COMPLIANCE
OVERSIGHT GUIDE

Claims Settlement

This guide is derived from NAIC Model Regulations, Acts, and/or Bulletins. Because states independently determine whether to adopt NAIC Models—and may do so in whole, in part, or with state-specific modifications—requirements can vary by jurisdiction. CEFLI Oversight Guides provide checklists of potential oversight elements to help support regulatory compliance. The guides and any referenced resources are not legal advice. CEFLI Member Companies should ensure their oversight programs reflect their specific product portfolios, distribution strategies, risk tolerances, internal controls and prior market conduct examination findings. Member Companies should carefully evaluate and incorporate unique state regulatory requirements, including any deviations from NAIC Models, in the states where they conduct business.

Helpful Resources

- NAIC Market Regulation Handbook 2025, Volume 1-IV
- NAIC Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903)
- NAIC Unfair Life, Accident and Health Claims Settlement Practices Model Regulation (#903) Adoption Chart
- NAIC Unfair Claims Settlement Practices Act Model Regulation (#900)
- NAIC Unfair Claims Settlement Practices Act Model Regulation (#900) Adoption Chart
- NAIC Claims Settlement Provisions (MC-50)
- NAIC Private Right of Action for Unfair Claims Settlement Practices (MC-55)

Scope of the Regulation

- **Includes**. The regulation includes health insurance, life insurance and annuity claims.
- **Excludes**. The regulation excludes workers' compensation insurance.

Claims Settlement Practices (Model Regulation 903)

- ☐ **Acknowledge Claims and Provide Forms and Instructions**. Within fifteen (15) days of receiving due notification of a claim, provide the claimant with the necessary claim form, instructions and reasonable assistance to file a claim. Refer to section 4.A.
- ☐ **Begin Investigation Timely**. Begin claims investigations within fifteen (15) days of receipt of proof of loss from a claimant. Refer to section 4.B.
- ☐ **Processing Standards.** Notice of claim or proof of loss submitted for one policy issued by the insurer satisfies the obligation for similar policies issued by the insurer and identified by the claimant. If additional information is required, the insurer may request it. When it is apparent that additional benefits would be payable, the insurer must communicate to, and cooperate with, the claimant in determining the insurer's liability. Refer to section 4.C.
- ☐ **Timely Claim Payment.** The insurer must affirm or deny liability on claims within a reasonable time and offer payment within thirty (30) days of affirmation of liability if the claim is determined and not in dispute. If portions of the claim are in dispute, the insurer must pay the portion that is not disputed within thirty (30) days. Refer to section 4.D.
- ☐ **Explanation of Benefits**. With each claim payment, provide the insured with an Explanation of Benefits that includes the name of the provider or services covered, dates of service and a reasonable explanation of the computation of benefits. Refer to section 4.E.

☐ Precertification Penalties. Insurers may not penalize claimants for not following precertification unless the penalty is set forth in the policy. Refer to section 4.F.

☐ Notice Regarding Delays. If a claim remains unresolved for thirty (30) days from receipt of proof of loss, the insurer must provide the insured or beneficiary with a reasonable written explanation for the delay. In credit, mortgage and assigned accident/health claims, the notice must be provided to the debtor/insured or medical provider in addition to the insured. If the investigation remains incomplete, the insurer must, forty-five (45) days from the date of initial notification and every forty-five (45) days thereafter, send the claimant a letter indicating the reason additional time is needed. Refer to section 4.G.

☐ Written Communications Related to Pending Claims. When the insurer receives written communications regarding pending claims, it must acknowledge and respond within fifteen (15) days. Refer to section 4.H.

☐ Denied Claims. When a claim is denied, written notice of the denial must be sent to the claimant within fifteen (15) days of the determination. The notice must reference the policy provision, condition or exclusion upon which the denial is based. Refer to section 4.I.

☐ Denials Based on Verbal Information. A claim may not be denied based on information obtained in a telephone conversation or personal interview unless the telephone conversation or personal interview is documented in the claim file. Refer to section 4.J.

☐ Cash Settlements. Insurers offering cash settlements of first party long-term disability income claims (except in cases where there is a bona fide dispute as to the coverage for, or amount of, the disability) must develop a present value calculation of future benefits (with probability corrections for mortality and morbidity) utilizing contingencies such as mortality, morbidity, and interest rate assumptions, etc. appropriate to the risk. A copy of the amount calculated must be provided to the insured and signed by the insured at the time a settlement is entered into. Refer to section 4.K.

☐ Representations Regarding Payments. The insurer may not indicate a payment is "final" or state there is "a release" of any claim unless the policy limit has been paid or there was a compromise settlement agreement supporting such. Refer to section 4.L.

☐ Corrections for Overpayments. Benefits payable may not be withheld to correct for an overpayment on a prior claim on the policy unless:

- The insurer's files contain clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding, or
- The insurer has clear, documented evidence that:
  - The over payment was clearly a mistake under the policy's provisions and there is no reasonable disagreement about the facts involved;
  - The error that resulted in the payment is not a mistake of the law;
  - The insurer has notified the insured within six (6) months of the date of the error, except that in instances of error prompted by representations or nondisclosures of claimants or third parties, the insurer notified the insured within fifteen (15) days after the date the evidence of discovery of such error is included in its file. The date of the error shall be the day on which the draft for benefits is issued; and
  - The notice clearly states the nature of the error and the amount of the overpayment.

Refer to section 4.M.

☐ Claimants Disputing a Claim Payment. If the claimant objects to an insurer's rejection of a claim, the insurer shall provide written notification to the claimant that they may have the matter reviewed by their state's Department of Insurance. The DOI's address and phone number must be provided. Refer to section 4.N.

☐ Record Retention. Claims records must be accessible and retrievable for examination. Records must include the claim number, line of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. Each document within the claim file must note the date received, date processed or date mailed. All records, regardless of format, must be capable of duplication to hard copy. Records shall be available for the current year and the two (2) preceding years. (Reminder: State record retention requirements may vary from the NAIC Model Regulation.) Refer to Section 5.

Unfair Claims Settlement Practices (Model Regulation 900)

☐ Unfair Claims Settlements Practices are Prohibited. Insurers may not commit an act defined in Section 4 of the Act if the act is committed flagrantly and in conscious disregard of the Act or related rules or if it has been committed with such frequency to indicate a general business practice. Refer to section 3.

☐ Defining Unfair Claims Practices. The following acts constitute unfair claims practices:

A. Knowingly misrepresenting relevant facts or policy provisions relating to coverages at issue;
B. Failing to promptly acknowledge pertinent claims communications;
C. Failing to adopt and implement reasonable standards for prompt investigation and settlement of claims;
D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted when liability has become reasonably clear;
E. Compelling insureds or beneficiaries to institute suits to recover amounts due by offering substantially less than the amounts ultimately recovered in suits brought by them;
F. Refusing to pay claims without conducting a reasonable investigation;
G. Failing to affirm or deny coverage of claims within a reasonable time after having completed an investigation of a claim;
H. Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;
I. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;
J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is made;
K. Unreasonably delaying an investigation or payment by requiring both a formal proof of loss form and a subsequent verification, resulting in duplication efforts;
L. Failing, in the case of claims denials or offers of compromise settlement, to promptly provide a reasonable and accurate explanation of the basis for such actions;
M. Failing to provide, within fifteen (15) calendar days of a request, the forms necessary to present claims along with a reasonable explanation regarding the form's use;
N. Lacking reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

Refer to section 4.