4) An investment made pursuant to the provisions of Paragraph (1), (2) or (3) of this subsection shall be subject to the following additional limitations:

(a) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities shall not exceed five percent (5%) of the assets of the trust;

(b) An investment in any one mortgage-related security shall not exceed five percent (5%) of the assets of the trust;

(c) The aggregate total investment in mortgage-related securities shall not exceed twenty-five percent (25%) of the assets of the trust; and

(d) Preferred or guaranteed shares issued or guaranteed by a solvent U.S. institution are permissible investments if all of the institution's obligations are eligible as investments under Paragraphs (2)(a) and (2)(c) of this subsection, but shall not exceed two percent (2%) of the assets of the trust.

(5) As used in this regulation:

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

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

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

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

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

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

(6) Equity interests

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

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

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

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

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

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

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

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

(8) Investment companies

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

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

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

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

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

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

(9) Letters of Credit

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

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

F. A specific security provided to a ceding insurer by an assuming insurer pursuant to Rule 22.11 of this regulation shall be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security prior to, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this section.

Source: *Miss. Code Ann.* § 83-19-151(d); § 83-19-155(b) (Rev. 2011)

Rule 22.08: Credit for Reinsurance – Certified Reinsurers

Pursuant to *Miss. Code Ann*. § 83-19-151(e), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this section. The credit allowed shall be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the commissioner. The security shall be in a form consistent with the provisions of *Miss. Code Ann*. § 83-19-151(e) and Rules 22.12, 22.13 or 22.14 of this Regulation. The amount of security required in order for full credit to be allowed shall correspond with the following requirements:

(1)

Ratings	**Security Required**
Secure – 1	0%
Secure – 2	10%
Secure – 3	20%
Secure – 4	50%
Secure – 5	75%
Vulnerable – 6	100%

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

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

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

Line 1: Fire

(a) Line 2: Allied Lines
(b) Line 3: Farmowners multiple peril
(c) Line 4: Homeowners multiple peril
(d) Line 5: Commercial multiple peril

(e) Line 9: Inland Marine
(f) Line 12: Earthquake
(g) Line 21: Auto physical damage

(5) Credit for reinsurance under this section shall apply only to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into prior to the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, shall only be subject to this section with respect to losses incurred and reserves reported from and after the effective date of the amendment or new contract.

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

B. Certification Procedure.

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

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

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

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

(b) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000 calculated in accordance with Subparagraph (4)(h) of this subsection. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital

and surplus equivalents (net of liabilities) of at least $250,000,000 and a central fund containing a balance of at least $250,000,000.

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

(i) Standard & Poor's;
(ii) Moody's Investors Service;
(iii) Fitch Ratings;
(iv) A.M. Best Company; or
(v) Any other Nationally Recognized Statistical Rating Organization.

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

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

(a) The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The commissioner shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least two financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification:

Ratings	Best	S&P	Moody's	Fitch

Secure – 1	A++	AAA	Aaa	AAA
Secure – 2	A+	AA+, AA, AA-	Aa1, Aa2, Aa3	AA+, AA, AA-
Secure – 3	A	A+, A	A1, A2	A+, A
Secure – 4	A-	A-	A3	A-
Secure – 5	B++, B+	BBB+, BBB, BBB-	Baa1, Baa2, Baa3	BBB+, BBB, BBB-
Vulnerable – 6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

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

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

(d) For certified reinsurers not domiciled in the U.S., a review annually of Form CR-F (for property/casualty reinsurers) or Form CR-S (for life and health reinsurers) (attached as exhibits to this regulation);

(e) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than ninety (90) days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership;

(f) Regulatory actions against the certified reinsurer;

(g) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in paragraph (h) below;

(h) For certified reinsurers not domiciled in the U.S., audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-U.S. jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the commissioner will consider audited financial statements for the last two (2) years filed with its non-U.S. jurisdiction supervisor;

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

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

(k) Any other information deemed relevant by the commissioner.

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

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

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

(6) The assuming insurer must submit a properly executed Form CR-1 (attached as an exhibit to this regulation) as evidence of its submission to the jurisdiction of this state, appointment of the commissioner as an agent for service of process in this state, and agreement to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable to reinsurance ceded by U.S. ceding insurers if it resists

enforcement of a final U.S. judgment. The commissioner shall not certify any assuming insurer that is domiciled in a jurisdiction that the commissioner has determined does not adequately and promptly enforce final U.S. judgments or arbitration awards.

(7) The certified reinsurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers which are not otherwise public information subject to disclosure shall be exempted from disclosure under *Miss. Code Ann*. §§ 25-61-1 through 25-61-19 and shall be withheld from public disclosure. The applicable information filing requirements are, as follows:

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

(b) Annually, Form CR-F or CR-S, as applicable as provided in this regulation as Rule 22.18 and Rule 22.19, respectively;

(c) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in Subsection (d) below;

(d) Annually, audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last two (2) years filed with the certified reinsurer's supervisor;

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

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

(g) Any other information that the commissioner may reasonably require.

(8) Change in Rating or Revocation of Certification.

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

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

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

(d) Upon revocation of the certification of a certified reinsurer by the commissioner, the assuming insurer shall be required to post security in accordance with Rule 22.11 in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust in accordance with Rule 22.07, the commissioner may allow additional credit equal to the ceding insurer's *pro rata* share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of three (3) months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the commissioner to be at high risk of uncollectibility.

C. Qualified Jurisdictions.

(1) If, upon conducting an evaluation under this section with respect to the reinsurance supervisory system of any non-U.S. assuming insurer, the commissioner determines that the jurisdiction qualifies to be recognized as

a qualified jurisdiction, the commissioner shall publish notice and evidence of such recognition in an appropriate manner. The commissioner may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.

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

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

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

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

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

(e) The domiciliary regulator’s willingness to cooperate with U.S. regulators in general and the commissioner in particular.

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

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

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

(i) Any other matters deemed relevant by the commissioner.

(3) A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification with respect to the criteria provided under Subsections 8.C(2)(a) to (i).

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

D. Recognition of Certification Issued by an NAIC Accredited Jurisdiction.

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

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

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

(4) The commissioner may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the commissioner suspends or revokes the certified reinsurer's certification in accordance with Subsection (B)(8) of this section, the certified reinsurer's certification shall remain in good standing in this state for a period of three (3) months, which shall be extended if additional time

is necessary to consider the assuming insurer's application for certification in this state.

E. Mandatory Funding Clause. In addition to the clauses required under Rule 22.15, reinsurance contracts entered into or renewed under this section shall include a proper funding clause, which requires the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this section for reinsurance ceded to the certified reinsurer.

F. The commissioner shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

Source: *Miss. Code Ann.* § 83-19-151(e) (Rev. 2011)

Rule 22.09: Credit for Reinsurance—Reciprocal Jurisdictions

A. Pursuant to *Miss. Code Ann*. §83-19-151(f), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by and has its head office or is domiciled in a Reciprocal Jurisdiction, and which meets the other requirements of this regulation.

B. A "Reciprocal Jurisdiction" is a jurisdiction, as designated by the commissioner pursuant to Subsection D, that meets one of the following:

(1) A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and the European Union, is a member state of the European Union. For purposes of this subsection, a "covered agreement" is an agreement entered into pursuant to the Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. §§ 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

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

(3) A qualified jurisdiction, as determined by the commissioner pursuant to *Miss. Code Ann*. § 83-19-151(e)(iii) and Rule 22.08 (c) of this Regulation, which is not otherwise described in paragraph (1) or (2) above and which the commissioner determines meets all of the following additional requirements:

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) If the assuming insurer has its head office or is domiciled in a Reciprocal Jurisdiction as defined in Section (B)(1) of this section, the ratio specified in the applicable covered agreement;

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

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

(4) The assuming insurer must agree to and provide adequate assurance, in the form of a properly executed Form RJ-1 (attached as an exhibit to this regulation), of its agreement to the following:

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

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

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

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

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

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

(e) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement, which involves this state's ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide one hundred percent (100%) security to the ceding insurer consistent with the terms of the scheme should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of *Miss. Code Ann.* §§83-19-151(e) and 83-19-153, and Rules 22.12, 22.13 or 22.14 of this Regulation. For purposes of this Regulation, the term "solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor, or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis, and which may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.

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

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

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

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

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

(d) Prior to entry into the reinsurance agreement and not more than semi-annually thereafter, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in Paragraph (6) of this subsection.

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

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

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

(c) The aggregate amount of reinsurance recoverable on paid losses which are not in dispute, but are overdue by 90 days or more,

exceeds $50,000,000, or as otherwise specified in a covered agreement.

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

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

D. The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

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

(2) The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets one or more of the requirements of a Reciprocal Jurisdiction, as provided by applicable law, regulation, or in accordance with a process published through the NAIC Committee Process, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under Section (B)(1) and (2). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to *Miss. Code Ann*. §§ 83-19-151 through 83-19-157 or this regulation

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

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

(2) When requesting that the commissioner defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly

executed Form RJ-1 and additional information as the commissioner may require. A state that has received such a request will notify other states through the NAIC Committee Process and provide relevant information with respect to the determination of eligibility.

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

(1) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Rule 22.11.

(2) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Rule 22.11.

G. Before denying statement credit or imposing a requirement to post security with respect to Section F of this section or adopting any similar requirement that will have substantially the same regulatory impact as security, the commissioner shall:

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

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

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

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

H. If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined

appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

Source: *Miss. Code Ann.* § 83-19-151(f) (Rev. 2011)

Rule 22.10: Credit for Reinsurance Required by Law

Pursuant to *Miss. Code Ann.* §83-19-151(g), the commissioner shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of *Miss. Code Ann*. §§ 83-19-151(a), (b), (c), (d), ~~or~~ (e), or (f) but only as to the insurance of risks located in jurisdictions where the reinsurance is required by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means state, district or territory of the United States and any lawful national government.

Source: *Miss. Code Ann.* § 83-19-151(f) (Rev. 2011)

Rule 22.11. Asset or Reduction from Liability for Reinsurance Ceded to an Unauthorized Assuming Insurer not Meeting the Requirements of Rules 22.04 through 22.10.

A. Pursuant to *Miss. Code Ann.* § 83-19-153, the commissioner shall allow a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of *Miss. Code Ann*. § 83-19-151 in an amount not exceeding the liabilities carried by the ceding insurer. Such reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations under the reinsurance contract. Such security must be held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer or, in the case of a trust, held in a qualified United States financial institution as defined in *Miss. Code Ann*. § 83-19-155. This security may be in the form of any of the following:

1. Cash.

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

3. Clean, irrevocable, unconditional and "evergreen" letters of credit issued or confirmed by a qualified United States institution, as defined in *Miss. Code Ann*. § 83-19-155(a), effective no later than December 31 of the year for which filing is being made, and in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance (or confirmation) shall, notwithstanding the issuing (or confirming) institution's subsequent failure to meet applicable

standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs.

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

B. An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant this section shall be allowed only when the requirements of Rule 22.15 and the applicable portions of Rules 22.12, 22.13, or 22.14 of this regulation have been satisfied.

Source: *Miss. Code Ann.* § 83-19-153; § 83-19-155 (Rev. 2011)

Rule 22.12: Trust Agreements Qualified Under Rule 22.11.

A. As used in this section:

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

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

3. "Obligations", as used in Subsection (B)(11) of this section, means:

a. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

b. Reserves for reinsured losses reported and outstanding;

c. Reserves for reinsured losses incurred but not reported; and

d. Reserves for allocated reinsured loss expenses and unearned premiums.

B. Required conditions.

1. The trust agreement shall be entered into between the beneficiary, the grantor and a trustee which shall be a qualified United States financial institution as defined in *Miss. Code Ann.* § 83-19-155(b).

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

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

4. The trust agreement shall provide that:

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

    b. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

    c. It is not subject to any conditions or qualifications outside of the trust agreement; and

    d. It shall not contain references to any other agreements or documents except as provided for under Paragraph (11) and (12) of this subsection.

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

6. The trust agreement shall require the trustee to:

    a. Receive assets and hold all assets in a safe place;

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

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

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

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

    f. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of but with notice to the beneficiary, upon call or

maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

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

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

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

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

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

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

    b. To make payment to the assuming insurer of any amounts held in the trust account that exceeded 102 percent of the actual amount required to fun the assuming insurer's obligations under the specific reinsurance agreement; or

    c. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged ten

(10) days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution as defined in *Miss. Code Ann*. § 83-19-155(b) apart from its general assets, in trust for such uses and purposes specified in Subparagraphs (a) and (b) above as may remain executor after such withdrawal and for any period after the termination date.

12. Notwithstanding other provisions of this regulation, when a trust agreement is established to meet the requirements of Rule 22.11 in conjunction with a reinsurance agreement covering life, annuities or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for the following purposes:

    a. To pay or reimburse the ceding insurer for:

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

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

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

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

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

C. Permitted conditions.

1. The trust agreement may provide that the trustee may resign upon delivery of a written notice of resignation, effective not less than ninety (90) days after the beneficiary and grantor receive the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than ninety (90) days after the trustee and the beneficiary receive the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

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

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

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

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

D. Additional conditions applicable to reinsurance agreements.

1. A reinsurance agreement may contain provisions that:

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

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

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

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

i. To pay or reimburse the ceding insurer for:

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

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

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

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

2. The reinsurance agreement may also contain provisions that:

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

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

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

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

c. Permit the award by any arbitration panel or court of competent jurisdiction of:

i. Interest at a rate different from that provided in Subparagraph (b) of this paragraph;

ii. Court of arbitration costs,

iii. Attorney's fees, and

iv. Any other reasonable expenses.

3. Financial reporting. A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with this department in compliance with the provisions of this regulation when established on or before the date of filing of the financial statement of the ceding insurer. Further, the reduction for the existence of an

acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

4. Existing agreements. Notwithstanding the effective date of this regulation, any trust agreement or underlying reinsurance agreement in existence prior to December 31, 1996, will continue to be acceptable until January 1, 1997, at which time the agreements will have to be in full compliance with this regulation for the trust agreement to be acceptable.

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

Source: *Miss. Code Ann.* §§83-19-155(b); 83-19-157 (Rev. 2011)

Rule 22.13: Letters of Credit Qualified Under Rule 22.11.

A. The letter of credit must be clean, irrevocable and unconditional and issued or confirmed by a qualified United States financial institution as defined in *Miss. Code Ann*. § 83-19-155(a). The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in Subsection H(1) of this section. As used in this section, "beneficiary" means the domestic insurer for whose benefit the letter of credit has been established and any successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator or liquidator).

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

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

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

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

F. If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce Publication 600 (UCP 600) or International Standby Practices of the International Chamber of Commerce Publication 590 (ISP98), or any successor publication, then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 36 of Publication 600 or any other successor publication, occur.

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

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

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

H. Reinsurance agreement provision.

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

a. Require the assuming insurer to provide letters of credit to the ceding insurer and specify what they are to cover.

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

i. To pay or reimburse the ceding insurer for:

I. The assuming insurer's share under the specific reinsurance agreement of premiums returned, but

not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

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

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

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

c. All of the foregoing provisions of Paragraph (1) of this subsection shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

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

a. An interest payment, at a rate not in excess of the prime rate of interest, on the amounts held pursuant to Paragraph (1)(b)(III) of this subsection; or

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

Source: *Miss. Code Ann.* § 83-19-155(a); § 83-19-157 (Rev. 2011)

Rule 22.14: **Other Security**

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States subject to withdrawal solely by the ceding insurer and under its exclusive control.

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.15: **Reinsurance Contract**

Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of Rules 22.04, 22.05. 22.06, 22.07, 22.08, 22.09 or 22.11 of this regulation or otherwise in compliance with *Miss. Code Ann*. § 83-19-151 after the adoption of this regulation unless the reinsurance agreement:

A. Includes a proper insolvency clause, which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company, pursuant to *Miss. Code Ann*. § 83-6-38 ; and

B. Includes a provision pursuant to *Miss. Code Ann.* § 83-19-151(f) whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternate dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel, and

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

Source: *Miss. Code Ann.* § 83-19-151 (Rev. 2011)

Rule 22.16: Contracts Affected

All new and renewal reinsurance transactions entered into on or after July 1, 2017, shall conform to the requirements of the Act and this Regulation, as amended, if credit is to be given to the ceding insurer for such reinsurance.

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.17: Form AR-1: Certificate of Assuming Insurer

FORM AR-1

CERTIFICATE OF ASSUMING INSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in

_____, hereby certify that
(name of state)

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in_____
(ceding insurer's state of domicile)

for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Commissioner of _____ to examine
(ceding insurer's state of domicile)
its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____
(ceding insurer's state of domicile)
reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated: _____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.18: Form CR-1: Certificate of Certified Reinsurer

FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)

under a reinsurance agreement with one or more insurers domiciled in _____,
(name of state)

in order to be considered for approval in this state, hereby certify that

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer's state of domicile)
for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with [cite relevant provision of the state equivalent of the Credit for Reinsurance Model Regulation].

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with [cite relevant provision of the state equivalent of the Credit for Reinsurance Model Regulation].

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____ _____
(name of assuming insurer)

BY: _____
(name of officer)

_____
(title of officer)

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 20.19. FORM RJ-1

CERTIFICATE OF REINSURER DOMICILED IN RECIPROCAL JURISDICTION

I, _____, _____
(name of officer) (title of officer)
of _____, the assuming insurer
(name of assuming insurer)
under a reinsurance agreement with one or more insurers domiciled in _____,
(name of state)
in order to be considered for approval in this state, hereby certify that
_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in [Name of State] for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. The assuming insurer agrees that it will include such consent in each reinsurance agreement, if requested by the commissioner. Nothing in this paragraph constitutes or should be understood to constitute a waiver of assuming insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws.

2. Designates the Insurance Commissioner of [Name of State] as its lawful attorney in and for the [Name of State] upon whom may be served any lawful process in any action, suit or proceeding in this state arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

4. Agrees to provide prompt written notice and explanation if it falls below the minimum capital and surplus or capital or surplus ratio, or if any regulatory action is taken against it for serious noncompliance with applicable law.

5. Confirms that it is not presently participating in any solvent scheme of arrangement, which involves insurers domiciled in [Name of State]. If the assuming insurer enters into such an arrangement, the assuming insurer agrees to notify the ceding insurer and the commissioner, and to provide 100% security to the ceding insurer consistent with the terms of the scheme.

6. Agrees that in each reinsurance agreement it will provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final U.S. judgment, that is enforceable under the law of the territory in which it was obtained, or a properly enforceable arbitration award whether obtained by the ceding insurer or by its resolution estate, if applicable.

7. Agrees to provide the documentation in accordance with of Rule 22.09(C)(5) of the Credit for Reinsurance Model Regulation, if requested by the commissioner.

Dated: _____ _____
(name of assuming insurer)
BY: _____
(name of officer)

_____
(title of officer)

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.20 Form CR-F

Form CR-F – PART 1

Assumed Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	Reinsurance On			9	10	11	12	13	14	15
					6	7	8							
Company Code or ID Number		Name of Reinsured	Domiciliary Jurisdiction	Assumed Premium	Paid Losses and Loss Adjustment Expenses	Known Case Losses and LAE	Cols. 6 + 7	Contingent Commissions Payable	Assumed Premiums Receivable	Unearned Premium	Funds Held By or Deposited With Reinsured Companies	Letters of Credit Posted	Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit	Amount of Assets Pledged or Collateral Held in Trust
9999999 Totals														

Form CR-F – PART 2

Ceded Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	6	Reinsurance Recoverable On									Reinsurance Payable		18	19
						7	8	9	10	11	12	13	14	15	16	17		
Company Code or ID Number		Name of Reinsurer	Domiciliary Jurisdiction	Reinsurance Contracts Ceding 75% or More of Direct Premiums Written	Reinsurance Premiums Ceded	Paid Losses	Paid LAE	Known Case Loss Reserves	Known Case LAE Reserves	IBNR Loss Reserves	IBNR LAE Reserves	Unearned Premiums	Contingent Commissions	Cols. 7 through 14 Totals	Ceded Balances Payable	Other Amounts Due to Reinsurers	Net Amount Recoverable From Reinsurers Cols. 15 – [16 + 17]	Funds Held by Company Under Reinsurance Treaties
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9999999 Totals					....	....	....	....	....	....	....	....	....	....	....	....	....	....

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Rule 22.21. Form CR-S

Form CR-S – PART 1 – SECTION 1

Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Location	6 Type of Reinsurance Assumed	7 Amount of In Force at End of Year	8 Reserve	9 Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 1 – SECTION 2

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Domiciliary Jurisdiction	6 Type of Reinsurance Assumed	7 Premiums	8 Unearned Premiums	9 Reserve Liability Other Than For Unearned Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
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Totals											

Form CR-S – PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Paid Losses	7 Unpaid Losses
Totals—Life, Annuity and Accident and Health						

Form CR-S – PART 3 – SECTION 1

Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Type of Reinsurance Ceded	7 Amount in Force at End of Year	Reserve Credit Taken		10 Premiums	Outstanding Surplus Relief		13 Modified Coinsurance Reserve	14 Funds Withheld Under Coinsurance
							8 Current Year	9 Prior Year		11 Current Year	12 Prior Year		
Totals													

Form CR-S – PART 3 – SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Type	7 Premiums	8 Unearned Premiums (Estimated)	9 Reserve Credit Taken Other than for Unearned Premiums	Outstanding Surplus Relief		12 Modified Coinsurance Reserve	13 Funds Withheld Under Coinsurance
									10 Current Year	11 Prior Year		
Totals												

Source: *Miss. Code Ann.* § 83-19-157 (Rev. 2011)

Part 1 Chapter 23: (98-3) Guidelines for Sale of Insurance by Financial Institutions in the State of Mississippi.

Rule 23.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by *Miss. Code Ann.* §§ 25-43-1 *et seq.*, 83-5-1 and 83-17-211, and is promulgated in accordance with Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Department of Insurance.

Source: *Miss. Code Ann.* § 25-43-1 *et seq.*; § 83-5-1 and § 83-17-211 (Rev. 2011)

Rule 23.02: Purpose

The purpose of this regulation is to provide guidelines under which financial institutions may sell insurance in the State of Mississippi and to protect the interests of the insurance policyholders of this state.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.03: Definitions

A. "Financial institution" shall mean a bank, savings bank, savings and loan association, trust company, credit union or any depository institution as defined by the Federal Deposit Insurance Act, and any other individual, corporation, partnership or association engaged in the taking or brokering of deposits or in the making or brokering of loans in this state. The term "financial institution" shall also include any person, including an insurance company that is soliciting the sale or purchase of insurance recommended or sponsored by, on the premises of, or in connection with a product offering of, a financial institution, regardless of whether the financial institution is located in the state. Except as otherwise set forth in this Section 3(A), the term "financial institution" does not include an insurance company.

B. The term "insurance" includes all products defined or regulated as insurance by Title 83, Mississippi Code of 1972, except:

    1. Credit property as defined in *Miss. Code Ann.* § 83-17-1, credit life, accident and health; credit involuntary unemployment insurance, mortgage life; and mortgage accident and health;

    2. Insurance placed by a financial institution in connection with collateralpledged as security for a loan when the debtor breaches the contractual obligation to provide that insurance;

    3. Private mortgage insurance;

4. Land Title; and

5. Travel Accident and Baggage.

C. The term "loan" means an agreement to lend money or to finance goods or services. The term "loan" does not include the financing of insurance premiums, loans made by broker-dealers registered in accordance with applicable State and Federal securities laws that are wholly collateralized by securities, or a loan from the cash value of an insurance policy.

D. The terms "agent" and "agency" shall include all persons or entities as defined by Title 83, Mississippi Code of 1972.

E. The term "person" shall include any natural person, partnership, corporation, association, unincorporated organization, or other form of business enterprise, plural or singular, as the case demands.

Source: *Miss. Code Ann.* § 83-17-1 (Rev. 2011)

Rule 23.04: Regulatory Authority

All financial institutions that are authorized to engage in the solicitation and sale of insurance products are subject to the insurance laws of the State of Mississippi and all other regulations of the Mississippi Department of Insurance and other applicable provisions of law.

Source: *Miss. Code Ann.* § 83-5-1; § 83-17-15 (Rev. 2011)

Rule 23.05: Licensure Requirement

Solicitation for the purchase or sale of any insurance products shall be conducted only by persons or entities who have complied with all applicable state insurance licensing, appointment laws and regulations and who have been issued an agent or broker's license pursuant to Miss. Code Ann. § 83-17-1, et seq. However, employees of financial institutions who are not licensed as an agent or broker may make referrals of financial institution customers or prospects to licensed agents and receive a one-time nominal fee per referral of a fixed dollar amount for each customer consistent to referral fees received in other non-deposit investment products. The term "nominal fee" means an amount not to exceed Twenty Dollars ($20.00). The payment of this referral fee cannot depend on whether the referral results in the sale or issuance of an insurance product or service.

Source: *Miss. Code Ann.* § 83-17-19; § 83-17-25 (Rev. 2011)

Rule 23.06: Separate Transactions, Records and Documents

It is strongly recommended that insurance sales activities be conducted throughseparate divisions or subsidiaries. However, whether the financial institution obtains an agency license or operates

through a subsidiary, division or affiliated agency, separate records must be maintained for all insurance transactions distinct from any other activities in connection with a loan or other credit transaction. These records shall be made available to the Mississippi Department of Insurance for inspection. The credit and insurance transactions must be completed separately and through separate documents.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.07: Extensions of Credit

No person shall delay or impede the completion of a loan transaction or other transactions involving the extension of credit for the purpose of influencing a customer to purchase insurance from them or through any affiliated entity.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.08: Insurance and Financial Institution Products

A. No person may offer banking products or services, or fix or vary the consideration of the offer, on a condition or requirement that the customer obtain insurance from the financial institution or any affiliate of the financial institution.

B. A financial institution that offers banking products or services in conformity with the provisions of 106 of the Bank Holding Company Act Amendments of 1970 (12 U.S.C. 1972), shall be deemed to be in compliance with the provisions of subsection (A) of this section.

C. No person shall require that a customer or prospective customer purchase an insurance product from any particular insurance agent as a condition for the lending of money or extension of credit, the establishment or maintenance of a checking, savings, or other deposit account, the establishment or maintenance of a trust account, or the provision of services related to any such activities.

D. No person may offer an insurance product in combination with banking products unless the insurance products and banking products are available separately.

E. No person may include the expense of insurance premiums in the primary credit transaction without the express written consent of the customer.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.09: Rebating and Discounting

A. No person may offer a rebate on an insurance product in violation of *Miss. Code Ann.* § 83-3-121 (Rev. 1991).

B. No person may offer a discount on a loan or extension of credit for the purpose of inducing the customer to purchase insurance required in connection with the loan or extension of credit.

Source: *Miss. Code Ann.* § 83-3-121 (Rev. 2011)

Rule 23.10: Discrimination

No financial institution may:

A. Require as a condition of providing any product or service or renewal of any contract for providing a product or service to any customer, that the customer acquire, finance, or negotiate any policy or contract of insurance through a particular insurer or insurance agent.

B. In connection with a loan or extension of credit that requires a borrower to obtain insurance, reject an insurance policy solely because the policy has been issued or underwritten by any person who is not associated with a particular entity;

C. Impose any requirement or additional charge for any insurance purchased from an agent who is not associated with a financial institution that is not imposed on any insurance agent who is associated with the financial institution.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.11: Disclosure

A. A financial institution shall prominently disclose in writing, in clear and concise language, to customers, including in any advertisement or promotional material, and orally during any customer contact, that the insurance product offered, recommended, sponsored, or sold:

1. Is not a deposit;

2. Is not insured by the Federal Deposit Insurance Corporation, or in the case of a credit union, by the National Credit Union Share Insurance Fund;

3. Is not guaranteed by the insured financial institution or an affiliated insured depository institution; and

4. Where appropriate, involves investment risk, including potential loss of principal.

B. Any financial institution that requires a customer to obtain insurance in connection with a loan or other extension of credit and that offers insurance either directly or through an affiliate shall clearly disclose to the customer their choice of insurance provider will not affect the decision of the financial institution in extending credit to the customer.

C. Any person required under subsections (A) or (B) of this section to make disclosures to a customer shall obtain a written acknowledgement of receipt by the customer of such disclosures, including the date of receipt and the customer's name and address, prior to or at the time of the execution of any application for insurance sold by the person. Such acknowledgement shall be in a separately executed document or in a separately signed section of the application for insurance. The acknowledgement required by this paragraph shall not be required if an executed application for insurance or other document by which the customer applies for insurance is not submitted in writing or is not executed by the customer.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.12: Misleading Advertising

No person may employ any advertisement that would mislead or otherwise cause a reasonable person to believe mistakenly that the State of Mississippi or the federal government is responsible for the insurance sales activities of the financial institution or stands behind the financial institution's credit, or that the financial institution, the State of Mississippi, or the federal government guarantees any returns on insurance products or is a source of payment of any insurance obligation of or sold by the financial institution.

Source: *Miss. Code Ann.* § 83-49-19 (Rev. 2011)

Rule 23.13: Commissions and Compensation

No person shall pay directly or indirectly, any commission, service fee, brokerage or other valuable consideration to any person for services as an insurance agent, unless the person performing the service holds a valid license for the class of insurance as to which the service is rendered. No person or agency shall accept any commission, service fee, brokerage or other valuable consideration for such services unless properly licensed in accordance with the Mississippi Department of Insurance. However, referral fees as provided in Section 5 are authorized.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.14: Confidential Customer Information

A. A financial institution may not release a customer's insurance information to any person other than an officer, director, employee, agent, or affiliate of the financial institution without the written consent of the customer. For the purposes of this Section, "insurance information" means information concerning the premiums, terms and conditions of insurance coverage, insurance claims, and the insurance history of a customer contained in the financial institution's records.

B. Subsection (A) of this section shall not apply to:

1. Names, addresses and telephone numbers derived in any manner from the financial institution's records; or

2. The release of insurance information as otherwise authorized or prohibited by State or federal law.

C. A financial institution shall not require premium information when requiring evidence of insurance in connection with a loan or extension of credit and shall not use such premium information for the purpose of soliciting insurance without the written consent of the customer.

D. A financial institution may not use health information obtained from a customer's insurance records for any purpose other than for its own activities pursuant to this Code.

Source: *Miss. Code Ann.* § 83-6-29 (Rev. 2011)

Rule 23.15: Severability

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

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 23.16: Effective Date

This regulation shall become effective March 31, 1999.

Source: *Miss. Code Ann.* § 25-43-3.106 (Rev. 2010)

Part 1 Chapter 24: Prescribing Mississippi Life and Health Insurance Guaranty Association Summary Document and Requiring Delivery of Summary Document to Policy or Contract Owner at Time of Delivery of Policy or Contract.

Rule 24.01. Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by *Miss. Code Ann.* §§ 83-5-1 and 83-23-235 in order to implement the provisions of the Mississippi Life and Health Insurance Guaranty Association Act, as amended, and is promulgated in accordance with 19 Miss. Admin. Code, Part 1, Chpt. 15 (formerly Mississippi Department of Insurance Regulation No. 88-101), said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §§83-5-1; 83-23-235 (Rev. 2011); Senate Bill 2227, 2020 Regular Session.

Rule 24.02. Purpose

The purpose of this Regulation is to implement *Miss. Code Ann.* § 83-23-235 by prescribing the form and content of the summary document describing the general purposes and current limitations of the Mississippi Life and Health Insurance Guaranty Association Act.

Source: *Miss. Code Ann.* §83-23-235 (Rev. 2011)

Rule 24.03. Application and form of summary document

No insurer may issue or deliver a life, health or annuity policy or contract to a policy or contract owner and no health maintenance organization (HMO) may issue or deliver a health maintenance organization subscriber contract or certificate in the State of Mississippi unless a summary document describing the general purposes and current limitations of the Mississippi Life and Health Insurance Guaranty Association Act is delivered to the policy or contract owner at the time of delivery of the policy or contract. The summary document shall also be available upon request by a policy or contract owner. Insurers and HMOs shall retain evidence of compliance with *Miss. Code Ann.* § 83-23-235(2) and this Regulation for so long as the policy or contract for which the notice is given remains in effect.

Such summary document shall be in the form attached hereto as Appendix A, which is hereby made a part of this Regulation. Insurers and HMOs may print the summary document on a separate sheet of paper but shall use the order, format and content of the summary document, as approved and prescribed by the Commissioner of Insurance. The summary document shall be printed or typed in easy-to-read type, size and style.

A form filing is not required for the summary document. The summary document shall not be made a part of the policy or contract with which it must be delivered.

Source: *Miss. Code Ann.* §83-23-235 (Rev. 2011); Senate Bill 2227, 2020 Regular Session.

Rule 24.04. Severability

If any provision of any section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of this Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 24.05. Effective Date

This Regulation shall become effective on and after January 1, 2021. Insurers and HMOs must begin using the summary document attached as Appendix "A" not later than sixty (60) days after

the effective date. In the interim, insurers may continue to use the summary document provided for in Rule 24.06 that became effective May 12, 2014.

Source: *Miss. Code Ann.* § 25-43-3.113(2)(b)(i) (Rev. 2010); Senate Bill 2227, 2020 Regular Session.

Rule 24.06: Appendix A- Summary Document

APPENDIX "A"

NOTICE OF PROTECTION PROVIDED BY
MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Mississippi Life and Health Insurance Guaranty Association (the "Association") and the protection it provides for policyholders. This safety net was created by Mississippi law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurer becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Mississippi law, with funding from assessments paid by other insurance companies. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

The basic protections provided by the Association are:

Life Insurance
- $300,000 in death benefits
- $100,000 in net cash surrender and net cash withdrawal values

Health Insurance
- $500,000 for health benefit plans (see definition below)
- $300,000 in disability income insurance benefits
- $300,000 in long-term care insurance benefits
- $100,000 in other types of health insurance benefits

Annuities
- $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in Miss. Code Ann. § 83-23-209 and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies

that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance (LTCI).

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Mississippi law.
Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

To learn more about the above protections, limitations and exclusions, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.mslifega.org, or contact:

Mississippi Life and Health Insurance Guaranty Association 330 North Mart Plaza Jackson, MS 39206-5327 601-981-0755	Mississippi Insurance Department Woolfolk Building 501 N. West Street, Suite 1001 Jackson, MS 39201 601-359-3569

To file a complaint or seek information about the financial condition of an insurer, contact the Mississippi Insurance Department.

Your insurer is required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation or inducement to purchase any form of insurance.

Source: *Miss. Code Ann.* §83-23-235 (Rev. 2011); Senate Bill 2227, 2020 Regular Session.

Part 1 Chapter 25: (2000-4) Guidelines for an Agent in Advancing an Insurance Premium for an Insured.

Rule 25.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. § 83-3-121 (Supp. 2000), as well as the provisions in the Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §83-3-121 (Rev. 2011)

Rule 25.02: Purpose

The purpose of this Regulation is to ensure reasonable standards for insurance agents who are in good faith advancing an insurance premium for the insured under Miss. Code Ann. § 83-3-121 (Supp. 2000).

Source: M*iss. Code Ann.* §83-3-121 (Rev. 2011)

Rule 25.03: Permissible Interest Rates

No insurance agent may issue or deliver any insurance policy in which they advanced the premium for the insured unless such advancement was made with an interest rate equal or lower than one and one-half percent (1.5%) per month.

Source: M*iss. Code Ann.* §83-3-121 (Rev. 2011)

Rule 25.04: Time Limits for Advancement

No insurance agent may issue or deliver any insurance policy in which they advanced the premium for the insured unless, within the original terms of credit, such advancement is to be repaid within 90 days. However, if insured is delinquent in payment, the agent may continue to charge the interest rate as specified in section 3 of this regulation until the payment is received.

Source: M*iss. Code Ann.* §83-3-121 (Rev. 2011)

Rule 25.05: Agent Responsibility During an Investigation

In the event of an investigation concerning this regulation, the agent will be responsible for supplying documentation of compliance. This documentation includes, but is not limited to, the original terms of credit and any effort to collect delinquent payments. Any noncompliance will be punished in accordance with Miss. Code Ann. §§ 83-17-123, 83-17-221, 83-5-45 and all other statutes allowing the Commissioner of Insurance to take regulatory actions for violations of Mississippi law and any regulationof the Mississippi Department of Insurance.

Source: M*iss. Code Ann.* §83-17-87 (Rev. 2011)

Rule 25.06: Severability

If any provision of any section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: M*iss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 25.07: Effective Date

This Regulation shall become effective November 13, 2000.

Source: *Miss. Code Ann.* § 25-43-3.133 (Rev. 2010)

Part 1 Chapter 26: **(**2000-5) Compliance with Health Insurance Portability and Accountability Act of 1996.

Rule 26.01: Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Miss. Code Ann. §§ 83-1-43 and 83-5-1 (Rev. 1999), and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure Before the MississippiInsurance Department.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.02: Purpose

It is the purpose of this Regulation to require full compliance with certain provisions contained in the Health Insurance Portability and Accountability Act of 1996, as Amended (hereinafter "HIPAA"), by health insurance issuers which offer group or individual health insurance coverage in the State of Mississippi.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.03: Definitions

A. For purposes of this Regulation, the term "health insurance issuer" means any insurance company, hospital or medical service plan or any entitydefined in Miss. Code Ann. § 83-41-303(n) (Rev. 1999), which offers group or individual health insurance coverage in the State of Mississippi.

B. For purposes of this Regulation, the terms "medical care", "health insurance coverage", "individual health insurance coverage", "health status-related factor", "network plan", "placed for adoption", "individual market", "large employer", "large group market", "small employer", " and "small group market" shall be defined as set forth at 42 U.S.C. § 300gg-91. Nothing in this Regulation shall apply to the excepted benefits as defined at 42 U.S.C. § 300gg-91(c).

C. Miss. Code Ann. §§ 83-63-3(g) and 83-63-6 (Rev. 1999), classify a sole proprietor as a small employer where certain conditions are met. Such classification of a sole proprietor as a small employer under Mississippi law shall not be affected by this Regulation.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.04: Individual Market Requirements

A. Guaranteed Renewability of Individual Health Insurance Coverage

At 42 U.S.C. § 300gg-42, and at 45 C.F.R. § 148.122, HIPAA requires health insurance issuers that provide individual health insurance coverage in the individual market to renew and or continue in force such coverage at the option of the individual, subject to certain exceptions. These provisions also set forth certain requirements for the uniform termination of coverage in the individual market. Every health insurance issuer which offers individual health insurance coverage in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-42 and 45 C.F.R. § 148.122.

B. Certificates of Creditable Coverage

At 42 U.S.C. § 300gg-43, and at 45 C.F.R. § 148.124, HIPAA requires health insurance issuers that provide individual health insurance coverage in the individual market to provide certificates of creditable coverage under a variety of circumstances when an individual's coverage terminates. Every health insurance issuer which offers individual health insurance coverage in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-43 and 45 C.F.R. § 148.124.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.05: Small Group Market Requirements

A. Guaranteed Availability of Coverage inthe Small Group Market

At 42 U.S.C. § 300gg-11(a), (c), (d), (e) and (f), HIPAA requires health insurance issuers that offer coverage in the small group market to accept every small employer that applies for coverage, including every eligible individual of the small employer. These provisions also prescribe special rules for network plans, apply certain financial capacity limits and set forth limited exceptions. At 45 C.F.R. § 146.150, HIPAA regulations clarify that health insurance issuers in the small group market generally must offer to each small employer all products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept any small employer that applies for any of those products. Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-11(a), (c), (d), (e) and (f) and 45 C.F.R. § 146.150.

B. Prohibition against Discrimination within Small Groups

At 42 U.S.C. § 300gg-1, and at 45 C.F.R. § 146.121, HIPAA bars health insurance issuers that offer coverage in the small group market from establishing rules for eligibility that are based on health status-related factors, and from requiring individuals within small groups to pay a higher premium or contribution than would a similarlysituated individual, based on a health status-related factor. Every health insurance issuer which offers coverage in the small group market in the State of

Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-1, and 45 C.F.R. § 146.121.

C. Preexisting Condition Exclusions

1. Miss. Code Ann. § 83-9-49 (1) (Rev. 1999) permits health insurance issuers in the small group market to apply preexisting condition limitations which do not contain a definition of a preexisting condition more restrictive than the following:

    a. A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

    b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

    At 42 U.S.C. § 300gg(a) and 45 C.F.R. § 146.111(a)(1)(i), HIPAA provides that a preexisting condition exclusion in a policy issued in the small group market can only relate to a condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date. Unlike Miss. Code Ann. § 83-9-49 (1) (b) (Rev. 1999), there is no provision under HIPAA allowing a health insurance issuer in the small group market to apply a preexisting condition limitation for a condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage.

    Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(a) and 45 C.F.R. § 146.111(a)(1)(i), which limit the definition of a preexisting condition to "a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date."

2. At 42 U.S.C. § 300gg(d), and at 45 C.F.R. § 146.111(b), HIPAA bars health insurance issuers offering coverage in the small group market from applying preexisting conditions to certain newborns, certain adopted children and to the condition of pregnancy. Every health insurance issuerwhich offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(d) and 45 C.F.R. § 146.111(b).

3. At 42 U.S.C. § 300gg(b)(1)(B), HIPAA bars health insurance issuers offering coverage in the small group market from applying preexisting condition

limitations to genetic information in the absence of a diagnosis of the condition related to such information. Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(b)(1)(B).

D. Rules Relating To Crediting Previous Coverage

At 42 U.S.C. § 300gg(c), and at 45 C.F.R. § 146.113, HIPAA requires health insurance issuers offering coverage in the small group market to reduce or eliminate the duration of any preexisting condition exclusion by the duration of the person's creditable coverage. Coverage is creditable if it ended within 63 days of the new coverage. The duration of consecutive creditable coverages are added to calculate the total amount of creditable coverage, as long as the break between such coverages does not exceed 63 days. Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(c) and 45 C.F.R. § 146.113.

E. Certificates Of Creditable Coverage

At 42 U.S.C. § 300gg(e), and at 45 C.F.R. § 146.115, HIPAA requires health insurance issuers in the small group market to provide certificates of creditable coverage under a variety of circumstances when a person's coverage terminates. Every health insurance issuer providing coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(e) and 45 C.F.R. § 146.115.

F. Special Enrollment Periods

At 42 U.S.C. § 300gg(f), and at 45 C.F.R. § 146.117, HIPAA requires health insurance issuers which offer coverage in the small group market to offer eligible employees and dependents special enrollment rights upon the loss of certain other coverage. These provisions also require health insurance issuers in the small group market to offer special enrollment rights when a new dependent becomes eligible through marriage, birth or adoption. Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(f) and 45 C.F.R. § 146.117.

G. Health Maintenance Organization Affiliation Period

At 42 U.S.C. § 300gg(g), and at 45 C.F.R. § 146.119, HIPAA permits health maintenance organizations ("HMOs") which offer coverage in the small group market to apply affiliation periods in the small group market only if the HMOs do not apply any preexisting condition exclusions, the period is applied uniformly without regard to health status-related factors, and the period does not exceed 2 months, or three months for late enrollees. Every HMO which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(g) and 45 C.F.R. § 146.119.

H. Guaranteed Renewability Of Coverage In The Small Group Market

At 42 U.S.C. § 300gg-12, and at 45 C.F.R. § 146.152, HIPAA requires health insurance issuers in the small group market to offer guaranteed renewal of policies, with some specific exceptions. These provisions also set forth certain requirements for the uniform termination of coverage in the small group market. Every health insurance issuer which offers coverage in the small group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-12 and 45 C.F.R. § 146.152.

Source: M*iss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.06: Large Group Market Requirements

A. Prohibition Against Discrimination Within Large Groups

At 42 U.S.C. § 300gg-1, and at 45 C.F.R. § 146.121, HIPAA bars health insurance issuers that offer coverage in the large group market from establishing rules for eligibility that are based on health status-related factors, and from requiring individuals within large groups to pay a higher premium or contribution than would a similarly situated individual, based on a health status-related factor. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-1 and 45 C.F.R. § 146.121.

B. Preexisting Condition Exclusions

1. Miss. Code Ann. § 83-9-49 (1) (Rev. 1999) permits health insurance issuers in the large group market to apply preexisting condition limitations which do not contain a definition of a preexisting condition more restrictive than the following:

    a. A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

    b. A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.
    At 42 U.S.C. § 300gg(a) and 45 C.F.R. § 146.111(a)(1)(i), HIPAA provides that a preexisting condition exclusion in a policy issued in the large group market can only relate to a condition, regardless of its cause, for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period ending on the enrollment date. Unlike Miss. Code Ann. § 83-9-49 (1) (b) (Rev. 1999), there is no provision under HIPAA allowing a health insurance issuer in the large group market to apply a preexisting condition limitation for a condition that would have caused an ordinary prudent person to seek medical advice,

diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage.

Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(a) and 45 C.F.R. § 146.111(a)(1)(i), which limit the definition of a preexisting condition to "a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date."

2. At 42 U.S.C. § 300gg(d), and at 45 C.F.R. § 146.111(b), HIPAA bars health insurance issuers offering coverage in the large group market from applying preexisting conditions to certain newborns, certain adopted children and to the condition of pregnancy. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(d) and 45 C.F.R. § 146.111(b).

3. At 42 U.S.C. § 300gg(b)(1)(B), HIPAA bars health insurance issuers offering coverage in the large group market from applying preexisting condition limitations to genetic information in the absence of a diagnosis of the condition related to such information. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(b)(1)(B).

C. Rules Relating To Crediting Previous Coverage

At 42 U.S.C. § 300gg(c), and at 45 C.F.R. § 146.113, HIPAA requires health insurance issuers offering coverage in the large group market to reduce or eliminate the duration of any preexisting condition exclusion by the duration of the person's creditable coverage. Coverage is creditable if it ended within 63 days of the new coverage. The duration of consecutive creditable coverages are added to calculate the total amount of creditable coverage, as long as the break between such coverages does not exceed 63 days. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg(c) and 45 C.F.R. § 146.113.

D. Certificates Of Creditable Coverage

At 42 U.S.C. § 300gg (e), and at 45 C.F.R. § 146.115, HIPAA requires health insurance issuers in the large group market to provide certificates of creditable coverage under a variety of circumstances when a person's coverage terminates. Every health insurance issuer providing coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg (e) and 45 C.F.R. § 146.115.

E. Guaranteed Renewability Of Coverage In The Large Group Market

At 42 U.S.C. § 300gg-12, and at 45 C.F.R. § 146.152, HIPAA requires health insurance issuers in the large group market to offer guaranteed renewal of policies, with some specific exceptions. These provisions also set forth certain requirements for the uniform termination of coverage in the large group market. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg-12 and 45 C.F.R. § 146.152.

F. Special Enrollment Periods

At 42 U.S.C. § 300gg(f), and at 45 C.F.R. § 146.117, HIPAA requires health insurance issuers which offer coverage in the large group market to offer eligible employees and dependents special enrollment rights upon the loss of certain other coverage. These provisions also require health insurance issuers in the large group market to offer special enrollment rights when a new dependent becomes eligible through marriage, birth or adoption. Every health insurance issuer which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg (f) and 45 C.F.R. § 146.117.

G. Health Maintenance Organization Affiliation Period

At 42 U.S.C. § 300gg (g), and at 45 C.F.R. § 146.119, HIPAA permits health maintenance organizations ("HMOs") which offer coverage in the large group market to applyaffiliation periods in the large group market only if the HMOs do not apply any preexisting condition exclusions, the period is applied uniformly without regard to health status-related factors, and the period does not exceed 2 months, or three months for late enrollees. Every HMO which offers coverage in the large group market in the State of Mississippi shall fully comply with the provisions of 42 U.S.C. § 300gg (g) and 45 C.F.R. § 146.119.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.07: Conflicts of Law

To the extent the provisions of this Regulation conflict with other provisions of State law, the provisions of this Regulation shall be controlling pursuant to the authority granted under Miss. Code Ann. § 83-1-43 (Rev. 1999), and the Health Insurance Portability and Accountability Act of 1996, as Amended.

Source: *Miss. Code Ann.* §83-1-43 (Rev. 2011)

Rule 26.08: Separability

If any provision of this Regulation, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Regulation, and the application of the

provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Source: *Miss. Code Ann.* §§83-1-43; 83-5-1 (Rev. 2011)

Rule 26.09: Effective Date

This Regulation shall become effective thirty (30) days after filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss. Code Ann.* §25-43-3.113 (Rev. 2010)

Part 1 Chapter 27: (2000-7) (Emergency Regulation) Privacy of Personal Information.

Rule 27.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. § 83-5-1 (Rev. 1999), and Title V of the Gramm-Leach-Bliley Act, 15 U.S.C §§ 6801-6827 (hereinafter "GLBA"), and is promulgated in accordance with the laws governing emergency rule-making proceedings found at Miss. Code Ann. § 25-43-7 (Rev. 1999), and Mississippi Department of Insurance Regulation No. 88-101.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 27.02: Purpose

The purpose of this Regulation is to establish the date by which Licensees regulated by the Mississippi Department of Insurance must comply with the provisions of Title V of GLBA, which becomes effective November 13, 2000. GLBA, *inter alia*, requires Licensees to establish privacy policies, develop systems for implementing those policies and protecting personal information of consumers and customers, and provide notices to all customers prior to either the effective date or a later compliance date established by rule by the regulator. This Regulation will establish a compliance date of July 1, 2001, for Licensees regulated by the Mississippi Department of Insurance. This date is consistent with the compliance date established by federal regulators responsible for enforcing GLBA as it applies to federally regulated financial institutions.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 27.03: Definition of Licensee

For purposes of this Regulation, Licensee shall mean all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of the State of Mississippi, including Health Maintenance Organizations as that term is defined at Miss. Code Ann. § 83-41-303(n)(Rev. 1999). Licensee shall also include an unauthorized insurer that accepts business

placed through a licensed excess line broker in Mississippi, but only in regard to the excess line placements placed pursuant to Miss. Code Ann. § 83-21-17 et seq. (Rev. 1999).

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 27.04: Extension of Time for Compliance

In order to provide sufficient time for Licensees to establish policies and systems to comply with the requirements of Title V of GLBA, which has an effective date of November 13, 2000, the Commissioner of Insurance hereby extends the time for compliance until July 1, 2001. Licensees will not be required to be in compliance with Title V of GLBA before July 1, 2001, but must be in full compliance on and after said date.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 27.05: Effective Date

This Emergency Regulation shall be effective immediately upon filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss. Code Ann.* §25-43-3.113 (Rev. 2010)

Part 1 Chapter 28: (2001-1) Privacy of Consumer Financial and Health Information Regulation

Rule 28.01: Authority

This regulation is promulgated pursuant to the authority granted by Senate Bill 2207 which was passed by the Mississippi Legislature in the 2001 Regular Session and 19 Miss. Admin. Code, Part 1, Chapter 15, said Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.02: Purpose and Scope

A. Purpose. This regulation governs the treatment of nonpublic personal health information and nonpublic personal financial information about individuals by all licensees of the state insurance department. This regulation:

    1. Requires a licensee to provide notice to individuals about its privacy policies and practices;

    2. Describes the conditions under which a licensee may disclose nonpublic personal health information and nonpublic personal financial information about individuals to affiliates and nonaffiliated third parties; and

3. Provides methods for individuals to prevent a licensee from disclosing that information.

B. Scope. This regulation applies to:

1. Nonpublic personal financial information about individuals who obtain or are claimants or beneficiaries of products or services primarily for personal, family or household purposes from licensees. This regulation does not apply to information about companies or about individuals who obtain products or services for business, commercial or agricultural purposes; and

2. All nonpublic personal health information.

C. Compliance. A licensee domiciled in this state that is in compliance with this regulation in a state that has not enacted laws or regulations that meet the requirements of Title V of the Gramm-Leach-Bliley Act, 15 U.S.C. §§ 6801 et seq., may nonetheless be deemed to be in compliance with Title V of the Gramm-Leach-Bliley Act in the other state.

Source: *Miss. Code Ann.*§83-1-45 (Rev. 2011)

Rule 28.03: Rule of Construction

The examples in this regulation and the sample clauses in Appendix A of this regulation are not exclusive. Compliance with an example or use of a sample clause, to the extent applicable, constitutes compliance with this regulation.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.04: Definitions

As used in this regulation, unless the context requires otherwise:

A. "Affiliate" means a company that controls, is controlled by or is under common control with another company.

B. "Clear and conspicuous" means that a notice is reasonably understandable and designed to call attention to the nature and significance of the information in the notice; Examples.

1. Reasonably understandable. A licensee makes its notice reasonably understandable if it:

a. Presents the information in the notice in clear, concise sentences, paragraphs and sections;

b. Uses short explanatory sentences or bullet lists whenever possible;

c. Uses definite, concrete, everyday words and active voice whenever possible;

d. Avoids multiple negatives;

e. Avoids legal and highly technical business terminology whenever possible; and

f. Avoids explanations that are imprecise and readily subject to different interpretations.

2. Designed to call attention. A licensee designs its notice to call attention to the nature and significance of the information in it if the licensee:

a. Uses a plain-language heading to call attention to the notice;

b. Uses a typeface and type size that are easy to read;

c. Provides wide margins and ample line spacing;

d. Uses boldface or italics for key words; and

e. In a form that combines the licensee's notice with other information, uses distinctive type size, style, and graphic devices, such as shading or sidebars.

3. Notices on web sites. If a licensee provides a notice on a web page, the licensee designs its notice to call attention to the nature and significance of the information in it if the licensee uses text or visual cues to encourage scrolling down the page if necessary to view the entire notice and ensure that other elements on the web site (such as text, graphics, hyperlinks or sound) do not distract attention from the notice, and the licensee either:

a. Places the notices on a screen that consumers frequently access, such as a page on which transactions are conducted; or

b. Places a link on a screen that consumers frequently access, such as a page on which transactions are conducted, that connects directly to the notice and is labeled appropriately to convey the importance, nature and relevance of the notice.

C. "Collect" means to obtain information that the licensee organizes or can retrieve by the name of an individual or by identifying number, symbol or other identifying particular assigned to the individual, irrespective of the source of the underlying information.

D. "Commissioner" means the insurance commissioner of the state of Mississippi.

E. "Company" means a corporation, limited liability company, business trust, general or limited partnership, association, sole proprietorship or similar organization.

F. "Consumer" means an individual who seeks to obtain, obtains or has obtained an insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, and about whom the licensee has nonpublic personal information, or that individual's legal representative.

1. Examples:

a. An individual who provides nonpublic personal information to a licensee in connection with obtaining or seeking to obtain financial, investment or economic advisory services relating to an insurance product or service is a consumer regardless of whether the licensee establishes an ongoing advisory relationship.

b. An applicant for insurance prior to the inception of insurance coverage is a licensee's consumer.

c. An individual who is a consumer of another financial institution is not a licensee's consumer solely because the licensee is acting as agent for, or provides processing or other services to, that financial institution.

d. An individual is a licensee's consumer if:

i. the individual is a beneficiary of a life insurance policy underwritten by the licensee;

ii. the individual is a claimant under an insurance policy issued by the licensee;

iii. the individual is an insured or an annuitant under an insurance policy or an annuity, respectively, issued by the licensee; or

iv. the individual is a mortgagor of a mortgage covered under a mortgage insurance policy; and

v. the licensee discloses nonpublic personal financial information about the individual to a nonaffiliated third party other than as permitted under Sections 14, 15 and 16 of this regulation.

e. Provided that the licensee provides the initial, annual and revised notices under Sections 5, 6 and 9 of this regulation to the plan sponsor, group or blanket insurance policyholder or group annuity contract holder, workers' compensation plan participant, and further provided that the licensee does

not disclose to a nonaffiliated third party nonpublic personal financial information about such an individual other than as permitted under Sections 14, 15 and 16 of this regulation, an individual is not the consumer of the licensee solely because he or she is:

i. A participant or a beneficiary of an employee benefit plan that the licensee administers or sponsors or for which the licensee acts as a trustee, insurer or fiduciary;

ii. Covered under a group or blanket insurance policy or group annuity contract issued by the licensee; or

iii. A beneficiary in a workers' compensation plan.

f. i. The individuals described in Subparagraph (e)(i) through (iii) of this paragraph are consumers of a licensee if the licensee does not meet all the conditions of Subparagraph (e).

ii. In no event shall the individuals, solely by virtue of the status described in Subparagraph (e)(i) through (iii) above, be deemed to be customers for purposes of this regulation.

g. An individual is not a licensee's consumer solely because he or she is a beneficiary of a trust for which the licensee is a trustee.

h. An individual is not a licensee's consumer solely because he or she has designated the licensee as trustee for a trust.

G. "Consumer reporting agency" has the same meaning as in Section 603(f) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(f)).

H. "Control" means:

1. Ownership, control or power to vote ten percent (10%) or more of the outstanding shares of any class of voting security of the company, directly or indirectly, or acting through one or more other persons;

2. Control in any manner over the election of a majority of the directors, trustees or general partners (or individuals exercising similar functions) of the company; or

3. The power to exercise, directly or indirectly, a controlling influence over the management or policies of the company, as the commissioner determines.

I. "Customer" means a consumer who has a customer relationship with a licensee.

J. "Customer relationship" means a continuing relationship between a consumer and a licensee under which the licensee provides one or more insurance products or services to the consumer that are to be used primarily for personal, family or household purposes.

1. Examples.

a. A consumer has a continuing relationship with a licensee if:

i. The consumer is a current policyholder of an insurance product issued by or through the licensee; or

ii. The consumer obtains financial, investment or economic advisory services relating to an insurance product or service from the licensee for a fee.

b. A consumer does not have a continuing relationship with a licensee if:

i. The consumer applies for insurance but does not purchase the insurance;

ii. The licensee sells the consumer airline travel insurance in an isolated transaction;

iii. The individual is no longer a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee;

iv. The consumer is a beneficiary or claimant under a policy and has submitted a claim under a policy choosing a settlement option involving an ongoing relationship with the licensee;

v. The consumer is a beneficiary or a claimant under a policy and has submitted a claim under that policy choosing a lump sum settlement option;

vi. The customer's policy is lapsed, expired, or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than annual privacy notices, material required by law or regulation, communication at the direction of a state or federal authority, or promotional materials;

vii. The individual is an insured or an annuitant under an insurance policy or annuity, respectively, but is not the policyholder or owner of the insurance policy or annuity; or

viii. For the purposes of this regulation, the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

K. "Financial institution" means any institution the business of which is engaging in activities that are financial in nature or incidental to such financial activities as described in Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

1. Financial institution does not include:

a. Any person or entity with respect to any financial activity that is subject to the jurisdiction of the Commodity Futures Trading Commission under the Commodity Exchange Act (7 U.S.C. 1 et seq.);

b. The Federal Agricultural Mortgage Corporation or any entity charged and operating under the Farm Credit Act of 1971 (12 U.S.C. 2001 et seq.); or

c. Institutions chartered by Congress specifically to engage in securitizations, secondary market sales (including sales of servicing rights) or similar transactions related to a transaction of a consumer, as long as the institutions do not sell or transfer nonpublic personal information to a nonaffiliated third party.

L. "Financial product or service" means a product or service that a financial holding company could offer by engaging in an activity that is financial in nature or incidental to such a financial activity under Section 4(k) of the Bank Holding Company Act of 1956 (12 U.S.C. 1843(k)).

Financial service includes a financial institution's evaluation or brokerage of information that the financial institution collects in connection with a request or an application from a consumer for a financial product or service.

M. "Health care" means:

1. Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care, services, procedures, tests or counseling that:

a. Relates to the physical, mental or behavioral condition of an individual; or

b. Affects the structure or function of the human body or any part of the human body, including the banking of blood, sperm, organs or any other tissue; or

2. Prescribing, dispensing or furnishing to an individual drugs or biologicals, or medical devices or health care equipment and supplies.

N. "Health care provider" means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law, or a health care facility.

O. "Health information" means any information or data except age or gender, whether oral or recorded in any form or medium, created by or derived from a health care provider or the consumer that relates to:

1. The past, present or future physical, mental or behavioral health or condition of an individual;

2. The provision of health care to an individual; or

3. Payment for the provision of health care to an individual.

P. "Insurance product or service" means any product or service that is offered by a licensee pursuant to the insurance laws of this state.

Insurance service includes a licensee's evaluation, brokerage or distribution of information that the licensee collects in connection with a request or an application from a consumer for an insurance product or service.

Q. "Licensee" means all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the Insurance Law of this state, including health maintenance organizations holding a certificate of authority pursuant to Miss. Code Ann. § 83-41-301 et seq.

1. A licensee is not subject to the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation if the licensee is an employee, agent or other representative of another licensee ("the principal") and:

a. The principal otherwise complies with, and provides the notices required by, the provisions of this regulation; and

b. The licensee does not disclose any nonpublic personal information to any person other than the principal or its affiliates in a manner permitted by this regulation.

2. Subject to Subparagraph (b), "licensee" shall also include an unauthorized insurer that accepts business placed through a licensed excess lines broker in this

state, but only in regard to the excess lines placements placed pursuant to Miss. Code Ann. § 83-21-17 et seq.

a. An excess lines broker or excess lines insurer shall be deemed to be in compliance with the notice and opt out requirements for nonpublic personal financial information set forth in Articles I, II, III and IV of this regulation provided:

i. The broker or insurer does not disclose nonpublic personal information of a consumer or a customer to nonaffiliated third parties for any purpose, including joint servicing or marketing under Section 14 of this regulation, except as permitted by Section 15 or 16 of this regulation; and

ii. The broker or insurer delivers a notice to the consumer at the time a customer relationship is established on which the following is printed in 16-point type:

PRIVACY NOTICE

"Neither the U.S. brokers that handled this insurance nor the insurers that have underwritten this insurance will disclose nonpublic personal information concerning the buyer to non-affiliates of the brokers or insurers except as permitted by law."

3. As used herein the term "licensee" shall not include any of the following:

a. Mississippi Workers' Compensation Assigned Risk Plan and Mississippi Workers' Compensation Assigned Risk Pool created pursuant to Miss. Code Ann. § 71-3-111;

b. Mississippi Workers' Compensation Self-Insurer Guaranty Association created pursuant to Miss. Code Ann. § 71-3-159;

c. Mississippi Comprehensive Health Insurance Risk Pool Association created pursuant to Miss. Code Ann. § 83-9-211;

d. Mississippi Insurance Guaranty Association created pursuant to Miss. Code Ann. § 83-23-111;

e. Mississippi Life and Health Insurance Guaranty Association created pursuant to Miss. Code Ann. § 83-23-211;

f. Mississippi Windstorm Underwriting Association created pursuant to Miss. Code Ann. § 83-34-3; and

g. Mississippi Rural Risk Insurance Association created pursuant to Miss. Code Ann. § 83-38-5.

R. 1. "Nonaffiliated third party" means any person except:

a. A licensee's affiliate; or

b. A person employed jointly by a licensee and any company that is not the licensee's affiliate (but nonaffiliated third party includes the other company that jointly employs the person).

2. Nonaffiliated third party includes any company that is an affiliate solely by virtue of the direct or indirect ownership or control of the company by the licensee or its affiliate in conducting merchant banking or investment banking activities of the type described in Section 4(k)(4)(H) or insurance company investment activities of the type described in Section 4(k)(4)(I) of the federal Bank Holding Company Act (12 U.S.C. 1843(k)(4)(H) and (I)).

S. "Nonpublic personal information" means nonpublic personal financial information and nonpublic personal health information.

T. "Nonpublic personal financial information" means:

1. Defined as:

a. Personally identifiable financial information; and

b. Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived using any personally identifiable financial information that is not publicly available.

2. Nonpublic personal financial information does not include:

a. Health information;

b. Publicly available information, except as included on a list described in Subsection T(1)(b) of this section; or

c. Any list, description or other grouping of consumers (and publicly available information pertaining to them) that is derived without using any personally identifiable financial information that is not publicly available.

3. Examples of lists.

a. Nonpublic personal financial information includes any list of individuals' names and street addresses that is derived in whole or in part using

personally identifiable financial information that is not publicly available, such as account numbers.

b. Nonpublic personal financial information does not include any list of individuals' names and addresses that contains only publicly available information, is not derived in whole or in part using personally identifiable financial information that is not publicly available, and is not disclosed in a manner that indicates that any of the individuals on the list is a consumer of a financial institution.

U. "Nonpublic personal health information" means health information:

1. That identifies an individual who is the subject of the information; or

2. With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

V. "Personally identifiable financial information" means any information:

1. Specifically:

a. A consumer provides to a licensee to obtain an insurance product or service from the licensee;

b. About a consumer resulting from a transaction involving an insurance product or service between a licensee and a consumer; or

c. The licensee otherwise obtains about a consumer in connection with providing an insurance product or service to that consumer.

2. Examples.

a. Information included. Personally identifiable financial information includes:

i. Information a consumer provides to a licensee on an application to obtain an insurance product or service;

ii. Account balance information and payment history;

iii. The fact that an individual is or has been one of the licensee's customers or has obtained an insurance product or service from the licensee.

iv. Any information about the licensee's consumer if it is disclosed in a manner that indicates that the individual is or has been the licensee's consumer;

v. Any information that a consumer provides to a licensee or that the licensee or its agent otherwise obtains in connection with collecting on a loan or servicing a loan;

vi. Any information the licensee collects through an Internet cookie (an information collecting device from a web server); and

vii. Information from a consumer report.

b. Information not included. Personally identifiable financial information does not include:

i. Health information;

ii. A list of names and addresses of customers of an entity that is not a financial institution; and

iii. Information that does not identify a consumer, such as aggregate information or blind data that does not contain personal identifiers such as account numbers, names or addresses.

W. "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from:

1. Specifically:

a. Federal, state or local government records;

b. Widely distributed media; or

c. Disclosures to the general public that are required to be made by federal, state or local law.

2. Reasonable basis. A licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

a. That the information is of the type that is available to the general public; and

b. Whether an individual can direct that the information not be made available to the general public and, if so, that the licensee's consumer has not done so.

3. Examples.

a. Government records. Publicly available information in government records includes information in government real estate records and security interest filings.

b. Widely distributed media. Publicly available information from widely distributed media includes information from a telephone book, a television or radio program, a newspaper or a web site that is available to the general public on an unrestricted basis. A web site is not restricted merely because an Internet service provider or a site operator requires a fee or a password, so long as access is available to the general public.

c. Reasonable basis.

i. A licensee has a reasonable basis to believe that mortgage information is lawfully made available to the general public if the licensee has determined that the information is of the type included on the public record in the jurisdiction where the mortgage would be recorded.

ii. A licensee has a reasonable basis to believe that an individual's telephone number is lawfully made available to the general public if the licensee has located the telephone number in the telephone book or the consumer has informed you that the telephone number is not unlisted.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.05: Initial Privacy Notice to Consumers Required

A. Initial notice requirement. A licensee shall provide a clear and conspicuous notice that accurately reflects its privacy policies and practices to:

1. Customer. An individual who becomes the licensee's customer, not later than when the licensee establishes a customer relationship, except as provided in Subsection E of this section; and

2. Consumer. A consumer, before the licensee discloses any nonpublic personal financial information about the consumer to any nonaffiliated third party, if the licensee makes a disclosure other than as authorized by Sections 15 and 16.

B. When initial notice to a consumer is not required. A licensee is not required to provide an initial notice to a consumer under Subsection A(2) of this section if:

1. The licensee does not disclose any nonpublic personal financial information about the consumer to any nonaffiliated third party, other than as authorized by Sections 15 and 16, and the licensee does not have a customer relationship with the consumer; or

2. A notice has been provided by an affiliated licensee, as long as the notice clearly identifies all licensees to whom the notice applies and is accurate with respect to the licensee and the other institutions.

C. When the licensee establishes a customer relationship.

1. General rule. A licensee establishes a customer relationship at the time the licensee and the consumer enter into a continuing relationship.

2. Examples of establishing customer relationship. A licensee establishes a customer relationship when the consumer:

a. Becomes a policyholder of a licensee that is an insurer when the insurer delivers an insurance policy or contract to the consumer, or in the case of a licensee that is an insurance producer or insurance broker, obtains insurance through that licensee; or

b. Agrees to obtain financial, economic or investment advisory services relating to insurance products or services for a fee from the licensee.

D. Existing customers. When an existing customer obtains a new insurance product or service from a licensee that is to be used primarily for personal, family or household purposes, the licensee satisfies the initial notice requirements of Subsection A of this section as follows:

1. The licensee may provide a revised policy notice, under Section 9, that covers the customer's new insurance product or service; or

2. If the initial, revised or annual notice that the licensee most recently provided to that customer was accurate with respect to the new insurance product or service, the licensee does not need to provide a new privacy notice under Subsection A of this section.

E. Exceptions to allow subsequent delivery of notice.

1. A licensee may provide the initial notice required by Subsection A(1) of this section within a reasonable time after the licensee establishes a customer relationship if:

a. Establishing the customer relationship is not at the customer's election; or

b. Providing notice not later than when the licensee establishes a customer relationship would substantially delay the customer's transaction and the customer agrees to receive the notice at a later time.

2. Examples of exceptions.

a. Not at customer's election. Establishing a customer relationship is not at the customer's election if a licensee acquires or is assigned a customer's policy from another financial institution or residual market mechanism and the customer does not have a choice about the licensee's acquisition or assignment.

b. Substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would substantially delay the customer's transaction when the licensee and the individual agree over the telephone to enter into a customer relationship involving prompt delivery of the insurance product or service.

c. No substantial delay of customer's transaction. Providing notice not later than when a licensee establishes a customer relationship would not substantially delay the customer's transaction when the relationship is initiated in person at the licensee's office or through other means by which the customer may view the notice, such as on a web site.

F. Delivery. When a licensee is required to deliver an initial privacy notice by this section, the licensee shall deliver it according to Section 10. If the licensee uses a short-form initial notice for non-customers according to Section 7D, the licensee may deliver its privacy notice according to Section 7D (3).

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.06: Annual Privacy Notice to Customers Required

A. General rule.

1. A licensee shall provide a clear and conspicuous notice to customers that accurately reflect its privacy policies and practices not less than annually during the continuation of the customer relationship. Annually means at least once in any period of twelve (12) consecutive months during which that relationship exists. A licensee may define twelve-consecutive month period, but the licensee shall apply it to the customer on a consistent basis.

2. Example. A licensee provides a notice annually if it defines the twelve-consecutive-month period as a calendar year and provides the annual notice to the customer once in each calendar year following the calendar year in which the licensee provided the initial notice. For example, if a customer opens an account on any day of year 1, the licensee shall provide an annual notice to that customer by December 31 of year 2.

B. Termination of customer relationship.

1. A licensee is not required to provide an annual notice to a former customer. A former customer is an individual with whom a licensee no longer has a continuing relationship.

2. Examples.

a. A licensee no longer has a continuing relationship with an individual if the individual no longer is a current policyholder of an insurance product or no longer obtains insurance services with or through the licensee.

b. A licensee no longer has a continuing relationship with an individual if the individual's policy is lapsed, expired or otherwise inactive or dormant under the licensee's business practices, and the licensee has not communicated with the customer about the relationship for a period of twelve (12) consecutive months, other than to provide annual privacy notices, material required by law or regulation, or promotional materials.

c. For the purposes of this regulation, a licensee no longer has a continuing relationship with an individual if the individual's last known address according to the licensee's records is deemed invalid. An address of record is deemed invalid if mail sent to that address by the licensee has been returned by the postal authorities as undeliverable and if subsequent attempts by the licensee to obtain a current valid address for the individual have been unsuccessful.

d. A licensee no longer has a continuing relationship with a customer in the case of providing real estate settlement services, at the time the customer completes execution of all documents related to the real estate closing, payment for those services has been received, or the licensee has completed all of its responsibilities with respect to the settlement, including filing documents on the public record, whichever is later.

C. Delivery. When a licensee is required by this section to deliver an annual privacy notice, the licensee shall deliver it according to Section 10.

D. Exemptions. A licensee shall not be required to deliver an annual privacy notice if the licensee:

1. Qualifies for exceptions under 15 U.S.C. § 6802(b)(2) or 15 U.S.C § 6802 (e) or Mississippi Insurance Department regulations prescribed under 15 U.S.C. § 6804(b), and

2. Has not changed its policies and practices with regard to disclosing nonpublic personal information since its most recent disclosure.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011); 15 U.S.C. § 6802 and § 6804.

Rule 28.07: Information to be Included in Privacy Notices

A. General rule. The initial, annual and revised privacy notices that a licensee provides under Sections 5, 6 and 9 shall include each of the following items of information, in addition to any other information the licensee wishes to provide, that applies to the licensee and to the consumers to whom the licensee sends its privacy notice:

1. The categories of nonpublic personal financial information that the licensee collects;

2. The categories of nonpublic personal financial information that the licensee discloses;

3. The categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information, other than those parties to whom the licensee discloses information under Sections 15 and 16;

4. The categories of nonpublic personal financial information about the licensee's former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal financial information about the licensee's former customers, other than those parties to whom the licensee discloses information under Sections 15 and 16;

5. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under Section 14 (and no other exception in Sections 15 and 16 applies to that disclosure), a separate description of the categories of information the licensee discloses and the categories of third parties with whom the licensee has contracted;

6. An explanation of the consumer's right under Section 11A to opt out of the disclosure of nonpublic personal financial information to nonaffiliated third parties, including the methods by which the consumer may exercise that right at that time;

7. Any disclosures that the licensee makes under Section 603(d)(2)(A)(iii) of the federal Fair Credit Reporting Act (15 U.S.C. 1681a(d)(2)(A)(iii) (that is, notices regarding the ability to opt out of disclosures of information among affiliates);

8. The licensee's policies and practices with respect to protecting the confidentiality and security of nonpublic personal information; and

9. Any disclosure that the licensee makes under Subsection B of this section.

B. Description of parties subject to exceptions. If a licensee discloses nonpublic personal financial information as authorized under Sections 15 and 16, the licensee is not required to list those exceptions in the initial or annual privacy notices required by Sections 5 and 6. When describing the categories of parties to whom disclosure is made, the licensee is required to state only that it makes disclosures to other affiliated or nonaffiliated third parties, as applicable, as permitted by law.

C. Examples.

1. Categories of nonpublic personal financial information that the licensee collects. A licensee satisfies the requirement to categorize the nonpublic personal financial information it collects if the licensee categorizes it according to the source of the information, as applicable:

a. Information from the consumer;

b. Information about the consumer's transactions with the licensee or its affiliates;

c. Information about the consumer's transactions with nonaffiliated third parties; and

d. Information from a consumer reporting agency.

2. Categories of nonpublic personal financial information a licensee discloses.

a. A licensee satisfies the requirement to categorize nonpublic personal financial information it discloses if the licensee categorizes the information according to source, as described in Paragraph (1), as applicable, and provides a few examples to illustrate the types of information in each category. These might include:

i. Information from the consumer, including application information, such as assets and income and identifying information, such as name, address and social security number;

ii. Transaction information, such as information about balances, payment history and parties to the transaction; and

iii. Information from consumer reports, such as a consumer's creditworthiness and credit history.

b. A licensee does not adequately categorize the information that it discloses if the licensee uses only general terms, such as transaction information about the consumer.

c. If a licensee reserves the right to disclose all of the nonpublic personal financial information about consumers that it collects, the licensee may simply state that fact without describing the categories or examples of nonpublic personal information that the licensee discloses.

3. Categories of affiliates and nonaffiliated third parties to whom the licensee discloses.

a. A licensee satisfies the requirement to categorize the affiliates and nonaffiliated third parties to which the licensee discloses nonpublic personal financial information about consumers if the licensee identifies the types of businesses in which they engage.

b. Types of businesses may be described by general terms only if the licensee uses a few illustrative examples of significant lines of business. For example, a licensee may use the term financial products or services if it includes appropriate examples of significant lines of businesses, such as life insurer, automobile insurer, consumer banking or securities brokerage.

c. A licensee also may categorize the affiliates and nonaffiliated third parties to which it discloses nonpublic personal financial information about consumers using more detailed categories.

4. Disclosures under exception for service providers and joint marketers. If a licensee discloses nonpublic personal financial information under the exception in Section 14 to a nonaffiliated third party to market products or services that it offers alone or jointly with another financial institution, the licensee satisfies the disclosure requirement of Subsection A(5) of this section if it:

a. Lists the categories of nonpublic personal financial information it discloses, using the same categories and examples the licensee used to meet the requirements of Subsection A(2) of this section, as applicable; and

b. States whether the third party is:

i. A service provider that performs marketing services on the licensee's behalf or on behalf of the licensee and another financial institution; or

ii. A financial institution with which the licensee has a joint marketing agreement.

5. Simplified notices. If a licensee does not disclose, and does not wish to reserve the right to disclose, nonpublic personal financial information about customers or former customers to affiliates or nonaffiliated third parties except as authorized under Sections 15 and 16, the licensee may simply state that fact, in addition to the information it shall provide under Subsections A(1), A(8), A(9) and Subsection B of this section.

6. Confidentiality and security. A licensee describes its policies and practices with respect to protecting the confidentiality and security of nonpublic personal financial information if it does both of the following:

a. Describes in general terms who is authorized to have access to the information; and

b. States whether the licensee has security practices and procedures in place to ensure the confidentiality of the information in accordance with the licensee's policy. The licensee is not required to describe technical information about the safeguards it uses.

D. Short-form initial notice with opt out notice for non-customers.

1. A licensee may satisfy the initial notice requirements in Sections 5A (2) and 8C for a consumer who is not a customer by providing a short-form initial notice at the same time as the licensee delivers an opt out notice as required in Section 8.

2. A short-form initial notice shall:

a. Be clear and conspicuous;

b. State that the licensee's privacy notice is available upon request; and

c. Explain a reasonable means by which the consumer may obtain that notice.

3. The licensee shall deliver its short form initial notice according to Section 10. The licensee is not required to deliver its privacy notice with its short form initial notice. The licensee instead may simply provide the consumer a reasonable means to obtain its privacy notice. If a consumer who receives the licensee's short

form notice requests the licensee's privacy notice, the licensee shall deliver its privacy notice according to Section 10.

4. Examples of obtaining privacy notice. The licensee provides a reasonable means by which a consumer may obtain a copy of its privacy notice if the licensee:

    a. Provides a toll free telephone number that the consumer may call to request the notice; or

    b. For a consumer who conducts business in person at the licensee's office, maintains copies of the notice on hand that the licensee provides to the consumer immediately upon request.

E. Future disclosures. The licensee's notice may include:

1. Categories of nonpublic personal financial information that the licensee reserves the right to disclose in the future, but does not currently disclose; and

2. Categories of affiliates or nonaffiliated third parties to whom the licensee reserves the right in the future to disclose, but to whom the licensee does not currently disclose, nonpublic personal financial information.

F. Sample clauses. Sample clauses illustrating some of the notice content required by this section are included in Appendix A of this regulation.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.08: Form of Opt Out Notice to Consumers and Opt Out Methods

A. Form of Opt out notice.

1. If a licensee is required to provide an opt-out notice under Section 11A, it shall provide a clear and conspicuous notice to each of its consumers that accurately explains the right to opt out under that section. The notice shall state:

    a. That the licensee discloses or reserves the right to disclose nonpublic personal financial information about its consumer to a nonaffiliated third party;

    b. That the consumer has the right to opt out of that disclosure; and

    c. A reasonable means by which the consumer may exercise the opt-out right.

2. Examples.

a. Adequate opt out notice. A licensee provides adequate notice that the consumer can opt out of the disclosure of nonpublic personal financial information to a nonaffiliated third party if the licensee:

   i. Identifies all of the categories of nonpublic personal financial information that it discloses or reserves the right to disclose, and all of the categories of nonaffiliated third parties to which the licensee discloses the information, as described in Section 7A(2) and (3), and states that the consumer can opt out of the disclosure of that information; and

   ii. Identifies the insurance products or services that the consumer obtains from the licensee, either singly or jointly, to which the opt-out direction would apply.

b. Reasonable opt out means. A licensee provides a reasonable means to exercise an opt out right if it:

   i. Designates check-off boxes in a prominent position on the relevant forms with the opt out notice;

   ii. Includes a reply form together with the opt out notice;

   iii. Provides an electronic means to opt out, such as a form that can be sent via electronic mail or a process at the licensee's web site, if the consumer agrees to the electronic delivery of information; or

   iv. Provides a toll-free telephone number that consumers may call to opt out.

c. Unreasonable opt out means. A licensee does not provide a reasonable means of opting out if:

   i. The only means of opting out is for the consumer to write his or her own letter to exercise that opt out right; or

   ii. The only means of opting out as described in any notice subsequent to the initial notice is to use a check-off box that the licensee provided with the initial notice but did not include with the subsequent notice.

d. Specific opt out means. A licensee may require each consumer to opt out through a specific means, as long as that means is reasonable for that consumer.

B. Same form as initial notice permitted. A licensee may provide the opt out notice together with or on the same written or electronic form as the initial notice the licensee provides in accordance with Section 5.

C. Initial notice required when opt-out notice delivered subsequent to initial notice. If a licensee provides the opt out notice later than required for the initial notice in accordance with Section 5, the licensee shall also include a copy of the initial notice with the opt out notice in writing or, if the consumer agrees, electronically.

D. Joint relationships.

1. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may provide a single opt out notice. The licensee's opt out notice shall explain how the licensee will treat an opt-out direction by a joint consumer (as explained in Paragraph (5) of this subsection).

2. Any of the joint consumers may exercise the right to opt out. The licensee may either:

    a. Treat an opt out direction by a joint consumer as applying to all of the associated joint consumers; or

    b. Permit each joint consumer to opt out separately.

3. If a licensee permits each joint consumer to opt out separately, the licensee shall permit one of the joint consumers to opt out on behalf of all of the joint consumers.

4. A licensee may not require all joint consumers to opt out before it implements any opt out direction.

5. Example. If John and Mary are both named policyholders on a homeowner's insurance policy issued by a licensee and the licensee sends policy statements to John's address, the licensee may do any of the following, but it shall explain in its opt out notice which opt out policy the licensee will follow:

    a. Send a single opt out notice to John's address, but the licensee shall accept an opt-out direction from either John or Mary.

    b. Treat an opt-out direction by either John or Mary as applying to the entire policy. If the licensee does so and John opts out, the licensee may not require Mary to opt out as well before implementing John's opt out direction.

    c. Permit John and Mary to make different opt out directions. If the licensee does so:

i. It shall permit John and Mary to opt out for each other.

ii. If both opt out, the licensee shall permit both of them to notify it in a single response (such as on a form or through a telephone call); and

iii. If John opts out and Mary does not, the licensee may only disclose nonpublic personal financial information about Mary, but not about John and not about John and Mary jointly.

E. Time to comply with opt out. A licensee shall comply with a consumer's opt out direction as soon as reasonably practicable after the licensee receives it.

F. Continuing right to opt out. A consumer may exercise the right to opt out at any time.

G. Duration of consumer's opt-out direction.

1. A consumer's direction to opt out under this section is effective until the consumer revokes it in writing or, if the consumer agrees, electronically.

2. When a customer relationship terminates, the customer's opt out direction continues to apply to the nonpublic personal financial information that the licensee collected during or related to that relationship. If the individual subsequently establishes a new customer relationship with the licensee, the opt-out direction that applied to the former relationship does not apply to the new relationship.

H. Delivery. When a licensee is required to deliver an opt out notice by this section, the licensee shall deliver it according to Section 10.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.09: Revised Privacy Notices

A. General rule. Except as otherwise authorized in this regulation, a licensee shall not, directly or through an affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party other than as described in the initial notice that the licensee provided to that consumer under Section 5, unless:

1. The licensee has provided to the consumer a clear and conspicuous revised notice that accurately describes its policies and practices;

2. The licensee has provided to the consumer a new opt out notice;

3. The licensee has given the consumer a reasonable opportunity, before the licensee discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

4. The consumer does not opt out.

B. Examples.

1. Except as otherwise permitted by Sections 14, 15 and 16, a licensee shall provide a revised notice before it:

a. Discloses a new category of nonpublic personal financial information to any nonaffiliated third party;

b. Discloses nonpublic personal financial information to a new category of nonaffiliated third party; or

c. Discloses nonpublic personal financial information about a former customer to a nonaffiliated third party, if that former customer has not had the opportunity to exercise an opt out right regarding that disclosure.

2. A revised notice is not required if the licensee discloses nonpublic personal financial information to a new nonaffiliated third party that the licensee adequately described in its prior notice.

C. Delivery. When a licensee is required to deliver a revised privacy notice by this section, the licensee shall deliver it according to Section 10.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.10: Delivery

A. How to provide notices. A licensee shall provide any notices that this regulation requires so that each consumer can reasonably be expected to receive actual notice in writing or, if the consumer agrees, electronically.

B. Examples of reasonable expectation of actual notice.

1. A licensee may reasonably expect that a consumer will receive actual notice if the licensee:

a. Hand delivers a printed copy of the notice to the consumer;

b. Mails a printed copy of the notice to the last known address of the consumer separately, or in a policy, billing or other written communication;

c. For a consumer who conducts transactions electronically, posts the notice on the electronic site and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining a particular insurance product or service; or

d. For an isolated transaction with a consumer, such as the licensee providing an insurance quote or selling the consumer travel insurance, posts the notice and requires the consumer to acknowledge receipt of the notice as a necessary step to obtaining the particular insurance product or service.

2. Examples of unreasonable expectation of actual notice. A licensee may not, however, reasonably expect that a consumer will receive actual notice of its privacy policies and practices if it:

a. Only posts a sign in its office or generally publishes advertisements of its privacy policies and practices; or

b. Sends the notice via electronic mail to a consumer who does not obtain an insurance product or service from the licensee electronically.

C. Annual notices only. A licensee may reasonably expect that a customer will receive actual notice of the licensee's annual privacy notice if:

1. The customer uses the licensee's web site to access insurance products and services electronically and agrees to receive notices at the web site and the licensee posts its current privacy notice continuously in a clear and conspicuous manner on the web site; or

2. The customer has requested that the licensee refrain from sending any information regarding the customer relationship, and the licensee's current privacy notice remains available to the customer upon request.

D. Oral description of notice insufficient. A licensee may not provide any notice required by this regulation solely by orally explaining the notice, either in person or over the telephone.

E. Retention or accessibility of notices for customers.

1. For customers only, a licensee shall provide the initial notice required by Section 5A(1), the annual notice required by Section 6A, and the revised notice required by Section 9 so that the customer can retain them or obtain them later in writing or, if the customer agrees, electronically.

2. Examples of retention or accessibility. A licensee provides a privacy notice to the customer so that the customer can retain it or obtain it later if the licensee:

a. Hand delivers a printed copy of the notice to the customer;

b. Mails a printed copy of the notice to the last known address of the customer; or

c. Makes its current privacy notice available on a web site (or a link to another web site) for the customer who obtains an insurance product or service electronically and agrees to receive the notice at the web site.

F. Joint notice with other financial institutions. A licensee may provide a joint notice from the licensee and one or more of its affiliates or other financial institutions, as identified in the notice, as long as the notice is accurate with respect to the licensee and the other institutions. A licensee also may provide a notice on behalf of another financial institution.

G. Joint relationships. If two (2) or more consumers jointly obtain an insurance product or service from a licensee, the licensee may satisfy the initial, annual and revised notice requirements of Sections 5A, 6A and 9A, respectively, by providing one notice to those consumers jointly.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.11: Limitation on Disclosure of Nonpublic Personal Financial Information to Non-affiliated Third Parties

A. Conditions for disclosure.

1. Except as otherwise authorized in this regulation, a licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer to a nonaffiliated third party unless:

a. The licensee has provided to the consumer an initial notice as required under Section 5;

b. The licensee has provided to the consumer an opt out notice as required in Section 8;

c. The licensee has given the consumer a reasonable opportunity, before it discloses the information to the nonaffiliated third party, to opt out of the disclosure; and

d. The consumer does not opt out.

2. Opt out definition: Opt out means a direction by the consumer that the licensees not disclose nonpublic personal financial information about that consumer to a nonaffiliated third party, other than as permitted by Sections 14, 15 and 16.

3. Examples of reasonable opportunity to opt out. A licensee provides a consumer with a reasonable opportunity to opt out if:

    a. By mail. The licensee mails the notices required in Paragraph (1) of this subsection to the consumer and allows the consumer to opt out by mailing a form, calling a toll-free telephone number or any other reasonable means within thirty (30) days from the date the licensee mailed the notices.

    b. By electronic means. A customer opens an on-line account with a licensee and agrees to receive the notices required in Paragraph (1) of this subsection electronically, and the licensee allows the customer to opt out by any reasonable means within thirty (30) days after the date that the customer acknowledges receipt of the notices in conjunction with opening the account.

    c. Isolated transaction with consumer. For an isolated transaction such as providing the consumer with an insurance quote, a licensee provides the consumer with a reasonable opportunity to opt out if the licensee provides the notices required in Paragraph (1) of this subsection at the time of the transaction and requests that the consumer decide, as a necessary part of the transaction, whether to opt out before completing the transaction.

B. Application of opt out to all consumers and all nonpublic personal financial information.

1. A licensee shall comply with this section, regardless of whether the licensee and the consumer have established a customer relationship.

2. Unless a licensee complies with this section, the licensee may not, directly or through any affiliate, disclose any nonpublic personal financial information about a consumer that the licensee has collected, regardless of whether the licensee collected it before or after receiving the direction to opt out from the consumer.

C. Partial opt out. A licensee may allow a consumer to select certain nonpublic personal financial information or certain nonaffiliated third parties with respect to which the consumer wishes to opt out.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.12: Limits on Redisclosure and Reuse of Nonpublic Personal Financial Information

A. Information the licensee receives under an exception.

1. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution under an exception in Sections 15 or 16 of this regulation, the licensee's disclosure and use of that information is limited as follows:

    a. Licensee may disclose the information to the affiliates of the financial institution from which the licensee received the information;

    b. The licensee may disclose the information to its affiliates, but the licensee's affiliates may, in turn, disclose and use the information only to the extent that the licensee may disclose and use the information; and

    c. The licensee may disclose and use the information pursuant to an exception in Sections 15 or 16 of this regulation, in the ordinary course of business to carry out the activity covered by the exception under which the licensee received the information.

2. Example. If a licensee receives information from a nonaffiliated financial institution for claims settlement purposes, the licensee may disclose the information for fraud prevention, or in response to a properly authorized subpoena. The licensee may not disclose that information to a third party for marketing purposes or use that information for its own marketing purposes.

B. Information a licensee receives outside of an exception.

1. If a licensee receives nonpublic personal financial information from a nonaffiliated financial institution other than under an exception in Sections 15 or 16 of this regulation, the licensee may disclose the information only:

    a. To the affiliates of the financial institution from which the licensee received the information;

    b. To its affiliates, but its affiliates may, in turn, disclose the information only to the extent that the licensee may disclose the information; and

    c. To any other person, if the disclosure would be lawful if made directly to that person by the financial institution from which the licensee received the information.

2. Example: If a licensee obtains a customer list from a nonaffiliated financial institution outside of the exceptions in Sections 15 or 16:

    a. The licensee may use that list for its own purposes; and

    b. The licensee may disclose that list to another nonaffiliated third party only if the financial institution from which the licensee purchased the list

could have lawfully disclosed the list to that third party. That is, the licensee may disclose the list in accordance with the privacy policy of the financial institution from which the licensee received the list, as limited by the opt out direction of each consumer whose nonpublic personal financial information the licensee intends to disclose, and the licensee may disclose the list in accordance with an exception in Sections 15 or 16, such as to the licensee's attorneys or accountants.

C. Information a licensee discloses under an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party under an exception in Sections 15 or 16 of this regulation, the third party may disclose and use that information only as follows:

1. The third party may disclose the information to the licensee's affiliates;

2. The third party may disclose the information to its affiliates, but its affiliates may, in turn, disclose and use the information only to the extent that the third party may disclose and use the information; and

3. The third party may disclose and use the information pursuant to an exception in Sections 15 or 16 in the ordinary course of business to carry out the activity covered by the exception under which it received the information.

D. Information a licensee discloses outside of an exception. If a licensee discloses nonpublic personal financial information to a nonaffiliated third party other than under an exception in Sections 15 or 16 of this regulation, the third party may disclose the information only:

1. To the licensee's affiliates;

2. To the third party's affiliates, but the third party's affiliates, in turn, may disclose the information only to the extent the third party can disclose the information; and

3. To any other person, if the disclosure would be lawful if the licensee made it directly to that person.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.13: Limits on Sharing Account Number Information for Marketing Purposes

A. General prohibition on disclosure of account numbers. A licensee shall not, directly or through an affiliate, disclose, other than to a consumer reporting agency, a policy number or similar form of access number or access code for a consumer's policy or transaction account to any nonaffiliated third party for use in telemarketing, direct mail marketing or other marketing through electronic mail to the consumer.

B. Exceptions. Subsection A of this section does not apply if a licensee discloses a policy number or similar form of access number or access code:

1. To the licensee's service provider solely in order to perform marketing for the licensee's own products or services, as long as the service provider is not authorized to directly initiate charges to the account;

2. To a licensee who is a producer solely in order to perform marketing for the licensee's own products or services; or

3. To a participant in an affinity or similar program where the participants in the program are identified to the customer when the customer enters into the program.

C. Examples.

1. Policy number. A policy number, or similar form of access number or access code, does not include a number or code in an encrypted form, as long as the licensee does not provide the recipient with a means to decode the number or code.

2. Policy or transaction account. For the purposes of this section, a policy or transaction account is an account other than a deposit account or a credit card account. A policy or transaction account does not include an account to which third parties cannot initiate charges.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.14: Exception to Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Service Providers and Joint Marketing

A. General rule.

1. The opt out requirements in Sections 8 and 11 do not apply when a licensee provides nonpublic personal financial information to a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf, if the licensee:

a. Provides the initial notice in accordance with Section 5; and

b. Enters into a contractual agreement with the third party that prohibits the third party from disclosing or using the information other than to carry out the purposes for which the licensee disclosed the information, including use under an exception in Sections 15 or 16 in the ordinary course of business to carry out those purposes.

2. Example. If a licensee discloses nonpublic personal financial information under this section to a financial institution with which the licensee performs joint

marketing, the licensee's contractual agreement with that institution meets the requirements of Paragraph (1)(b) of this subsection if it prohibits the institution from disclosing or using the nonpublic personal financial information except as necessary to carry out the joint marketing or under an exception in Sections 15 or 16 in the ordinary course of business to carry out that joint marketing.

B. Service may include joint marketing. The services a nonaffiliated third party performs for a licensee under Subsection A of this section may include marketing of the licensee's own products or services or marketing of financial products or services offered pursuant to joint agreements between the licensee and one or more financial institutions.

C. Definition of "joint agreement". For purposes of this section, "joint agreement" means a written contract pursuant to which a licensee and one or more financial institutions jointly offer, endorse or sponsor a financial product or service.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.15: Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information for Processing and Servicing Transactions

A. Exceptions for processing transactions at consumer's request. The requirements for initial notice in Section 5A(2), the opt out in Sections 8 and 11, and service providers and joint marketing in Section 14 do not apply if the licensee discloses nonpublic personal financial information as necessary to effect, administer or enforce a transaction that a consumer requests or authorizes, or in connection with:

1. Servicing or processing an insurance product or service that a consumer requests or authorizes;

2. Maintaining or servicing the consumer's account with a licensee, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity;

3. A proposed or actual securitization, secondary market sale (including sales of servicing rights) or similar transaction related to a transaction of the consumer; or

4. Reinsurance or stop loss or excess loss insurance.

B. "Necessary to effect, administer or enforce a transaction" means that the disclosure is:

1. Required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out the financial transaction or providing the product or service; or

2. Required, or is a usual, appropriate or acceptable method:

a. To carry out the transaction or the product or service business of which the transaction is a part, and record, service or maintain the consumer's account in the ordinary course of providing the insurance product or service;

b. To administer or service benefits or claims relating to the transaction or the product or service business of which it is a part;

c. To provide a confirmation, statement or other record of the transaction, or information on the status or value of the insurance product or service to the consumer or the consumer's agent or broker;

d. To accrue or recognize incentives or bonuses associated with the transaction that are provided by the licensee or any other party;

e. To underwrite insurance at the consumer's request or for any of the following purposes as they relate to a consumer's insurance: account administration, reporting, investigating or preventing fraud or material misrepresentation, processing premium payments, processing insurance claims, administering insurance benefits (including utilization review activities), participating in research projects or as otherwise required or specifically permitted by federal or state law; or

f. In connection with:

    i. The authorization, settlement, billing, processing, clearing, transferring, reconciling or collection of amounts charged, debited or otherwise paid using a debit, credit or other payment card, check or account number, or by other payment means;

    ii. The transfer of receivables, accounts or interests therein; or

    iii. The audit of debit, credit or other payment information.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.16: Other Exceptions to Notice and Opt Out Requirements for Disclosure of Nonpublic Personal Financial Information

A. Exceptions to opt out requirements. The requirements for initial notice to consumers in Section 5A(2), the opt out in Sections 8 and 11, and service providers and joint marketing in Section 14 do not apply when a licensee discloses nonpublic personal financial information:

1. With the consent or at the direction of the consumer, provided that the consumer has not revoked the consent or direction;

2. To protect:

    a. the confidentiality or security of a licensee's records pertaining to the consumer, service, product or transaction;

    b. To protect against or prevent actual or potential fraud or unauthorized transactions;

    c. For required institutional risk control or for resolving consumer disputes or inquiries;

    d. To persons holding a legal or beneficial interest relating to the consumer; or

    e. To persons acting in a fiduciary or representative capacity on behalf of the consumer;

3. To provide information to insurance rate advisory organizations, guaranty funds or agencies, agencies that are rating a licensee, persons that are assessing the licensee's compliance with industry standards, and the licensee's attorneys, accountants and auditors;

4. To the extent specifically permitted or required under other provisions of law and in accordance with the federal Right to Financial Privacy Act of 1978 (12 U.S.C. 3401 et seq.), to law enforcement agencies (including the Federal Reserve Board, Office of the Comptroller of the Currency, Federal Deposit Insurance corporation, Office of Thrift Supervision, National Credit Union Administration, the Securities and Exchange Commission, the Secretary of the Treasury, with respect to 31 U.S.C. Chapter 53, Subchapter II (Records and Reports on Monetary Instruments and Transactions) and 12 U.S.C. Chapter 21 (Financial Recordkeeping), a state insurance authority, and the Federal Trade Commission), self-regulatory organizations or for an investigation on a matter related to public safety;

5. Consumer reports:

    a. To a consumer reporting agency in accordance with the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); or

    b. From a consumer report reported by a consumer reporting agency;

6. In connection with a proposed or actual sale, merger, transfer or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal financial information concerns solely consumers of the business or unit;

7. That is:

    a. To comply with federal, state or local laws, rules and other applicable legal requirements;

    b. To comply with a properly authorized civil, criminal or regulatory investigation, or subpoena or summons by federal, state or local authorities; or

    c. To respond to judicial process or government regulatory authorities having jurisdiction over a licensee for examination, compliance or other purposes as authorized by law; or

8. For purposes related to the replacement of a group benefit plan, a group health plan, a group welfare plan or a workers' compensation plan.

B. Example of revocation of consent. A consumer may revoke consent by subsequently exercising the right to opt out of future disclosures of nonpublic personal information as permitted under Section 8F.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.17: When Authorization Required for Disclosure of Nonpublic Personal Health Information

A. A licensee shall not disclose nonpublic personal health information about a consumer or customer unless an authorization is obtained from the consumer or customer whose nonpublic personal health information is sought to be disclosed.

B. Nothing in this section shall prohibit, restrict or require an authorization for the disclosure of nonpublic personal health information by a licensee for the performance of the following insurance functions by or on behalf of the licensee: claims administration; claims adjustment and management; detection, investigation or reporting of actual or potential fraud, misrepresentation or criminal activity; underwriting; policy placement or issuance; loss control; ratemaking and guaranty fund functions; reinsurance and excess loss insurance; risk management; case management; disease management; quality assurance; quality improvement; performance evaluation; provider credentialing verification; utilization review; peer review activities; actuarial, scientific, medical or public policy research; grievance procedures; internal administration of compliance, managerial, and information systems; policyholder service functions; auditing; reporting; database security; administration of consumer disputes and inquiries; external accreditation standards; the replacement of a group benefit plan or workers compensation policy or program; activities in connection with a sale, merger, transfer or exchange of all or part of a business or operating unit; any activity that permits disclosure without authorization pursuant to the federal Health Insurance Portability and Accountability Act

privacy rules promulgated by the U.S. Department of Health and Human Services; disclosure that is required, or is one of the lawful or appropriate methods, to enforce the licensee's rights or the rights of other persons engaged in carrying out a transaction or providing a product or service that a consumer requests or authorizes; and any activity otherwise permitted by law, required pursuant to governmental reporting authority, or to comply with legal process. Additional insurance functions may be added with the approval of the commissioner to the extent they are necessary for appropriate performance of insurance functions and are fair and reasonable to the interest of consumers.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.18: Authorizations

A. A valid authorization to disclose nonpublic personal health information pursuant to this Article V shall be in written or electronic form and shall contain all of the following:

1. The identity of the consumer or customer who is the subject of the nonpublic personal health information;

2. A general description of the types of nonpublic personal health information to be disclosed;

3. General descriptions of the parties to whom the licensee discloses nonpublic personal health information, the purpose of the disclosure and how the information will be used;

4. The signature of the consumer or customer who is the subject of the nonpublic personal health information or the individual who is legally empowered to grant authority and the date signed; and

5. Notice of the length of time for which the authorization is valid and that the consumer or customer may revoke the authorization at any time and the procedure for making a revocation.

B. An authorization for the purposes of this Article V shall specify a length of time for which the authorization shall remain valid, which in no event shall be for more than twenty-four (24) months.

C. A consumer or customer who is the subject of nonpublic personal health information may revoke an authorization provided pursuant to this Article V at any time, subject to the rights of an individual who acted in reliance on the authorization prior to notice of the revocation.

D. A licensee shall retain the authorization or a copy thereof in the record of the individual who is the subject of nonpublic personal health information.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.19: Authorization Request Delivery

A request for authorization and an authorization form may be delivered to a consumer or a customer as part of an opt-out notice pursuant to Section 10, provided that the request and the authorization form are clear and conspicuous. An authorization form is not required to be delivered to the consumer or customer or included in any other notices unless the licensee intends to disclose protected health information pursuant to Section 17A.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.20: Relationship to Federal Rules

Irrespective of whether a licensee is subject to the federal Health Insurance Portability and Accountability Act privacy rule as promulgated by the U.S. Department of Health and Human Services, 45 CFR 160, 164 (the "federal rule"), if a licensee complies with all requirements of the federal rule except for its effective date provision, the licensee shall not be subject to the provisions of this Article V.

Source*: Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.21: Relationship to State Laws

Nothing in this article shall preempt or supersede existing state law related to medical records, health or insurance information privacy.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.22: Protection of Fair Credit Reporting Act

Nothing in this regulation shall be construed to modify, limit or supersede the operation of the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.), and no inference shall be drawn on the basis of the provisions of this regulation regarding whether information is transaction or experience information under Section 603 of that Act.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.23: Nondiscrimination

A. A licensee shall not unfairly discriminate against any consumer or customer because that consumer or customer has opted out from the disclosure of his or her nonpublic personal financial information pursuant to the provisions of this regulation.

B. A license shall not unfairly discriminate against a consumer or customer because that consumer or customer has not granted authorization for the disclosure of his or her nonpublic personal health information pursuant to the provisions of this regulation.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.24: Violation

Any violation of the provisions of this regulation by a licensee shall be subject to the provisions of *Miss. Code Ann.* §§ 83-5-29 to 83-5-51, and to other applicable provisions of the insurance laws of the State of Mississippi.

Source: *Miss. Code Ann.* §83-5-29 to 83-5-51 (Rev. 2011)

Rule 28.25: Severability

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 28.26: Effective Date

A. Effective date. This regulation is effective August 1, 2001.

B. Notice requirement for consumers:

1. Who are the licensee's customers on the compliance date. By August 1, 2001, a licensee shall provide an initial notice, as required by Section 5, to consumers who are the licensee's customers on August 1, 2001.

2. Example: A licensee provides an initial notice to consumers who are its customers on August 1, 2001, if, by that date, the licensee has established a system for providing an initial notice to all new customers and has mailed the initial notice to all the licensee's existing customers.

C. Two-year grandfathering of service agreements. Until July 1, 2002, a contract that a licensee has entered into with a nonaffiliated third party to perform services for the licensee or functions on the licensee's behalf satisfies the provisions of Section14A (1) (b) of this regulation, even if the contract does not include a requirement that the third party maintain the confidentiality of nonpublic personal information, as long as the licensee entered into the agreement on or before July 1, 2000.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 28.27: Appendix A- Sample Clauses

Licensees, including a group of financial holding company affiliates that use a common privacy notice, may use the following sample clauses, if the clause is accurate for each institution that uses the notice. (Note that disclosure of certain information, such as assets, income and information from a consumer reporting agency, may give rise to obligations under the federal Fair Credit Reporting Act, such as a requirement to permit a consumer to opt out of disclosures to affiliates or designation as a consumer reporting agency if disclosures are made to nonaffiliated third parties.)

A-1 - Categories of information a licensee collects (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of Section 7A (1) to describe the categories of nonpublic personal information the licensee collects.

Sample Clause A-1:

We collect nonpublic personal information about you from the following sources:

1. Information we receive from you on applications or other forms;
2. Information about your transactions with us, our affiliates or others; and
3. Information we receive from a consumer reporting agency.

A-2 - Categories of information a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use one of these clauses, as applicable, to meet the requirement of Section 7A (2) to describe the categories of nonpublic personal information the licensee discloses. The licensee may use these clauses if it discloses nonpublic personal information other than as permitted by the exceptions in Sections 14, 15 and 16.

Sample Clause A-2, Alternative 1:

We may disclose the following kinds of nonpublic personal information about you:

1. Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

2. Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premiums, and payment history"]; and

3. Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Sample Clause A-2, Alternative 2:

We may disclose all the information that we collect, as described [describe location in the notice, such as "above" or "below"].

A-3 - Categories of information a licensee discloses and parties to whom the licensee discloses (institutions that do not disclose outside of the exceptions)

A license may use this clause, as applicable, to meet the requirements of Sections 7A (2), (3), and (4) to describe the categories of nonpublic personal information about customers and former customers that the licensee discloses and the categories of affiliates and nonaffiliated third parties to whom the licensee discloses. A licensee may use this clause if the licensee does not disclose nonpublic personal information to any party, other than as permitted by the exceptions in Sections 15 and 16.

Sample Clause A-3:

We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted by law.

A-4 - Categories of parties to whom a licensee discloses (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(3) to describe the categories of affiliates and nonaffiliated third parties to whom the licensee discloses nonpublic personal information. This clause may be used if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 14, 15 and 16, as well as when permitted by the exceptions in Sections 15 and 16.

Sample Clause A-4:

We may disclose nonpublic personal information about you to the following types of third parties:

1. Financial service providers, such as [provide illustrative examples, such as "life insurers, automobile insurers, mortgage bankers, securities broker dealers, and insurance agents"];

2. Non-financial companies, such as [provide illustrative examples, such as "retailers, direct marketers, airlines, and publishers"]; and

3. Others, such as [provide illustrative examples, such as "non-profit organizations"].

We may also disclose nonpublic personal information about you to nonaffiliated third parties as permitted by law.

A-5 - Service provider/joint marketing exception

A licensee may use one of these clauses, as applicable, to meet the requirements of Section 7A (5) related to the exception for service providers and joint marketers in Section 14. If a licensee discloses nonpublic personal information under this exception, the licensee shall describe the categories of nonpublic personal information the licensee discloses and the categories of third parties with which the licensee has contracted.

Sample Clause A-5, Alternative 1:

We may disclose the following information to companies that perform marketing services on our behalf or to other financial institutions with which we have joint marketing agreements:

1. Information we receive from you on applications or other forms, such as [provide illustrative examples, such as "your name, address, social security number, assets, income, and beneficiaries"];

2. Information about your transactions with us, our affiliates or others, such as [provide illustrative examples, such as "your policy coverage, premium, and payment history"]; and

3. Information we receive from a consumer reporting agency, such as [provide illustrative examples, such as "your creditworthiness and credit history"].

Sample Clause A-5, Alternative 2:

We may disclose all of the information we collect, as described [describe location in the notice, such as "above" or "below"] to companies that perform marketing services on our behalf or to other financial institutions with whom we have joint marketing agreements.

A-6 - Explanation of opt out right (institutions that disclose outside of the exceptions)

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(6) to provide an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method(s) by which the consumer may exercise that right. The licensee may use this clause if the licensee discloses nonpublic personal information other than as permitted by the exceptions in Sections 14, 15 and 16.

Sample Clause A-6:

If you prefer that we not disclose nonpublic personal information about you to nonaffiliated third parties, you may opt out of those disclosures, that is, you may direct us not to make those disclosures (other than disclosures permitted by law). If you wish to opt out of disclosures to nonaffiliated third parties, you may [describe a reasonable means of opting out, such as "call the following toll free number": (insert number)].

A-7 - Confidentiality and security (all institutions)

A licensee may use this clause, as applicable, to meet the requirement of Section 7A(8) to describe its policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Sample Clause A-7:

We restrict access to nonpublic personal information about you to [provide an appropriate description, such as "those employees who need to know that information to provide products or services to you"]. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Part 1 Chapter 29: (2001-2) (Emergency Regulation) Privacy of Personal Information (Gramm-Leach-Bliley Act)

Rule 29.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. § 83-5-1 (Rev. 1999), and Title V of the Gramm-Leach-Bliley Act, 15 U.S.C. §§ 6801-6827 (hereinafter "GLBA"), and is promulgated in accordance with the laws governing emergency rule-making proceedings found at Miss. Code Ann. § 25-43-7 (Rev. 1999), and Mississippi Department of Insurance Regulation No. 88-101.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 29.02: Purpose

The purpose of this Regulation is to extend the date by which Licensees regulated by the Mississippi Department of Insurance must comply with the provisions of Title Vof GLBA, which became effective November 13, 2000. GLBA, *inter alia*, requires Licensees to establish privacy policies, develop systems for implementing those policies and protecting personal information of consumers and customers, and provide notices to all customers prior to either the effective date or a later compliance date established by rule by the regulator.

Mississippi Department of Insurance Emergency Regulation No. 2000-7, adopted on September 19, 2000, and further adopted as Final Regulation No. 2000-6 on November 15, 2000, required Licensees to comply with Title V of GLBA by July 1, 2001. It is the purpose of this Emergency Regulation No. 2001-2 to extend said compliance date to August 1, 2001, for Licensees regulated by the Mississippi Department of Insurance.

Source: *Miss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 29.03: Definition of Licensee

For purposes of this Regulation, Licensee shall mean all licensed insurers, producers and other persons licensed or required to be licensed, or authorized or required to be authorized, or registered or required to be registered pursuant to the insurance laws of the State of Mississippi, including Health Maintenance Organizations as that term is defined at Miss. Code Ann. § 83-41-303(n) (Rev. 1999). Licensee shall also include an unauthorized insurer that accepts business placed through a licensed excess line broker in Mississippi, but only in regard to the excess line placements placed pursuant to Miss. Code Ann. § 83-21-17 et seq. (Rev. 1999).

Source: M*iss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 29.04: Extension of Time for Compliance

In order to provide sufficient time for Licensees to establish policies and systems to comply with the requirements of Title V of GLBA, which had an effective date of November 13, 2000, the Commissioner of Insurance hereby extends the time for compliance from July 1, 2001, until August 1, 2001. Licensees will not be required to be in compliance with Title V of GLBA before August 1, 2001, but must be in full compliance on and after said date.

Source: M*iss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 29.05: Repealer

This Emergency Regulation No. 2001-2 shall repeal and supersede Mississippi Department of Insurance Emergency Regulation No. 2000-7, and Final Regulation No. 2000-6, only to the extent that said Regulations require Licensees to comply with Title V of GLBA by July 1, 2001.

Source: M*iss. Code Ann.* §83-1-45 (Rev. 2011)

Rule 29.06: Effective Date

This Emergency Regulation shall be effective immediately upon filing with the Office of the Secretary of State of the State of Mississippi.

Source: M*iss. Code Ann.* §25-43-3.113 (Rev. 2010)

Part 1 Chapter 30: **(**2002-2) Issuance of Limited Licenses to Motor Vehicle Rental Companies Permitting the Selling, Soliciting, or Negotiating of Insurance in Connection with Rental of Vehicles.

Rule 30.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. §§ 83-17-1, 83-17-41, and 83-17-87 (Supp. 2001), as well as

the provisions of Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §§83-17-41; 83-17-87 (Rev. 2011)

Rule 30.02: Purpose

The purpose of this Regulation is to allow vehicle rental companies and their employees to obtain limited licenses to permit the selling, soliciting, or negotiating of specific categories of insurance in connection with the rental of vehicles in accordance with Miss. Code Ann. § 83-17-41.

Source: *Miss. Code Ann.* §83-17-41 (Rev. 2011)

Rule 30.03: Definitions

For the purposes of this Regulation, the following terms shall have the following meanings:

A. "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

B. "Limited licensee" means a person or business entity authorized to sell, solicit, or negotiate certain coverage relating to the rental of vehicles pursuant to this regulation.

C. "Rental agreement" means any written agreement setting forth the terms and conditions governing the use of a vehicle provided by the rental company for rental or lease.

D. "Rental company" means any person or business entity in the business of providing primarily motor passenger vehicles to the public under a rental agreement. For the purposes of this Regulation, rental companies are a type of “vehicles sales agency" as provided in Miss. Code Ann. § 83-17-1 (Supp. 2001).

E. "Rental period" means the term of the rental agreement.

F. "Renter" means any person obtaining the use of a vehicle from a rental company under the terms of a rental agreement.

G. "Vehicle" or "rental vehicle" means a motor vehicle of the private passenger type, including cars, passenger vans, minivans, and sport utility vehicles, and of the cargo type, including cargo vans, pickup trucks, and trucks with gross vehicle weight of less than twenty-six thousand (26,000) pounds and which do not require the operator to possess a commercial driver's license.

Source: *Miss. Code Ann.* §83-17-87 (Rev. 2011)

Rule 30.04: Authorization, Prerequisites, Violations

A. The Commissioner may issue to a rental company that has complied with the requirements of this section a limited license authorizing the limited licensee to sell, solicit, or negotiate insurance in connection with the rental of vehicles. Each limited licensee rental company shall designate a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

B. As a prerequisite for issuance of a rental company's limited license under this section, there shall be filed with the Commissioner a written application for a limited license including the designation of at least one licensed producer in accordance with Miss. Code Ann. § 83-17-61 (2)(b) (Supp. 2001) and this Regulation, signed by an officer of the applicant rental company, using the form and containing such information as the Commissioner may prescribe.

C. In the event that any applicable provision of Title 83 of the Mississippi Code, or any Regulation or of Bulletin issued by the Mississippi Department of Insurance is violated by a limited licensee, the Commissioner may, after a notice and a hearing place on probation, suspend, revoke or refuse to issue or renew the limited license or impose other administrative penalties in accordance with Miss. Code Ann. § 83-17-71 (Supp. 2001).

Source: *Miss. Code Ann.* §§83-17-71; 83-17-87 (Rev. 2011)

Rule 30.05: Categories of Insurance to be Offered: Requirements

A. The rental company licensed pursuant to subsection (1) of Section 4 of this Regulation may sell, solicit, or negotiate insurance only in connection with an incidental to the rental of vehicles, whether at the rental office, over the internet or by pre-selection of coverage in a master, corporate, individual, or group rental agreement, in any of the following general categories:

1. Personal accident insurance covering the risks of travel, including, but not limited to, accident and health insurance that provides coverage, as applicable, to renters and other rental vehicle occupants for accidental death or dismemberment and reimbursement for medical expenses resulting from an accident that occurs during the rental period;

2. Liability insurance which may include uninsured motorist coverage whether offered separately or in combination with other liability insurance, that provides coverage, as applicable, to renters and other authorized drivers of rental vehicles for liability arisingfrom the operation of the rental vehicle;

3. Personal effects insurance that provides coverage, as applicable, to renters and other vehicle occupants for the loss of, or damage to, personal effects that occurs during the rental period; and

4. Such other motor vehicle related insurance as may be approved by the Commissioner.

B. No insurance may be issued by a limited licensee pursuant to this section unless the coverage is placed with a licensed insurer as defined in Miss. Code Ann. § 83-6-1. All rates, disclosures, and policy forms must be approved by the Mississippi Department of Insurance in accordance with Miss. Code Ann. § 83-2-5 prior to use.

C. The categories of insurance set forth in this section and governed by this Regulation shall not include a Rental Company's agreement to waive its right of indemnity against a Renter for damages to the rental vehicle.

Source: M*iss. Code Ann.* §83-17-41 (Rev. 2011)

Rule 30.06: Facsimile Signatures

Facsimile signatures may be used in accordance with Miss. Code Ann. § 83-17-21.

Source: M*iss. Code Ann.* §83-17-21 (Rev. 2011)

Rule 30.07: Prohibition Against Advertisement as Agent or Broker

No limited licensee under this Regulation shall advertise, represent, or otherwise hold itself or any of its employees out as licensed insurers, insurance agents, or insurance brokers.

Source: M*iss. Code Ann.* §83-17-87 (Rev. 2011)

Rule 30.08: Payment of Premium

Premium payments should be made payable either to the Insurance Company issuing the policy or the motor vehicle rental company which has obtained this limited license. If the payment is made payable to the licensed motor vehicle rental company, then it will be the rental company's responsibility to forward such premium funds to the insurance company.

Source: M*iss. Code Ann.* §83-17-87 (Rev. 2011)

Rule 30.09: Severability

If any provision of any section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: M*iss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 30.10: Effective Date

The Effective Date of this Regulation shall be thirty (30) days from and after its adoption and filing with the Secretary of State's Office of the State of Mississippi.

Source: M*iss. Code Ann.* §25-43-3.113 (Rev. 2011)

Part 1 Chapter 31: (2003-1) Use of Credit Information for Determining Rates and Eligibility for Personal Insurance.

Rule 31.01: Purpose

The purpose of this Regulation is to set forth restrictions and procedural requirements for personal lines insurers licensed in Mississippi regarding the use of an applicant's credit history and/or insurance scores for calculating rates and determining eligibility for coverage or tier placement.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.02: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. §§ 83-5-1 and 83-5-29 through 83-5-51 (Rev. 1999), as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.03: Scope

This Regulation shall apply to personal insurance written by all personal lines insurers licensed in the State of Mississippi. Personal insurance is defined herein and must be for personal, family or household use.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.04: Definitions

The following definitions shall apply for purposes of this Regulation:

A. Adverse Action - A denial, non-renewal, or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of personal insurance.

B. Affiliate - Any company that controls, is controlled by, or is under common control with another company.

C. Applicant - An individual who has applied to be covered by a personal insurance policy with an insurer or who is in the process of applying for such coverage. The term applicant may also include an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

D. Consumer Reporting Agency - Any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties. For purposes of this Regulation, consumer reporting agency shall include any entity that prepares, assembles, evaluates, calculates and/or furnishes insurance scores.

E. Credit History - Any written, oral, or other communication of information by a consumer reporting agency bearing on an applicant's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

F. Denial - The act of refusing to offer personal insurance coverage to an applicant. An offer of placement with an affiliate insurer does not constitute denial, cancellation or nonrenewal of coverage.

G. Insurance Score - A number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or inpart on credit history for the purpose of predicting the future insuranceloss exposure of an individual applicant or insured.

H. Insurer - Any company licensed in Mississippi to write personal lines or personal insurance in Mississippi.

I. No-Hit - An absence of credit history.

J. Personal Lines or Personal Insurance - Any one of the following:

1. Private Passenger Automobile coverage.

2. Homeowner's coverage, including Renter's coverage.

3. Mobile or Manufactured Homeowner's coverage.

4. Condominium Owner's coverage.

5. Non-commercial Dwelling Fire or Dwelling Property coverage.

K. Thin File - An inability to determine credit history.

L. Tier - A category within an insurer's personal lines program into which applicants with substantially like insuring risk, or exposure factors, and expense elements are placed for purposes of determining rate or premium.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.05: Requirements

A. Insurers must maintain and make available upon request by the Department specific written procedures detailing their practices regarding credit history and insurance scores, including the following information:

1. When credit history will be ordered and when insurance scores will be ordered or calculated, e.g. at initial underwriting, upon applicant's request,etc;

2. About whom such information will be ordered or calculated, e.g. the named applicant, all known household members, etc; and,

3. How such information will be used, e.g. to calculate rates, to determine eligibility for coverage, etc.

B. If an insurer relies, in whole or in part, on an insurance score to initially underwrite or rate any applicant, or to re-underwrite or re-rate any existing class or subclass of insureds, or for tier placement, the insurer shall, before its use in determining any applicant's risk, file the insurance scoring model with the Commissioner. A Third Party may file scoring models on behalf of personal lines insurers licensed in this state. This filing shall include the factors or characteristics from an applicant's credit history that are utilized in determining an insurance score, and the algorithm, computer program, model, or other process used in determining an insurance score. The underlying support, including statistical validation, for the development of the algorithm, computer program, model, or other process that is used in determining an insurance score shall also be filed.

C. If an insurer relies, in whole or in part, on credit history or an insurance score to initially underwrite or rate any applicant, or to underwrite or re-rate an existing class or subclass of insureds, or for tier placement, the insurer shall maintain and make available upon request by the Department samples of the notification and disclosure forms utilized by the insurer as required in Section 7 of this Regulation. The insurer shall also maintain and make available upon request by the Department evidence that the notification and disclosure forms as required in Section 7 of this Regulation were furnished to the applicant.

D. If an applicant is eligible for a particular rate or tier based on all other criteria, except for the fact that an applicant's credit history or insurance score is unavailable ("no-hit") or incomplete ("thin file") for that applicant, the applicant will be given that rate or tier unless said insurer files and the Department concurs with actuarial documentation which supports other practices. The actuarial documentation shall include age segmentation as well as other reasonable criteria. Notwithstanding the above, the insurer may treat the applicant as if the applicant had neutral credit.

E. If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit history of an insured is incorrect or incomplete and if the insurer receives notice and documentation of this determination from either the consumer reporting agency or the insured, the insurer shall within thirty (30) days after receiving notice:

    1. Re-underwrite or re-rate the insured; and,

    2. Adjust the premium as indicated in Subsection G below.

F. If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit history of an applicant is incorrect or incomplete and if the insurer receives notice and documentation of this determination from either the consumer reporting agency or the applicant, the insurer shall within thirty (30) days after receiving the notice correct its records by removing the incorrect or incomplete information pertaining to the applicant.

G. If it is determined by the re-underwriting or re-rating in accordance withSubsection E. above that the insured has overpaid the premium, the insurer shall refund or credit to the insured the amount of the overpayment of premium. Such refund shall be calculated back to the shorter of either the last twelve (12) months or the actual policy period.

H. Any filing made in response to Section 5.B. of this Regulation is considered to be a commercially valuable trade secret and proprietary information of the entity filing the information. Any release of information that is filed with the Department on a proprietary basis shall be governed by Miss. Code Ann. § 25-61-9 (Rev. 1999). Any proprietary information shall be submitted under separate cover and must clearly state the desires of the party filing the information as to its confidentiality.

I. An insurance company writing personal insurance that uses credit history or insurance scores, in whole or in part, to initially underwrite or rate any applicant, or to re-underwrite or re-rate any existing class or subclass of insureds, or for tier placement, shall provide its producers with informational materials pertaining to the company's use of credit history or insurance scores in the underwriting and rating of its policies.

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.06: Prohibited Procedures

A. Insurers shall not deny, cancel or non-renew personal insurance coverage, calculate an insurance score, determine personal insurance premiums or rates, or place an applicant in a tier based on the following types of credit history:

    1. The type of credit card, charge card or debit card used by an applicant.

    2. Credit information that the insurer knows to be in dispute, if it is disputed on the applicant's credit report.

B. Insurers shall not deny, cancel or non-renew personal insurance coverage, determine personal insurance premiums, or place an applicant in a tier based solely on a lack of credit history or insurance score ("no-hit") or incomplete credit history ("thin file"), if the insurer has received accurate and complete information from the applicant.

C. Insurers shall not refuse to insure an applicant based solely on the applicant's credit history or insurance score (where insurance score is based solely on credit history), without consideration of any other applicable factor independent of credit history.

D. Insurers shall not rely solely on an applicant's credit history or insurance score (where insurance score is based solely on credit history) when electing to cancel or non-renew a policy, without consideration of any other applicable factor independent of credit history.

E. Insurers shall not use credit history or insurance score for any arbitrary, capricious, or unfairly discriminatory reason.

F. Insurers shall not request an applicant's credit history or an insurance score based on residence, sex, race, color, creed, occupation, income, physical handicap, or disability of an applicant.

G. Insurers shall not cancel or refuse to issue or renew a policy solely because the applicant does not have a credit card account.

H. Insurers shall not base an insured's initial or renewal rates for personal insurance or make a determination on an insured's application for another line of personal insurance solely upon credit history or insurance score (where insurance score is based solely on credit history), without consideration of any other applicable factor independent of credit history.

I. Insurers or Third Parties shall not use the following as a negative factor in any insurance scoring methodology or in reviewing credit history for the purpose of underwriting or rating a policy of personal insurance:

    1. Credit inquiries not initiated by the applicant or inquiries requested by the applicant for his or her own credit information.

2. Inquiries relating to insurance coverage.

3. Collection accounts with a medical industry code, if identified in the credit history.

4. Multiple lender inquiries from the home mortgage industry made within thirty (30) days of one another, unless only one (1) inquiry is considered.

5. Multiple lender inquiries from the automobile lending industrymade within thirty (30) days of one another, unless only one (1) inquiry is considered.

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.07: Notice Requirements

A. If an insurer writing personal insurance uses credit history or an insurance score in underwriting or rating an applicant, the insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit history and/or an insurance score in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such insured has previously been provided a disclosure statement.

   Use of the following example disclosure statement constitutes compliance with this subsection: "In connection with this application for insurance, we may review your credit history or obtain or use a credit-based insurance score based on the information contained in that credit history. We may use a third party in connection with the development of your insurance score."

B. Any adverse action by an insurer as defined in Section 4.A. of this Regulation shall comply with the notice requirements of the Fair Credit Reporting Act, 15 U.S.C. § 1681.

C. If an insurer takes an adverse action based upon credit history or an insurance score, the insurer shall provide notification to the applicant that an adverse action has been taken in accordance with the Fair Credit Reporting Act, 15 U.S.C. § 1681m(a). The notification may be done in writing, orally or by electronic means and must include the following:

   1. The name, address and telephone number of the consumer reporting agency, including a toll-free telephone number if it is a nationwide consumer reporting agency that provided the report.

   2. A statement that the consumer reporting agency did not make the adverse decision and is not able to explain why the decision was made.

3. A statement setting forth the applicant's right to obtain a free disclosure of the applicant's report from the consumer reporting agency.

4. A statement setting forth the applicant's right to dispute directly with the consumer reporting agency the accuracy or completeness of any information provided by the consumer reporting agency.

5. A statement explaining the reasons for the adverse action. The reasonsmust be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history", "poor credit rating", or "poor insurance score" does not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies are deemed to comply with this subsection.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.08: Indemnification

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of an agent who obtains or uses credit history and/or insurance scores for an insurer, provided the agent follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this section shall be construed to provide an applicant or insured with a cause of action that does not exist in the absence of this section.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.09: Sale of Policy Term Information By Consumer Reporting Agency

A. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about an insured's credit history or a request for an insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which an insured's insurance may expire and the terms and conditions of the insured's insurance coverage.

B. The restrictions provided in subsection (A) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance agent from whom information was received, the insurer on whose behalf such agent acted, or such insurer's affiliates or holding companies.

C. Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.10: Revocation of Certificate of Authority

Failure to comply with a material provision of this regulation is considered a violation of Miss. Code Ann. § 83-5-17 (Rev. 1999) and Miss. Code Ann. §§ 83-5-29 through 83-5-51 (Rev. 1999). Violation of said statutes may subject the insurer to the suspension or revocation of the insurer's Certificate of Authority, the imposition of an administrative fine, or both.

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.11: Protection of Fair Credit Reporting Act

Nothing in this Regulation shall be construed to modify, limit, or supersede the operation of the Fair Credit Reporting Act, 15 U.S.C. §1681, *et seq.*

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 31.12: Severability

If any section or portion of a section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of this Regulation are declared to be severable.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 31.13: Effective Date

The Effective Date of this Regulation shall be thirty (30) days from and after its adoption and filing with the Secretary of State's Office of the State of Mississippi. In order to provide sufficient time for the insurers to establish policies and systems to comply with this Regulation, the time for compliance with this Regulation is extended to March 1, 2004.

Source: *Miss. Code Ann.* §25-43-3.113 (Rev. 2010)

Rule 31.14: Mississippi Regulation 2003-1 Compliance Checklist.

Mississippi Regulation 2003-1 Compliance Checklist

Throughout this document, "Insurer" refers to company name _____, _____AIC number _____. Please check all boxes that apply and return the signed, completed checklist to the Mississippi Department of Insurance.

- ☐ The Insurer maintains and makes available upon request by the Department the following information:

-When credit history will be ordered and when insurance scores will be ordered or calculated, about whom such information will be ordered and calculated, and how such information will be used (refer to Section 5.A. for examples);
-Disclosure forms (refer to Section 7.A. for further details) provided to the applicant advising that credit report information will be ordered, as well as evidence that the disclosure forms were furnished to the applicant; and
-The adverse action notification, as detailed in Section 7.C.

☐ The Insurer (or a third party on behalf of the Insurer) has filed its insurance scoring model and underlying statistical support with the Commissioner.

☐ Check this box if any of the following applies to the Insurer and check the box below to signify which is applicable:

☐ The Insurer treats all consumers whose credit history is unavailable ("no-hit") or incomplete ("thin file") as having the most favorable credit history.

☐ Subsequent to the passing of Regulation 2003-1, the Insurer has filed and the Department is reviewing or has concurred with actuarial documentation that supports the Insurer's practices regarding no-hits and thin files. The no-hit and thin file support data submitted was segmented by age of insured.

☐ The Insurer treats no-hit and thin file applicants as having neutral credit.

☐ The Insurer provides its producers with informational materials pertaining to the Insurer's use of credit history or insurance scores in the underwriting and rating of its policies.

☐ The Insurer does not deny, cancel, or non-renew personal insurance coverage, calculate an insurance score, determine personal insurance premiums or rates, or place an applicant in a tier based on the type of credit card, charge card, or debit card used by an applicant or based on credit information that the Insurer knows to be in dispute, if it is disputed on the applicant's credit report.

☐ The Insurer does not deny, cancel, or non-renew personal insurance coverage, determine personal insurance premiums, or place an applicant in a tier based solely on an applicant's credit history being a no-hit or thin file if the Insurer has received accurate and complete information from the applicant.

☐ The Insurer does not refuse to insure an applicant based solely on the applicant's credit history or insurance score.

☐ The Insurer does not cancel or non-renew any policy based solely on the insured's credit history or insurance score.

- ☐ The Insurer does not use credit history or insurance scores for any arbitrary, capricious, or unfairly discriminatory reason.

- ☐ The Insurer does not request or calculate an applicant's credit history or reinsurance score based on residence, sex, race, color, creed, occupation, income, physical handicap, or disability of an applicant.

- ☐ The Insurer does not cancel or refuse to issue or renew any policy solely because the applicant or insured does not have a credit card account.

- ☐ The Insurer does not determine any insured's initial or renewal rates for personal insurance, or make a determination on an insured's application for another line of personal insurance, solely based upon credit history or insurance score.

- ☐ The Insurer (or third party insurance score provider) shall not use any of the following as a negative factor in any insurance scoring methodology or in reviewing credit history for the purpose of underwriting or rating a policy of personal insurance:

  -Credit inquiries not initiated by the applicant or inquiries requested by the applicant for his or her own credit information;
  -Inquiries relating to insurance coverage;
  -Collection accounts with a medical industry code, if so identified in the credit history; or
  -Multiple lender inquiries from the home mortgage industry made within 30 days of one another, unless only one inquiry is considered.
  -Multiple lender inquiries from the automobile lending industry made within 30 days of one another, unless only one inquiry is considered.

- ☐ The Insurer has reviewed and complies with the treatment of inaccurate credit history information as outlined in Sections 5.E., 5.F., and 5.G. of MS Regulation 2003-1.

- ☐ The Insurer has reviewed and complies with the notice requirements outlined in Section 7. of Mississippi Regulation 2003-1.

I, _____, as an officer of _____ do certify that said Insurer has reviewed and fully complies with Mississippi Insurance Regulation No. 2003-1. Dated: _____

Signature: _____

Source: *Miss. Code Ann.* §83-5-29 (Rev. 2011)

Part 1 Chapter 32: **(**2005-2) Special Mediation Program for Personal Lines Residential Insurance Claims Resulting from Hurricane Katrina.

Rule 32.01: Authority

The 2005 Hurricane season has been extremely destructive for Mississippi. Extensive and devastating damage was caused by Hurricane Katrina, which hit the Mississippi Gulf Coast on August 29, 2005, as a category 4 hurricane. Hurricane Katrina continued northward, blanketing the State and causing widespread major damage to homes, loss of personal belongings and corresponding loss of employment.

In response in part to the devastation of Hurricane Katrina, Senate Bill 2381, 2006 Regular Legislative Session, was passed by the Mississippi Legislature, signed by Governor Barbour on March 1, 2006, and made effective that date. Pursuant to Senate Bill 2381, the Commissioner of Insurance has the authority to establish a non-adversarial alternative dispute resolution procedure for the handling of personal lines residential insurance claims.

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. §§ 83-5-1; 83-5-29 through 83-5-51; and 83-17-1 through 83-17-89 (Rev. 2001), Senate Bill 2381, 2006 Regular Legislative Session; as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.*§83-1-47 (Rev. 2011)

Rule 32.02: Purpose and Scope

This regulation establishes a special mediation program for personal lines residential insurance claims resulting from Hurricane Katrina. It creates procedures for notice of the right to mediation, request for mediation, assignment of mediators, payment for mediation, and the conduct of mediation proceedings.

Before resorting to these procedures, insureds and insurers are encouraged to resolve claims as quickly and fairly as possible. The procedures established by this regulation are available to all first party claimants prior to commencing either litigation or the appraisal process, who have personal lines claims resulting from damage to residential property in Mississippi caused by Hurricane Katrina. Insureds that have elected to commence the appraisal process under their policies must first complete that process prior to being eligible to request the mediation procedures established hereunder. This regulation does not apply to commercial insurance (including forced-placed lender protection programs), private passenger motor vehicle insurance or to liability coverage contained in property insurance policies.

The mediation procedures established under this regulation shall not be available to the insured where the underlying issue is whether the policy was canceled, non-renewed or lapsed prior to the loss resulting from Hurricane Katrina. Insureds may submit these issues to the Consumer Assistance Division of the Department for review.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.03: Definitions

A. "Administrator" means the American Arbitration Association.

B. "Claim" means any matter on which there is a dispute or for which the insurer has denied payment. Unless the parties agree to mediate a claim involving a lesser amount, a claim involves a dispute in which the difference between the positions of the parties is $500.00 or more. Claim does not include a dispute with respect to which the insurer has reported allegations of fraud to the Department, based on an investigation by the insurer's special investigative unit.

C. "Department" means the Mississippi Department of Insurance or its designee.

D. "Insurer" means only those companies subject to the jurisdiction of the Department as provided in Miss. Code Ann. § 83-5-1 (Rev. 1999), and which provide personal residential property insurance coverage in the State of Mississippi. The term insurer shall include eligible non-admitted insurers/surplus lines insurers doing business in Mississippi pursuant to § 83-21-17 et seq. (Rev. 1999), and the Mississippi Windstorm Underwriting Association. The term insurer shall not include the National Flood Insurance Program.

E. "Mediator" means an individual selected by the Administrator designated by the Department to mediate disputes pursuant to this regulation. Mediators will be selected from a panel of mediators approved pursuant to the Mississippi Court Annexed Mediation Rules For Civil Litigation, adopted by the Mississippi Supreme Court on October 2, 1998.

F. "Party" or "Parties" means the insured and his or her insurer, including the Mississippi Windstorm Underwriting Association. The terms Party or Parties shall not include the National Flood Insurance Program.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.04: Notification of the Right to Mediate

Within 10 days of the time an insured files a first-party claim, the insurer shall mail to the insured a notice of the right to mediate disputed claims. No other materials, forms or documents may be included in the mailing that contains this notice. A sample notification letter for use by insurers is attached hereto as Exhibit "A". Use of this letter by insurers will satisfy the notification requirements of this Section.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.05: Request for Mediation

After 10 days from the date of the notice, an insured may request mediation by writing the Administrator at American Arbitration Association, Attn. MS Insurance mediation, 13455 Noel Road, Suite 1750, Dallas, TX 75240; by calling the Administrator at 1-800-426-8792; by faxing a request to the Administrator at 972-490-9008; or by contacting the Administrator on-line at Msinsmediation@adr.org.

The insured should provide the following information, if known:

A. Name, address, and daytime telephone number of the insured and location of the property if different from the address given;

B. The claim and policy number for the insured;

C. A brief description of the nature of the dispute;

D. The name of the insurer and the name, address and phone number of the insured's contact person for scheduling mediation; and

E. Information with respect to any other policies of insurance that may provide coverage of the insured property for named perils such as flood or windstorm.

Source: M*iss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.06: Scheduling of Mediation

The Administrator will select a mediator and the Administrator will schedule the mediation conference. The Administrator will attempt to facilitate reduced travel and expense to the parties and the mediator when selecting a mediator and scheduling the mediation conference. The Administrator shall confer with the mediator and all parties prior to scheduling a mediation conference. The conference shall be scheduled within 20 days from the date the Administrator received the request. The Administrator shall notify each party in writing of the date, time and place of the mediation conference at least 10 days prior to the date of the conference and concurrently send a copy of the notice to the Department. The insurer shall notify the Administrator as soon as possible after settlement of any claim that is scheduled for mediation pursuant to this regulation.

Source: M*iss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.07: Mediation Conference

A. The representative of the insurer attending the conference must bring a copy of the policy and the entire claims file to the conference. Disclosure of material from the claims file is within the discretion of the mediator, and the mediator shall avoid production of privileged materials. The representative of the insurer attending the conference must know the facts and circumstances of the claim and be knowledgeable of the provisions of

the policy. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full amount of the claim or lacks the ability to disburse the settlement amount at the conclusion of the conference.

B. A party may move to disqualify a mediator for good cause at any time. The request shall be directed to the Administrator if the grounds are known prior to the mediation conference. Good cause consists of conflict of interest between a party and the mediator, inability of the mediator to handle the conference competently, or other reasons that would reasonably be expected to impair the conference.

C. The insurer shall pay the costs of the mediation. Within 5 days of the insurer's receipt of the request for mediation, the insurer shall pay a non-refundable administrative fee in the amount of $100.00 to the Administrator, which shall be used to defer the expenses of the Administrator. The insurer shall also pay $250.00 to the Administrator for the mediator's fee not later than 5 days prior to the date scheduled for the mediation conference. However, if the mediation is cancelled for any reason more than 120 hours prior to the scheduled mediation time and date, the insurer shall pay $50.00 to the Administrator for the mediator's fee instead of $250.00. No part of the fee for the mediator shall be refunded to the insurer if the conference is cancelled within 120 hoursof the scheduled time.

D. If the insured fails to appear, without good cause as determined by the Administrator, the insured may have the conference rescheduled only upon the insured's payment of the mediation fees for the rescheduled conference. If the insurer fails to appear at the conference, without good cause as determined by the Administrator, the insurer shall pay the insured's actual expenses incurred in attending the conference and shall pay the mediator's fee whether or not good cause exists. Failure of a party to arrive at the mediation conference within 30 minutes of the conference's starting time shall be considered a failure to appear. Good cause shall consist of severe illness, injury, or other emergency which could not be controlled by the insured or the insurer and, with respect to an insurer, could not reasonably be remedied prior to the conference by providing a replacement representative or otherwise. If an insurer fails to appear at conferences with such frequency as to evidence a general business practice of failure to appear, the insurer shall be subject to penalties under Miss. Code Ann. § 83-5-29 et seq. and other applicablelaw.

E. The Department reserves the right to have a representative present at any mediation conference conducted pursuant to this regulation.

F. The mediator will be in charge of the mediation conference and will establish and describe the procedures to be followed. Each party will be given an opportunity to present their side of the controversy. In so doing, parties may utilize any relevant documents and may bring any individuals with knowledge of the issues, such as adjustors, appraisers, or contractors, to address the mediator. The mediator may meet with the parties separately, encourage meaningful communications and negotiations, and otherwise assist the parties to arrive at a settlement. The parties may be represented by

counsel at the mediation conference. A party who will be represented by counsel at the mediation conference must notify the Administrator at least 10 days prior to the date scheduled for the mediation conference. All statements made and documents reviewed at a mediation conference shall be deemed settlement negotiations in anticipation of litigation.

G. Both parties must negotiate in good faith at the mediation conference. A party will be determined to have not negotiated in good faith if the party or a person participating on the party's behalf, continuously disrupts, becomes unduly argumentative or adversarial, or otherwise inhibits the negotiations as determined by the mediator. The mediator shall terminate the conference if the mediator determines that either party is not negotiating in good faith.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.08: Post Mediation

A. Within 5 days of the conclusion of the mediation conference the mediator shall file with the Department and the Administrator a mediator's status report indicating whether or not the parties reached a settlement. If the parties reached a settlement, the mediator shall include a copy of the settlement agreement with the status report.

B. Mediation is non-binding. However, if a settlement is reached, the insured shall have 3 business days within which he or she may rescind any settlement agreement provided that the insured has not cashed or deposited any check or draft disbursed to him or her for the disputed matters as a result of the mediation conference. If a settlement agreement is reached and is not rescinded, it shall act as a release of all specific claims that were presented and actually settled. However, the release shall not constitute a final waiver of rights of the insured with respect to claims for damages or expenses if circumstances that are reasonably unforeseen arise resulting in additional costs that would have been covered under the policy but for the release.

C. If the insured decides not to participate in the mediation process or if the parties are unsuccessful at resolving the claim, the insured may choose to proceed under the appraisal process set forth in the insured's insurance policy, by litigation, or by any other dispute resolution procedure available under Mississippi law. Nothing in this regulation shall preclude an insured’s right to pursue these remedies should mediation be unsuccessful.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.09: Designation of Administrator

The Department has designated the American Arbitration Association as its Administrator to carry out certain duties and responsibilities under this regulation.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 32.10: Severability

If a court holds any subsection or portion of a subsection of this emergency regulation or the applicability thereof to any person or circumstance invalid, the remainder of the regulation shall not be affected thereby.

Source: *Miss. Code Ann.* §83-5-1 (Rev. 2011)

Rule 32.11: Effective Date

This regulation shall be effective thirty (30) days upon filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss. Code Ann.* §25-43-3.113 (Rev. 2010)

Part 1 Chapter 33: (2006-4) Availability of Hurricane Katrina Special Mediation Program to Parties in Litigation.

Rule 33.01: Authority

This Emergency Regulation is promulgated by the Commissioner of Insurance "Commissioner") pursuant to the authority granted to him by Miss. Code Ann. §§ 33-15-11(b)(9), 33-15-11(c)(4), and 83-5-1 et seq. 83-1-47; the Governor's Proclamations dated August 26, 2005, and September 2, 2005; and the State of Mississippi Emergency Operations Plan and Executive Order No. 653.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 33.02: Reasons for Finding an Imminent Peril to the Public Health, Safety or Welfare

The 2005 Hurricane season was extremely destructive for Mississippi. Extensive and devastating damage was caused by Hurricane Katrina, which hit the Mississippi Gulf Coast on August 29, 2005, as a Category 4 Hurricane. Hurricane Katrina continued northward, blanketing the State and causing widespread major damage to homes, loss of personal belongings and corresponding loss of employment.

In an effort to help resolve residential property insurance claims resulting from Katrina so that homeowners could move forward with the repair and rebuilding process, on December 20, 2005, the Commissioner adopted Emergency Regulation No. 2005-2, which established a temporary "Special Mediation Program For Personal Lines Residential Insurance Claims" ("Mediation Program" or "Program"). Subsequently, pursuant to the authority granted in Senate Bill 2381, which was passed by the Mississippi Legislature in the 2006 Regular Legislative Session, the Commissioner adopted Regulation No. 2005-2, as Amended, which established the Mediation Program on a permanent basis.

In Section 2, Regulation No. 2005-2, as Amended, provides that the Mediation Program is "...available to all first party claimants **prior to commencing either litigation** or the appraisal process." (emphasis added) While many Katrina claims have been resolved, some remain unresolved and claimants are pursuing litigation. This pending litigation has resulted in crowded court dockets and a critical need for litigants to have access to an alternative procedure for the effective, fair and timely handling of residential insurance claims. Consequently, in order to promote and secure the safety and protection of the citizens of the State of Mississippi, this Regulation is being issued by the Commissioner to expand the Mediation Program for Katrina claims to allow parties in litigation to participate, upon the issuance of an order by a court of competent jurisdiction.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 33.03: Availability of Mediation Program to Parties in Litigation

Notwithstanding any provisions to the contrary, the Mediation Program established by Regulation No. 2005-2, as Amended, shall be available for any parties ordered to participate in the Program by a court of competent jurisdiction.

In the case of parties participating in the Program by court order, the provisions of Regulation No. 2005-2, as Amended, will be followed unless the respective court directs otherwise with regard to mediation for those parties, or unless otherwise specified herein.

This Emergency Regulation applies only to mediation involving parties to litigation arising from a disputed Hurricane Katrina claim. Otherwise, the provisions of Regulation No. 2005-2, as Amended, shall remain in full force and effect.

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 33.04: Fees

With respect to court ordered mediation involving parties to litigation arising from a disputed Hurricane Katrina claim, the applicable fees shall be as follows:

A. Administrator - $200.00 per case
B. Mediator - $400.00 per case

Source: *Miss. Code Ann.* §83-1-47 (Rev. 2011)

Rule 33.05: Severability

If a court holds any subsection or portion of a subsection of this Regulation or the applicability thereof to any person or circumstance invalid, the remainder of the Regulation shall not be affected thereby.

Source: Miss. *Code Ann.* §83-5-1 (Rev. 2011)

Rule 33.06: Effective date

This Regulation No. 2006-4, shall be effective on May 25, 2007. Upon final adoption, Regulation 2006-4 shall supersede Emergency Regulation 2006-4.

Filed this the 3rd day of April, 2007.

Source: M*iss. Code Ann.* §25-43-3.113(Rev. 2011)

Part 1 Chapter 34: **(2007-1)** Mississippi Homeowner Insurance Policyholder Bill of Rights**.**

Rule 34.01: Purpose

After Hurricane Katrina hit the Mississippi Gulf Coast on August 29, 2005, and caused massive destruction within the State, the Department found that many homeowner insurance policyholders who filed property loss claims were inadequately insured or did not fully understand the insurance they had purchased.

The purpose and intent of this Regulation is to address these issues by setting forth procedures and requirements that ensure policyholders understand their rights as policyholders in the State of Mississippi, and by enacting a requirement that property and casualty insurance companies writing homeowners personal lines residential insurance property coverage establish standard checklists of policy contents.

To accomplish these goals, this Regulation sets forth the rights Mississippi policyholders have with respect to their insurance policies and insurance companies. This Regulation also requires that property and casualty insurers provide an outline of coverage and a standard checklist of policy contents to policyholders.

Policyholders should be aware that Mississippi law provides that insureds have an affirmative duty to read a contract of insurance and are bound by the contents thereof. Any outline of coverage and comprehensive policy checklist is for informational purposes only, and does not change the coverage selected and paid for by the policyholder. This Regulation is being promulgated by the Commissioner of Insurance in order to facilitate the public's understanding of homeowners' policies.

Source: *Miss. Code Ann.* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 34.02: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. §§ 83-5-1, and 83-5-29 through 83-5- 51(Rev. 2011), as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said

Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 34.03: Scope

This Regulation shall apply to all insurance companies (including surplus lines companies, the Mississippi Windstorm Underwriting Association, and the Mississippi Residential Property Insurance Underwriting Association) writing homeowners personal lines residential property coverage insurance policies in the State of Mississippi. For the purposes of this Regulation, personal lines residential property coverage shall include condominium insurance, dwelling fire policies, renters/tenants insurance and mobile home/manufactured housing property coverage, even if said coverage is classified as an automobile property policy. Creditor-placed property coverage and condominium association or homeowner association property coverage is excluded from the provisions of this Regulation.

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.04: Policyholder Bill of Rights

The rights set forth below shall serve as standards to be followed by the Mississippi Department of Insurance in exercising the Department's powers and duties, in exercising administrative discretion, in dispensing administrative interpretations of the law, and in regulating insurance companies pursuant to the Unfair and Deceptive Trade Practices Act, Miss. Code Ann. §§83-5-29 through 83-5-51. These rights include, but are not limited to, the following:

A. Policyholders shall have the right to competitive pricing practices and marketing methods that enable them to determine the best value among comparable coverage.

B. Policyholders shall have the right to insurance advertising and other selling approaches that provide accurate and balanced information on the benefits and limitations of a policy.

C. Policyholders shall have the right to assurance that the insurance market in general and their insurance company in particular is financially stable.

D. Policyholders shall have the right to receive good service from competent, honest individuals and producers, and to have their questions addressed promptly.

E. Policyholders shall have the right to a policy in an easily readable format, to receive a complete policy, and to request a duplicate or replacement policy as needed.

F. Policyholders shall have the right to assurance that their insurance company is regulated to comply with Mississippi laws requiring economic delivery of coverage and loss prevention measures.

G. Policyholders shall have the right to balanced and positive regulation by the Mississippi Department of Insurance.

H. Policyholders shall have the right to request the license status of an insurance company or producer.

I. Policyholders shall have the right to receive in writing from their insurance company the reason for any cancellation or nonrenewal of coverage. The written statement from the insurance company must provide an adequate explanation for the cancellation or nonrenewal of coverage.

J. Policyholders shall have the right to cancel their policy and receive a refund of any unearned premium. If a policy was funded by a premium finance company, the unearned premium will be returned to the premium finance company to pay toward the policyholder's financing loan.

K. Policyholders shall have the right to a written notification detailing any change in policy provisions relating to their coverage at renewal.

L. Policyholders shall have the right to receive a written explanation of why a claim is denied, in whole or in part.

M. Policyholders shall have the right to request and receive from the insurance company any adjuster reports, engineer reports, contractor reports, statements or documents which are not legally privileged documents that the insurance company prepared, had prepared, or used during its adjustment of the policyholder's claim. A company may keep confidential any documents they prepare in conjunction with a fraud investigation.

N. Policyholders shall have the right to have any decision regarding the denial or nonrenewal of their policy, or the adjustment of their rates not be based solely on the basis of their credit history without consideration of other factors. If an insurance company uses credit history, it must comply with the provisions set forth in 19 Miss. Admin. Code, Part 1, Chapter 31, "Use of Credit History and Insurance Scores for Determining Rates and Eligibility for Personal Insurance", and the Federal Fair Credit Reporting Act.

O. Policyholders shall have the right to prevent an insurance company, agent, adjuster or financial institution from disclosing their personal financial information to companies or entities that are not affiliated with the insurance company or financial institution, subject to the provisions set out in 19 Miss. Admin. Code, Part 1, Chapter 28, "Privacy of Consumer Financial and Health Information Regulation".

P. Policyholders shall have the right to receive at least thirty (30) days' notice of the nonrenewal of their policy pursuant to the provisions of Miss. Code Ann. § 83-5-28.

Q. Policyholders shall have the right to be treated fairly and honestly when making a claim.

R. Policyholders shall have the right to reject any settlement amount offered by the insurance company.

S. Policyholders shall have the right to file a written complaint against any insurance company or insurance producer with the Mississippi Department of Insurance, and to have that complaint investigated by the Mississippi Department of Insurance.

On or after September 1, 2009, no homeowners' personal lines residential property coverage insurance policy shall be delivered or issued for delivery in this state, or at renewal, unless a copy of the Policyholder Bill of Rights is included with the policy.

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.05: Outline of Coverage and Comprehensive Policy Checklist

No homeowners personal lines residential property coverage insurance policy shall be delivered or issued for delivery in this state unless an appropriate outline of coverage and comprehensive policy checklist have been delivered to the policyholder prior to or shortly thereafter issuance of the policy under separate cover, or accompany the policy when issued. The comprehensive policy checklist shall contain a list of provisions and elements, as required by this Regulation, whether or not they are included in the particular policy being issued, in a format that allows the insurer to indicate whether the provision is included so that the policyholder can see both what is included and what is not included in the policy. The outline of coverage and comprehensive policy checklist shall also be furnished at each renewal of the policy. The outline of coverage and comprehensive policy checklist shall provide information on the policy and may, but is not required, to include coverage by endorsement.

To be in compliance with this section, an insurer may use the Outline of Coverage and Comprehensive Policy Checklist prepared by the Department and attached hereto as Rule 34.11 or the insurer may create its own Outline of Coverage and Comprehensive Policy Checklist, provided the following information is included.

A. The Outline of Coverage shall provide information on the policy and may, but is not required, to include coverage by endorsement, and shall contain, at a minimum, the information set forth below.

    1. A brief description of the type of coverage provided in the policy, amount of coverage, and whether the coverage is replacement cost or actual cash value ("ACV").

    2. A summary statement of the principal exclusions and limitations or reductions contained in the policy, and any other limitations or reductions.

3. A summary of any additional coverage provided through any rider or endorsement that accompanies the policy, amount of that coverage, and whether the coverage is replacement cost or ACV.

   Any insurer electing not to use Rule 34.11, or deviating from Rule 34.11, shall file its Outline of Coverage and Comprehensive Policy Checklist with the Department for approval prior to use.

B. An insurer must insert the following language on the outline of coverage:

"The following is an outline of coverage and comprehensive policy checklist of your insurance policy and is for informational purposes only. Mississippi law prohibits this checklist from changing any of the provisions of the insurance contract which is the subject of this checklist. Any endorsement regarding changes in types of coverage, exclusions, limitations, reductions, deductibles, coinsurance, renewal provisions, cancellation provisions, surcharges, or credits is not included in this checklist, unless otherwise indicated. This checklist does not operate to expand coverage beyond the coverage provided in the policy. If there is a contradiction between this checklist and the policy, the terms of the policy govern.

Policyholders should read their policy thoroughly. Policyholders should review their insurance policy annually with their insurance producer to ensure they are adequately covered."

C. Comprehensive Policy Checklist:

As part of the Outline of Coverage for homeowners personal lines residential property coverage insurance policies, an insurance company shall prepare a Comprehensive Policy Checklist. This comprehensive checklist shall contain a list of provisions and elements as required by this Regulation, whether or not they are included in the particular policy being issued, in a format that allows the insurer to indicate whether the provision is included so that the policyholder can see both what is included and what is not included in the policy. The comprehensive Policy checklist shall address, at a minimum, the following:

1. Property coverage for the principal premises shown in the declarations;

2. Property coverage for other structures on the residence premises;

3. Whether the principal premises and other structures are insured against the following perils:

   a. Fire
   b. Lightening
   c. Explosion
   d. Wind and Hail

e. Flood
f. Earthquake
g. Collapse
h. Mold
i. Theft;

4. Personal property/contents coverage and amounts or percentage of coverage;

5. Whether personal property/contents are insured against the following perils:

a. Fire
b. Lightening
c. Explosion
d. Wind and Hail
e. Flood
f. Earthquake
g. Collapse
h. Mold
i. Theft; and,

6. Whether the policy provides the following additional coverage;

a. Debris Removal
b. Loss assessment
c. Additional living expenses
d. Personal Liability coverage
e. Medical payments coverage
f. Named Windstorm Deductible
g. Building ordinance or law coverage

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.06: Burden of Proof

As demonstrated by the ruling of the Fifth Circuit Court of Appeals in Leonard v. Nationwide, insurance companies are advised that in an all risk homeowners insurance policy an "insurer bears the burden of proving that a particular peril falls within a policy exclusion; the insurer must plead and prove the applicability of an exclusion as an affirmative defense". Leonard v. Nationwide Mutual Ins. Co.,499 F.3d 419, 429 (5th Cir. 2007).

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.07: Cause of Action

No provision contained herein shall be construed as creating a civil cause of action by any individual policyholder against any individual insurer or insurance producer. This Regulation does not operate to expand coverage beyond the coverage provided by the policy.

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.08: Violations and Penalties

The failure of an insurance company writing homeowners personal lines residential property coverage insurance policies in this State to comply with a material provision of this Regulation shall be considered a violation of Miss. Code Ann. § 83-5-1 and §§ 83-5-29 through 83-5-51 (Rev. 2011). Violation of said statutes may subject the insurance company to the suspension or revocation of the insurer's Certificate of Authority, the imposition of an administrative fine, or both.

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 34.09: Severability

If any section or portion of a section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of the Regulation are declared to be severable.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 34.10: Effective Date

The Effective Date of this amended Regulation shall be thirty (30) days from date of final filing with the Secretary of State.

Source: *Miss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Rule 34.11: Outline of Coverage and Comprehensive Policy Checklist

OUTLINE OF COVERAGE AND
COMPREHENSIVE POLICY CHECKLIST

The following is an outline of coverage and comprehensive policy checklist (hereinafter "checklist") of your insurance policy and is for informational purposes only. Mississippi law prohibits this checklist from changing any of the provisions of the insurance contract which is the subject of this checklist. Any endorsement regarding changes in types of coverage, exclusions, limitations, reductions, deductibles, coinsurance, renewal provisions, cancellation provisions, surcharges, or credits is not included in this checklist, unless otherwise indicated.

This checklist does not operate to expand coverage beyond the coverage provided in the policy. If there is a contradiction between this checklist and the policy, the terms of the policy govern.

You should read your policy thoroughly. You should review your insurance policy annually with your insurance producer to ensure you are adequately covered.

Reviewing this checklist together with your policy can help you gain a better understanding of your policy's actual coverages and limitations, and may even answer general questions. By addressing any questions now, you will be more prepared later in the event of a claim. A clear understanding of your policy's coverages and limitations will reduce confusion that may arise during claims settlement.

To fully understand your insurance policy, you should read all provisions contained therein. If you have questions regarding your policy, please contact your agent. Consumer assistance is available from the Mississippi Insurance Department, Division of Consumer Services, 1-800-562-2957 or www.mid.ms.gov .

Policy Type: (Homeowners, mobile/manufactured housing, renters/tenant)

Provide general description: **Example**: **Policy Type:** Homeowners

Your homeowners insurance policy is a package policy that combines coverage for your property that is destroyed or damaged by various perils, and provides you certain coverage for liability exposure.

Dwelling Structure Coverage

Limit of Insurance: (Policy Limits) Loss Settlement Basis: (ACV or Replacement)

Other Structure Coverage (Detached from Dwelling)

Limit of Insurance:_____ Loss Settlement Basis:_____

Personal Property Coverage

Limit of Insurance:_____ Loss Settlement Basis:_____

Deductibles

Deductible: (Amount)
Hurricane/Named Windstorm Deductible: (Amount; if applicable)

Residence and Other Structure Coverage

Items marked with a **Y(Yes)** indicate coverage **IS** included; those marked with a **N(No)** indicate coverage is **NOT** included. **Special limits and loss settlements exceptions may apply to certain limits. Refer to your policy for details. If there is a contradiction between this checklist and your policy, the terms of the policy govern.**

Coverage	**Peril**
Y	Fire
	Lightening
	Explosion
	Wind and Hail
N	Flood
	Earthquake
	Collapse
	Mold
	Theft

Personal Property/Contents Coverage

The Limit of Insurance, Deductibles, and Loss Settlement Basis apply to the following perils insured against. Items marked with a **Y(Yes)** indicate coverage **IS** included; those marked with a **N(No)** indicate coverage is **NOT** included. **Special limits and loss settlements exceptions may**

apply to certain limits. Refer to your policy for details. If there is a contradiction between this checklist and your policy, the terms of the policy govern.

Coverage	**Peril**
Y	Fire
	Lightening
	Explosion
	Wind and Hail
N	Flood
	Earthquake
	Collapse
	Mold
	Theft

Additional Coverage

Items below marked **Y(Yes)** indicate coverage **IS** include; those marked **N(No)** indicate coverage is **NOT** included. **Special limits and loss settlements exceptions may apply to certain limits. Refer to your policy for details. If there is a contradiction between this checklist and your policy, the terms of the policy govern.**

Coverage	Peril	Limit of Insurance	Time Limit
Y	Debris Removal	$5,000	n/a
	Loss Assessment		
Y	Additional Living Expenses	Actual loss sustained	24 months
	Personal		

	Liability Coverage		
	Medical payments coverage		
	Building, Ordinance or Law coverage		
	Named Windstorm Deductible	Percentage of Deductible	n/a

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Part 1 Chapter 35: (2007-3) Special Non-Binding Arbitration Program for Personal Lines Residential Insurance Claims Resulting from Hurricane Katrina**.**

Rule 35.01: Authority

The 2005 Hurricane season was extremely destructive for Mississippi. Extensive and devastating damage was caused by Hurricane Katrina, which hit the Mississippi Gulf Coast on August 29, 2005, as a Category 4 hurricane. Hurricane Katrina continued northward, blanketing the State and causing widespread major damage to homes, loss of personal belongings and corresponding loss of employment.

In response in part to the devastation of Hurricane Katrina, the Mississippi Department of Insurance ("Department") sought the passage of Senate Bill 2381, 2006 Regular Legislative Session, which was passed by the Mississippi Legislature, signed by Governor Barbour on March 1, 2006, and made effective that date. Codified as Miss. Code Ann. § 83-1-47, this statute gives the Commissioner of Insurance the authority to establish a non-binding, non-adversarial alternative dispute resolution procedure for the handling of personal lines residential insurance claims.

Furthermore, pursuant to the Governor's Proclamations dated August 26, 2005, and September 2, 2005, Governor Barbour declared a state of emergency invoking his emergency powers pursuant to Miss. Code Ann. § 35-15-11, and directed agencies of the State to discharge their emergency responsibilities as deemed necessary as set forth in the State of Mississippi Emergency Operations Plan and Executive Order No. 653, dated November 16, 1990. In accordance with the Proclamations and Executive Order, and Miss. Code Ann. §§ 33-15-11(b)(9) and 33-15-11(c)(4), there was a delegation of those emergency powers to the Commissioner of Insurance

which allows him, in his discretion, to promulgate emergency regulations and guidelines to promote and secure the safety and protection of the citizens of this State.

Regulation 2007-3 is hereby promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. §§ 83-1-47; 83-5-1; 83-5-29 through 83-5-51; as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department. This filing makes Regulation 2007-3 a permanent Regulation.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.02: Purpose and Scope

Mississippi Insurance Department Regulation 2005-2 was adopted by the Commissioner of Insurance on December 20, 2005, to allow for all Mississippi insureds to enter into a non-binding voluntary mediation conference with their insurance company regarding any claim disputes arising from Hurricane Katrina. This program has allowed over 3400 insureds' claim disputes to be resolved, and has seen an 83% successful resolution for all insureds who have participated in the Mississippi Insurance Department Hurricane Katrina Mediation Program.

As a result of the success of the Department's Hurricane Katrina Mediation Program, the Department was contacted by U.S. District Judge L.T. Senter, Jr., who is presiding over most of the Hurricane Katrina lawsuits filed in the U.S. District Court in South Mississippi. Judge Senter asked the Department to include in its regulation a mediation program for those insureds who had lawsuits pending in his court. The Commissioner of Insurance thereby adopted Mississippi Insurance Department Regulation 2006-4, which allowed any court of competent jurisdiction to order any party in litigation to participate in the Mississippi Department of Insurance Hurricane Katrina Mediation Program. This program is experiencing a successful resolution rate of approximately 50% for all litigants who participate.

However, even with the success of both mediation programs, there are insuredswho still do not have their Hurricane Katrina claims resolved. Representatives of the Department have been working on multiple fronts in an effort to find other means to have claims paid and lawsuits resolved so Mississippi can continue its rebuilding and recovery.

Therefore, on March 30, 2007, Emergency Regulation 2007-3 was promulgated by the Commissioner of Insurance. On July 27, 2007, the Emergency Regulation was extended for ninety (90) days. Due to the success of the non-binding arbitration program, the Commissioner of Insurance hereby files to make Emergency Regulation 2007-3 a permanent Regulation.

This Regulation establishes a special non-binding arbitration program for personal lines residential insurance claims resulting from Hurricane Katrina. It creates procedures for notice of the right to arbitration, request for arbitration, assignment of arbitrators, payment for arbitration, and the conduct of arbitration proceedings.

This program will allow insureds another avenue to try and have their claim resolved without requiring the insured to settle or extinguishing their right to file legal action if the matter is not resolved. It will also allow Judge Senter and any other court of competent jurisdiction to order any litigant before their Court to participate in this non-binding arbitration program in addition or as an alternative to non-binding mediation.

Except as otherwise provided in this Regulation, the procedures established by this Regulation are available to all first party claimants who have not commenced either litigation or the appraisal process who have personal lines claims resulting from damage to residential property in Mississippi caused by Hurricane Katrina. Insureds who have elected to commence the appraisal process under their policies must first complete that process prior to being eligible to request the arbitration procedures established hereunder. This Regulation does not supersede an insured's right to commence an appraisal process under their policy or to request non-binding mediation. This Regulation does not apply to commercial insurance (including forced-placed lender protection programs), private passenger motor vehicle insurance or to liability coverage contained in property insurance policies.

The arbitration procedures established under this Regulation shall not be available to the insured where the underlying issue is whether the policy was canceled, non-renewed or lapsed prior to the loss resulting from Hurricane Katrina. Insureds may submit these issues to the Consumer Assistance Division of the Department for review.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.03: Definitions

A. "Administrator" means the American Arbitration Association.

B. "Claim" means any matter on which there is a dispute or for which the insurer has denied payment. Unless the parties agree to arbitrate a claim involving a lesser amount, a claim involves a dispute in which the difference between the positions of the parties is $5000.00 or more. Claim does not include a dispute with respect to which the insurer has reported allegations of fraud to the Department or any law enforcement agency, based on an investigation by the insurer's special investigative unit.

C. "Department" means the Mississippi Department of Insurance or its designee.

D. "Insurer" means only those companies subject to the jurisdiction of the Department as provided in Miss. Code Ann. § 83-5-1 (Rev. 1999), and which provide personal residential property insurance coverage in the State of Mississippi. The term insurer shall include eligible non-admitted insurers/surplus lines insurers doing business in Mississippi pursuant to §83-21-17 et seq. (Rev. 1999), and the Mississippi Windstorm Underwriting Association. The term insurer shall not include the National Flood Insurance Program.

E. "Arbitrator" means an individual selected by the Administrator designated by the Department to arbitrate disputes pursuant to this regulation. Arbitrators will be selected from a panel of arbitrators established and maintained by the Administrator.

F. "Party" or "Parties" means the insured and his or her insurer, including the Mississippi Windstorm Underwriting Association. The terms Party or Parties shall not include the National Flood Insurance Program.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.04: Notification of the Right to Arbitrate

Insurers are to send to all insureds who have a disputed Hurricane Katrina claim insurers a Notification of the Right to Arbitrate within fourteen (14) days of the date of the adoption of this Regulation. A sample notification letter for use by insurers is attached hereto as Exhibit "A". Use of this letter by insurers will satisfy the notification requirements of this Section.

Insurers that previously sent a Notification of the Right to Arbitrate to their insureds pursuant to the requirements of Section 4 of Emergency Regulation 2007-3 are not required to send an additional notice to insureds upon the adoption of Regulation 2007-3.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.05: Request for Arbitration

After ten (10) days from the date of the notice, an insured may request arbitration by writing the Administrator at American Arbitration Association, Attn: MS Insurance Arbitration, 13455 Noel Road, Suite 1750, Dallas, TX 75240; by calling the Administrator at 1-800-426-8792; by faxing a request to the Administrator at 972-490-9008; or by contacting the Administrator on-line at Msinsarbitration@adr.org.

The insured should provide the following information, if known:

A. Name, address, and daytime telephone number of the insured and location of the property if different from the address given;

B. The claim and policy number for the insured;

C. A brief description of the nature of the dispute;

D. The name of the insurer and the name, address and phone number of the insured's contact person for scheduling arbitration; and,

E. Information with respect to any other policies of insurance that may provide coverage of the insured property for named perils such as flood or windstorm.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.06: Arbitrator and Scheduling of Arbitration

A. Appointment of Arbitrator

A list of available arbitrators will be posted online at www.adr.org. The parties are encouraged to agree to an arbitrator from this list and to advise the Administrator within ten (10) days of the Request of Arbitration of their agreement. If the parties are unable to agree upon an arbitrator, the Administrator shall make the appointment from members of the panel.

B. Disqualification of Arbitrator

The parties shall be given written notice at least twenty (20) days prior to the Arbitration Conference of the name of the Arbitrator. The parties shall have seven (7) days to file a written request that the Arbitrator be disqualified. A written request for disqualification may be made for good cause; specifically, good cause shall consist of any substantive conflict of interest between a party and the arbitrator; an inabilityof the arbitrator to handle the conference competently, with diligence or good faith; or other reason provided by applicable law. Any request for disqualification must be made in good faith. Any request to disqualify not made in good faith will result in the request for disqualification being denied.If an arbitrator is disqualified for good cause,a new arbitrator will be named within five (5) days.The Administrator shall make the determination if an arbitrator should be disqualified.

C. Scheduling of Arbitration

The Administrator will schedule the arbitration conference. The Administrator will attempt to facilitate reduced travel and expense to the parties and the arbitrator when selecting an arbitrator and scheduling the arbitration conference. The Administrator shall confer with the arbitrator and all parties prior to scheduling an arbitration conference. The parties shall receive at least twenty (20) days written notice of the date, time, and place of the arbitration conference, and the designation of the arbitrator. The insurer shall notify the Administrator as soon as possible after settlement of any claim that is scheduled for arbitration pursuant to this Regulation.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.07: Arbitration Conference

A. Exchange of Information

At least two (2) business days prior to the hearing, the parties shall exchange copies of all exhibits they intend to submit at the hearing. The arbitrator shall resolve disputes concerning the exchange of exhibits.

B. Attendance at Conference

The Arbitrator shall maintain the privacy of the conference. Any person having a direct interest in the arbitration is entitled to attend the conference. The arbitrator shall have the power to require the exclusion of any witness, other than a party or other essential person, during the testimony of any other witness. It shall be discretionary with the arbitrator to determine the propriety of the attendance of any other person other than a party and its representative. However, the Department reserves the right to have a representative present at any arbitration conference conducted pursuant to this Regulation.

The Arbitrator may postpone any conference upon agreement of the parties, upon request of a party for good cause shown, or upon the arbitrator's own initiative. Good cause shall consist of severe illness, injury, or other emergency which could not be controlled by the insured or the insurer and, with respect to an insurer, could not reasonably be remedied prior to the conference by providing a replacement representative or otherwise.

C. Representation

A party may be represented by counsel or their authorized representative. A public adjuster contracted by the insured may attend the conference, but the insured must also be present at the conference. A party intending to be represented shall notify the other party and the administrator of the name and address of the representative at least five (5) days prior to the date set for conference.

D. Conduct of Proceeding

The arbitrator shall have the right to require witnesses to testify under oath administered by any duly qualified person. The insured shall present evidence to support its claim. The insurer shall then present evidence to support its defense. Witnesses for each party shall also submit to questions from the arbitrator and the adverse party. The arbitrator has the discretion to vary this procedure, provided that the parties are treated with equality and that each party has the right to be heard and is given a fair opportunity to present its case.

The arbitrator, in its discretion, shall conduct the proceedings with a view to expediting the resolution of the dispute and may direct the order of proof, bifurcate proceedings and direct the parties to focus their presentations on issues the decisions of which could dispose of all or part of the case.

E. Evidence

The parties may offer such evidence as is relevant and material to the dispute and shall produce such evidence as the arbitrator may deem necessary to an understanding and determination of the dispute. Conformity to legal rules of evidence shall not be

necessary. All evidence shall be taken in the presence of the arbitrator and all the parties, except where any of the parties is absent, in default or has waived the right to be present. However, the arbitrator may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the arbitrator deems it entitled to after consideration of any objection made to its admission.

The arbitrator shall determine the admissibility, relevance and materiality of the evidence offered and may exclude evidence deemed by the arbitrator to be cumulative or irrelevant. The arbitrator shall take into account applicable principles of legal privilege, such as those involving the confidentiality of communications between a lawyer and client.

The representative of the insurer attending the conference must know the facts and circumstances of the claim and be knowledgeable of the provisions of the policy. An insurer will be deemed to have failed to appear if the insurer's representative lacks authority to settle the full amount of the claim.

F. Confidentiality

Confidential or privileged information disclosed to an arbitrator by the parties or by witnesses in the course of arbitration shall not be divulged by the arbitrator. All records, reports, or other documents received by an arbitrator while serving in that capacity shall be confidential. The arbitrator shall not be compelled to divulge such records or testify in regard to the arbitration in any adversary proceeding or judicial forum. All statements made and documents reviewed at the arbitration conference shall be deemed settlement negotiations in anticipation of litigation.

Neither the Department, the Administrator, or any arbitrator in a proceeding under this Regulation is a necessary or proper party in judicial proceedings related to the arbitration.

G. Mediation

At any stage of the proceedings, the parties may agree to conduct a mediation conference under the Mississippi Department of Insurance Hurricane Katrina Mediation Program as established pursuant to Regulation 2005-2, as amended. The mediator shall not be an arbitrator appointed to the case. Where the parties to a pending arbitration agree to mediate under this Regulation, no additional administrative fee shall be required to initiate the mediation.

Source: M*iss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.08: Costs of Arbitration

A. Administrative Fee

Within five (5) days of the insurer's receipt of the request for arbitration, the insurer shall pay a non-refundable administrative fee in the amount of $250.00 to the Administrator, which shall be used to defer the expenses of the Administrator.

B. Fee to Arbitrator

Arbitrators shall receive $600.00 for a three (3) hour arbitration conference, which shall be paid by the insurer. Arbitrators shall not receive costs or expenses.

The insurer shall pay $600.00 to the Administrator for the arbitrator's fee not later than five (5) days prior to the date of the arbitration conference. If the arbitration is cancelled for any reason more than 120 hours prior to the scheduled arbitration time and date, the insurer shall pay $50.00 to the Administrator for the arbitrator's fee instead of $200.00 per hour. If the conference is cancelled within 120 hours of the scheduled time, the insurer shall pay $600.00 to the Administrator for the arbitrator's fee.

C. Length of Arbitration

Each arbitration shall be scheduled for three (3) hours. The parties and the arbitrator may agree to extend the arbitration conference time. If an arbitration conference is extended beyond three (3) hours, the Arbitrator shall receive $200.00 an hour for any time over the three (3) hour conference. The insurer shall pay the additional costs to the Administrator within five (5) days after the arbitration conference.

D. Failure to Appear

If the insured fails to appear without good cause as determined by the Administrator, the insured may have the conference rescheduled only upon the insured's payment of the arbitration fees for the rescheduled conference. If the insurer fails to appear at the conference, without good cause as determined by the Administrator, the insurer shall pay the insured's actual expenses incurred in attending the conference and shall pay the arbitrator's fee whether or not good cause exists. Failure of a party to arrive at the arbitration conference within 30 minutes of the conference's starting time shall be considered a failure to appear.

Good cause shall consist of severe illness, injury, or other emergency which could not be controlled by the insured or the insurer and, with respect to an insurer, could not reasonably be remedied prior to the conference by providing a replacement representative.

If an insurer fails to appear at conferences with such frequency as to evidence a general business practice of failure to appear, the insurer shall be subject to penalties under Miss. Code Ann. § 83-5-29 et seq. and other applicable law.

Source: M*iss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.09: Post Arbitration Hearing

A. Findings of the Arbitrator

Within fourteen (14) days of the Arbitration conference, the arbitrator shall submit to the Administrator and the parties a written finding of fact. The written findings of fact shall state what remedy or relief that the arbitrator deems as just and equitable and within the scope of the agreement of the parties. The Findings of the Arbitrator are confidential and shall not be used in any other proceeding. The arbitrator shall not make any finding relating to the award of punitive damages.

Within seven (7) days of the issuance of the Findings of the Arbitrator, the parties shall contact the Administrator in writing to either accept or refuse the Findings. If the parties accept the Findings, and an award is to be made to the insured, the insurer has seven (7) days to disburse the award to the insured.

B. Settlement of Parties

If at any time throughout this process the parties are able to reach a settlement, the arbitrator shall include a copy of the settlement agreement with the status report. If a settlement is reached, the insured shall have three (3) business days to rescind any settlement agreement provided that the insured has not cashed or deposited any check or draft disbursed to him or her for the disputed matters as a result of the arbitration conference. A settlement agreement can be rescinded by contacting the Mississippi Department of Insurance at (601) 359-3581. If a settlement agreement is reached and is not rescinded, it shall act as a release of all specific claims that were presented and actually settled. However, the release shall not constitute a final waiver of rights of the insured with respect to claims for damages or expenses if circumstances that are reasonably unforeseen arise resulting in additional costs that would have been covered under the policy but for the release. If an award is to be made to the insured, the insurer has seven (7) days to disburse the award to the insured.

C. Non-binding Arbitration

This program is non-binding; therefore, neither the insured nor insurer must settle the claim or accept the Findings of the Arbitrator. Nothing in this Regulation shall preclude an insured's right to pursue any other remedy, including but not limited to, mediation, the appraisal process set forth in the insured's insurance policy, litigation, or any other dispute resolution procedure available under Mississippi law.

Source: *Miss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.10: Designation of Arbitration

The Department has designated the American Arbitration Association as its Administrator to carry out certain duties and responsibilities under this Regulation.

Source: M*iss. Code Ann.*§ 83-1-47 (Rev. 2011)

Rule 35.11: Court Ordered Arbitration

As stated above, this Regulation shall apply and be available to all first party claimants who have not commenced litigation; however, notwithstanding other provisions of this Regulation, this non-binding arbitration program shall be available to any party ordered to participate in this program by a court of competent jurisdiction.

Source: M*iss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.12: Immunity

Parties to arbitration under this Regulation shall be deemed to have consentedthat neither the Department, the Administrator nor any arbitrator shall be liable to any party in any action for damages or injunctive relief for any act or omission in connection with any arbitration under this Regulation.

Source: M*iss. Code Ann.* § 83-1-47 (Rev. 2011)

Rule 35.13: Severability

If a court holds any subsection or portion of a subsection of this Regulation or the applicability thereof to any person or circumstance invalid, the remainder of the Regulation shall not be affected thereby.

Source: M*iss. Code Ann.* § 83-5-1(Rev. 2011)

Rule 35.14: Effective Date

This Regulation shall be effective upon adoption with the Office of the Secretary of State of the State of Mississippi.

Signed this 30th day of August, 2007.

Source: M*iss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Part 1 Chapter 36: (2007-4) Licensure and Regulation of Public Adjusters

Rule 36.01: Purpose

The purpose of this Regulation is to set forth the rules and regulations for the licensure and regulation of public adjusters in the State of Mississippi.

Source: M*iss. Code Ann.* §§ 83-5-1; 83-17-501, *et seq*. (Rev. 2011)

Rule 36.02: Authority

This Regulation is promulgated by the Commissioner of Insurance as required pursuant to the provisions of the Licensure and Regulation of Public Adjusters Act ("Act") House Bill 1524, 2007 Regular Session, as approved by the Governor of Mississippi, as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: M*iss. Code Ann.* §§ 83-5-1; 83-17-501, *et seq*. (Rev. 2011)

Rule 36.03: Scope

This Regulation shall apply to individuals who act as a public adjuster in the State of Mississippi as defined in said Act and Section 4(E) of this Regulation.

Source: M*iss. Code Ann.* §§ 83-5-1; 83-17-503 (Rev. 2011)

Rule 36.04: Definitions

As used in this Regulation, the following terms shall be defined as follows:

A. Commissioner - Commissioner of Insurance.

B. Department - Mississippi Insurance Department.

C. Insured - person or business entity who is the policyholder under a real or personal property insurance claim.

D. Insurer - any insurance company or self-insured person or entity, includingsurplus lines companies.

E. Public Adjuster - any person who, for compensation or any other thing of value on behalf of the insured and subject to the prohibition provided in Section 73-3-55:

1. Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

2. Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or,

3. Directly or indirectly solicits business, investigates or adjusts loses an insured about first party claims for losses or damages arising out of polices of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy for the insured.

   A public adjuster shall not include an attorney at law.

Source: Miss. *Code Ann.* §§83-5-1; 83-17-501 (Rev. 2011)

Rule 36.05: Licensing Requirements

The Department shall issue licenses to public adjusters and emergency public adjusters in the State of Mississippi. The licensing procedure and requirements are as follows:

A. Individual Public Adjuster License - To apply for this license, an applicant must provide the following information and meet the following conditions.

   1. Licensing Requirements:

      a. Applicant is at least twenty-one (21) years of age;

      b. Applicant is a bona fide resident of this state, or is a resident of a state which will permit residents of this state to act as a public adjuster in such other state;

      c. Applicant is a trustworthy person;

      d. Applicant has had experience or special education or training with reference to the handling of loss claims under insurance contracts of sufficient duration and extent to make him competent to fulfill the responsibilities of a public adjuster, as will be discussed furtherin this Regulation;

      e. Applicant has successfully passed an examination as required by the Commissioner or has been exempted according to the provisions of the Act and this Regulation;

      f. Applicant submits documentation that he has either a bond or an errors or omissions policy in force in the amount of Fifty Thousand Dollars ($50,000) to cover any loss or claims practice of the public adjuster, or any holder of an emergency license certified by him, a copy of the Bond form is attached hereto as Exhibit "A"; and,

      g. Submission of the license and application fee in the amount of Fifty Dollars ($50.00) as set forth in Miss. Code Ann. § 27-15-97.

2. This license shall be valid for a period of one (1) year from June 1st to May 31st of the following year and shall be renewed annually

B. Business Entity Public Adjuster License- A business entity acting as a public adjuster is required to obtain a public adjuster license. This license shall be subject to the same conditions and terms as the Individual Public Adjuster License.

1. Application shall include:

a. Application form;

b. The name of the licensed individual public adjuster that shall be responsible for the business entity's compliance with the insurance laws, rules and regulations of this state;

c. Payment of license fee in the amount of Two Hundred Dollars ($200.00) as set forth in Miss. Code Ann. § 27-15-97.

2. Each public adjuster employed or connected to the business entity adjusting claims in Mississippi must also hold an individual public adjuster license.

C. Emergency License - The Commissioner may issue Emergency Licenses in the event of a catastrophe or emergency which arises out of a disaster, Act of God, riot, civil commotion, conflagration or other similar occurrence to persons who are residents or nonresidents of this state and who may or may not be licensed as public adjusters.

1. To apply for this emergency license, an applicant must provide the following information and meet the following conditions:

a. An applicant must be certified by either a person licensed under the provisions of the Act, or by any other person as approved by the Commissioner. Certification shall mean any written representations addressed to the Commissioner concerning the integrity, competence and qualification of a person, in form and content satisfactory to the Commissioner. Any person who certifies an applicant shall be responsible for the loss or claims practices of the emergency license holder;

b. The application and certification must be filed with the Departmentwithin five (5) days of the applicant beginning work as a public adjuster; and,

c. Submission of the license and application fee in the amount of Fifty Dollars ($50.00), submitted to the Commissioner within thirty (30) days of the issuance of the emergency license.

2. Emergency licenses shall be in force for ninety (90) days and may be extended for an additional ninety (90) day period by the Commissioner.

3. Should the public adjuster who certifies the emergency public adjuster either forfeit, surrender, or has his license revoked by the Commissioner, that shall also serve to revoke the emergency license of the emergency public adjuster immediately and without notice or hearing.

D. Public Adjuster Trainee Registration - An individual, who is undergoing education and training as a public adjuster under the direction and supervision of a licensed public adjuster for a period not exceeding twelve (12) months may act as a public adjuster without having a public adjuster's license, upon the following conditions:

1. At the beginning of such training period, the name of such trainee shall be registered as such with the Commissioner along with the information regarding the licensed public adjuster who is training the public adjuster trainee; and,

2. Submission of a registration fee in the amount of Fifty Dollars ($50.00) as set forth in Miss. Code Ann. § 27-15-97, shall be submitted to the Commissioner at the time of registration.

Source: M*iss. Code Ann.* §§83-5-1; 83-17-501 (Rev. 2011)

Rule 36.06: Reciprocity

The Commissioner may enter into reciprocal agreements with other states for mutual recognition of individual license holders, education or continuing education courses, provided that the other state will award licenses or recognize education or continuing education courses to residents of this state and as long as that state's requirements are substantially equivalent to those set forth under the Act or this Regulation.

Source: M*iss. Code Ann.* §§83-5-1; 83-17-507 (Rev. 2011)

Rule 36.07: Continuing Education Requirements

Every individual seeking to receive a renewal license under the Act or this Regulation shall satisfactorily complete twelve (12) hoursof study in approved courses during each twelve -month period.

A. Renewal Period - Continuing education requirements are good for one year. It shall be the responsibility of each individual to maintain records documenting continuing education activity and to submit this documentation upon completion of the course.

B. Approved Courses - Only those courses approved by the Department for individual adjusters or public adjusters shall fulfill the requirements of the Act and this Regulation.

1. Department Approved Courses - To be approved by the Department, the course or program must be one that educates on the aspects of adjusting real or personal property. For any course to be approved as a continuing education class must be submitted to the Department pursuant to Miss. Code Ann. § 83-17-253 and the Continuing Education Guidelines set forth by the Commissioner with a course outline and receive approval prior to the actual class being held.

2. Other Credits - The Commissioner may, at his discretion, approve continuing education credits for teaching of classes or for any other class, work or activity performed that the Commissioner approves as satisfaction of the continuing education requirements. It is the responsibility of the individual person to receive such approval from the Commissioner.

C. Failure to Complete Requirements - The failure of any individual to timely complete or submit their continuing education requirements shall result in denial of theirrenewal license until said continuing education requirements are met.Failure to satisfy the requirements within twelve (12) months of renewal will result in the public adjuster having to reapply for a license and take the pre-licensing examination.

D. Continuing Education Reciprocity - An individual's satisfaction of his or her home state's continuing education requirements for licensure shall constitute satisfaction of this state's continuing education requirements if the individual's home state recognizes the satisfaction of its continuing education requirements imposed upon individuals from this state on the same basis.

Source: M*iss. Code Ann.* §§83-5-1; 83-17-513 (Rev. 2011)

Rule 36.08: Pre-Licensing Examination

Each initial applicant shall take and pass an examination given by the Commissioner, or any entity he designates, to verify the applicant's knowledge, qualifications and competency. The failure of an applicant to pass the examination shall constitute denial of their license application. However, an initial applicant who is licensed as a public adjuster in another state with whom the Department has a reciprocity agreement as defined in Section 6 of this Regulation may be exempt from this requirement upon verification of the applicant's completion of the reciprocal state's pre-licensing requirements.

Source: M*iss. Code Ann.* §§83-5-1; 83-17-515 (Rev. 2011)

Rule 36.09: Violations and Penalties

The Commissioner shall have the ability to issue penalties due to violations of the Act or Regulation, as more specifically stated in this Section.

A. Violations: The following are violations that will result in administrative actions by the Commissioner:

1. Intentionally making a material misstatement in the application for an initial or renewal license;

2. Obtaining, or attempting to obtain, a license by fraud or misrepresentation;

3. Misappropriating, converting, or withholding money belonging to or entity;

4. Demonstrating a lack of trustworthiness or competence to act as a public adjuster, including ethical violations as set forth in this Regulation;

5. Convicted of fraudulent or dishonest practices or a felony;

6. Materially misrepresented the terms and conditions of insurance policies or contracts or failed to identify himself as a publicadjuster;

7. Obtaining or attempting to obtain a license for a purpose other than holding himself out to the general public as a public adjuster;

8. Violating any insurance law, regulation, subpoena, or order of the Commissioner of any other state's commissioner of insurance

9. Failure to notify the Commissioner in writing within thirty (30)days of final disposition of any administrative action or of any criminal action taken against the public adjuster in any jurisdiction; or,

10. Failure to timely respond to any inquiry by the Commissioner.

The Department reserves the right to forward any information concerning a violation to the proper law enforcement entity or the Office of the Attorney General for further investigation or action.

B. Notice and Hearing.

1. Before any license shall be denied, refused, suspended, or revoked, or an administrative penalty of not more than Five Thousand Dollars ($5000.00) be issued, the Commissioner shall give the applicant or licensee at least twenty (20) days written notice of his intention to hold a hearing on this matter. Service may be by certified mail, return receipt, or by personal service.

2. Once notice is received by a licensee that shall constituteimmediate suspension of their license.

3. The hearing shall be conducted pursuant to the Department's Rules of Practice and Procedure before the Mississippi Insurance Department, Regulation 88-101.

4. No licensee whose license was revoked pursuant to this Act or Regulation shall be entitled to file another application for a licensewithin one (1) year from the effective date of final order of revocation.

Source: *Miss. Code Ann.* §§83-5-1; 83-17-519 (Rev. 2011)

Rule 36.10: Written Contracts and Ethical Requirements

A. Written Contracts - all contracts shall be in writing, signed by the insured and the public adjuster who solicits the contract, and a copy of the contract shall be provided to the insured upon execution. Furthermore, all contracts must meet the following requirements:

1. A public adjuster may only receive compensation, payment, commission, fee or other thing of value of no more than ten percent (10%) of any insurance settlement or the proceeds of any claim investigated.The contract must expressly state that this may include monies from any previously proposed or received offers of settlement.

2. No public adjuster may require, demand or accept any fee, retainer, and compensation, deposit of other thing of value, prior to partial or full settlement of the claim.

3. Any additional costs to be reimbursed to the public adjuster shall be out of the proceeds of a settlement and shall be specified by kind and estimated amounts.

4. The insured shall have the right to revoke the contract within five (5) business days after execution. The insured may also pursue anycivil legal remedy to revoke or cancel the contract after the expiration of the cancellation period.

5. A copy of the written contract shall be kept for at least five (5) years after the termination of the transaction and shall be open to the examination by the Commissioner at all times.

6. Exhibit "B" is attached hereto containing all required provisions for use by public adjusters in their contracts.

B. Ethical Requirements - A violation of the following may result in administrative action being taken by the Department against the public adjuster pursuant to the Act and Section 9 of this Regulation:

1. No public adjuster shall undertake to adjust a claim for which he is not competent and knowledgeable to the terms and conditions of the insurance coverage or which otherwise exceeds the public adjuster's current expertise.

2. No public adjuster may represent a person or entity for which the public adjuster previously adjusted a claim as an independent adjuster, either directly or indirectly.

3. No public adjuster shall knowingly make any oral or written misrepresentations or statements to any insured or potential insured which are false and intended to injure any person engaged in the business of insurance.

4. No public adjuster shall knowingly enter into a contract to adjust a residential property claim subsequent to a declaration of total loss by an insurer, unless the services to be provided by the public adjuster can reasonably be expected to result in the insured obtaining an insurance settlement, net of the public adjuster's compensation, in excess of the amount the insured would have obtained without the services of the public adjuster.

5. At the time of entering into the contract, the public adjuster advise the insured that the insured has the right to retain an attorney at law of his choice throughout the public adjuster's investigation and adjustment of the claim.

6. If the claim is not settled by the public adjuster, the public adjuster shall advise the insured that the insured has the right to retain an attorney at law of the insured's choice.

7. No public adjuster shall contract for, agree to, or receive anything of value from any attorney at law or other person acting in concert with an attorney at law for referring claims to the attorney, or in connection with any claim for which the public adjuster has performed or intends to perform services.

8. No public adjuster shall split any attorney's fee with any attorney at law.

9. No public adjuster shall testify as an expert witness in any judicialor administrative action while maintaining a pecuniary interest in the proceeding. A public adjuster may testify as an expert witness if:

    a. His contract is converted to a specific hourly rate which constitutes reasonable, fair market value for the services provided as agreed upon by the parties; and,

    b. His contract is not subject to any contingency arrangement.

    Furthermore, the prior fee agreement between the insured and the public adjuster shall be inadmissible at trial.

Source: M*iss. Code Ann.* §§83-5-1; 83-17-523 (Rev. 2011)

Rule 36.11: Severability

If any section or portion of a section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of the Regulation are declared to be severable.

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 36.12: Effective Date

The Effective Date of this Regulation shall be July 1, 2007.

Source: *Miss. Code Ann.* § 25-43-3.113(Rev. 2010)

Rule 36.13: Exhibit A- Surety Bond for Public Adjuster Filed with the Mississippi Insurance Department

SURETY BOND FOR PUBLIC ADJUSTER FILED WITH
THE MISSISSIPPI INSURANCE DEPARTMENT

STATE OF _____
COUNTY OF _____ This form shall not be altered in any way.

Part 1: Bond, Surety and Principal.

Bond #:	Original Bond Date of Issuance:	If a Continuation Bond, Effective Date:
Name of the Surety Company:	NAIC # of Surety Company:	MID License Number of Surety Company:
Name of Principal (Public Adjuster)	MID License Number of Public Adjuster:	Amount of Bond: $50,000.00

Part 2: Type and Bond Amount.

The type and amount of the bond for one year commencing on the original date of issuance or continuation stated hereinabove at Part 1 is as follows:

Public Adjuster, Bond Equal to Fifty Thousand current U.S. Dollars ($50,000.00)

Part 3: KNOW ALL MEN BY THESE PRESENTS THAT, the Principal and Surety, who, after being duly sworn, deposed and said:

THAT they are firmly bound unto the Commissioner of Insurance , State of Mississippi, or his successor in office, under the surety bond, delivered in lieu of errors and omissions liability insurance coverage, conditioned only for and dedicated exclusively to the prompt payment of all claims arising and accruing to any persons who sustained damages as a result of the Principals erroneous acts, failure to act, conviction of fraud, or conviction of unfair practices in his capacity as a public adjuster for which the Principal and Surety bind themselves, their heirs, administrators, executors, successors and assigns, jointly and severally, by this agreement;

THAT the Commissioner of Insurance shall be authorized to recover on behalf of any person in the State of Mississippi who sustained damages described herein;

THAT the condition of this obligation is such that if the above named Principal shall well and faithfully discharge and perform the duties incumbent on him under the provisions of all applicable laws, including but not limited to Title 83 of the Mississippi Code and Mississippi Insurance Department Regulation 2007-4, then in such case the above obligation is to become null and void, else to remain in full force, effect and virtue;

THAT the provisions of all applicable laws, including but not limited to Title 83 of the Mississippi Code and Mississippi Insurance Department Regulation 2007-4, for principals and sureties are applicable;

THAT this surety bond shall not be terminated unless at least thirty days' prior written notice will have been filed with the Commissioner of Insurance, State of Mississippi, and given to the principal;

THAT this obligation may be continued for any subsequent year by a continuation certificate duly signed and sealed by the Principal and Surety, subject to the terms and conditions of the original bond, and filed with the Commissioner of Insurance, State of Mississippi;

IN WITNESS THEREOF, Principal and Surety have executed this bond on the dates stated hereinbelow.

Part 4. Signatures and Notary. Complete all information

BY:

Principal	Date	Surety's Authorized Representative	Date
Print Name		Print Name/Title of Surety's Authorized Representative	
Physical Address of Principal		Physical Address of Surety	

Subscribed and sworn to before me this the _____ day of _____, 20__

{Seal of Notary Public}

_____

Notary Public

If a power of attorney used, a copy of the power of attorney or the authorized agent of the surety company must accompany the bond.

Source: *Miss. Code Ann.* §§83-5-1; 83-17-505 (Rev. 2011)

Rule 36.14: Exhibit B- Public Adjuster Contract

PUBLIC ADJUSTER CONTRACT

The contract must be in writing and contain the following:

A. Name and address of the adjuster and the insured;
B. The home state of the adjuster;
C. MS Department of Insurance license number;
D. Insured's insurance company and policy number;
E. Description of the loss and services to be provided to the insured;

F. Signatures of the public adjuster and the insured;
G. If public adjuster is a business entity, the designated licensed public adjuster must sign the contract;
H. Date the contract was signed;
I. Notice to the insured that they may cancel the contract within five (5) business days. The following language should be used:

> "You may cancel this contract at any time prior to midnight of the fifth business days after the date this contract was signed. If you decide to cancel this contract, you will be liable for reasonable and necessary emergency out-of-pocket expenses or services which were paid for in incurred by the public adjuster to protect the interest of the insured during the period preceding cancellation.
>
> If you cancel this contract, anything of value given by you under this contract shall be returned to you within fifteen (15) business days following the receipt by the public adjuster of your cancellation notice, and any security interest arising out of the contract will be cancelled. To cancel this contract, mail, fax or deliver in person a signed and dated written notice indicating your intent to cancel this contract to (name of public adjuster) at (business address)."

J. An attestation the public adjuster is fully bonded or insured, along with a copy of the bond or errors and omissions coverage policy;
K. Specify the amount of the public adjuster's contingency fee, not to exceed 10% of monies recovered under claim. The contract must clearly state if the contingency fee shall be based upon amounts the insured previously received from the insurer for the particular claim and, if so, that provision must be initialed by the insured; and,
L. State what type of out-of-pocket expenses public adjuster would be entitled to, if any, and dollar estimates.

A copy of the executed contract must be given to the insured.

Source: *Miss. Code Ann.* §§83-5-1; 83-17-519 (Rev. 2011)

Part 1 Chapter 37: (2008-1) Military Sales Practices (Adopted 6/1/2008)

Rule 37.01: Purpose

A. The purpose of this regulation is to set forth standards to protect active duty service members of the United States Armed Forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair.

B. Nothing herein shall be construed to create or imply a private cause of action for a violation of this regulation.

Source: M*iss. Code Ann.* §§83-5-1; 83-5-29 (Rev. 2011)

Rule 37.02: Scope

This regulation shall apply onlyto the solicitation or sale of any life insurance or annuity product by an insurer orinsurance producer to an active duty service member of the United States Armed Forces.

Source: M*iss. Code Ann.* §83-5-29 (Rev. 2011)

Rule 37.03: Authority

This regulation is issued under the authority of Mississippi Code Ann. 83-5-29 through 83-5-51.

Source: M*iss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.04: Exemptions

A. This regulation shall not apply to solicitations or sales involving:

1. Credit insurance;

2. Group life insurance or group annuities where there is no in-person, face-to-facesolicitation of individuals by an insurance produceror where the contract or certificate does not include a side fund;

3. An application to the existing insurer that issued the existing policy or contract when a contractual change or a conversion privilege is being exercised; or, when the existing policy or contract is being replaced by the same insurer pursuant to a program filed with and approved by the commissioner; or, when a term conversion privilege is exercised among corporate affiliates;

4. Individual stand-alone health policies, including disability incomepolicies;

5. Contracts offered by Servicemembers' Group Life Insurance (SGLI) or Veterans' Group Life Insurance (VGLI), as authorized by 38 U.S.C. Section 1965 *et seq.*;

6. Life insurance contracts offered through or by a non-profit military association, qualifying under Section 501 (c) (23) of the Internal Revenue Code (IRC), and which are not underwritten by an insurer; or

7. Contracts used to fund:

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

b. A plan described by Sections 401(a), 401(k), 403(b), 408(k) or 408(p) of the IRC, as amended, if established or maintained by an employer;
c. A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax exempt organization under Section 457 of the IRC;
d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;
e. Settlements of or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or
f. Prearranged funeral contracts.

B. Nothing herein shall be construed to abrogate the ability of nonprofit organizations (and/or other organizations) to educate members of the United States Armed Forces in accordance with Department ofDefenseDoD Instruction 1344.07 –PERSONAL COMMERCIAL SOLICITATION ON DOD INSTALLATIONS or successor directive.

C. For purposes of this regulation, general advertisements, direct mail and internet marketing shall not constitute "solicitation."Telephone marketing shall not constitute "solicitation" provided the caller explicitly and conspicuously discloses that the product concerned is life insurance and makes no statements that avoid a clear and unequivocal statement that life insurance is the subject matter of the solicitation.Provided however, nothing in this subsectionshall be construed to exempt an insurer or insurance producer from this regulation in any in-person, face-to-face meeting established as a result of the "solicitation" exemptions identified in this subsection.

Source: *Miss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.05: Definitions

A. "Active Duty" means full-time duty in the active military service of the United States and includes members of the reserve component (National Guard and Reserve) while serving under published orders for active duty or full-time training. The term does not include members of the reserve component who are performing active duty or active duty for training under military calls or orders specifying periods of less than 31 calendar days.

B. "Department of Defense (DoD) Personnel" meansall active duty service members'employees, including non-appropriated fund employees and special government employees, of the Department of Defense.

C. "Door to Door" means a solicitation or sales method whereby aninsuranceproducer proceeds randomly or selectively from household to household without prior specific appointment.

D. “General Advertisement” means an advertisement having as its sole purpose the promotion of the reader's or viewer's interest in the concept of insurance, or the promotion of the insurer or the insurance producer.

E. “Insurer” means an insurance company required to be licensed under the laws of this state to provide life insurance products, including annuities.

F. “Insurance producer” means a person required to be licensed under the laws of this state to sell, solicit or negotiate life insurance, including annuities.

G. “Known” or “Knowingly” means, depending on its use herein, the insurance producer or insurer had actual awareness, or in the exercise of ordinary care should have known, at the time of the act or practice complained of, that the person solicited:

1. is a servicemember; or
2. is a service member with a pay grade of E-4 or below.

H. “Life Insurance” means insurance coverage on humanlives including benefits of endowment and annuities, and may includebenefits in the event of death or dismemberment by accident and benefits for disability income and unless otherwise specifically excluded, includes individually issuedannuities.

I. “Military Installation” means any federally owned, leased, or operated base, reservation, post, camp, building, or other facility to which service members are assigned for duty, including barracks, transient housing, and family quarters.

J. “MyPay” is a Defense Finance and Accounting Service (DFAS) web-based system that enables service members to process certaindiscretionary pay transactions or provide updates to personal information data elements without using paper forms.

K. “Service Member” meansany active duty officer (commissioned and warrant) or enlisted member of theUnited States Armed Forces.

L. “Side Fund” meansa fund or reserve that is part of or otherwise attached to a life insurance policy (excluding individually issuedannuities) by rider, endorsement or other mechanism which accumulates premium or deposits with interest or by other means. The term does not include:

1. accumulated valueor cash value or secondary guarantees provided by a universal life policy;

2. cash values provided by a whole life policy which are subject to standard nonforfeiture law for life insurance; or

3. a premium deposit fund which:
    a. contains only premiums paid in advance which accumulate at interest;

b. imposes no penalty for withdrawal;
c. does not permit funding beyond future required premiums;
d. is not marketed or intended as an investment; and
e. does not carry a commission, either paid or calculated.

M. "Specific Appointment" means a prearranged appointment agreed upon by both parties and definite as to place and time.

N. "United States Armed Forces" means all components of the Army, Navy, Air Force, Marine Corps, and Coast Guard.

Source: Miss. *Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.06: Practices Declared False, Misleading, Deceptive or Unfair on a Military Installation

A. The following acts or practices when committed on a military installation by an insurer or insurance producer with respect to the in-person, face-to-face solicitation of life insurance are declared to be false, misleading, deceptive or unfair:

1. Knowingly soliciting the purchase of any life insurance product "door to door" or without first establishing a specific appointment for each meeting with the prospective purchaser.

2. Soliciting service members in a group or "mass" audience or in a"captive" audience where attendance is not voluntary.

3. Knowingly making appointments with or soliciting servicemembers during their normally scheduled duty hours.

4. Making appointments with or soliciting service membersin barracks, day rooms, unit areas, or transient personnel housing or other areas where the installation commander has prohibited solicitation.

5. Soliciting the sale of life insurance without first obtaining permission from the installation commanderor the commander's designee.

6. Posting unauthorized bulletins, notices or advertisements.

7. Failing to present DD Form 2885, *Personal Commercial Solicitation Evaluation*, to service members solicited or encouraging service members solicited not to complete or submit a DD Form 2885.

8. Knowingly accepting an application for life insurance or issuing a policy of life insurance on the life of an enlisted member of the United States Armed Forces without first obtaining for the insurer's files a completed copy of any required

form which confirms that the applicant has received counseling or fulfilled any other similar requirement for the sale of life insurance established by regulations, directives or rules of the DoD or any branch of the Armed Forces.

B. The following acts or practices when committed on a military installation by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

1. Using DoDpersonnel, directly or indirectly, as a representative or agent in any official or business capacity with or without compensation with respect to the solicitation or sale of life insurance to service members.

2. Using an insurance producer to participate in any United States Armed Forces sponsored education or orientation program.

Source: M*iss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.07: Practices Declared False, Misleading, Deceptive or Unfair Regardless of Location

A. The following acts or practices by an insurer or insurance producer constitute corrupt practices, improper influences or inducements and are declared to be false, misleading, deceptive or unfair:

1. Submitting, processing or assisting in the submission or processing of any allotment form or similar device used by the United States Armed Forces to direct a service member's pay to a third party for the purchase of life insurance. The foregoing includes, but is not limited to, using or assisting in using a service member's "MyPay" account or other similar internet or electronic medium for such purposes. This subsectiondoes not prohibit assisting a service member by providing insurer or premium information necessary to complete any allotment form.

2. Knowingly receiving funds from a service member for the payment of premium from a depository institution with which the service member has no formal banking relationship. For purposes of this section, aformal banking relationship is established whenthe depository institution:

a. provides the service member a deposit agreement and periodic statements and makes the disclosures required by theTruth in Savings Act, 12 U.S.C. § 4301 *et seq*. and the regulations promulgated thereunder; and

b. permits the service member to make deposits and withdrawals unrelated to the payment or processing of insurance premiums.

3. Employing any device or method or entering into any agreement whereby funds received from a service member by allotment for the payment of insurance

premiums are identified on the service member's Leave and Earnings Statement or equivalent or successor form as "Savings" or "Checking"and where the service member has no formal bankingrelationship as defined in subsection 7 (A)(2).

4. Entering into any agreement with a depository institution for the purpose of receiving funds from a service member whereby the depository institution, with or without compensation, agrees to accept direct deposits from a service member with whom it has no formal banking relationship.

5. Using DoDpersonnel, directly or indirectly, as a representative or agent in any official or unofficialcapacity with or without compensation with respect to the solicitation or sale of life insurance to service members who are junior in rank or grade, or to the family members of such personnel.

6. Offering or giving anything of value, directly or indirectly, to DoDpersonnel to procure their assistance in encouraging, assisting or facilitating the solicitation or sale of life insurance to another service member.

7. Knowingly offering or giving anything of value to a service member with a pay grade of E-4 or below for his or her attendance to any event where an application for life insurance is solicited.

8. Advising a service member with a pay grade of E-4 or below to change his or her income tax withholding or State of legal residence for the sole purpose of increasing disposable income to purchase life insurance.

B. The following acts or practices by an insurer or insurance producer lead to confusion regarding source, sponsorship, approval or affiliation and are declared to be false, misleading, deceptive or unfair:

1. Making any representation, or using any device, title, descriptive name or identifier that has the tendency or capacity to confuse or mislead a service member into believing that the insurer, insurance producer or product offered is affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, the United States Armed Forces, or any state or federal agency or government entity. Examples of prohibited insurance producer titles include, but are not limited to, "Battalion Insurance Counselor," "Unit Insurance Advisor," "Servicemen's Group Life Insurance Conversion Consultant" or "Veteran's Benefits Counselor."

   Nothing herein shall be construed to prohibit a person from using a professional designation awarded after the successful completion of a course of instruction in the business of insurance by anaccredited institution of higher learning. Such designations include, but are not limited to, Chartered Life Underwriter (CLU), Chartered Financial Consultant (ChFC), Certified Financial Planner (CFP),

Master of Science In Financial Services (MSFS), or Masters of Science Financial Planning (MS).

2. Soliciting the purchase of any life insurance product through the use of or in conjunction with any third partyorganization that promotes the welfare of or assists members of the United States Armed Forces in a manner that has the tendency or capacity to confuse or mislead a service member into believing that eitherthe insurer, insurance producer or insurance productis affiliated, connected or associated with, endorsed, sponsored, sanctioned or recommended by the U.S. Government, or the United States Armed Forces.

C. The following acts or practices by an insurer or insurance producer lead to confusion regarding premiums, costs or investment returns and are declared to be false, misleading, deceptive or unfair:

1. Using or describing the credited interest rate on a life insurance policy in a manner that implies that the credited interest rate is a net return on premium paid.

2. Excluding individually issued annuities, misrepresenting the mortality costs of a life insurance product, including stating or implying that the product "costs nothing" or is "free."

D. The following acts or practices by an insurer or insurance producer regardingSGLI or VGLI are declared to be false, misleading, deceptive or unfair:

1. Making any representation regarding the availability, suitability,amount, cost, exclusions or limitations to coverage provided to a service member or dependentsby SGLI or VGLI, which is false, misleading or deceptive.

2. Making any representation regardingconversion requirements, includingthe costs of coverage, or exclusions or limitations to coverage of SGLI or VGLI to private insurers which is false, misleading or deceptive.

3. Suggesting, recommending or encouraging a service member to cancel or terminate his or her SGLI policy or issuing a life insurance policy which replaces an existing SGLI policy unless the replacement shall take effect upon or after the service member’s separation from the United States Armed Forces.

E. The following acts or practices by an insurer and or insurance producer regarding disclosure are declared to be false, misleading, deceptive or unfair:

1. Deploying, using or contracting for any lead generating materials designed exclusively for use with service members that do not clearly and conspicuously disclose that the recipient will be contacted by an insurance producer, if that is the case, for the purpose of soliciting the purchase of lifeinsurance.

2. Failing to disclose that a solicitation for the sale of life insurance will be made when establishing a specific appointment for an in-person, face-to-facemeeting with a prospective purchaser.

3. Excluding individually issuedannuities, failing to clearly and conspicuously disclosethe fact that the product being sold is life insurance.

4. Failing to make, at the time of sale or offerto an individual known to be a service member, the written disclosures required by Section 10 of the "Military Personnel Financial Services Protection Act,"Pub. L. No. 109-290, p.16.

5. Excluding individually issued annuities, when the sale is conducted in-person face-to-facewith an individual known to be a service member, failing to provide the applicant at the time the application is taken:

    a. an explanation of any free look period with instructions on how to cancel if a policy is issued; and

    b. either a copy of the application or a written disclosure. The copy of the application or the written disclosure shall clearly and concisely set out the type of life insurance, the death benefit applied for and its expected first year cost. A basic illustration that meets the requirements of Mississippi Regulation 98-2 shall be deemed sufficient to meet this requirement for a written disclosure.

F. The following acts or practices by an insurer or insurance producer with respect to the sale of certain life insurance products are declared to be false, misleading, deceptive or unfair:

1. Excluding individually issued annuities, recommending the purchase of any life insurance product which includes a side fund to a service member in pay grades E-4 and below unless the insurer has reasonable grounds for believing that the life insurancedeath benefit, standing alone, is suitable.

2. Offering for sale or sellinga life insurance product which includes a side fund to a service member in pay grades E-4 and below who is currently enrolled in SGLI, is presumed unsuitable unless, after the completion of a needs assessment, the insurer demonstrates that the applicant's SGLI death benefit, together with any other military survivor benefits, savings and investments, survivor income, and other life insurance are insufficient to meet the applicant's insurable needs for life insurance.

    a. "Insurable needs" are the risks associated with premature death taking into consideration the financial obligations and immediate and future cash needs of the applicant's estate and/or survivors or dependents.

b. “Other military survivor benefits” include, but are not limited to: the Death Gratuity, Funeral Reimbursement, Transition Assistance, Survivor and Dependents’ Educational Assistance,Dependency and Indemnity Compensation, TRICARE Healthcare benefits, Survivor Housing Benefits and Allowances, Federal Income Tax Forgiveness, and Social Security Survivor Benefits.

3. Excluding individually issuedannuities, offering for sale or selling any life insurance contract which includes a side fund:

   a. unless interest credited accrues from the date of deposit to the date of withdrawal and permits withdrawals without limit or penalty;

   b. unless the applicant has been provided with a schedule of effective rates of return based upon cash flows of the combined product. For this disclosure, the effective rate of return will consider all premiums and cash contributions made by the policyholder and all cash accumulations and cash surrender values available to the policyholder in addition to life insurance coverage. This schedule will be provided for at least each policy year from one (1) to ten (10) and for every fifth policy year thereafter ending at age 100, policy maturity or final expiration; and

   c. which by default diverts or transfers funds accumulated in the side fund to pay, reduce or offset any premiums due.

4. Excludingindividually issued annuities, offering for sale or selling any life insurance contract which after considering all policy benefits, including but not limited to endowment, return of premium or persistency, does not comply with standard nonforfeiture law for life insurance.

5. Selling any life insurance productto an individual known to be a service member that excludes coverage if the insured’s death is related to war, declared or undeclared, or any act related to military service except for accidental death coverage, *e.g*., double indemnity, which may be excluded.

Source: M*iss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.08: Severability

If any provision of these sections or the application thereof to any person or circumstance is held invalid for any reason, the invalidity shall not affect the other provisions or any other application of these sections which can be given effect without the invalid provisions or application. To this end all provisions of these sections are declared to be severable.

Source: M*iss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 37.09: Repeal of Regulation 2007-5

Upon adoption of Regulation 2008-1, Regulation 2007-5 shall be repealed.

Source: M*iss. Code Ann.* § 83-5-29 (Rev. 2011)

Rule 37.10: Effective Date

This regulation shall become effective June 1, 2008 and shall apply to acts or practices committed on or after the effective date.

Source: M*iss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Part 1 Chapter 38: **(**2008-2) Filing Option to Expedite Form and Rate Review for All Life, Credit Life, Annuity, and Accident and Health Contracts.
Rule 38.01: Purpose

The Mississippi Department of Insurance has seen a dramatic increase in the number of filings made in the life, annuity, and accident and health arena. These filings are becoming more complex thereby requiring a more detailed analysis. Due to the complexity of these filings, more have to be reviewed by the Department's consulting actuaries. As a result of the aforementioned, these reviews are taking longer than they have in the past.

In an attempt to expedite and become more efficient in our review and approval of form and rate filings in Mississippi, the Mississippi Department of Insurance will, pursuant to the authority granted to the Department in Senate Bill 2502, offer all companies licensed to write life, credit life, annuity, and accident and health contracts in Mississippi the option of paying the actuarial fees associated with the review and approval of said forms.

The purpose of this Regulation is to establish an expedited form and rate review process for all life, credit life, annuity, and accident and health contracts filed with the Mississippi Department of Insurance.

Source: M*iss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.02: Authority

This Regulation is promulgated by the Commissioner of Insurance as required pursuant to the provisions of Senate Bill 2502, 2008 Regular Session, as approved by the Governor of Mississippi, as well as the provisions of Mississippi Department of Insurance Regulation No. 88-101, said regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: M*iss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.03: Scope

All companies licensed to write life, credit life, annuity, and accident and healthcontracts in Mississippi shall have the option of electing the expedited review process, and paying the actuarial fees associated with the review and approval of said forms.

Source: M*iss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.04: Expedited Review Filing Procedure

All companies licensed to write life, credit life, annuity, and accident and health contracts in Mississippi have the option of electing the following procedure for the review and approval of each form and/or rate submitted:

A. Form Filings.

All companies will continue to make their form and rate filings with the Mississippi Department of Insurance.

B. Election of Expedited Review Filing.

At the time of filing, a company may elect to use the expedited filing procedure by completing the Expedited Review Filing Election Form, attached hereto as Exhibit "A".

Companies that elect to use the expedited filing procedure shall continue to send the form and rate filing to the Department. The Department will forward the form and rate filing to the actuary. Companies shall not send their form and rate filings to the actuary.

C. Expedited Review Filing Fees.

If a company elects this option, they shall include payment for each form and/or rate per the actuarial fee schedule (see subparagraph D. below), any applicable statutory fees and written notification that they are electing the expedited approval process.

D. Actuarial Fee Schedule.

The actuarial fees will be represented in a fee schedule, prepared and agreed upon by the actuary, itemizing a flat fee for each type of form or rate. Said fee schedule will be subject to semi-annual review and revision. Each company will be provided with a copy of said fee schedule and therefore will be deemed informed of the flat fee assigned to each type of form or rate. The flat fee assigned to each form or rate applies to its corresponding form or rate only, and is not affected by the actual number of filings made. Please note that the fees represented in the fee schedule reflect the initial review only. Follow-up filings

requiring substantial in-depth review or numerous revisions will require an additional fee equal to 50% of the initial filing fee in order to maintain review of the filing on the expedited track. Prompt revisions by the filer in response to basic objections will avoid the necessity of this additional fee. The Mississippi Department of Insurance shall determine what filings necessitate this additional fee.The initial fee schedule is attached hereto as Exhibit "B".

E. Payment of Fees.

If a company elects to use the expedited filing procedure, the following payments shall be made in the expressed manner:

1. Statutory Fee Payment: All applicable statutory fees shall be paid to the **Mississippi Department of Insurance**by check made payable to the Department, and said check shall be included with each request for expedited review along with the original Expedited Review Filing Election Form.

2. Actuarial Fee Payment: The actuarial fee for the applicable expeditedreview fee for each form and/or rate submitted and shall be paid by check made payable to **Actuarial Resources Corporation of Georgia**and submitted to Actuarial Resources Corporation, 2753 State Road 580, Suite 101, Clearwater, FL 33761, along with a copy of the Expedited Review Filing Election Form. Actuarial fees shall not be submitted to the Mississippi Department of Insurance.

F. Approval/Disapproval of Form and/or Rate.

All companies electing to exercise this option will receive objections, approval or disapproval of each form submitted within five (5) business days of receipt by the actuary.

G. Actuary Review.

Once a week, the Mississippi Department of Insurance shall forward all filings, marked for expedited approval, to the actuary for review. The five (5) business day time period for action on a filing does not begin to accrue until the actuary physically receives each individual form and/or rate and the applicable expedited review fee. Please note that no rates or forms will be forwarded to the actuary until all statutory fees have been received by the Mississippi Department of Insurance, and no action will be taken by the actuary until all applicable funds said actuary for review of each individual form and/or rate filing have been received by the Actuarial Resources Corporation of Georgia.

Source: *Miss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.05: Standard Filing Procedure

The Expedited Review Filing Procedure set forth in this Regulation is an optional service being offered by the Mississippi Department of Insurance in an effort to expedite form and rate filing review and approval. Companies may forego the expedited review and approval process and continue to file rates and forms as they have in the past pursuant to the provisions of Miss. Code Ann. §§ 83-7-17 and 83-9-3. Such filings shall continue to be approved or disapproved by the Department in the order in which they are received and assigned.

Source: M*iss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.06: Severability

If any section or portion of a section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of the Regulation are declared to be severable.

Source: M*iss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 38.07: Effective Date

The Effective Date of this Regulation shall be August 1, 2008.

Source: M*iss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Rule 38.08: Exhibit A- Mississippi Department of Insurance Expedited Review Filing Election Form

EXHIBIT A

MISSISSIPPI DEPARTMENT OF INSURANCE
EXPEDITED REVIEW FILING ELECTION FORM

Company Name:_____

Form Filing SERFF Number:_____

Check One:

_____ I elect to use the expedited for filing procedure. I have enclosed a check payable to the Mississippi Department of Insurance for all applicable statutory fees. I also verify I have sent a check to the Actuarial Resources Corporation of Georgia for the applicable expedited review fee.

_____ I elect to use the Standard Filing Procedure.

Source: Miss. *Code Ann.* § 83-9-3(5) (Rev. 2011)

Rule 38.09: Exhibit B- Mississippi Product and Rate Filing Fee Schedule

EXHIBIT B

MISSISSIPPI PRODUCT AND RATE FILING FEE SCHEDULE

Effective June 1, 2017

Filing Rating Classifications:

5 - Extremely High Degree of Analysis - $1,100

4 - Medium High Degree of Analysis - $825

3 - Average Degree of Analysis - $550

2 - Medium Low Degree of Analysis - $275

1 - Low Degree of Analysis - $175

1) Individual Life Insurance Policies

- Traditional Whole Life (Fixed Level or Increasing Benefits), Variable or Non-Variable 1
- Indeterminate Premium Whole Life - 2
- Single Premium Whole Life, Variable or Non-Variable - 2
- Term Life (Other than ROP Term and Deposit Term) - 3
- ROP Term - 4
- Deposit Term - 4
- Flexible Premium Adjustable WL (UL), Variable or Non-Variable, Without Secondary Guarantees - 5
- Equity Indexed (EI) Flexible Premium Adjustable WL (UL) Without Secondary Guarantees - 4
- EI Flexible Premium Adjustable WL (UL) With Secondary Guarantees - 5
- Fixed Premium Current Assumption Whole Life (CAWL) - 4
- Credit Life - 2

2) Group Life Insurance

- Group Term Life Insurance - 1
- Group Permanent Life (excluding group UL) - 2
- Group Flexible Premium Adjustable WL (UL) - 4

3) Individual Life Policy Riders/Benefits

- Accidental Death (and Dismemberment) Rider - 1
- Waiver of Premium Rider - 1
- Guaranteed Insurability Rider - 1
- Payor Death and/or Disability Rider - 1
- Waiver of Monthly Deductions (UL/CAWL) Rider - 3
- Accelerated Death Benefit Rider/Benefit - 4
- Critical Illness Rider – 4
- Long Term Care Extension of Benefits Rider - 4

4) Individual Deferred and Immediate Annuities

- Non-Equity Indexed (EI Flexible Premium Deferred Annuity With Nonforfeiture Rate Redetermination, Variable and Non-Variable - 4
- Non-Equity Indexed (EI) Flexible Premium Deferred Annuity Without Nonforfeiture Rate Redetermination, Variable and Non-Variable - 3
- EI Flexible Premium Deferred Annuity Without Nonforfeiture Rate Redetermination, Variable and Non-Variable - 4
- EI Flexible Premium Deferred Annuity With Nonforfeiture Rate Redetermination, Variable and Non-Variable - 5
- Non-EI Single Premium Deferred Annuity Without Nonforfeiture Rate Redetermination, Variable and Non-Variable - 2
- Non-EI Single Premium Deferred Annuity With Nonforfeiture Rate Redermination, Variable and Non-Variable - 3
- EI Single Premium Deferred Annuity Without Nonforfeiture Rate Redetermination, Variable and Non-Variable - 3
- EI Single Premium Deferred Annuity With Nonforfeiture Rate Redetermination, Variable and Non-Variable - 4
- Single Premium Immediate Annuity, Life Contingent/Non-Life Contingent - 2
- Variable Single Premium Immediate Annuity, Life Contingent/Non-Life Contingent – 3
- Guaranteed Living Benefits Rider - 4

5) Group Deferred Annuities

- Group Deferred Annuity - 2
- Group Variable Deferred Annuity – 3
- Guaranteed Investment Contract – 2
- EI Guaranteed Investment Contract - 3

6) Individual Accident and Health Insurance Forms (Including Initial rate Filing)

- ~~Standardized~~ Medicare Supplement Insurance - 4
- Long Term Care Insurance - 4

- Major Medical Insurance - 3
- Short Term Disability Insurance (STD) - 2
- Long Term Disability Insurance (LTD) - 2
- Hospital Indemnity Insurance - 2
- Accidental Death (and Dismemberment) Insurance - 1
- Medical/Surgical Insurance - 3
- Cancer Insurance - 3
- Credit Accident and Health – 3
- Critical Illness Insurance - 4

7) Group Accident and Health Insurance Forms (Including Initial Rate Filing)

- Medicare Supplement Insurance - 4
- Long Term Care Insurance - 4
- Large Group Major Medical Insurance - 3
- Small Group Major Medical Insurance –5
- Short Term Disability Insurance (STD) - 3
- Long Term Disability Insurance (LTD) – 2
- Critical Illness Insurance - 4

8) Individual Accident and Health Insurance Renewal Rate Filings

- Medicare Supplement Insurance - 4
- Long Term Care Insurance - 5
- Major Medical Insurance –5
- Short Term Disability Insurance (STD) - 3
- Long Term Disability Insurance (LTD) - 3
- Hospital Indemnity Insurance - 2
- Accidental Death (and Dismemberment) Insurance - 1
- Medical/Surgical Insurance - 2
- Cancer Insurance – 3
- Critical Illness Insurance - 4

9) Group Accident and Health Insurance Renewal Rate Filings

- Small Group Major Medical Insurance – ~~4~~ 5
- Long Term Care Insurance - 5
- Medicare Supplement Insurance – 4
- Critical Illness Insurance - 4

Source: *Miss. Code Ann.* § 83-9-3(5) (Rev. 2011)

Part 1 Chapter 39: **(**2009-2) Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition.

Rule 39.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to Miss. Code Ann. §§ 83-1-29; 83-1-155; 83-5-17; 83-6-37; 83-7-43; 83-19-31; 83-21-13; 83-23-1; 83-30-59; 83-30-61; 83-41-339; 83-41-341; 83-41-343; 83-24-1 et seq., and any other section where the term "hazardous financial condition" or a similar term is used; and in accordance with the provisions of Mississippi Insurance Department Regulation No. 88-101, saidregulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* § 83-5-17, et al. (Rev. 2011)

Rule 39.02: Purpose

The purpose of this regulation is to set forth the standards which the Commissioner may use for identifying insurers found to be in such condition as to render the continuance of their business hazardous to their policyholders, creditors or the general public. This regulation shall not be interpreted to limit the powers granted the Commissioner by any laws or parts of laws of this State, nor shall this regulation be interpreted to supersede any laws or parts of laws of this State, except as otherwise provided in Section 7 hereof.

Source: *Miss. Code Ann.* § 83-5-17, et al. (Rev. 2011)

Rule 39.03: Standards

The following standards, either singly or a combination of two or more, may be considered by the Commissioner to determine whether the continued operation of any insurer transacting an insurance business in this State might be deemed to be hazardous to its policyholders, creditors or the general public. The Commissioner may consider:

A. Adverse findings reported in financial condition and market conduct examination reports, audit reports, and actuarial opinions, reports or summaries;

B. The National Association of Insurance Commissioners Insurance Regulatory Information System and its other financial analysis solvency tools and reports;

C. Whether the insurer has made adequate provision, according to presently accepted actuarial standards of practice, for the anticipated cash flows required by the contractual obligations and related expenses of the insurer, whenconsidered in light of the assets held by the insurer with respect to such reserves and related actuarial items including, but not limited to, the investment earnings on such assets, and the considerations anticipated to be received and retained under such policies and contracts;

D. The ability of an assuming reinsurer to perform and whether the insurer's reinsurance program provides sufficient protection for the insurer's remaining surplus after taking into account the insurer's cash flow and the classes of business written as well as the financial condition of the assuming reinsurer;

E. Whether the insurer’s operating loss in the last twelve-month period or any shorter period of time, including but not limited to net capital gain or loss, change in non-admitted assets, and cash dividends paid to shareholders, is greater than fifty percent (50%) of the insurer’s remaining surplus as regards policyholders in excess of the minimum required;

F. Whether the insurer's operating loss in the last twelve-month period or any shorter period of time, excluding net capital gains, is greater than twenty percent (20%) of the insurer's remaining surplus as regards policyholders in excess of the minimum required;

G. Whether a reinsurer, obligor or any entity within theinsurer’s insurance holding company system, is insolvent, threatened with insolvency, or delinquent in payment of its monetary or other obligations, and which in the opinion of the Commissioner may affect the solvency of the insurer;

H. Contingent liabilities, pledges or guaranties which either individually or collectively involve a total amount which in the opinion of theCommissioner may affect the solvency of the insurer;

I. Whether any “controlling person” of an insurer is delinquent in the transmitting to, or payment of, net premiums to the insurer;

J. The age and collectability of receivables;

K. Whether the management of an insurer, including officers, directors, or any other person who directly or indirectly controls the operation of the insurer, fails to possess and demonstrate the competence, fitness and reputation deemed necessary to serve the insurer in such position;

L. Whether management of an insurer has failed to respond to inquiries relative to the condition of the insurer or has furnished false and misleading information concerning an inquiry;

M. Whether the insurer has failed to meet financial and holding company filing requirements in the absence of a reason satisfactory to the Commissioner; whether management of an insurer either has filed any false or misleading sworn financial statement, or has released any false or misleading financial statement to lending institutions or to the general public, or has made a false or misleading entry, or has omitted an entry of material amount in the books of the insurer;

N. Whether the insurer has grown so rapidly and to such an extent that it lacks adequate financial and administrative capacity to meet its obligations in a timely manner;

O. Whether the insurer has experienced or will experience in the foreseeable future cash flow or liquidity problems;

P. Whether management has established reserves that do not comply with minimum standards established by state insurance laws, regulations, statutory accounting standards, sound actuarial principles and standards of practice;

Q. Whether management persistently engages in material under reserving that results in adverse development;

R. Whether transactions among affiliates, subsidiaries or controlling persons for which the insurer receives assets or capital gains, or both, do not provide sufficient value, liquidity or diversity to assure the insurer's ability to meet its outstanding obligations as they mature; and,

S. Anyother finding determined by the Commissioner to be hazardous to the insurer's policyholders, creditors or general public.

Source: M*iss. Code Ann.* § 83-5-17, et al. (Rev. 2011)

Rule 39.04: Commissioner's Authority

A. For the purposes of making a determination of an insurer's financial condition under this regulation, the Commissioner may:

1. Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to a delinquency proceeding;

2. Make appropriate adjustments including disallowance to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates consistent with the NAICAccounting Policies And Procedures Manual, state lawsand regulations;

3. Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the financial condition of the debtor; and,

4. Increase the insurer's liability in an amount equal to any contingent liability, pledge, or guarantee not otherwise included if there is a substantial riskthat the insurer will be called upon to meet the obligation undertaken within the next twelve-month period.

B. If the Commissioner determines that the continued operation of the insurer licensed to transact business in this State may be hazardous to its policyholders, creditors or the general public, then the Commissioner may, upon a determination, issue an order requiring the insurer to:

1. Reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. Reduce, suspend or limit the volume of business being accepted or renewed;

3. Reduce general insurance and commission expenses by specified methods;

4. Increase the insurer's capital and surplus;

5. Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. File reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

7. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

8. Document the adequacy of premium rates in relation to therisks insured;

9. File, in addition to regular annual statements, interim financial reports on the form adopted by the National Association of Insurance Commissioners or in such format as promulgated by the Commissioner;

10. Correct corporate governance practice deficiencies, and adopt and utilize governance practices acceptable to the Commissioner;

11. Provide a business plan to the Commissioner in order to continue totransact business in the state;

12. Notwithstanding any other provision of law limiting the frequency or amount of premium rate adjustments, adjust rates for any non-life insurance product written by the insurer that the Commissioner considers necessary to improve the financial condition of the insurer.

13. If the insurer is a foreign insurer, the Commissioner’s order may be limited to the extent provided by statute.

C. An insurer subject to an order under Subsection B may request a hearing to review that order. The notice of hearing shall be served upon the insurer pursuant to Mississippi Insurance Department Regulation No. 88-101(VIII)(A). The notice of hearing shall state the time and place of hearing, and the conduct, condition or ground upon which the Commissioner based the order. Unless mutually agreed between the Commissioner and the insurer, the hearing shall occur not less than ten (10) days nor more than thirty (30) days afternotice is served. The Commissioner shall hold all hearings under this

subsection privately, unless the insurer requests a public hearing, in which case the hearing shall be public.

Source: Miss. *Code Ann.* § 83-5-17, et al. (Rev. 2011)

Rule 39.05: Judicial Review

Any order or decision of the Commissioner may be appealed at the instance of any party to the proceedings whose interests are substantially affected to the Chancery Court of the First Judicial District of Hinds County, Mississippi, in the manner provided by law.

Source: Miss. Const. Art. 3,§ 14 (Rev. 2005)

Rule 39.06: Severability

If any section or portion of a section of this regulation or the application thereof is heldby a court to be invalid, such invalidity shall not affect any other provision of that section or application of the regulation which can be given effect without the invalid provision or application, and to this end the provisions of the regulation are declared to be severable.

Source: Miss. *Code Ann.* § 83-5-1 (Rev. 2011)

Rule 39.07: Repeal of Regulation 91-101

Regulation 91-101 is hereby repealed and replaced by this regulation.

Source: Miss. *Code Ann.* § 83-5-1 (Rev. 2011)

Rule 39.08: Effective Date

The effective date of this regulation shall be August 1, 2009.

Source: Miss. *Code Ann.* § 25-43-3.113 (Rev. 2010)

Part 1 Chapter 40: (2011-1)Establishment of Insurer Safety Programs

Rule 40.01: Authority

This regulation is promulgated by the Commissioner of Insurance (hereinafter "Commissioner") pursuant to the authority granted to him by Miss. Code Ann. §71-3-121 (Rev. 2000).

Source: Miss. *Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.02: Purpose

The purpose of this Regulation is to implement the requirements of Miss. Code Ann. §71-3-121 (Rev. 2000).

Source: M*iss. Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.03: Scope

This Regulation shall apply to all insurance companies authorized in this state to provide coverage for an employer's liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state worker's compensation laws.

Source: M*iss. Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.04: Definitions

For the purposes of this Regulation, the definitions found in Miss. Code Ann. §§71-3-3 and 71-7-1, as they may be amended from time to time, will control.

Source: M*iss. Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.05: Safety Program Required

A. Every insurer shall establish a safety program for the health and benefit of theemployees of its insureds. An insurer may use any reasonable methods to notify its insureds of the availability of the materials that comprise its program,and deliver those materials upon the request of an insured.

B. Insurer safety programs shall includean explanation of an employee's rights under the Workers' Compensation Law, Miss. Code Ann. §71-3-1, et seq., and the Rules of the Mississippi Workers' Compensation Commission which the insureds may make readily available to their employees.

C. Insurer safety programs shall make available toinsured employers notice of the employer’s rightto implement and maintain a written policy for drug and alcohol workplace. The notice shall inform the employer that such policy shall comply with the requirements of Miss. Code Ann. §§71-7-1 et seq. and the rules and regulations for drug and alcohol testing of employees and job applicants by public and private employers promulgated by the Mississippi State Board of Health. Pursuant to §71-7-1, *etseq.*, the election of a public or private employer to conduct drug and alcohol testing is voluntary.

Source: M*iss. Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.06: Filings

Within 120days of the effective date of this Regulation, each insurer shall file a copy of its safety program with the Commissioner of Insurance, for informational purposes only, in order to verify compliance with this regulation.

Source: M*iss. Code Ann.* § 71-3-121 (Rev. 2011)

Rule 40.07: Severability

If any section or portion of a section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of the Regulation are declared to be severable.

Source: M*iss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 40.08: Effective Date

This Regulation shall become effective upon adoption.

Source: M*iss. Code Ann.* § 25-43-3.113 (Rev. 2010)

Part 1 Chapter 41: Named Storm Deductible and Hurricane Deductible.

Rule 41.01: Authority

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. § 83-5-1 and Miss. Code Ann. § 83-2-3 as amended by House Bill 756, 2014 Regular Session, as well as the provisions of the Mississippi Department of Insurance Regulation "Rules of Practice and Procedure before the Mississippi Insurance Department" 19 Miss. Admin. Code, Part 1, Chapter 15.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); 19 Miss. Admin. Code, Part 1, Chapter 15; HB 756, 2014 Regular Session

Rule 41.02: Purpose and Scope

The purpose of this Regulation is to implement the provisions contained in House Bill 756, 2014 Regular Session. This Regulation applies to homeowners' insurance policies written by admitted carriers in this state that contain a named storm deductible or a hurricane deductible. This Regulation shall not apply to policies providing windstorm and hail coverage written by the Mississippi Windstorm Underwriting Association or homeowners' insurance policies written by non-admitted carriers who are doing business in this state pursuant to Section 83-21-17 et seq. (Rev. 2011).

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.03: Definitions

For the purposes of this Regulation, the following definitions shall apply:

A. "Deductible" shall mean a policy provision that requires the insured to be responsible for a specific amount or percentage of a loss or the percentage of insured value on the policy and the insurer to pay covered losses in excess of that amount.

B. "Department" shall mean the Mississippi Insurance Department.

C. "Homeowners' Insurance Policies" means any personal lines residential property insurance coverage including any homeowner, dwelling, mobile home, tenant or condominium unit owner form of coverage. For the purposes of this Regulation, this shall include mobile home/manufactured home insurance coverage.

D. "Hurricane" shall mean a storm system that has been declared to be a hurricane by the National Hurricane Center of the National Weather Service.

E. "Hurricane Deductible" shall mean a percentage wind deductible applicable during an event which is a Hurricane.

F. "Insurer" shall mean an insurance company writing homeowners' insurance coverage in this state. For the purposes of this Regulation, the term "Insurer" does not include the Mississippi Windstorm Underwriting Association or non-admitted carriers who are doing business in this state pursuant to Section 83-21-17, et seq. (Rev. 2011).

G. "Named Storm" means a storm system that has been declared a named storm by the National Hurricane Center of the National Weather Service.

H. "Named Storm Deductible" shall mean a percentage wind deductible applicable during an event which is a Named Storm.

I. "National Weather Service" means the weather information service, which includes the National Hurricane Center that is a line office of the National Oceanic and Atmospheric Administration (NOAA).

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.04: Deductibles

Insurers are not required to include a named storm deductible or a hurricane deductible in a homeowners' insurance policy. However, should an insurer include a named storm deductible or a hurricane deductible in their policy filing, the insurer must comply with the provisions set forth in Miss. Code Ann. § 83-2-3; House Bill 756, 2014 Regular Session; and this Regulation.

A. Named Storm Deductible – a homeowners' insurance policy may offer a percentage deductible for the peril of wind from a named storm. If a percentage deductible is provided, the insurer shall offer a buy-back provision for that deductible as set forth in Rule 41.05 of this Regulation.

B. Hurricane Deductible – a homeowners' insurance policy may offer a percentage deductible for the peril of wind from a hurricane. If a percentage deductible is provided, the insurer shall offer a buy-back provision for that deductible as set forth in Rule 41.05 of this Regulation.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.05: Buy-Back Provisions

If a homeowners' policy includes a percentage named storm deductible or a percentage hurricane deductible, the insurer shall offer a buy-back provision that is actuarially sound; however the Commissioner of Insurance may grant a waiver from the mandatory buy-back provision in accordance with the following procedure and criteria:

A. The insurer shall make a formal filing requesting a waiver from the buy-back provision requirement with the Commissioner;

B. The insurer shall submit written proof in its formal filing as to why it is in the best interest of Mississippi policyholders to receive a waiver from the buy-back provision requirement and shall provide any supporting documentation requested by the Commissioner deemed appropriate to make his decision; and,

C. All expenses incurred by the Commissioner to determine the validity of the waiver request shall be borne by the petitioning insurer.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.06: Uniform Policy Language for Named Storm Deductibles

Any homeowners' insurance policy or endorsement that includes a named storm deductible must include the following language in the policy:

A. Definition of Named Storm – the policy must define a named storm as set forth in the definition found at Rule 41.03(G) of this Regulation.

B. Period when a Named Storm Deductible Applies – the policy must state that the named storm deductible is only applicable to wind, wind gusts, hail, rain, tornado, or cyclone losses occurring during the duration of a named storm and define the duration as follows:

1. Beginning at the time a named storm watch or warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

2. Continuing for the time period during which the named storm conditions exist anywhere in Mississippi; and,

3. Ending twenty-four (24) hours following the termination of the last named storm watch or warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

C. The policy or endorsement must clearly state what Coverages under the policy are subject to the Named Storm Deductible.

D. Rule 41.13 of this Regulation, entitled "Attachment A - Named Storm Deductible Uniform Policy Language" provides the minimum language that must be included in the policy or endorsement. Any additions to this uniform language must be filed with and approved by the Department prior to use.

E. The institution and/or modification of a named storm deductible is considered a material change and is subject to the provisions of Miss. Code Ann. § 83-2-3.

F. Insurers must file their Named Storm Deductible Uniform Policy Language with the Department prior to use. Policies issued or renewals processed on or after October 1, 2014, must include approved Named Storm Deductible Uniform Policy Language.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.07: Uniform Policy Language for Hurricane Deductibles

Any homeowners' insurance policy or endorsement that includes a hurricane deductible must include the following language in the policy:

A. Definition of Hurricane – the policy must define a hurricane as set forth in the definition found at Rule 41.03(D) of this Regulation.

B. Period when the Hurricane Deductible Applies – the policy must state that the hurricane deductible is only applicable to wind, wind gusts, hail, rain, tornado, or cyclone losses occurring during the duration of a hurricane and define the duration as follows:

    1. Beginning at the time a hurricane watch or warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

    2. Continuing for the time period during which the hurricane conditions exist anywhere in Mississippi; and,

    3. Ending twenty-four (24) hours following the termination of the last hurricane watch or hurricane warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

C. The policy or endorsement must clearly state what Coverages under the policy are subject to the Hurricane Deductible.

D. Rule 41.14 of this Regulation, entitled "Attachment B - Hurricane Deductible Uniform Policy Language" provides the minimum language that must be included in the policy or endorsement. Any additions to this uniform language must be filed with and approved by the Department prior to use.

E. The institution and/or modification of a hurricane deductible is considered a material change and is subject to the provisions of Miss. Code Ann. § 83-2-3.

F. Insurers must file their Hurricane Deductible Uniform Policy Language with the Department prior to use. Policies issued or renewals processed on or after October 1, 2014, must include approved Hurricane Deductible Uniform Policy Language.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.08: Notice of Named Storm Deductibles

A. Insurers are required to provide clear and prominent notice of all named storm deductibles. Notices of named storm deductibles must comply with the provisions of this Regulation; Miss. Code Ann. § 83-2-3; and HB 756, 2014 Regular Session.

1. The notice shall be included in either the policy issuance and renewal package; in a separate mailing sent at the time of policy issuance or renewal; the Outline of Coverage and Comprehensive Policy Checklist; or the billing statement.

2. The notice shall clearly and fully disclose all details pertaining to all named storm deductibles in no less than 10-point type.

    a. While the information provided will vary depending upon the specifics of the deductible, at a minimum the insurer must explain how the deductible will be applied and details about when the deductible applies.

    b. The purpose of the notice is to inform the insured of all information necessary to make an informed decision concerning named storm deductibles in the policy.

    c. Insurers are strongly encouraged to include the actual dollar amount of the percentage deductible based on the Coverage A coverage amount on the notice. If the insurer is unable to do so, the notice must specify that the actual dollar amount is included on the declarations page.

B. Insurers must offer a practical example of how the named storm deductible works.

1. The example does not have to be tailored to the insured value of the specific property but must show clearly how the deductible works in a named storm scenario.

2. The actual dollar amount of a percentage deductible based on the Coverage A coverage amount must be shown on the declarations page.

C. The provisions of this Regulation provide the minimum that must be included in the notice. Insurers may provide any other information to assist in the insured's understanding of the deductible and its application to the insurance policy.

D. Insurers must file their Notice of a Named Storm Deductible with the Department prior to use. Policies issued or renewals processed on or after October 1, 2014, must include a Notice of Named Storm Deductible if the policy includes a named storm deductible.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.09: Notice of Hurricane Deductibles

A. Insurers are required to provide clear and prominent notice of all hurricane deductibles. Notices of hurricane deductibles must comply with the provisions of this Regulation; Miss. Code Ann. § 83-2-3; and HB 756, 2014 Regular Session.

1. The notice shall be included in either the policy issuance and renewal package; in a separate mailing sent at the time of policy issuance or renewal; the Outline of Coverage and Comprehensive Policy Checklist; or the billing statement.

2. The notice shall clearly and fully disclose all details pertaining to all hurricane deductibles in no less than 10 point type.

    a. While the information provided will vary depending upon the specifics of the deductible, at a minimum the insurer must explain how the deductible will be applied and details about when the deductible applies.

    b. The purpose of the notice is to inform the insured of all information necessary to make an informed decision concerning the hurricane deductibles in the policy.

    c. Insurers are strongly encouraged to include the actual dollar amount of the percentage deductible based on the Coverage A coverage amount on the notice. If the insurer is unable to do so, the notice must specify that the actual dollar amount is included on the declarations page.

B. Insurers must offer a practical example of how the hurricane deductible works.

1. The example does not have to be tailored to the insured value of the specific property but must show clearly how the deductible works in a hurricane scenario.

2. The actual dollar amount of a percentage deductible based on the Coverage A coverage amount must be shown on the declarations page.

C. The provisions of this Regulation provide the minimum that must be included in the notice. Insurers may provide any other information to assist in the insured's understanding of the deductible and its application to the insurance policy.

D. Insurers must file their Notice of a Hurricane Deductible with the Department prior to use. Policies issued or renewals processed on or after October 1, 2014, must include a Notice of Hurricane Deductible if the policy includes a hurricane deductible.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.10: Rate and Policy Form Filings

A. All rate filings must provide sufficient actuarial justification for rate variances, premium offsets and premium credits for a named storm deductible or hurricane deductible.

B. Insurers must demonstrate that rates are not excessive, inadequate or unfairly discriminatory.

C. Insurers that choose to utilize hurricane models in the setting of rates must identify the model(s) used, including the version of the Model(s) used, as well as provide a complete explanation of (1) the reasons(s) that the particular model(s) was chosen; and (2) the effect that use of the model(s) may have had on the rates requested. Any changes in the model(s) utilized from a prior filing must be fully explained.

D. If an insurer is requesting an increase in premium due to increased reinsurance costs, the insurer must provide an explanation of the increased cost. This explanation should include an explanation of alternatives to reinsurance (i.e. CAT bonds, surplus notes, etc.). Insurers should fully disclose how reinsurance costs are allocated to Mississippi.

   If a portion of the filing is considered by the insurer to be proprietary and a trade secret, it will be the duty of the insurer to identify the specific portions of the filing that they wish to be held confidential in accordance with the provisions of Miss. Code Ann. § 79-23-1.

E. From and after October 1, 2014, insurers may not continue to use forms previously approved which are not in compliance with this Regulation; Miss. Code Ann. § 83-2-3; and HB 756.

Source: *Miss. Code Ann.* §§ 79-23-1; 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.11: Severability

If any provision of any section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end the provisions of the Regulation are declared to be severable.

Source: *Miss. Code Ann.*§83-5-1 (Rev. 2011)

Rule 41.12: Effective Date

The Effective Date of this Regulation shall be July 1, 2014. Insurers must be in full compliance with the provisions of this Regulation by October 1, 2014.

Source: *Miss. Code Ann.* §§ 25-43-3.113(2)(b)(i); 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.13: Attachment A – Named Storm Deductible Uniform Policy Language

Attachment A

NAMED STORM DEDUCTIBLE UNIFORM POLICY LANGUAGE

For the premium charged, we will pay only that part of the total of the loss for all Section I Property Coverages that exceeds the Named Storm Deductible noted below:

This deductible applies, as described below, in the event of direct physical loss to property covered under this policy, caused directly or indirectly by wind, wind gusts, hail, rain, tornadoes, or cyclones occurring during a named storm and shall replace any other applicable deductible during that event. A named storm shall mean a storm system that has been declared a named storm by the National Hurricane Center of the National Weather Service.

The duration of the named storm occurs during the time period:

a. Beginning at the time a named storm watch or warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

b. Continuing for the time period during which the named storm conditions exist anywhere in Mississippi; and,

c. Ending twenty-four (24) hours following the termination of the last named storm watch or warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

The Named Storm deductible shown in the Declarations applies only for loss or damage to covered property caused by wind, wind gusts, hail, rain, tornadoes, or cyclones occurring during a named storm. The Named Storm deductible also applies to any objects driven by wind which are not otherwise excluded if your covered loss occurs during the time period.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Rule 41.14: Attachment B – Hurricane Deductible Uniform Policy Language

Attachment B

HURRICANE DEDUCTIBLE UNIFORM POLICY LANGUAGE

For the premium charged, we will pay only that part of the total of the loss for all Section I Property Coverages that exceeds the Hurricane Deductible noted below:

This deductible applies, as described below, in the event of direct physical loss to property covered under this policy, caused directly or indirectly by wind, wind gusts, hail, rain, tornadoes, or cyclones occurring during a hurricane and shall replace any other applicable deductible during that event. A hurricane shall mean a storm system that has been declared a hurricane by the National Hurricane Center of the National Weather Service.

The duration of the hurricane occurs during the time period:

a. Beginning at the time a hurricane watch or warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

b. Continuing for the time period during which the hurricane conditions exist anywhere in Mississippi; and,

c. Ending twenty-four (24) hours following the termination of the last hurricane watch or warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

The Hurricane deductible shown in the Declarations applies only for loss or damage to covered property caused by wind, wind gusts, hail, rain, tornadoes, or cyclones occurring during a hurricane. The Hurricane deductible also applies to any objects driven by wind not otherwise excluded if your covered loss occurs during the time period.

Source: *Miss. Code Ann.* §§ 83-5-1; 83-2-3 (Rev 2011); HB 756, 2014 Regular Session

Part 1 Chapter 42: Non-Admitted Policy Fee Account Regulation

Rule 42.01: Authority

This regulation is promulgated pursuant to the authority granted by Senate Bill 2467 which was passed by the Mississippi Legislature in the 2018 Regular Session and 19 Miss. Admin. Code, Part 1, Chapter 15, said Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: *Miss. Code Ann.* §83-21-1, et seq. (Rev. 2011); SB 2467, 2018 Mississippi Legislature Regular Session

Rule 42.02: Purpose and Scope

D. Purpose. This regulation is promulgated to provide information to surplus lines insurance producers regarding the collection and remittance of the non-admitted policy fee pursuant to the enactment of Senate Bill 2467.

E. Scope. This regulation applies to all single risk surplus lines policies that are written on risks and contents located in Mississippi; and on multi-state risks wherein Mississippi is the home state as defined by the federal Nonadmitted and Reinsurance Reform Act ("NRRA") and *Miss. Code Ann.* § 83-21-18(2).

Source: *Miss. Code Ann.* §83-21-18 (Rev. 2011); SB 2467, 2018 Mississippi Legislature Regular Session

Rule 42.03: Senate Bill 2467

Senate Bill 2467 amends Section 83-34-4, to require for one (1) year beginning July 1, 2018, that Four Million Five Hundred Thousand Dollars ($4,500,000.00) derived from the nonadmitted policy fee be deposited into the Rural Fire Truck or Supplementary Rural Fire Truck Fund, and One Million Five Hundred Thousand Dollars derived from the nonadmitted policy fee be deposited into the Capital Expense Fund, before any monies are forwarded to the Mississippi Windstorm Underwriting Association ("MWUA").

Source: SB 2467, 2018 Mississippi Legislature Regular Session

Rule 42.04: Reporting and Collection of the Non-admitted Policy Fee on and after July 1, 2018

A. A clearing house account has been established in Trustmark Bank, entitled the "Non-admitted Policy Fee Account", for which the Mississippi Insurance Department ("MID") shall be the administrator.

B. The Mississippi Surplus Lines Association ("MSLA") shall be provided with the account number for this account, and MSLA shall provide this information to surplus lines insurance producers, along with instructions on how to remit any and all non-admitted policy fees collected on or after July 1, 2018.

C. When making payment for the Non-admitted policy fee on the MSLA website, the surplus lines insurance producer will enter SLIP and click the BILLING tab as usual.

D. Prior to July 1, 2018, surplus lines insurance producers that have a fraud service on their bank account will need to provide their bank with a new ACH Company ID as the Company ID for the MWUA Fee will be different starting July 1, 2018. There will be a link to the New MWUA Company ID at the BILLING tab in SLIP.

E. It will be the responsibility of the MID to transfer monies from the Non-admitted Policy Fee Account to the Capital Expense Fund Account and Rural Fire Truck Fund

Account. When the amounts required by SB 2467 have been forwarded to those accounts, the MID shall transfer the remaining monies collected to the MWUA.

F. As SB 2467 provides for the diversion of these monies to the Capital Expense Fund Account and Rural Fire Truck Fund Account for one (1) year, MID and MSLA shall provide notice to surplus lines insurance producers of any subsequent changes that may or may not be made during the 2019 Regular Legislative Session.

Source: SB 2467, 2018 Mississippi Legislature Regular Session

Rule 42.05: Severability Clause

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

Source: *Miss. Code Ann.* § 83-5-1 (Rev. 2011)

Rule 42.06: Effective Date

This Regulation shall be effective on and after July 1, 2018.

Source: *Miss. Code Ann.* §§ 25-43-3.112; 83-5-1 (Rev. 2011); SB 2467, 2018 Mississippi Legislature Regular Session

Part 1, Chapter 43: Corporate Governance Annual Disclosure Regulation

Rule 43.01. Authority

This regulation is promulgated pursuant to the authority granted in House Bill 324 which was passed by the Mississippi Legislature in the 2019 Regular Legislative Session and 19 Miss. Admin. Code, Part 1, Chapter 15, said Regulation being the Rules of Practice and Procedure before the Mississippi Insurance Department.

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.02. Purpose

The purpose of this regulation is to set forth the procedures for filing and the required contents of the Corporate Governance Annual Disclosure (CGAD), deemed necessary by the Commissioner to carry out the provisions of House Bill 324, 2019 Regular Legislative Session.

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.03. Definitions.

A. "Commissioner." The Insurance Commissioner of the State.

B. "Insurance group." For the purpose of this Act, the term "insurance group" shall mean those insurers and affiliates included within an insurance holding company system as defined in Miss. Ann. Code § 83-6-1(d) (Rev. 2011).

C. "Insurer." The term "insurer" shall have the same meaning as set forth in Miss. Ann. Code § 83-6-1(e) (Rev. 2011), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

D. "Senior Management." The term "senior management" shall mean any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the Chief Executive Officer ("CEO"), Chief Financial Officer ("CFO"), Chief Operations Officer ("COO"), Chief Procurement Officer ("CPO"), Chief Legal Officer ("CLO"), Chief Information Officer ("CIO"), Chief Technology Officer ("CTO"), Chief Revenue Officer ("CRO"), Chief Visionary Officer ("CVO"), or any other "C" level executive.

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.04. Filing Procedures

A. An insurer, or the insurance group of which the insurer is a member, required to file a CGAD pursuant to the provisions of House Bill 324, 2019 Regular Legislative Session, shall, no later than June 1 of each calendar year, submit to the Commissioner a CGAD that contains the information described in Rule 43.05 of this regulation.

B. The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's Board of Directors (hereafter "Board") or the appropriate committee thereof.

C. The insurer or insurance group shall have discretion regarding the appropriate format for providing the information required by these regulations and is permitted to customize the CGAD to provide the most relevant information necessary to permit the Commissioner to gain an understanding of the corporate governance structure, policies and practices utilized by the insurer or insurance group.

D. For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it shall indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

E. Notwithstanding Subsection A of this Section, and as outlined in Rule 43.03 of the Corporate Governance Annual Disclosure Model Act, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

F. An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA Summary Report, Holding Company Form B or F Filings, Securities and Exchange Commission (SEC) Proxy Statements, foreign regulatory reporting requirements, etc.) if the documents provide information that is comparable to the information described in Rule 43.05. The insurer or insurance group shall clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the regulator.

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

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.05. Contents of Corporate Governance Annual Disclosure

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

B. The CGAD shall describe the insurer's or insurance group's corporate

governance framework and structure including consideration of the following.

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

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

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

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

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

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

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

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

(b) Whether term limits are placed on directors.

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

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

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

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

(1) Any processes or practices (i.e., suitability standards) to determine

whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their prospective roles, including:

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

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

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

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

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

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

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

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

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

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

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

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

(4) The insurer's or insurance group's plans for CEO and Senior Management

succession.

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

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

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

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

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

(b) Actuarial function;

(c) Investment decision-making processes;

(d) Reinsurance decision-making processes;

(e) Business strategy/finance decision-making processes;

(f) Compliance function;

(g) Financial reporting/internal auditing; and

(h) Market conduct decision-making processes.

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.06. Severability Clause

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

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 43.07. Effective Date

This regulation shall be effective on and after January 1, 2020.

Source: Miss. Code Ann. §§83-5-7-1 through 83-5-717

Rule 45.01: Authority.

This Regulation is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Miss. Code Ann. Sections 83-5-1 and 83-2-1 et seq. (Rev. 2011), as well as the provisions of the Mississippi Insurance Department ("MID") Regulation entitled "Rules of Practice and Procedure before the Mississippi Insurance Department", 19 Miss. Admin. Code, Part 1, Chapter 15.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-1 et seq. (Rev. 2011); 19 Miss. Admin. Code, Part 1, Chapter 15.

Rule 45.02 Purpose.

The purpose of this Regulation is to implement a more efficient, reasonable and competitive property and casualty insurance market and regulatory environment that benefits Mississippi consumers by establishing a Flexible Rating System applicable to certain lines of business as specified below.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-1 et seq. (Rev. 2011).

Rule 45.03: Scope.

The Flexible Rating System set forth in this Regulation shall be allowed for any residential or commercial earthquake policies, residential or commercial flood insurance policies that are not written through the National Flood Insurance Program, commercial liability and cybersecurity coverages, whether the insurance policies/coverages are endorsed to, or otherwise made a part of, another kind of insurance policy, or sold as a stand-alone policy.

This Regulation shall not apply to workers' compensation insurance, medical malpractice insurance, assigned risk/residual market plans or the Mississippi Windstorm Underwriting Association.

Rate service organizations, as defined in Miss. Code Ann. § 83-2-1(d), shall not be eligible to submit filings pursuant to the Flexible Rating System as set forth in this Regulation.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-1 et seq. (Rev. 2011).

Rule 45.04 Definition of Flexible Rating System.

For purposes of this Regulation, the term "Flexible Rating System" shall mean a proposed rate plan filed with MID pursuant to Section 83-2-1 et seq., which allows for an automatic ability on the part of the insurer to raise in the aggregate or lower in the aggregate rates by 15% without the need for approval by MID so long as the change is within the overall approved +/- 15% range.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-1 et seq. (Rev. 2011).

Rule 45.05 Filing Requirements.

A Flexible Rating System filing made pursuant to this Regulation shall be in compliance with all applicable provisions in Section 83-2-1 et seq., and shall include the rate, rating plans and rating systems used by the insurer. Supporting actuarial data shall accompany every filing and shall be in sufficient detail to justify the rate.

At the point that aggregate rate changes by the insurer under the Flexible Rating System approved by MID total either an aggregate increase of 15%, or an aggregate decrease of 15%, a new rate filing shall be required pursuant to the provisions of Section 83-2-1 et seq. prior to making any further rate adjustments. There is no annual reset for the 15% flexible rating band.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-1 et seq. (Rev. 2011).

Rule 45.06 Notice to Department.

An insurer shall notify MID of any change in rates implemented under the Flexible Rating System within thirty (30) days after the effective date of the change. The notice must include the name of the insurer and the average percentage change in rates statewide and by zone or territory. Any rate change made pursuant to the Flexible Rating System may only be applied to a policy at the beginning of the policy period.

Should the Commissioner determine that any change in rates implemented pursuant to this Regulation is excessive, inadequate or unfairly discriminatory, he shall disapprove the change in rates pursuant to the procedure provided in Section 83-2-11(2)(b).

No more than one (1) rate adjustment may be made by an insurer during a twelve (12) month period pursuant to the Flexible Rating System set forth in this Regulation; however, upon written application by the insurer, the Commissioner may authorize more than one (1) rate adjustment during any twelve (12) month period, subject to the percentage limitations prescribed herein,

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-3; 83-2-7; 83-2-11(2)(b) (Rev. 2011).

Rule 45.07 Policy Forms.

With respect to policy form filings for coverages subject to this Regulation, insurers must comply with Section 83-2-7 prior to the use of any policy form.

Source: *Miss. Code Ann.* Sections 83-5-1; 83-2-7 (Rev. 2011).

Rule 45.08 Rating Modification on Individual Commercial Risks.

Insurers are still allowed to follow established procedures allowing for a debit or credit to be recognized regarding the special characteristics of an **individual** commercial risk which may not fully be reflected in the basic company premium or rates. Filings of this nature are distinct from filings made under the Flexible Rating System as set forth in this Regulation, as Flexible Rating System filings are applicable to all policies within the subject line of insurance, whereas the rating modification referenced within this section is applicable only to an individual risk.

Source: *Miss. Code Ann.* Section 83-5-1 (Rev. 2011).

Rule 45.09. Severability.

If any provision of any section of this Regulation or the application thereof is held by a court to be invalid, such invalidity shall not affect any other provision of that section or application of the Regulation which can be given effect without the invalid provision or application, and to this end, the provisions of the Regulation are declared to be severable.

Source: *Miss. Code Ann.* Section 83-5-1 (Rev. 2011).

Rule 45.10 Effective Date.

The effective date of this Regulation shall be thirty days after filing for final adoption with the Office of the Secretary of State. Filings made on and after this date may contain a Flexible Rating System component.

Source: *Miss. Code Ann.* Sections 25-43-3.113(2)(b)(i) (Rev. 2018); 83-5-1; 83-2-3; 83-2-7 (Rev. 2011).