

AN ACT

Relating to insurance; establishing an insurance department; and amending, revising, and consolidating the law relating to the licensing, qualification, regulation, examination, suspension, and dissolution of insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and certain societies and orders, the examination and regulation of fire insurance rating bureaus, and the licensing and regulation of insurance agents and brokers; the service of legal process upon foreign insurance companies, associations or exchanges; providing penalties, and repealing existing laws. (Title amended Apr. 27, 1927, P.L.476, No.302)

TABLE OF CONTENTS

....

ARTICLE V.
SUSPENSION OF BUSINESS - INVOLUNTARY DISSOLUTIONS

(a) General Provisions.

Section 501. Construction and Purpose.
Section 502. Persons Covered.
Section 503. Definitions.
Section 504. Jurisdiction and Venue.
Section 505. Injunction and Orders.
Section 506. Cooperation of Officers and Employees.
Section 507. Bonds.
Section 508. Commissioner's Reports.
Section 509. Continuation of Delinquency.

(b) Summary Proceedings.

Section 510. Commissioner's Summary Orders.
Section 511. Commissioner's Supervision.
Section 512. Court's Seizure Order.
Section 513. Conduct of Hearings in Summary Proceedings.

(c) Formal Proceedings.

A. Rehabilitation.

Section 514. Grounds for Rehabilitation.
Section 515. Rehabilitation Orders.
Section 516. Powers and Duties of the Rehabilitator.
Section 517. Actions By and Against Rehabilitator.
Section 518. Termination of Rehabilitation.

B. Liquidation.

1. Initiation of Proceeding.

Section 519. Grounds for Liquidation.
Section 520. Liquidation Orders.
Section 521. Continuance of Coverage.
Section 522. Dissolution of Insurer.

2. Powers and Duties of Liquidators and Others

Section 523. Powers of Liquidator.
Section 523.1. Policyholder Collateral, Deductible
Reimbursement and Other Policyholder
Obligations.
Section 524. Notice to Creditors and Others.
Section 525. Duties of Agents.
Section 526. Actions By and Against Liquidator.

3. Estate of Insurer.

Section 527. Collection and Lists of Assets.
Section 528. Fraudulent Transfers Prior to Petition.
Section 529. Fraudulent Transfers After Petition.
Section 530. Voidable Preferences and Liens.
Section 531. Claims of Holders of Void or Voidable Rights.
Section 532. Setoffs and Counterclaims.
Section 533. Assessments.
Section 534. Reinsurer's Liability.
Section 535. Recovery of Premiums Owed.
Section 536. Liquidators Proposal to Distribute Assets.

4. Claims.

Section 537. Filing of Claims.
Section 538. Proof of Claims.
Section 539. Special Claim.
Section 540. Special Provisions for Third Party Claims.
Section 541. Disputed Claims.
Section 542. Claims of Surety.
Section 543. Secured Creditors Claims.
Section 544. Order of Distribution.
Section 545. Liquidators Recommendations to the Court.
Section 546. Distribution of Assets.
Section 547. Unclaimed and Withheld Funds.
Section 548. Termination of Proceedings.
Section 549. Reopening Liquidation.
Section 550. Disposition of Records During and After
Termination of Liquidation.
Section 551. External Audit of the Receiver's Books.
Section 552. Federal Receivership.

(d) Interstate Relations.

Section 553. Conservation of Property of Foreign or Alien
Insurers Found in This State.

Section 554. Liquidation of Property of Foreign or Alien Insurers Found in This State.
Section 555. Foreign, Domiciliary Receivers in Other States.
Section 556. Ancillary Formal Proceedings.
Section 557. Ancillary Summary Proceedings.
Section 558. Claims of Nonresidents Against Insurers Domiciled in This State.
Section 559. Claims of Residents Against Insurers Domiciled in Reciprocal States.
Section 560. Attachment Garnishment and Levy of Execution.
Section 561. Interstate Priorities.
Section 562. Subordination of Claims for Non-cooperation.
Section 563. Constitutionality.

**ARTICLE V-A.
RISK-BASED CAPITAL REQUIREMENTS**

Section 501-A. Definitions.
Section 502-A. RBC Reports Required; Domestic Insurers.
Section 503-A. RBC Requirements; Foreign Insurers.
Section 504-A. Calculation of RBC Relating to Life or Health Insurers.
Section 505-A. Calculation of RBC Relating to Property or Casualty Insurers.
Section 506-A. Company Action Level Event.
Section 507-A. Regulatory Action Level Event.
Section 508-A. Authorized Control Level Event.
Section 509-A. Mandatory Control Level Event.
Section 510-A. Hearing.
Section 511-A. Notices.
Section 512-A. Confidentiality; Prohibition on Announcements; Prohibition on Use in Ratemaking.
Section 513-A. Exemptions.
Section 514-A. Supplemental Provisions; Rules.
Section 515-A. Additional Penalties.

**ARTICLE V-B.
RISKED-BASED CAPITAL REQUIREMENTS - HEALTH ORGANIZATIONS**

Section 501-B. Definitions.
Section 502-B. RBC Reports Required; Domestic Health Organizations.
Section 503-B. RBC Reports Required; Foreign Health Organizations.
Section 504-B. Calculation of RBC.
Section 505-B. Company Action Level Event.
Section 506-B. Regulatory Action Level Event.
Section 507-B. Authorized Control Level Event.
Section 508-B. Mandatory Control Level Event.
Section 509-B. Hearings.
Section 510-B. Notices.
Section 511-B. Confidentiality; Prohibition on Announcements; Prohibition on Use in Ratemaking.
Section 512-B. Exemptions.
Section 513-B. Supplemental Provisions; Rules.
Section 514-B. Additional Penalties.
Section 515-B. Phase in Provisions.

ARTICLE V
SUSPENSION OF BUSINESS - INVOLUNTARY DISSOLUTIONS
SECTIONS 501-511

Compiler's Note: Article V was repealed Dec. 14, 1977, P.L.280, No.92, and a new Article V was added.

Section 501. Suspension of Business of Insurance Companies of Other States and Foreign Government, Et Cetera, by Insurance Commissioner. (501 repealed Dec. 14, 1977, P.L.280, No.92)

Section 502. Suspension of and Applications to Court to Take Over Business of Domestic Companies, Et Cetera, for Protection of Policyholders, Creditors, Et Cetera. (502 repealed Dec. 14, 1977, P.L.280, No.92)

Section 503. Nonpayment of Judgments by Mutual Companies; Assessment of Policyholders; Dissolution. (503 repealed Dec. 14, 1977, P.L.280, No.92)

Section 504. Service of Process. (504 repealed Dec. 14, 1977, P.L.280, No.92)

Section 505. Injunction; Return of Order to Show Cause and Decrees Thereon. (505 repealed Dec. 14, 1977, P.L.280, No.92)

Section 506. Orders for Liquidation of Affairs of Companies, Et Cetera; Insurance Commissioner To Act as Receiver. (506 repealed Dec. 14, 1977, P.L.280, No.92)

Section 507. Insurance Commissioner to Supersede Other Receivers. (507 repealed Dec. 14, 1977, P.L.280, No.92)

Section 508. Superseded Receivers, Et Cetera, To Deliver Over Property and File Accounts. (508 repealed Dec. 14, 1977, P.L.280, No.92)

Section 509. Appointment of Special Deputies to Conduct Business or Liquidate Affairs of Companies, Et Cetera; Special Counsel; Compensation; Power to Administer Oaths and Subpoena Witnesses. (509 repealed Dec. 14, 1977, P.L.280, No.92)

Section 509.1. Assessment of Members of a Mutual Insurance Company by Insurance Commissioner. (509.1 repealed Dec. 14, 1977, P.L.280, No.92)

Section 510. Report of Insurance Commissioner as Receiver; Procedure Thereon. (510 repealed Dec. 14, 1977, P.L.280, No.92)

Section 511. Liquidation of Title Insurance Companies Partially Under Supervision of Department of Banking. (511 repealed Dec. 14, 1977, P.L.280, No.92)

Section 501. Construction and Purpose.--(a) This article shall not be interpreted to limit the powers granted the commissioner by other provisions of the law.

(b) This article shall be liberally construed to effect the purpose stated in subsection (c).

(c) The purpose of this article is the protection of the interests of insureds, creditors, and the public generally, with minimum interference with the normal prerogatives of the owners and managers of insurers, through (i) early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures; (ii) improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance

industry; (iii) enhanced efficiency and economy of liquidation, through clarification and specification of the law, to minimize legal uncertainty and litigation; (iv) equitable apportionment of any unavoidable loss; (v) lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this Commonwealth; and (vi) regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business.

(501 added Dec. 14, 1977, P.L.280, No.92)

Section 502. Persons Covered.--The proceedings authorized by this article may be applied to:

(1) All insurers who are doing, or have done, an insurance business in this Commonwealth, and against whom claims arising from that business may exist now or in the future.

(2) All insurers who purport to do an insurance business in this Commonwealth.

(3) All insurers who have insureds resident in this Commonwealth.

(4) All other persons organized or in the process of organizing with the intent to do an insurance business in this Commonwealth.

(5) All nonprofit service plans and all fraternal benefit societies and beneficial societies subject to Title 40 of the Pennsylvania Consolidated Statutes (relating to insurance).

(6) All title insurance companies, subject to Article VII of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(502 added Dec. 14, 1977, P.L.280, No.92)

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 502 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 502 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 503. Definitions.--The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Ancillary state" means any state other than a domiciliary state.

"Commissioner" means the Insurance Commissioner of the Commonwealth of Pennsylvania.

"Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

"Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under sections 510 through 513.

"Doing business" shall include any of the following acts, whether effected by mail or otherwise:

(1) the issuance or delivery of contracts or certificates of insurance to persons resident in this Commonwealth;

(2) the solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(3) the collection of premiums, membership fees, assessments or other consideration for such contracts; or

(4) the transaction of matters subsequent to execution of such contracts and arising out of them.

"Domiciliary state" means the state in which an insurer is incorporated or organized, or, in the case of an alien insurer, its state of entry.

"Fair consideration" is given for property or obligation:

(1) when in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(2) when such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

"Federal Home Loan Bank Act" means the Federal Home Loan Bank Act (47 Stat. 725, 12 U.S.C. § 1421 et seq.). (Def. added Oct. 14, 2014, P.L.2502, No.144)

"FHLBank" means a bank as defined in section 2(1)(A) of the Federal Home Loan Bank Act (47 Stat. 725, 12 U.S.C. § 1422(1)(A)). (Def. added Oct. 14, 2014, P.L.2502, No.144)

"FHLBank security agreement" means any pledge, security, collateral or guarantee agreement or any similar arrangement or credit enhancement in favor of an FHLBank. (Def. added Oct. 14, 2014, P.L.2502, No.144)

"Foreign country" means any other jurisdiction not in any state.

"General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited, or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders and creditors shall be treated as general assets.

"Guaranty association." The Pennsylvania Insurance Guaranty Association provided for by the act of November 25, 1970 (P.L.716, No.232), known as "The Pennsylvania Insurance Guaranty Association Act," and the Workmen's Compensation Security Fund provided for by the act of July 1, 1937 (P.L.2532, No.470), known as the "Workmen's Compensation Security Fund Act," as amended, and any other similar entity now or hereafter created by the Legislature of this or any other state for the payment of claims of insolvent insurers.

"Insolvency" means:

(1) For an insurer issuing only assessable fire insurance policies; (i) the inability to pay any obligation within thirty days after it becomes payable, or (ii) if an assessment be made within thirty days after such date, the inability to pay such obligation thirty days following the date specified in the first assessment notice issued after the date of loss pursuant to section 808 of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(2) For any other insurer the inability to pay its obligations when they are due, or whose admitted assets do not exceed its liabilities plus the greater of (i) any capital and surplus required by law for its organization, or (ii) its authorized and issued capital stock. For any insurer licensed to do business in the Commonwealth as of the effective date of this act which does not meet this standard, the term "insolvency" shall mean for a period not to exceed three years from the effective date of this act that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law. In determining the financial condition of an insurer, the Insurance Commissioner shall consider assets to be admitted or nonadmitted as provided in section 320.1 of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

For purposes of this article "liabilities" shall include but not be limited to reserves required by statute or by insurance department general regulations or specific requirements imposed by the commissioner upon a subject company at the time of admission or subsequent thereto, and any other capital and surplus requirements.

(Def. amended Feb. 17, 1994, P.L.79, No.8)

"Insurer" means any person who is doing, has done, purports to do, or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization or conservation by any insurance commissioner. For purposes of this article, any other persons included under section 502 shall be deemed to be insurers.

"Insurer-member" means an insurer that is a member of an FHLBank. (Def. added Oct. 14, 2014, P.L.2502, No.144)

"Preferred claim" means any claim with respect to which the terms of this act accord priority of payment from the general assets of the insurer.

"Receiver" means receiver, liquidator, rehabilitator, or conservator as the context requires.

"Reciprocal state" means any state other than this Commonwealth in which in substance and effect sections 520(a), 555, 556 and 558 through 560 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

"Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow or otherwise, but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

"Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

"State" means any state, district or territory of the United States and the Panama Canal Zone.

"Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the

possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 503 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 503 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 504. Jurisdiction and Venue.--(a) No court of this Commonwealth shall have jurisdiction to entertain, hear or determine any delinquency proceeding other than as provided in this article.

(b) In addition to other grounds for jurisdiction provided by the law of this Commonwealth, a court of this Commonwealth having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Pennsylvania Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this Commonwealth (i) if the person served is obligated to the insurer in any way as an incident to any agency or brokerage arrangement that may exist or has existed between the insurer and the agent or broker, in any action on or incident to the obligation; or (ii) if the person served is a reinsurer who has at any time written a policy of reinsurance for an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or (iii) if the person served is or has been an officer, manager, trustee, organizer, promoter or person in a position of comparable authority or influence in an insurer against which a rehabilitation or liquidation order is in effect when the action is commenced, in any action resulting from the relationship with the insurer.

(c) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this Commonwealth, the court may enter an appropriate order to stay further proceedings on the action in this Commonwealth.

(d) All action herein authorized shall be brought in the Commonwealth Court of the Commonwealth of Pennsylvania.

(504 added Dec. 14, 1977, P.L.280, No.92)

Section 505. Injunctions and Orders.--(a) Any receiver appointed in a proceeding under this article may at any time apply for and the Commonwealth Court may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent: (i) the transaction of further business; (ii) the transfer of property; (iii) interference with the receiver or with the proceeding; (iv) waste of the insurer's assets; (v) dissipation and transfer of bank accounts; (vi) the institution or further prosecution of any actions or proceedings; (vii) the obtaining of preferences, judgments, attachments, garnishments, or liens against the insurer, its assets or its policyholders; (viii) the levying of execution

against the insurer, its assets or its policyholders; (ix) the making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of this insurer; (x) the withholding from the receiver of books, accounts, documents or other records relating to the business of the insurer; or (xi) any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors, or shareholders, or the administration of the proceeding.

(a.1) Notwithstanding subsection (a) or any other provision of this article to the contrary, no FHLBank shall be stayed, enjoined or prohibited from exercising any right or enforcing any obligation under an FHLBank security agreement relating to collateral pledged by an insurer-member to the FHLBank. ((a.1) amended Oct. 14, 2014, P.L.2502, No.144)

(b) The receiver may apply to any court outside of the Commonwealth for the relief described in subsection (a) or suspension of any insurance licenses issued by the commissioner.

Section 506. Cooperation of Officers and Employees.--(a) Any employe, officer, manager, trustee, or general agent of any insurer, and any other person with executive authority over or in charge of any segment of the insurer's affairs shall cooperate with the commissioner in any proceeding under this article or any investigation preliminary or incidental to the proceeding. The term "person" as used in this section, shall include any person who exercises control directly or indirectly over activities of an insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to the following:

(1) to reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(2) to make available and deliver to the commissioner any books, accounts, documents, or other records, or information or property of or pertaining to the insurer and in his possession, custody or control.

(b) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(c) This section shall not be construed to abridge otherwise legal rights to resist a petition for liquidation or other delinquency proceedings:

(i) An insurer shall have the right to engage legal counsel for defense of and appeal with respect to a delinquency proceeding. Reasonable costs and fees therefore may be paid from the general assets of the insurer, subject to the approval of the administrative or judicial body to which appeal was made.

In the event that such proceedings result in a declaration of insolvency or are subsequent thereto, the approved costs thereof shall be administrative costs or expenses as provided under section 544(b).

(ii) If a stay of proceedings or order is specifically requested in a petition filed by an insurer, the administrative agency or court to which such petition is made may, in its discretion, grant such stay.

(d) Any person included within subsection (a) who fails to cooperate with the commissioner, or any person who obstructs

or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any valid order the commissioner issued under this article may be sentenced to pay a fine not exceeding ten thousand dollars (\$10,000) or to undergo imprisonment for a term of not more than one year, or both, or any person shall, after a hearing, be subject to the imposition by the commissioner, of a civil penalty not to exceed ten thousand dollars (\$10,000) and shall be subject further to the revocation or suspension of any insurance license issued by the commissioner.

(506 added Dec. 14, 1977, P.L.280, No.92)

Section 507. Bonds.--In any proceeding under this article, the commissioner and his deputies shall be responsible on their official bonds for the faithful performance of their duties. If the court deems it desirable for the protection of the assets, it may at any time require an additional bond from the commissioner or his deputies. Such additional bond shall be paid for out of the assets of the insurer as a cost of administration.

(507 added Dec. 14, 1977, P.L.280, No.92)

Section 508. Commissioner's Reports.--The commissioner shall as receiver make such reports to the court at such times and in such manner as the court shall require.

(508 added Dec. 14, 1977, P.L.280, No.92)

Section 509. Continuation of Delinquency.--Every proceeding heretofore commenced under the laws in effect before the enactment of the amendment of this article effective, 1977, shall be deemed to have commenced under this article so amended for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this article not been so amended.

(509 added Dec. 14, 1977, P.L.280, No.92)

(b) SUMMARY PROCEEDINGS

Section 510. Commissioner's Summary Orders.--(a) Whenever the commissioner has reasonable cause to believe, and determines, after a hearing held as prescribed in subsection (c), that any insurer has committed or engaged in any act, practice or transaction that would subject it to formal delinquency proceedings under this article, he may make and serve upon the insurer and any other persons involved, such orders, including an order suspending the business of an insurer, as are reasonably necessary to correct, eliminate or remedy such conduct, condition or ground.

(b) If the conditions of subsection (a), other than notice and hearing, are satisfied, and if the commissioner has reasonable grounds to believe that irreparable harm to the property or business of the insurer or to the interests of its policy or certificate holders, creditors or the public may occur unless he issues with immediate effect the orders described in subsection (a), he may make and serve such orders without notice and before hearing, simultaneously serving upon the insurer notice of hearing under subsection (c).

(c) The notice of hearing under subsections (a) or (b) and the summary order issued under subsections (a) or (b) shall be served pursuant to the applicable rules of civil or administrative procedure. The notice of hearing under subsection (a) shall state the time and place of hearing, and the conduct, condition or ground upon which the commissioner would base his order; the notice of hearing under subsection (b) shall state the time and place of hearing. Unless mutually agreed between the commissioner and the insurer, the hearing shall occur not more than fifteen days after notice is served and shall be either in Dauphin County or in some other place convenient to the parties to be designated by the commissioner. The commissioner shall not publicize such hearings and shall hold all hearings in summary proceedings privately unless the insurer requests a public hearing, in which case the hearing shall be public.

(d) Any suspension order made by the commissioner under the provisions of subsection (a) shall prohibit issuance of policies, transfers of property, and payments of moneys, without prior written approval of the commissioner. Notice of such suspension shall be given, by first class mail within fifteen days thereof, by the suspended organization to those who were creditors, policyholders, members and certificate holders at the date of suspension. Notice of such suspension shall be given, within fifteen days thereof, by the commissioner to creditors, policyholders, members and certificate holders by advertising the same by one publication in a newspaper of general circulation in the county where the suspended organization has its principal office. From the date of such suspension on the ground that the insurer is insolvent, or is in such condition that its further transaction of business will be hazardous financially to its policyholders, creditors, or the public, no action at law or equity shall be commenced or prosecuted nor shall any judgment be entered against nor shall any execution or attachment be issued or prosecuted against the suspended insurer, or against its property, in any court of this Commonwealth: Provided, That if such suspension order be vacated by the Commonwealth Court for the reason that the suspended insurer is no longer insolvent, or in such condition that its further transaction of business will be hazardous to its policyholders or to its creditors or to the public, these restraints upon legal process regarding the insurer shall thereafter cease to be operative.

(e) If the commissioner issues a summary order before hearing under this section, the insurer may at any time waive the commissioner's hearing and apply for immediate judicial relief by means of any remedy afforded by law without first exhausting administrative remedies.

(f) If any person has violated any order issued under this section which as to him was then still in effect, he shall be liable to pay a civil penalty imposed by the Commonwealth Court not to exceed ten thousand dollars (\$10,000).

(g) The commissioner may apply for and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to enforce a summary order.

(510 added Dec. 14, 1977, P.L.280, No.92)

Compiler's Note: Section 2(a) of Act 53 of 1978 provided section 510 is repealed in part. However, the specific references in the repeal were to language contained in the prior version of section 510 which was repealed in 1977. Therefore, the specific repeals could not be applied against the language of the existing section.

Section 511. Commissioner's Supervision.--(a) If upon examination or at any other time the commissioner has reasonable cause to believe, and determines, that an insurer has committed, engaged, or is about to engage in any act, practice, or transaction that would subject it to formal delinquency proceedings under this article, or if such insurance company gives its consent, then the commissioner shall upon his determination notify the insurer of his determination and furnish to the insurer an order or orders containing a written list of the commissioner's requirements to abate his determination. If the commissioner after a hearing held as provided in subsection 510(c) makes a further determination to supervise he shall issue an order to the insurer notifying it that it is under the supervision of the commissioner and that the commissioner is applying and effecting the provisions of this section. The commissioner may issue an order under this section without a hearing under the conditions provided under section 510(b), and shall simultaneously serve upon the insurer notice of a hearing to be held in accordance with the provisions of section 510(c), and in such event, the insurer may file an appeal in accordance with the provisions of section 510(e). Such insurer shall comply with the lawful requirements of the commissioner and, if placed under an order of supervision shall have ninety days from the date of service of such order within which to comply with the requirements of the commissioner. In the event of such insurer's failure to comply within such time, the commissioner may institute proceedings in the Commonwealth Court to have a rehabilitator or liquidator appointed under the provisions of this article, or issue an order extending an existing order of supervision. Such order extending any existing order shall be issued prior to the end of each ninety-day period, unless otherwise agreed to by the insurer.

(b) The commissioner may appoint a supervisor to supervise such insurer and may provide that the insurer may not do any of the following acts, during the period of supervision, without the prior written approval of the commissioner or his supervisor: (i) dispose of, convey or encumber any of its assets or its business in force; (ii) withdraw any of its bank accounts; (iii) lend any of its funds; (iv) invest any of its funds; (v) transfer any of its property; (vi) incur any debit, obligation or liability; (vii) merge or consolidate with another company; or (viii) enter into any new reinsurance contract or treaty.

(c) In the event that any person, subject to the provisions of this article including those persons described in section 506(a), shall violate any valid order of the commissioner issued under the provisions of this section and, as a result, the net worth of the insurer shall be reduced or the insurer shall otherwise suffer loss said person shall become personally liable to the insurer for the amount of any such reduction or loss. The commissioner or supervisor is authorized to bring an action on behalf of the insurer in the

Commonwealth Court to recover the amount of the reduction or loss together with any costs.

(511 added Dec. 14, 1977, P.L.280, No.92)

Section 512. Court's Seizure Order.--(a) Upon the filing by the commissioner in the Commonwealth Court of this Commonwealth of a petition alleging, (i) any ground that would justify a court order for a formal delinquency proceeding against an insurer under this article, and (ii) that the interests of policyholders, creditors or the public will be endangered by delay, and (iii) setting out the order deemed necessary by the commissioner, the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for the transaction of its business, and until further order of the court enjoin the insurer and its officers, managers, agents, and employes from disposition of its property and from transaction of its business except with the written consent of the commissioner.

(b) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. Such initial duration or any extension thereof shall not exceed ninety days. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten, or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this article prior to the expiration of a seizure order or any extension thereof. An order of the court pursuant to a formal proceeding under this article shall ipso facto vacate the seizure order.

(c) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(d) An insurer subject to an ex parte order of the Commonwealth Court issued under the provisions of this section may petition the court at any time after the issuance of such order for a hearing and review of the order, and the court shall grant such a hearing and review within ten days of the filing of such petition.

(512 added Dec. 14, 1977, P.L.280, No.92)

Section 513. Conduct of Hearings in Summary Proceedings.--

(a) The Commonwealth Court may hold all hearings in summary proceedings and judicial review thereof privately in chambers, and shall do so on request of the insurer proceeded against.

(b) In all summary proceedings and judicial reviews thereof, all records of the insurer, other documents, and all Insurance Department files and court records and papers, so far as they pertain to or are a part of the record of the summary proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the Commonwealth Court, after hearing arguments from the parties in chambers, shall order otherwise, or unless the insurer requests that the matter be made public. Until such court

order, all papers filed with the clerk of the Commonwealth Court shall be held by him in a confidential file.

(c) Any person having possession or custody of and refusing to deliver any of the property, books, accounts, documents or other records of or relating to an insurer against which a seizure order or a summary order has been issued by the commissioner or by the Commonwealth Court, may be fined not more than ten thousand dollars (\$10,000) or sentenced to undergo imprisonment for not more than one year, or both.

(513 added Dec. 14, 1977, P.L.280, No.92)

(c) FORMAL PROCEEDINGS

A. Rehabilitation

Section 514. Grounds for Rehabilitation.--An order of rehabilitation may be based on one or more of the following grounds:

(1) The insurer is insolvent, or is in such condition that the further transaction of business would be hazardous, financially, to its policyholders, creditors or the public.

(2) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(3) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employe, or other person, if the person has been found after notice and hearing to be dishonest or untrustworthy in a way affecting the insurer's business.

(4) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be dishonest or untrustworthy.

(5) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employe, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this Commonwealth or elsewhere, and after reasonable notice of the fact the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(6) After demand, the insurer has failed to submit promptly any of its own property, books, accounts, documents or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer, to examination. If the insurer is unable to submit the property, books, accounts, documents or other records of a person having executive authority in the insurer, it shall be excused from doing so if it promptly and effectively terminates the relationship of the person to the insurer.

(7) Without first obtaining his written consent of the commissioner, the insurer has transferred, or attempted to transfer, substantially its entire property or business, or has entered into any transaction the effect of which is to

merge, consolidate, or reinsure substantially its entire property or business in or with the property or business of any other person.

(8) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this Commonwealth, and such appointment has been made or is imminent, and such appointment might oust the courts of this Commonwealth of jurisdiction or prejudice orderly delinquency proceedings under this article.

(9) Within the previous four years the insurer has willfully violated its charter or articles of incorporation or its bylaws or any insurance law in a manner which may result or has resulted in substantial harm to the property or business of an insurer or to the interests of its policy or certificate holders, creditors, or the public, or any valid order of the commissioner under sections 510 and 511.

(10) The insurer has failed to pay within sixty days after due date any obligation to this Commonwealth or any subdivision thereof or any judgment entered in this Commonwealth, except that such nonpayment shall not be a ground until sixty days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(11) The insurer has failed to file its annual report or other report within the time allowed by law and, after written demand by the commissioner, has failed to give a satisfactory explanation immediately.

(12) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities specified in section 502, request or consent to rehabilitation under this article.

(514 added Dec. 14, 1977, P.L.280, No.92)

Section 515. Rehabilitation Orders.--(a) The commissioner may apply by petition to the Commonwealth Court, for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this Commonwealth, alleging that the insurer has committed one or more acts which may constitute grounds for rehabilitation as set forth in section 514 of this article.

(b) An order of the Commonwealth Court to rehabilitate the business of an insurer shall be issued only after a hearing before the court or pursuant to a written consent of the insurer.

(c) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this Commonwealth, shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer including any deposits held by the commissioner, and to administer them under the orders of the court. The filing or recording of the order with the clerk of the Commonwealth Court or recorder of deeds of the county in which the

principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer.

(515 added Dec. 14, 1977, P.L.280, No.92)

Section 516. Powers and Duties of the Rehabilitator.--(a) The commissioner as rehabilitator may appoint a special deputy who shall have all the powers of the rehabilitator granted under this section. The commissioner shall make such arrangements for compensation as are necessary to obtain a special deputy of proven ability. The special deputy shall serve at the pleasure of the commissioner.

(b) The rehabilitator may take such action as he deems necessary or expedient to correct the condition or conditions which constituted the grounds for the order of the court to rehabilitate the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(c) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee, or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(d) The rehabilitator may prepare a plan for the reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer. Upon application of the rehabilitator for approval of the plan, and after such notice and hearing as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. If it is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the equities of policyholders of the company, provided that all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(e) The rehabilitator shall have the power to avoid fraudulent transfers under sections 528 and 529.

(516 added Dec. 14, 1977, P.L.280, No.92)

Section 517. Actions By and Against Rehabilitator.--(a) On request of the rehabilitator, any court in this State before which any action or proceeding by or against an insurer is pending when a rehabilitation order against the insurer is entered shall stay the action or proceeding for such time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The Commonwealth Court shall order the rehabilitator to take such action respecting the pending litigation as the court deems necessary in the interests of justice and for the protection

of creditors, policyholders, and the public. The rehabilitator shall immediately consider all litigation pending outside this Commonwealth and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(b) The time between the filing of a petition for rehabilitation against an insurer and denial of the petition or an order of rehabilitation shall not be considered to be a part of the time within which any action may be commenced by or against the insurer. Any action by or against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the order of rehabilitation is entered.

(517 added Dec. 14, 1977, P.L.280, No.92)

Section 518. Termination of Rehabilitation.--(a) Whenever he has reasonable cause to believe that further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policy and certificate holders, or the public, or would be futile, the rehabilitator may petition the Commonwealth Court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under section 520. The Commonwealth Court shall permit the directors to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(b) The rehabilitator may at any time petition the Commonwealth Court for an order terminating rehabilitation of an insurer. If the Commonwealth Court finds that rehabilitation has been accomplished and that grounds for rehabilitation under section 514 no longer exists, it shall order that the insurer be restored to possession of its property and the control of its business. The Commonwealth Court may also make that finding and issue that order at any time upon its own motion.

(518 added Dec. 14, 1977, P.L.280, No.92)

B. Liquidation

1. Initiation of Proceeding

Section 519. Grounds for Liquidation.--Any ground on which an order of rehabilitation may be based, as specified in section 514, whether or not there has been a prior order of rehabilitation of the insurer shall be grounds for liquidation.

(519 added Dec. 14, 1977, P.L.280, No.92)

Section 520. Liquidation Orders.--(a) The commissioner may apply by petition to the Commonwealth Court for an order directing him to liquidate a domestic insurer, domiciled in this Commonwealth, alleging that the insurer has committed one or more acts which may constitute grounds for liquidation as set forth in sections 514 and 519 of this article.

(b) An order of the Commonwealth Court to liquidate the business of an insurer shall be issued only after a hearing before the court or pursuant to a written consent of the insurer.

(c) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his successors in office

liquidator and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the orders of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action and all of the books and records of the insurer ordered liquidated, wherever located, as of the date of the filing of the petition for liquidation. He may recover and reduce the same to possession except that ancillary receivers in reciprocal states shall have, as to assets located in their respective states, the rights and powers which are prescribed in section 556(c) for ancillary receivers appointed in this Commonwealth as to assets located in this Commonwealth. The filing or recording of the order with the Clerk of the Commonwealth Court or with the recorder of deeds of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(d) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of filing of the petition for liquidation, except as provided in sections 521 and 539.

(e) An order to liquidate the business of an alien insurer domiciled in this Commonwealth shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(f) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, following an administrative hearing, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as are permitted for appeals from administrative agencies, the court may make the declaration.

(520 added Dec. 14, 1977, P.L.280, No.92)

Section 521. Continuance of Coverage.--All insurance in effect at the time of issuance an order of liquidation shall continue in force only with respect to the risks in effect, at that time (i) for a period of thirty days from the date of entry of the liquidation order; (ii) until the normal expiration of the policy coverage; (iii) until the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy; or (iv) until the liquidator has effected a transfer of the policy obligation pursuant to section 523(8), whichever time is less.

(521 added Dec. 14, 1977, P.L.280, No.92)

Section 522. Dissolution of Insurer.--The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this Commonwealth at the time he applied for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution

has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator.

(522 added Dec. 14, 1977, P.L.280, No.92)

2. Powers and Duties of Liquidators and Others

Section 523. Powers of Liquidator.--The liquidator shall have the power:

(1) To appoint a special deputy to act for him under this article, and to determine his compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the commissioner.

(2) To employ employes and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation.

(3) To fix the compensation of employes and agents, legal counsel, actuaries, accountants, appraisers and consultants without complying with civil service regulations.

(4) To pay compensation to persons appointed and to defray all expenses of taking possession of, conserving, conducting, liquidating, disposing of or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner shall advance the costs so incurred out of the appropriation for the maintenance of the Insurance Department. Any amounts so paid shall be deemed expense of administration and shall be repaid to the commissioner for the use of the Insurance Department out of the first available moneys of the insurer.

(5) To hold hearings, to subpoena witnesses, to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing, and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry.

(6) To collect all debts and moneys due and claims belonging to the insurer which it is economical to collect, wherever located, and for this purpose to institute timely action in other jurisdictions, in order to forestall garnishment and attachment proceedings against such debts; to do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign for purposes of collection upon such terms and conditions as he deems best, any bad or doubtful debts; to pursue any creditor's remedies available to enforce his claims.

(7) To conduct public and private sales of the property of the insurer.

(8) To use assets of the estate to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under section 544.

(9) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such

terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation is pending, the liquidator shall cause to be filed with the recorder of deeds for the county in which the property is located a certified copy of the order appointing him liquidator.

(10) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation.

(11) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(12) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings, in this Commonwealth or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under section 522, he shall have the power to apply to any court in this State or elsewhere for leave to substitute himself for the insurer as plaintiff.

(13) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person.

(14) To remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation.

(15) To deposit in one or more banks in this Commonwealth such sums as are required for meeting current administration and operating costs.

(16) To invest, all sums not currently needed, unless the court orders otherwise.

(17) To file any necessary documents for record in the office of any recorder of deeds or record office in this Commonwealth or elsewhere where property of the insurer is located.

(18) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds and the defense of usury; a waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the commissioner. When a guaranty association has an obligation to defend a suit, the liquidator shall give precedence to such obligations and shall defend only in the absence of a defense by the guaranty association.

(19) To exercise and enforce all the rights, remedies, and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with sections 528 through 530.

(20) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

(21) To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(22) To exercise all powers now held or hereafter conferred upon receivers by the laws of this Commonwealth not inconsistent with the provisions of this article.

(23) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated, or otherwise provided for, as may be necessary or expedient for the accomplishment of or in aid of the purpose of liquidation.

(523 added Dec. 14, 1977, P.L.280, No.92)

Section 523.1. Policyholder Collateral, Deductible Reimbursements and Other Policyholder Obligations.--

(a) Collateral shall not be considered an asset of the estate and shall be maintained and administered by the receiver as provided in this section, notwithstanding any other provision of law or contract to the contrary.

(b) Subject to the provisions of this section, the collateral shall be used to secure the policyholder's obligation to fund or reimburse claims payment within the agreed deductible amount.

(c) If a claim that is subject to a deductible agreement and secured by collateral is not covered by any guaranty association and the policyholder is unwilling or unable to take over the handling and payment of the non-covered claims, the receiver shall adjust and pay the non-covered claims utilizing the collateral but only to the extent the available collateral, after allocation under subsection (d), is sufficient to pay all outstanding and anticipated claims. A claim against the collateral by a third-party claimant is not a claim against the insolvent insurer's estate for the purposes of releasing the policyholder to the extent of applicable policy coverage. If the collateral is exhausted and the insured is not able to provide funds to pay the remaining claims within the deductible after all collection means against the insured have been exhausted, the receiver's obligation to pay such claims from the collateral terminates, and the remaining claims shall be claims against the insurer's estate subject to complying with other provisions of this article for the filing and allowance of claims. When the liquidator determines the collateral provided by the insured is insufficient to pay all additional and anticipated claims against the insured, the liquidator may file a plan for equitably allocating the collateral among claimants of the insured which provided the collateral, subject to court approval.

(d) To the extent that the receiver is holding collateral that secures other obligations of the policyholder to pay the insurer directly or indirectly amounts that will become assets of the estate, such as reinsurance obligations under a captive reinsurance program or premium obligations under a retrospectively rated insurance policy where the premium due is subject to adjustment based upon actual loss experience, the receiver shall equitably allocate the collateral among

such obligations and administer the collateral allocated to the deductible agreement pursuant to this section. With respect to the collateral allocated to obligations under the deductible agreement, if the collateral-secured reimbursement obligations are under more than one line of insurance, then the collateral shall be equitably allocated among the various lines based upon the estimated ultimate exposure within the deductible amount for each line. The receiver shall inform the guaranty associations of the method and details of all the foregoing allocations.

(e) Regardless of whether there is collateral, if the insurer has contractually agreed to allow the policyholder to fund its own claims within the deductible amount pursuant to a deductible agreement either through the policyholder's own administration of its claims or through the policyholder providing funds directly to a third-party administrator who administers the claims, the receiver shall allow such funding arrangement to continue and, where applicable, will enforce such arrangements to the fullest extent possible. The funding of such claims by the policyholder within the deductible amount will act as a bar to a claim for such amount in the liquidation proceeding, including, but not limited to, a claim by the policyholder or the third-party claimant. The funding will extinguish both the obligation, if any, of any guaranty association to pay such claims within the deductible amount, as well as the obligation, if any, of the policyholder or the third-party administrator to reimburse the guaranty association. No charge of any kind shall be made against a guaranty association on the basis of the policyholder funding of claims payment made pursuant to the mechanism set forth in this subsection.

(f) (1) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement from the policyholder under the terms of the deductible agreement and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall promptly bill the policyholder for such reimbursement, and the policyholder will be obligated to pay such amount to the receiver for the benefit of the guaranty associations who paid such claims. Neither the insolvency of the insurer nor its inability to perform any of its obligations under the deductible agreement shall be a defense to the policyholder's reimbursements obligation under the deductible agreement. When the policyholder reimbursements are collected, the receiver shall promptly reimburse such guaranty association for claims paid that were subject to the deductible. If the policyholder fails to pay the amounts due within sixty days after such bill for such reimbursements is due, the receiver shall use the collateral to the extent necessary to reimburse the guaranty association and, at the same time, may pursue other collections efforts against the policyholder. If the policyholder reimbursements are not collected due to the reduction in such reimbursements as provided in paragraph (2), the receiver shall nonetheless reimburse such guaranty association as if such reimbursements had been collected. The receiver will obtain funds to reimburse a guaranty association

claim affected by paragraph (2) by subtracting from funds collected by the receiver for other policyholder claim reimbursements under this paragraph amounts sufficient to reimburse the guaranty association affected by the application of paragraph (2). Subtraction of funds shall be made against all guaranty associations, including the guaranty association affected by paragraph (2) on the basis of the ratio stated in paragraph (3). If more than one guaranty association has a claim against the same collateral and the available collateral, after allocation under subsection (d), along with billing and collection efforts, are together insufficient to pay each guaranty association in full, then the receiver will prorate payments to each guaranty association based upon the proportion of the amount of claims each guaranty association has paid bears to the total of all claims paid by such guaranty associations.

(2) The obligation of a policyholder arising solely from a deductible agreement to reimburse the receiver for the benefit of one or more guaranty associations under paragraph (1) for losses paid by one or more guaranty associations shall be reduced by the amount of premium paid by or on behalf of the policyholder for one or more policies issued by a wholly owned affiliate or subsidiary of the insurer, which affiliate or subsidiary was either licensed to do business in this Commonwealth or was an eligible surplus lines insurer under Article XVI of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," at the time of the issuance of such policies where such policies were purchased to fund the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement, but in no event shall the reduction in liability be less than ninety per centum of the total premiums paid to the insurer and such affiliate or subsidiary for such policies and coverage provided under the related deductible agreement, provided that the policyholder's reimbursement obligation shall be reduced only if: (i) the wholly owned affiliate or subsidiary was merged into the insurer that was a party to the deductible agreement before the entry of a liquidation order against the insurer; (ii) the merger was approved by the commissioner; and (iii) the merger took place before the enactment of this section.

(3) The reduction as a result of paragraph (2) in the amount of deductible reimbursements that one or more guaranty associations would have been entitled to claim from a policyholder of the insurer under paragraph (1) shall be allocated by the receiver pursuant to this paragraph pro rata among all guaranty associations receiving deductible reimbursements under paragraph (1). The pro rata allocation among guaranty associations shall be based upon the ratio of: (i) claims paid and to be paid as estimated by each guaranty association that are referred to in paragraph (1) to (ii) the total amount of claims paid and to be paid estimated by all the guaranty associations that are referred to in paragraph (1). Amounts used for the pro rata allocation shall be determined after giving effect to the provisions referred to in subsection (k) relating to insured net worth.

(4) Any claim of the policyholder under one or more policies issued by the affiliate or subsidiary as described in paragraph (2) is hereby waived except for those claims under

policies that are not paid by a guaranty association as a covered claim or amounts the policyholder has reimbursed a guaranty association under Article XVIII of "The Insurance Company Law of 1921" or similar laws in other states.

(g) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present, to the extent a guaranty association is required by applicable State law to pay any claims for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy and to the extent the claims have not been paid by the policyholder or by a third party, the receiver shall first make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the guaranty associations to the extent of claims paid within the deductible. To the extent the receiver is unable in whole or in part to recover first under the deductible reimbursement policy for claims paid by the guaranty associations, the receiver shall promptly bill the policyholder for the reimbursement, and the policyholder will be obligated to pay the amount to the receiver for the benefit of the guaranty associations who paid the claims. The policyholder shall retain any and all defenses that may be asserted in connection with the receiver's efforts to collect reimbursements from the policyholder.

(h) If the insurer has not contractually agreed to allow the policyholder to fund its own claims within the deductible amount and a deductible reimbursement policy is present and if a guaranty association is not paying claims for any reason for which the insurer would have been entitled to reimbursement under the deductible reimbursement policy, to the extent claims covered under a deductible reimbursement policy have been paid by the policyholder and sufficient information on the payments has been provided by the policyholder to the receiver for purposes of billing under the deductible reimbursement policy, the receiver shall make a good faith attempt to recover reimbursements or collateral under the deductible reimbursement policy from the insurer of the deductible reimbursement policy. Any resulting recoveries under the deductible reimbursement policy shall be payable to the policyholder.

(i) Receiver's duties and powers:

(1) The receiver is entitled to deduct from reimbursements owed to guaranty associations and/or policyholders under this section or collateral to be returned to a policyholder reasonable actual expenses incurred in fulfilling the responsibilities under this provision, not to exceed three per centum of the collateral or the total deductible reimbursements actually collected by the receiver.

(2) With respect to claim payments made by any guaranty associations, the receiver shall promptly provide the guaranty associations with a complete accounting of the receiver's deductible billing and collection activities, including, but not limited to, copies of the policyholder billings when rendered, the reimbursements collected, the available amounts and use of collateral for each account and any proration of

payments when it occurs. The receiver's costs of accounting shall be included with expenses referred to under this subsection and, together with other reasonable actual expenses, be subject to the overall limit called for by this subsection. If the receiver fails to make a good faith effort within one hundred twenty days of receipt of claims payment reports to collect reimbursements due from a policyholder under a deductible agreement based on claim payments made by one or more guaranty associations, then after such one-hundred-twenty-day-period such guaranty associations may pursue collection from the policyholders directly on the same basis as the receiver and with the same rights and remedies and will report any amounts so collected from each policyholder to the receiver. To the extent that guaranty associations pay claims within the deductible amount but are not reimbursed by either the receiver under this section or by policyholder payments from the guaranty association's own collection efforts, the guaranty association shall have a claim in the insolvent insurer's estate for such unreimbursed claims payments.

(3) The receiver shall periodically adjust the collateral being held while the claims subject to the deductible agreement are run off, provided that adequate collateral is maintained to secure the entire estimated ultimate obligation of the policyholder plus a reasonable safety factor, and the receiver shall not be required to adjust the collateral more than once a year. The guaranty associations and the policyholder shall be informed of all such collateral reviews, including, but not limited to, the basis for the adjustment. Once all claims covered by the collateral have been paid and the receiver is satisfied that no new claims can be presented, the receiver will release any remaining collateral to the policyholder.

(j) The Commonwealth Court shall have jurisdiction to resolve disputes arising under this section.

(k) Nothing in this section is intended to limit or adversely affect any right the guaranty associations may have under applicable State law to obtain reimbursement from certain classes of policyholders for claims payments made by such guaranty associations under policies of the insolvent insurer, or for related expenses the guaranty associations incur.

(l) This section will apply to all delinquency proceedings which are open and pending as of the effective date of this section.

(m) This section shall not apply to first party claims, or to claims funded by a guaranty association net of the deductible unless subsection (e) applies.

(n) For purposes of this section, the following terms shall have the meanings given to them in this subsection:

"Collateral" shall mean collateral held by, for the benefit of or assigned to the insurer or subsequently to the receiver in order to secure the obligations of a policyholder under a deductible agreement and also any collateral recovered or held by the receiver that secured the obligations of a policyholder under a deductible reimbursement policy.

"Deductible agreement" shall include any combination of one or more policies, endorsements, contracts or security

agreements which provide for the policyholder to bear the risk of loss within a specified amount per each claim or occurrence covered under a policy of insurance and may be subject to aggregate limit of policyholder reimbursement obligations as set forth in an endorsement to a policy or in a program agreement.

"Deductible reimbursement policy" shall mean a policy other than one referred to in subsection (f)(2), purchased by the policyholder to secure the policyholder's obligation to reimburse the insurer for deductibles under the deductible agreement.

"Non-covered claims" shall mean a claim that is subject to a deductible agreement, may be secured by collateral and is not covered by a guaranty association.

(523.1 added June 28, 2004, P.L.443, No.46)

Section 524. Notice to Creditors and Others.--(a) The liquidator shall give notice of the liquidation order as soon as possible by first class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is licensed to do business, by first class mail and by telephone to any responsible guaranty association of this Commonwealth, by first class mail to all insurance agents having a duty under section 525 and to all known policyholders, creditors and claimants.

(b) Notice to potential claimants under subsection (a) shall require claimants to file with the liquidator their claims together with proper proofs thereof under section 538, on or before a date the liquidator shall specify in the notice. All claimants shall have a duty to keep the liquidator informed of any change of address.

(524 added Dec. 14, 1977, P.L.280, No.92)

Section 525. Duties of Agents.--(a) Every person who receives notice in the form prescribed in section 524 that an insurer which he represents as an independent agent is the subject of a liquidation order, shall within fifteen days of such notice give notice of the liquidation order. The notice shall be sent by first class mail to the last address contained in the agent's records to each policyholder or other person named in any policy issued through the agent by the insurer, if he has a record of the address of the policyholder or other person. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy; or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another. The written notice shall include the name and address of the insurer, the name and address of the agent, identification of the policy impaired and the nature of the impairment including termination of coverage, as described in section 521. Notice by a general agent satisfies the notice requirement for any agents under contract to him.

(b) Any agent failing to give notice as required in subsection (a) may be subject to payment of a penalty of not more than one thousand dollars (\$1,000) and may have his license suspended, said penalty to be imposed after a hearing held by the insurance commissioner.

(525 added Dec. 14, 1977, P.L.280, No.92)

Section 526. Actions By and Against Liquidator.--(a) Upon issuance of an order appointing the commissioner liquidator of a domestic insurer or of an alien insurer domiciled in this Commonwealth, no action at law or equity shall be brought by or against the insurer, whether in this Commonwealth or elsewhere, nor shall any such existing actions be continued after issuance of such order. Whenever in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this Commonwealth, with approval of the court he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(b) The liquidator may, upon or after an order for liquidation, within two years or such additional time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition, the liquidator may, for the benefit of the estate, take any such action or do any such act, required of or permitted to the insurer, within a period of one hundred and eighty days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(c) The time between the filing of a petition for liquidation against an insurer and the denial of the petition shall not be considered to be a part of the time within which any action may be commenced against the insurer. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty days after the petition is denied.

(526 added Dec. 14, 1977, P.L.280, No.92)

3. Estate of Insurer

Section 527. Collection and List of Assets.--(a) As soon as practicable after the liquidation order, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the court shall require. One copy shall be filed in the office of the clerk of the Commonwealth Court and one copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(b) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation as rapidly and economically as he can.

(527 added Dec. 14, 1977, P.L.280, No.92)

Section 528. Fraudulent Transfers Prior to Petition.--(a) Every transfer made or suffered and every obligation incurred by an insurer within one year prior to the filing of a successful petition for rehabilitation or liquidation under this article is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay, or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this article, which is fraudulent under this section, may be avoided by the receiver, except as to a person who in good faith is a purchaser, lienor, or obligee for a present fair equivalent value, and except that any purchaser, lienor, or obligee, who in good faith has given a consideration less than fair for such transfer, lien, or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event, the receiver shall succeed to and may enforce the rights of the purchaser, lienor, or obligee. Notwithstanding this subsection or any other provision of this article to the contrary, a receiver shall not avoid a transfer of money or other property arising under or in connection with an FHLBank security agreement that is made before the commencement of a formal delinquency proceeding under this article in the ordinary course of business and in compliance with the FHLBank security agreement unless such transfer was made with actual intent to hinder, delay or defraud the insurer-member, the receiver appointed for the insurer-member or existing or future creditors. ((a) amended Oct. 14, 2014, P.L.2502, No.144)

(b) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee, under section 530(c).

A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(c) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be avoided by the receiver under subsection (a) if (i) the transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transaction, unless the reinsurer gives a present fair equivalent value for the release; and (ii) any part of the transaction took place

within one year prior to the date of filing of the petition through which the receivership was commenced.

(528 added Dec. 14, 1977, P.L.280, No.92)

Section 529. Fraudulent Transfers After Petition.--(a) After a petition for rehabilitation or liquidation a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the recorder of deeds in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(b) After a petition for rehabilitation or liquidation and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(1) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value, or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(2) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(3) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(4) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or in behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(c) Nothing in this article shall impair the negotiability of currency or negotiable instruments.

(529 added Dec. 14, 1977, P.L.280, No.92)

Section 530. Voidable Preferences and Liens.--(a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one year before the filing of a successful petition for liquidation under this article the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer

is already subject to a rehabilitation order, then transfers otherwise qualifying shall be deemed preferences if made or suffered within one year before the filing of the successful petition for rehabilitation or within two years before the filing of the successful petition for liquidation, whichever time is shorter.

Any preference may be avoided by the liquidator, if (i) the insurer was insolvent at the time of the transfer; (ii) the transfer was made within four months before the filing of the petition; (iii) the creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or (iv) the creditor receiving it was an officer, any employe or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding directly or indirectly more than five per centum of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length. Where the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property, except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. Where a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate, in which event the lien or title shall pass to the liquidator.

(a.1) Notwithstanding subsection (a) or any other provision of this article to the contrary, (i) a receiver shall not avoid a transfer of money or other property arising under or in connection with an FHLBank security agreement that is made before the commencement of a formal proceeding under this article in the ordinary course of business and in compliance with the security agreement unless such transfer was made with actual intent to hinder, delay or defraud the insurer-member, a receiver appointed for the insurer-member or existing or future creditors; and (ii) a receiver shall not void a redemption or repurchase of any stock or equity securities which was made by the FHLBank within four months of a formal commencement of the delinquency proceedings or which received prior approval of the receiver. ((a.1) added Oct. 14, 2014, P.L.2502, No.144)

(a.2) Following the appointment of a receiver for an insurer-member and upon request of the receiver, the FHLBank shall, within ten days of such request, provide a process and establish timing for all of the following:

(1) The release of collateral that exceeds the lending value, as determined in accordance with the FHLBank security agreement, required to support secured obligations remaining after any repayment of advances.

(2) The release of any collateral remaining in the FHLBank's possession following repayment of all outstanding secured obligations in full.

(3) The payment of fees and the operation of deposits and other accounts with the FHLBank.

(4) The possible redemption or repurchase of FHLBank stock or excess stock of any class that an insurer-member is required to own.

((a.2) added Oct. 14, 2014, P.L.2502, No.144)

(a.3) Upon the request of the receiver for an insurer-member, the FHLBank shall provide any available options for such insurer-member to renew or restructure an advance to defer associated prepayment fees, to the extent that market conditions, the terms of the advance outstanding to the insurer-member, the applicable policies of the FHLBank and compliance with the Federal Home Loan Bank Act and corresponding regulations permit. ((a.3) added Oct. 14, 2014, P.L.2502, No.144)

(a.4) Nothing in this section shall affect the receiver's rights pursuant to section 12 CFR § 1266.4 (relating to limitations on access to advances) regarding advances to an insurer-member in delinquency proceedings. ((a.4) added Oct. 14, 2014, P.L.2502, No.144)

(b) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(c) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (b), if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (b) through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the

agreement or concurrence of any third party or which require any further judicial action, or ruling.

(d) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (b) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

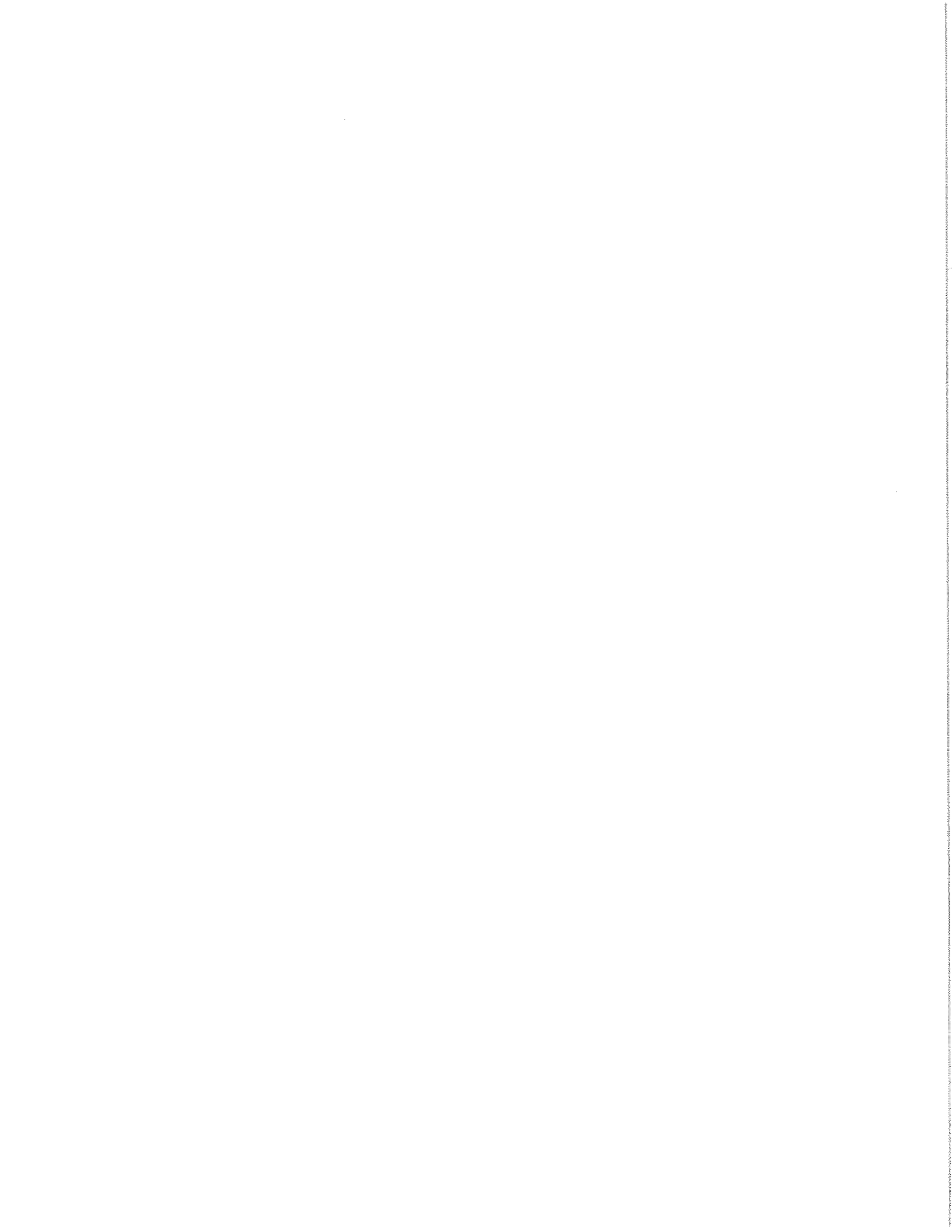
(e) If any lien deemed voidable under the second paragraph of subsection (a) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien upon any property of an insurer before the filing of a petition under this article which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(f) The property affected by any lien deemed voidable under subsections (a) and (e) shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(g) The Commonwealth Court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. Where an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(h) The liability of a surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and avoided by the liquidator, or where the property is retained under subsection (g) to the extent of the amount paid to the liquidator.

(i) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the



time of the petition may be setoff against the preference which would otherwise be recoverable from him.

(j) If an insurer shall, directly or indirectly, within four months before the filing of a successful petition for liquidation under this article, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transaction may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefit of the estate provided that where the attorney is in a position of influence in the insurer or an affiliate thereof payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of subsection (a)(iv).

(k) Every officer, manager, employe, shareholder, member, subscriber, attorney, or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is reasonable cause to so believe if the transfer was made within four months before the date of filing of the successful petition for liquidation.

Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (a) shall be personally liable therefor and shall be bound to account to the liquidator.

Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

(530 added Dec. 14, 1977, P.L.280, No.92)

Section 531. Claims of Holders of Void or Voidable Rights.--

(a) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance, voidable under this article, shall be allowed unless he surrenders the preference, lien, conveyance, transfer assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(b) A claim allowable under subsection (a) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment, or encumbrance, may be filed as an excused late filing under section 537 if filed within thirty days from the date of the avoidance, or within the further time allowed by the court under subsection (a).

(531 added Dec. 14, 1977, P.L.280, No.92)

Section 532. Setoffs and Counterclaims.--(a) Mutual debts or mutual credits between the insurer and another person in connection with any action or proceeding under this article

shall be setoff and the balance only shall be allowed or paid, except as provided in subsection (b).

(b) No setoff or counterclaim shall be allowed in favor of any person where:

(1) the obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer;

(2) the obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a setoff;

(3) the obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution; or

(4) the obligation of the person is to pay premiums, whether earned or unearned, to the insurer.

(532 added Dec. 14, 1977, P.L.280, No.92)

Section 533. Assessments.--(a) As soon as practicable but not more than two years from the date of an order of liquidation under this article of an insurer issuing assessable policies, the liquidator shall make a report to the Commonwealth Court setting forth:

(1) the reasonable value of the assets of the insurer;

(2) the insurer's probable total liabilities;

(3) the probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(4) whether or not an assessment should be made and what amount.

(b) Upon the basis of the report provided in subsection (a), including any supplements and amendments thereto, the Commonwealth Court may levy one or more assessments against all members of the insurer who are subject to assessment. No member shall be assessed for any loss that occurred when his policy was not in effect. No assessment shall be made or collection procedures begun after two years from the expiration date of a policy. The maximum assessment against any member for each year or part thereof in which a policy or policies issued to such member were in effect shall not exceed one hundred per centum of the average total annual premium during the life of the policy as written in such policy or policies including any increase or reduction in premium as the result of any endorsement thereto.

Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(c) After levy of assessment under subsection (b) the commissioner shall issue an order directing each member who has not paid the assessment pursuant to the order, to show cause why the liquidator should not pursue a judgment therefor.

(d) The liquidator shall give notice of the order to show cause by publication and by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least twenty days before the return day of the order to show cause.

(e) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (c), the court shall make an order adjudging the member liable for the amount of the assessment against him and other indebtedness, pursuant to subsection (c), together with costs, and the liquidator shall have a judgment against the member therefor. If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(f) The liquidator may enforce any order or collect any judgment under subsection (e) by any lawful means.

(533 added Dec. 14, 1977, P.L.280, No.92)

Section 534. Reinsurer's Liability.--The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of an individual named insured and the payment was made in discharge of that obligation.

(534 added Dec. 14, 1977, P.L.280, No.92)

Section 535. Recovery of Premiums Owed.--(a) An insured, agent, broker, premium finance company or any other person responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency whether earned or unearned as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits and/or setoff shall not be allowed to an agent, broker or premium finance company on account of any credits volunteered by such person.

(b) Upon satisfactory evidence of a violation of this section, the Insurance Commissioner may, in his discretion, pursue any one or more of the following courses of action:

(1) Suspend or revoke or refuse to renew the licenses of such offending party or parties.

(2) Impose a penalty of not more than one thousand dollars (\$1,000) for each and every act in violation of this section by said party or parties.

Before the Insurance Commissioner shall take any action as above set forth, he shall give written notice to the person, company, association, or exchange accused of violating the law, stating specifically the nature of the alleged violation, and fixing a time and place, at least ten days thereafter, when a hearing of the matter shall be held. After such hearing, or upon failure of the accused to appear at such

hearing, the Insurance Commissioner shall impose such of the above penalties as he deems advisable.

When the Insurance Commissioner shall take action in any or all of the ways above recited, the party aggrieved may appeal from said action to the Commonwealth Court.

(535 added Dec. 14, 1977, P.L.280, No.92)

Section 536. Liquidator's Proposal to Distribute Assets.--

(a) Within one hundred twenty days of a final determination that an insurer is insolvent or in such condition that its further transaction of business will be hazardous to its policyholders, or to its creditors, or to the public by a court of competent jurisdiction of this Commonwealth, the liquidator shall make application to the Commonwealth Court for approval of a proposal to disburse assets out of such company's marshalled assets, from time to time as such assets become available, to any guaranty association in the Commonwealth or in any other state having substantially the same provision of law. The liquidator need not make application, as required above, in instances where it is reasonable to conclude that the assets of the insolvent insurer will not exceed the amounts necessary to pay the costs of liquidation and the payment of claims of creditors either secured or with a priority higher than the claims of policyholders. A guaranty association shall have the right to petition the Commonwealth Court to review an order of the liquidator concluding the assets will not exceed such costs.

(b) The proposal shall at least include provisions for:

(1) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors to the extent of the value of the security held and claims having a priority higher than that of the claims of policyholders.

(2) Disbursement of assets marshalled to date and subsequent disbursement of assets as they become available.

(3) Equitable allocation of disbursements to each of the associations entitled thereto.

(4) The securing by the liquidator, from each of the associations entitled to disbursements pursuant to this section, of an agreement to return to the liquidator such assets previously disbursed as may be required to pay the claims of secured creditors, claims falling within the priorities referred to in subsection (b)(1) and the proportional share of the assets disbursed required by the liquidator to make equivalent distribution to creditors of the same class of priority as policyholders in the event that the association may have received a disbursement of assets in excess of that available to pay all creditors of the insolvent insurer in the same class of priority as policyholders. An association shall return such assets to the liquidator when needed upon its own initiative or upon demand of the liquidator together with any investment income earned on the assets reimbursed. No bond shall be required of any such association.

(5) The liquidator may require reports to be made by an association at such time and covering such matters as he may determine. A full report shall be made by the association to the liquidator when assets received have been disbursed or the obligation of an association to pay covered claims of the

insolvent insurer has been fulfilled accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets and any other matter as the court may direct.

(c) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated to be at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the associations then disbursements shall be in the amount of available assets.

(d) Notice of such application shall be given to the associations and to the commissioners of insurance of each of the states where the company is licensed. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty days prior to the submission of such application to the Commonwealth Court. Action on the application may be taken by the court provided the above required notice has been given and provided further that the liquidator's proposal complies with subsection (b)(1) and (4).

(536 added Dec. 14, 1977, P.L.280, No.92)

4. Claims

Section 537. Filing of Claims.--(a) Proof of all claims shall be filed with the liquidator in the form required by section 538 on or before the last day for filing specified in the notice required under section 524, except that proofs of claim for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(b) For good cause shown, the liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation. Good cause shall include but shall not be limited to the following:

(1) that existence of claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(2) that a transfer to a creditor was avoided under sections 528 through 530, or was voluntarily surrendered under section 531, and that the filing satisfies the conditions of section 531;

(3) that valuation under section 543 of security held by a secured creditor shows a deficiency, which is filed within thirty days after the valuation;

(4) that a claim was contingent and became absolute, and was filed as soon as reasonably possible after it became absolute; and

(5) that the claim was the claim of a guaranty association for reimbursement of covered claims paid and/or expenses incurred, subsequent to the last day for filing where such payments were made and expenses incurred as a result of requirements of law.

(c) The liquidator may consider any claim filed late which is not covered by subsection (b), and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to other claimants of the same priority plus the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

(537 added Dec. 14, 1977, P.L.280, No.92)

Section 538. Proof of Claim.--(a) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

- (1) the particulars of the claim including the consideration given for it;
- (2) the identity and amount of the security on the claim;
- (3) the payments made on the debt, if any;
- (4) that the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;
- (5) any right of priority of payment or other specific right asserted by the claimants;
- (6) a copy of written instrument which is the foundation of the claim;
- (7) in the case of any third party claim based on a liability policy issued by the insurer, a conditional release of the insured pursuant to section 540(a); and
- (8) the name and address of the claimant and the attorney who represents him, if any.

No claim need be considered or allowed if it does not contain all the foregoing information which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(b) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (a) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(c) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion need be considered as evidence of liability or of quantum of damages.

(d) A claim of a guaranty association for reimbursement of payments made for the payments of covered claims and for expenses shall be in such form and contain such substantiation as may be agreed to by the guaranty association and the liquidator subject to review by the Commonwealth Court.

(538 added Dec. 14, 1977, P.L.280, No.92)

Section 539. Special Claims.--(a) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(b) Any claim that would have become absolute if there had been no termination of coverage under section 521, and which was not covered by insurance acquired to replace the

terminated coverage, shall be allowed as if the coverage had remained in effect, unless at least ten days before the insured event occurred either the claimant had actual notice of the termination or notice was mailed to him as prescribed by section 524(a) or 525(a). If allowed the claim shall share in distributions under section 544(f).

(c) A claim may be allowed even if contingent, if it is filed in accordance with section 537(b). It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(d) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(e) The treasurer of this State in his capacity as custodian of the workmen's compensation security funds may file a claim with the liquidator for all sums paid or to be paid from those funds.

(539 added Dec. 14, 1977, P.L.280, No.92)

Section 540. Special Provisions for Third Party Claims.--

(a) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation the third party may file a claim with the liquidator. The filing of the claim shall operate as a release of the insured's liability to the third party on that cause of action in the amount of the applicable policy limit, but the liquidator shall also insert in any form used for the filing of third party claims appropriate language to constitute such a release. The release shall be null and void if the insurance coverage is avoided by the liquidator.

(b) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty days after mailing of the notice required by section 524(a), whichever is later, he shall be deemed to be an unexcused late filer.

(c) The liquidator shall make his recommendations to the court under section 545 for the allowance of an insured's claim under subsection (b) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action, and the probable costs and expenses of defense. Such recommendations as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed recommendations, subject thereafter to later modification or to rulings made by the court pursuant to section 541. After allowance by the court, the liquidator shall withhold any distributions payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled, the claimant shall be paid from the amount withheld the same percentage distribution as was paid on other claims of like priority, based on the lesser of either: (i) the amount allowed on the claims by the

court, or (ii) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expenses of defense. After all claims are settled, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(d) In the event several claims founded upon one policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, then each claim as allowed shall be reduced a proportionate amount so that the total equals the policy limit. Claims by the insured shall be evaluated as in subsection (c). If any insured's claim is subsequently reduced under subsection (c), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(540 added Dec. 14, 1977, P.L.280, No.92)

Section 541. Disputed Claims.--(a) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant and his attorney by first class mail at the address shown in the proof of claim. Within sixty days from the mailing of the notice, the claimant may file his objections with the court. If no such filing is made, the claimant may not further object to the determination.

(b) Whenever objections are filed with the liquidator, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected, not less than ten nor more than thirty days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

(541 added Dec. 14, 1977, P.L.280, No.92)

Section 542. Claims of Surety.--Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution, however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person," as used in this section is not intended to apply to a guaranty association.

(542 added Dec. 14, 1977, P.L.280, No.92)

Section 543. Secured Creditor's Claims.--The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(1) by converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditor; or

(2) by agreement, arbitration, compromise or litigation between the creditor and the liquidator.

The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

(543 added Dec. 14, 1977, P.L.280, No.92)

Section 544. Order of Distribution.--The order of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class.

(a) The costs and expenses of administration, including but not limited to the following; the actual and necessary costs of preserving or recovering the assets of the insurer; compensation for all services rendered in the liquidation; any necessary filing fees; the fees and mileage payable to witnesses; reasonable attorney's fees; the expenses of a guaranty association in handling claims.

(b) All claims under policies for losses wherever incurred, including third party claims, and all claims against the insurer for liability for bodily injury or for injury to or destruction of tangible property which are not under policies, shall have the next priority. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds, or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligations of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment made by an employer to his employe shall be treated as a gratuity.

(c) Claims of the Federal government other than those claims included in subsection (b).

(d) Debts due to employes for services performed to the extent that they do not exceed one thousand dollars (\$1,000) and represent payment for services performed within one year before the filing of the petition for liquidation. Officers and directors shall not be entitled to the benefit of this priority. This priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employes.

(e) Claims under nonassessable policies for unearned premium or other premium refunds and claims of general creditors.

(f) Claims of state or local government. Claims, including those of any governmental body, for a penalty or forfeiture shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or

proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (h).

(g) The following claims:

(1) Claims under section 539(b), to the extent that such claims were disallowed under that section.

(2) Claims filed late.

(3) Claims or portions of claims, payment of which is provided by other benefits or advantages recovered by the claimant.

(h) Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(i) The claims of shareholders or other owners.

(544 amended July 2, 1996, P.L.463, No.72)

Compiler's Note: Section 6 of Act 72 of 1996, which amended section 544, provided that the amendment of section 544 shall apply to the distribution of claims in existing estates in receivership and future estates in receivership.

5. Settlement of the Estate

Section 545. Liquidator's Recommendations to the Court.--(a) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may comport, compromise or in any other manner negotiate the amount for which claims will be recommended to the court. Unresolved disputes shall be determined under section 541. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant, the particulars of the claim, and the amount of the claim finally recommended, if any.

(b) The court may approve, disapprove, or modify, the report on claims by the liquidator, except that the liquidator's agreements with other parties shall be final and binding on the court to the extent permitted by law. Such recommendations as are not modified by the court within a period of sixty days following submission by the liquidator shall be treated by the liquidator as allowed recommendations, subject thereafter to later modification or to rulings made by the court pursuant to section 541. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

(545 added Dec. 14, 1977, P.L.280, No.92)

Section 546. Distribution of Assets.--Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

(546 added Dec. 14, 1977, P.L.280, No.92)

Section 547. Unclaimed and Withheld Funds.--(a) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the State Treasurer. Any amount on deposit not claimed within six years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and be deposited with the General Fund. Any amounts barred shall become the property of the Commonwealth, and the State Treasurer shall at the end of each fiscal year transfer the amount so barred to the General Fund for the use and operation of liquidation proceedings.

(b) All funds withheld under section 540 and not distributed shall upon discharge of the liquidator be deposited with the State Treasurer and paid by him in accordance with section 540. Any sums remaining which under section 540 would revert to the undistributed assets of the insurer shall be transferred to the State Treasurer and become the property of the Commonwealth under subsection (a), unless the commissioner in his discretion petitions the court to reopen the liquidation under section 549.

(547 added Dec. 14, 1977, P.L.280, No.92)

Section 548. Termination of Proceedings.--(a) When all assets justifying the expense of collection and distribution have been collected and distributed under this article, the liquidator shall apply to the court for discharge. The court may grant the discharge, and make any other orders deemed appropriate, including an order to transfer any remaining funds that are uneconomic to distribute as may be deemed appropriate.

(b) Any other person may apply to the court at any time for an order under subsection (a). If the application is denied, the applicant shall pay the costs and expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

(548 added Dec. 14, 1977, P.L.280, No.92)

Section 549. Reopening Liquidation.--After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the Commonwealth Court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

(549 added Dec. 14, 1977, P.L.280, No.92)

Section 550. Disposition of Records During and After Termination of Liquidation.--Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court what records should be retained for future reference and what should be destroyed.

(550 added Dec. 14, 1977, P.L.280, No.92)

Section 551. External Audit of the Receiver's Books.--The Commonwealth Court may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this article, and a report of

each audit shall be filed with the commissioner and with the court. The books, records, and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

(551 added Dec. 14, 1977, P.L.280, No.92)

Section 552. Federal Receivership.--(a) Whenever in the commissioner's opinion, liquidation of a domestic insurer or an alien insurer domiciled in this State would be facilitated by a Federal receivership, and when any ground exists upon which the commissioner might petition the court for an order of rehabilitation or liquidation under section 514 or section 519, or if an order of rehabilitation or liquidation has already been entered, the commissioner may request another commissioner of another state to petition any appropriate Federal District Court for the appointment of a Federal receiver. The commissioner shall have power to intervene in any such action to support or oppose the petition, and shall have power to accept appointment as the receiver if he is so designated. So much of this act shall apply to the receivership as can be made applicable and is appropriate. Upon motion of the commissioner, the Commonwealth Court shall relinquish all jurisdiction over the insurer for purposes of rehabilitation or liquidation.

(b) If the commissioner is appointed receiver under this section, he shall comply with any requirements necessary to give him title to and control over the assets and affairs of the insurer.

(552 added Dec. 14, 1977, P.L.280, No.92)

(d) INTERSTATE RELATIONS

Section 553. Conservation of Property of Foreign or Alien Insurers Found in This State.--(a) If a domiciliary liquidator has not been appointed, the commissioner may apply to the Commonwealth Court by verified petition for an order directing him to conserve the property of an alien insurer not domiciled in this Commonwealth or a foreign insurer on any one or more of the following grounds:

(1) any of the grounds in section 514;

(2) that any of its property has been sequestered by official action in its domiciliary state, or in any other state;

(3) that enough of its property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent; or

(4) that (i) its certificate of authority to do business in this Commonwealth has been revoked or that none was ever issued, and (ii) there are residents of this Commonwealth with outstanding claims or outstanding policies.

(b) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds of Dauphin County shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) The conservator may at any time petition for and the court may grant an order under section 554 to liquidate the

assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under section 556, to be appointed ancillary receiver.

(d) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party.

(553 added Dec. 14, 1977, P.L.280, No.92)

Section 554. Liquidation of Property of Foreign or Alien Insurers Found in This State.--(a) If no domiciliary receiver has been appointed, the commissioner may apply to the Commonwealth Court by verified petition for an order directing him to liquidate the assets found in this Commonwealth of a foreign insurer or an alien insurer not domiciled in this Commonwealth, on any of the following grounds:

(1) any of the grounds in section 514; or

(2) any of the grounds in section 553.

(b) If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the clerk of the Commonwealth Court shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under section 556. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under section 556.

(d) On the same grounds as are specified in subsection (a), the commissioner may petition any appropriate Federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this Commonwealth. The commissioner may accept appointment as Federal receiver if another person files a petition.

(554 added Dec. 14, 1977, P.L.280, No.92)

Section 555. Foreign Domiciliary Receivers in Other States.-
-(a) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts and other records of the insurer located in this Commonwealth. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to

obtain possession of the books, accounts and other records of the insurer located in this Commonwealth. He also shall have the right to recover the other assets of the insurer located in this Commonwealth, subject to section 556.

(b) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this Commonwealth shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books, accounts and other records of the insurer located in this Commonwealth, at the same time and that the domiciliary liquidator is vested with title in the state of domicile. The commissioner of this Commonwealth may petition for a conservation or liquidation order under section 553 or 554, or for an ancillary receivership under section 556, or after approval by the Commonwealth Court, may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(c) Claimants residing in the Commonwealth may file claims with the liquidator or ancillary receiver, if any, in this Commonwealth, or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

(d) Subject to the provisions of this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this Commonwealth.

(555 added Dec. 14, 1977, P.L.280, No.92)

Section 556. Ancillary Formal Proceedings.--(a) If a domiciliary liquidator has been appointed for an insurer not domiciled in this Commonwealth, the commissioner may file a petition with the Commonwealth Court requesting appointment as ancillary receiver in this Commonwealth:

(1) if he finds that there are sufficient assets of the insurer located in this Commonwealth to justify the appointment of an ancillary receiver; or

(2) if the protection of creditors or policyholders in this Commonwealth so requires.

(b) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order with the recorder of deeds of Dauphin County shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that recorder of deeds would have imparted.

(c) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this Commonwealth under subsection (a) shall have the sole right to recover all the assets of the insurer in this Commonwealth not already recovered by the domiciliary liquidator. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this Commonwealth, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have

the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this Commonwealth.

(d) When a domiciliary liquidator has been appointed in this Commonwealth, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (c) for ancillary receivers appointed in this Commonwealth.

(556 added Dec. 14, 1977, P.L.280, No.92)

Section 557. Ancillary Summary Proceedings.--The commissioner in his sole discretion may institute proceedings under sections 510 through 513 at the request of the appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this State.

(557 added Dec. 14, 1977, P.L.280, No.92)

Section 558. Claims of Nonresidents Against Insurers Domiciled in This State.--(a) In a liquidation proceeding begun in this Commonwealth against an insurer domiciled in this Commonwealth, claimants residing in foreign countries or in states not reciprocal states must file claims in this Commonwealth, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in their respective states, or with the domiciliary liquidator. In reciprocal states, where an ancillary receiver has been appointed, a guaranty association of that state must file its claims with the ancillary receiver. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this Commonwealth as provided in this article, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claim and opportunity to appear and be heard is afforded the domiciliary liquidator of this Commonwealth as provided in section 559(b) with respect to ancillary proceedings in this Commonwealth, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under section 544.

(558 added Dec. 14, 1977, P.L.280, No.92)

Section 559. Claims of Residents Against Insurers Domiciled in Reciprocal States.--(a) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this Commonwealth may file claims either with the ancillary receiver, if any, in this Commonwealth, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(b) Claims belonging to claimants residing in this Commonwealth may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this Commonwealth. If a claimant elects to prove his claim in this Commonwealth, he shall file his claim with the

liquidator in the manner provided in sections 537 and 538. The ancillary receiver shall make his recommendation to the court as under section 545. He shall also arrange a date for hearing if necessary under section 541 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty days prior to the date set for hearing. If the domiciliary liquidator, within thirty days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this Commonwealth involving the adjudication of the claims. The final allowance of the claim by the courts of this Commonwealth shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this Commonwealth.

(559 added Dec. 14, 1977, P.L.280, No.92)

Section 560. Attachment, Garnishment and Levy of Execution.--During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this Commonwealth against the delinquent insurer or its assets.

(560 added Dec. 14, 1977, P.L.280, No.92)

Section 561. Interstate Priorities.--(a) In a liquidation proceeding in this Commonwealth involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(b) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(c) The owner of a secured claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with section 543, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

(561 added Dec. 14, 1977, P.L.280, No.92)

Section 562. Subordination of Claims for Non-cooperation.--If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this Commonwealth any assets within his control other than special deposits, diminished only by

the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under section 544(f).

(562 added Dec. 14, 1977, P.L.280, No.92)

Section 563. Constitutionality.--If any provision or clause of this article or the application thereof to any person or situation is held invalid, such invalidity shall not affect other provisions or applications of the article which can be given effect without the invalid provision or application, and to this end the provisions of this article are declared to be severable.

(563 added Dec. 14, 1977, P.L.280, No.92)

ARTICLE V-A.

RISK-BASED CAPITAL REQUIREMENTS.

(Art. added June 25, 1997, P.L.349, No.40)

Section 501-A. Definitions.

The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Adjusted RBC report" means an RBC report that has been recalculated by the Insurance Commissioner in accordance with section 502-A(c).

"Authorized control level event" means one or more of the following events:

(1) The filing of an RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC.

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1).

(3) The failure of the insurer to respond, in a manner satisfactory to the Insurance Commissioner, to a corrective order, provided the insurer has not challenged the corrective order under section 510-A.

(4) If the insurer has challenged a corrective order under section 510-A and the Insurance Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Insurance Commissioner, to the corrective order subsequent to rejection or modification by the Insurance Commissioner.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company action level event" means one or more of the following events:

(1) The filing of an RBC report by an insurer that indicates that:

(i) the insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) if a life or health insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend; or

(iii) if a property or casualty insurer, the insurer has total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and a trend test result that triggers regulatory attention, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

(2) The notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (1).

(Def. amended May 22, 2012, P.L.544, No.51)

"Corrective order" means an order issued by the Insurance Commissioner specifying corrective actions that the Insurance Commissioner has determined are required under section 507-A(b).

"Department" means the Insurance Department of the Commonwealth.

"Domestic insurer" means an insurer that is incorporated or organized under the laws of this Commonwealth.

"Foreign insurer" means an insurer that is licensed by the Insurance Department to do business in this Commonwealth and incorporated or organized under the laws of a jurisdiction other than this Commonwealth.

"Insurer" means life or health insurers and property or casualty insurers.

"Life or health insurer" means a stock or mutual insurance company, association, exchange or fraternal benefit society licensed by the Insurance Department to transact life or accident and health insurance coverages or both. (Def. amended May 22, 2012, P.L.544, No.51)

"Mandatory control level event" means one or more of the following events:

(1) The filing of an RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC.

(2) Notification by the Insurance Commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (1).

"NAIC" means the National Association of Insurance Commissioners or successor organization.

"Negative trend" means, with respect to a life or health insurer, a decrease over a period of time, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

"Property or casualty insurer" means a stock or mutual insurance company, association or exchange licensed by the Insurance Department to transact property or casualty insurance coverages or both.

"RBC" means risk-based capital.

"RBC instructions" means the RBC report, including RBC instructions and formula adopted by the NAIC as required by the Insurance Commissioner under section 320(a)(2) of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

"RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(1) "Company action level RBC" means the product of 2.0 and the authorized control level RBC.

(2) "Regulatory action level RBC" means the product of 1.5 and the authorized control level RBC.

(3) "Authorized control level RBC" means the amount of an insurer's authorized control level RBC calculated under the RBC formula in accordance with the RBC instructions.

(4) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

"RBC plan" means a comprehensive financial plan containing the elements specified in section 506-A(a).

"RBC report" means the report required under sections 502-A and 503-A.

"Regulatory action level event" means one or more of the following events:

(1) The filing of an RBC report by the insurer that indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC.

(2) The notification by the Insurance Commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (1).

(3) The failure of the insurer to file an RBC report by the date required under this article unless the insurer has provided an explanation for the failure that is satisfactory to the Insurance Commissioner and has cured the failure within ten days after the date the report is required to be filed under this article.

(4) The failure of the insurer to submit an RBC plan or revised RBC plan to the Insurance Commissioner within the time period set forth in section 506-A(b) and (d).

(5) Notification by the Insurance Commissioner to the insurer that:

(i) the RBC plan or revised RBC plan submitted by the insurer is in the judgment of the Insurance Commissioner unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer.

(6) Notification by the Insurance Commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if the failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the Insurance Commissioner has so stated in the notification.

"Revised RBC plan" means an RBC plan that has been rejected by the Insurance Commissioner and revised by the insurer, with or without the Insurance Commissioner's recommendation.

"Total adjusted capital" means the sum of:

(1) an insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to its annual financial statements filed with the Insurance Department; and

(2) other items as the RBC instructions may provide.

(501-A added June 25, 1997, P.L.349, No.40)

Section 502-A. RBC Reports Required; Domestic Insurers.--
(a) Every domestic insurer shall, on or prior to each March 1, prepare and submit to the commissioner and to the NAIC a

report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions.

(b) In addition, every domestic insurer shall file its RBC report with the chief insurance regulatory official in any jurisdiction in which the insurer is authorized to do business if the chief insurance regulatory official of the jurisdiction has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(1) the date instructed by the chief insurance regulatory official of the jurisdiction requesting the filing; or

(2) March 1 of the year following the end of the calendar year for which the report is requested.

(c) If a domestic insurer files an RBC report that, in the judgment of the commissioner, is inaccurate, the commissioner shall recalculate the RBC report to correct the inaccuracy and shall notify the insurer of the amount of the recalculation. The notice shall contain a statement of the reason for the recalculation. If, within thirty days after the notification from the commissioner, the insurer fails to prepare and submit to the commissioner and to the NAIC an adjusted RBC report to correct the inaccuracy in accordance with the commissioner's notification, the commissioner may enter an order calling for an investigatory hearing with no less than twenty days' notice to the insurer for purposes of obtaining additional documentation, data, information and testimony. Following the hearing, the commissioner shall issue a final order accepting the RBC report as filed or the adjusted RBC report as initially recalculated or with other corrections.

(502-A added June 25, 1997, P.L.349, No.40)

Section 503-A. RBC Requirements; Foreign Insurers.--(a) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the calendar year just ended no later than the later of:

(1) the date an RBC report would be required to be filed by a domestic insurer under this article; or

(2) fifteen days after the request is received by the foreign insurer.

(b) A foreign insurer shall, upon the written request of the commissioner, submit to the commissioner a copy of an RBC plan that is filed with the chief insurance regulatory official of any other jurisdiction, within fifteen days after receiving the request from the commissioner.

(c) In the event of a company action level event, regulatory action level event or authorized control level event with respect to a foreign insurer as determined under the RBC statute applicable in the jurisdiction of domicile of the insurer or, if no RBC statute is in force in that jurisdiction, under the provisions of this article, if the chief insurance regulatory official of the jurisdiction of domicile of the foreign insurer fails to require the foreign insurer to file an RBC plan in the manner specified under that state's RBC statute or, if no RBC statute is in force in that jurisdiction, under this article, the commissioner may require the foreign insurer to file an RBC plan with the commissioner. The failure of the foreign insurer to file an RBC plan with

the commissioner under this section shall be grounds to order the insurer to cease and desist from writing new insurance business in this Commonwealth. The commissioner shall give written notice to the foreign insurer, stating specifically the nature of the grounds for the order and fixing a time and place, at least ten days thereafter, when a hearing before the commissioner regarding the matter shall be held.

(d) In the event of a mandatory control level event with respect to a foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the jurisdiction of domicile of the foreign insurer, the commissioner may make application to the Commonwealth Court under sections 553 and 554, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application under sections 553(a) and 554(a).

(503-A added June 25, 1997, P.L.349, No.40)

Section 504-A. Calculation of RBC Relating to Life or Health Insurers.--(a) A life or health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall take into account and may adjust for the covariance between the following risks determined in each case by applying the factors in the manner set forth in the RBC instructions:

- (1) The risk with respect to the insurer's assets.
- (2) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations.
- (3) The interest rate risk with respect to the insurer's business.
- (4) All other business risks and other relevant risks as set forth in the RBC instructions.

(504-A added June 25, 1997, P.L.349, No.40)

Section 505-A. Calculation of RBC Relating to Property or Casualty Insurers.--(a) A property or casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall take into account and may adjust for the covariance between the following risks determined in each case by applying the factors in the manner set forth in the RBC instructions:

- (1) Asset risk.
- (2) Credit risk.
- (3) Underwriting risk.
- (4) All other business risks and other relevant risks as are set forth in the RBC instructions.

(505-A added June 25, 1997, P.L.349, No.40)

Section 506-A. Company Action Level Event.--(a) In the event of a company action level event, the insurer shall prepare and submit to the commissioner an RBC plan that shall include, at a minimum, all of the following:

- (1) Identification of the conditions that contribute to the company action level event.
- (2) Proposals of corrective actions that the insurer intends to take and that would be expected to result in the elimination of the company action level event.

(3) Projections of the insurer's financial results for the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. Projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component.

(4) Identification of the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions.

(5) Identification of the quality of and problems associated with the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) The RBC plan required under this section shall be submitted within forty-five days after the occurrence of the company action level event.

(c) Within sixty days after the submission by an insurer of an RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or whether the RBC plan is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination and may set forth proposed revisions that will render the RBC plan satisfactory in the judgment of the commissioner.

(d) Upon notification from the commissioner of a determination that the RBC plan is unsatisfactory, the insurer shall prepare a revised RBC plan which may incorporate by reference any revisions proposed by the commissioner and, unless the commissioner has taken action under subsection (e), shall submit the revised RBC plan to the commissioner within forty-five days after the notification from the commissioner.

(e) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event or take action as necessary to place the insurer under regulatory control under Article V.

(f) Every domestic insurer that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the chief insurance regulatory official in any jurisdiction in which the insurer is authorized to do business if:

(1) The jurisdiction has an RBC provision substantially similar to section 512-A(a) and (b).

(2) The chief insurance regulatory official of that jurisdiction has notified the insurer of his request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that jurisdiction no later than the later of:

(i) fifteen days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the jurisdiction; or

(ii) the date on which the RBC plan or revised RBC plan is filed under this section.

(506-A added June 25, 1997, P.L.349, No.40)

Section 507-A. Regulatory Action Level Event.--(a) In the event of a regulatory action level event, the commissioner:

- (1) may require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;
- (2) shall perform an examination under Article IX or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer, including, if applicable, a review of its RBC plan or revised RBC plan; and
- (3) subsequent to an examination or analysis performed under paragraph (2) shall issue an order specifying corrective actions as the commissioner shall determine are required.

(b) In determining corrective actions, the commissioner may take into account factors as the commissioner deems relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC instructions.

(c) The RBC plan or revised RBC plan required under this section shall be submitted within forty-five days after the occurrence of the regulatory action level event.

(d) The commissioner may retain actuaries, investment experts, attorneys, appraisers, certified public accountants and other professionals and specialists as may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to professionals and specialists retained under this section shall be charged to and paid by the affected insurer or other party as directed by the commissioner.

(507-A added June 25, 1997, P.L.349, No.40)

Section 508-A. Authorized Control Level Event.--In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(1) Take such actions as are required under section 507-A regarding an insurer with respect to which a regulatory action level event has occurred.

(2) If the commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take actions necessary to cause the insurer to be placed under regulatory control under Article V. In the event the commissioner takes action under Article V, the authorized control level event shall be deemed sufficient grounds for the commissioner to take that action.

(508-A added June 25, 1997, P.L.349, No.40)

Section 509-A. Mandatory Control Level Event.--In the event of a mandatory control level event:

(1) With respect to a life or health insurer, the commissioner shall take actions necessary to place the insurer under regulatory control under sections 512 through 563. The mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under section 514; however, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the

mandatory control level event may be eliminated within the ninety-day period.

(2) With respect to a property or casualty insurer, the commissioner shall take actions necessary to place the insurer under regulatory control under sections 512 through 563 or, in the case of an insurer that is writing no business, may allow the insurer to run off its existing business under the supervision of the commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under section 514; however, the commissioner may forego action for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(509-A added June 25, 1997, P.L.349, No.40)

Section 510-A. Hearings.--(a) The insurer shall have the right to a confidential departmental hearing at which the insurer may challenge a determination or action by the commissioner upon one or more of the following events:

(1) Issuance of a final order by the commissioner accepting an adjusted RBC report under section 502-A(c).

(2) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

(b) The insurer shall notify the commissioner of the insurer's request for a hearing under this section within five days after the action or notification by the commissioner under subsection (a). Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten days nor more than thirty days after the date of the insurer's request.

(510-A added June 25, 1997, P.L.349, No.40)

Section 511-A. Notices.--(a) Notices by the commissioner to an insurer which may result in regulatory action under this article shall be effective upon dispatch if transmitted by certified mail or any other form of delivery that insures signature upon receipt.

(b) Notices by the commissioner to an insurer transmitted by a form of delivery other than that provided in subsection (a) shall be effective upon the insurer's receipt of the notice.

(511-A added June 25, 1997, P.L.349, No.40)

Section 512-A. Confidentiality; Prohibition on Announcements; Prohibition on Use in Ratemaking.--(a) RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed under this article, and any corrective order issued by the commissioner pursuant to examination or analysis with respect to a domestic insurer or foreign insurer that are filed with the commissioner constitute information that may be damaging to the insurer if made available to its competitors and therefore shall be kept confidential by the commissioner.

(b) Information described in subsection (a) shall be given confidential treatment, may not be subject to subpoena by any Federal, state or other jurisdiction and may not be made public by the commissioner or any other person, except to

insurance or other regulatory officials of this or other jurisdictions, without the prior written consent of the insurer to which the information pertains unless the commissioner determines to make the information public for purposes of actions taken by the commissioner under Article V.

(c) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool that may indicate the need for possible corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this article, the making, publishing, disseminating, circulating or placing before the public or causing, directly or indirectly, to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication or in the form of a notice, circular, pamphlet, letter or poster or over a radio or television station or in any other way an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of an insurer or of a component derived in the calculation by an insurer, agent, broker or other person would be misleading and is prohibited, provided, however, that if a materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the insurer's RBC levels is published in a written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity or inappropriateness of the statement, the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

(d) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or any affiliate is authorized to write.

(512-A added June 25, 1997, P.L.349, No.40)

Section 513-A. Exemptions.--(a) The following insurers are exempt from this article:

- (1) Monoline mortgage guaranty insurers.
- (2) Financial guaranty insurers.
- (3) Title insurers.
- (4) Foreign or alien fraternal benefit societies.

(b) A domestic property or casualty insurer that meets all of the following conditions is exempt from this article unless the commissioner makes a specific finding that application of this article to the insurer is necessary for the commissioner to carry out statutory responsibilities:

- (1) Writes direct business only in this Commonwealth.
- (2) Writes direct annual premiums of ten million dollars (\$10,000,000) or less or such higher amount as the commissioner may order in five-year intervals as necessary to reflect the impact of inflationary factors.

(3) Assumes no reinsurance in excess of five per centum of direct premium written except for assumed reinsurance of business directly written in this Commonwealth if the assuming insurer's total annual net written premium, direct plus assumed minus ceded, is ten million dollars (\$10,000,000) or less.

(513-A amended May 22, 2012, P.L.544, No.51)

Section 514-A. Supplemental Provisions; Rules.--(a) The provisions of this article are supplemental to any other provisions of the laws of this Commonwealth and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, Article V and 31 Pa. Code Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition) and Article XXIV of the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

(b) The commissioner may adopt regulations necessary for the implementation of this article.

(514-A amended May 22, 2012, P.L.544, No.51)

Section 515-A. Additional Penalties.--An insurer that fails to file an RBC report or adjusted RBC report within the time required under this article shall, in addition to any other penalties provided by law, forfeit a sum not to exceed two hundred dollars (\$200) for each day during which the insurer fails to file.

(515-A added June 25, 1997, P.L.349, No.40)

ARTICLE V-B.

RISK-BASED CAPITAL REQUIREMENTS - HEALTH ORGANIZATIONS.

(Art. added June 22, 2000, P.L.457, No.62)

Section 501-B. Definitions.--The following words and phrases when used in this article shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Adjusted RBC report" means an RBC report that has been recalculated by the Insurance Department in accordance with section 502-B(c).

"Authorized control event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

(3) Failure to respond, in a manner satisfactory to the Insurance Commissioner, to a corrective order, provided the health organization has not challenged the corrective order under section 509-B.

(4) If the health organization has challenged a corrective order under section 509-B and the Insurance Commissioner has, after a hearing, rejected the challenge or modified the corrective order, failure to respond, in a manner satisfactory to the Insurance Commissioner, to the corrective order subsequent to rejection or modification by the Insurance Commissioner.

"Commissioner" means the Insurance Commissioner of the Commonwealth.

"Company action level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC.

(1.1) Filing of an RBC report that indicates the health organization's total adjusted capital is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and the health organization's trend test result triggers regulatory attention, as determined in accordance with the Trend Test Calculation included in the RBC instructions.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1) or (1.1).

(Def. amended May 22, 2012, P.L.544, No.51)

"Corrective order" means an order issued by the Insurance Commissioner specifying corrective actions that the Insurance Commissioner has determined are required under section 506-B(b).

"Department" means the Insurance Department of the Commonwealth.

"Domestic health organization" means a health organization incorporated or organized under the laws of this Commonwealth.

"Foreign health organization" means a health organization that is licensed by the Insurance Department to do business in this Commonwealth and incorporated or organized under the laws of a jurisdiction other than this Commonwealth.

"Health organization" means a health maintenance organization as defined in the act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act," a hospital plan corporation as defined in 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations), a professional health services plan corporation as defined in 40 Pa.C.S. Ch. 63 (relating to professional health services plan corporations), a preferred provider organization as defined in the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921," except that the term does not include a life or health insurer or a property or casualty insurer subject to Article V-A.

"Mandatory control level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is less than its mandatory control level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

"NAIC" means the National Association of Insurance Commissioners or successor organization.

"RBC" means risk-based capital.

"RBC instructions" means the RBC report including RBC instructions adopted by the NAIC for health organizations as required by the Insurance Commissioner under section 11 of the act of December 29, 1972 (P.L.1701, No.364), known as the

"Health Maintenance Organization Act," 40 Pa.C.S. §§ 6125 (relating to reports and examinations) and 6331 (relating to reports and examinations) and the act of May 17, 1921 (P.L.682, No.284), known as "The Insurance Company Law of 1921."

"RBC level" means a health organization's company action level RBC, regulatory action level RBC, authorized control level RBC or mandatory control level RBC where:

(1) "Company action level RBC" means the product of 2.0 and the authorized control level RBC.

(2) "Regulatory action level RBC" means the product of 1.5 and the authorized control level RBC.

(3) "Authorized control level RBC" means the amount of a health organization's authorized control level RBC calculated under the RBC formula in accordance with the RBC instructions.

(4) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

"RBC plan" means a comprehensive financial plan filed in accordance with section 505-B(a).

"RBC report" means a report of RBC levels.

"Regulatory action level event" means any of the following events:

(1) Filing of an RBC report that indicates that the health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC.

(2) Notification by the Insurance Department to a health organization of an adjusted RBC report that indicates an event under paragraph (1).

(3) Failure to file an RBC report by the required date unless the Insurance Department determines that the health organization has provided an adequate explanation for the failure to file and the health organization has filed the report within ten days of the filing date under this article.

(4) Failure to submit an RBC plan or revised RBC plan within the time set forth under this article.

(5) Notification by the Insurance Department to the health organization that:

(i) the RBC plan or revised RBC plan is unsatisfactory under section 506-B; and

(ii) the notification constitutes a regulatory action level event.

(6) Notification by the Insurance Department that the health organization has failed to comply with its RBC plan or revised RBC plan if the failure has a substantial adverse effect on the ability of the health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan.

"Revised RBC plan" means an RBC plan that has been rejected by the Insurance Department and revised by the health organization.

"Total adjusted capital" means the sum of the total assets less total liabilities as calculated and reported in accordance with required NAIC annual statement instructions and accounting practices and procedures manual for annual financial statements and any other items required by the RBC instructions.

(501-B added June 22, 2000, P.L.457, No.2)

Section 502-B. RBC Reports Required; Domestic Health Organizations.--(a) Every domestic health organization shall, on or before March 1 of every year, submit a report of its RBC levels as of the end of the preceding calendar year to the department and the NAIC as prescribed by the RBC instructions.

(b) Every domestic health organization shall, upon the written request of the chief insurance regulatory official of any jurisdiction in which the health organization is authorized to do business, file its RBC report with that jurisdiction by the date required by the requesting chief insurance regulatory official or March 1 of the year following the calendar year for which the report is requested, whichever is later.

(c) If the department determines that an RBC report is inaccurate, the department shall correct the inaccuracy and notify the health organization of the amount of the recalculation and the reason for the recalculation. If, within thirty days of the notification under this subsection, the health organization fails to submit an adjusted RBC report to the department and the NAIC that corrects the inaccuracy in accordance with the department's notification, the commissioner may order an investigatory hearing. The department shall provide notice to the health organization at least twenty days prior to the hearing. Following the hearing, the commissioner shall issue a final order accepting the original RBC report or an adjusted RBC report.

(502-B added June 22, 2000, P.L.457, No.62)

Section 503-B. RBC Reports Required; Foreign Health Organizations.--(a) A foreign health organization shall, upon the written request of the department, submit an RBC report for the immediate preceding calendar year within fifteen days of the receipt of the request or by the date an RBC report would be required to be filed by a domestic health organization under this article, whichever is later.

(b) A foreign health organization shall, upon the written request of the department, submit to the department a copy of an RBC plan that is filed with the chief insurance regulatory official of any other jurisdiction within fifteen days of receipt of the request.

(c) If a foreign health organization experiences a company action level event, regulatory action level event or authorized control level event under the RBC statute in effect in the jurisdiction of domicile or, if no RBC statute is in effect in the jurisdiction of domicile, under this article and the chief insurance regulatory official of the jurisdiction of domicile fails to require an RBC plan under the RBC statute in effect or this act, the department may require the foreign health organization to file an RBC plan with the department. The commissioner may order a foreign health organization to cease and desist from writing new insurance business in the Commonwealth if the foreign health organization fails to file the RBC plan with the department under this subsection. The commissioner shall provide written notice of the order, including the specific reasons for the order and the date and time of a hearing on the order, to the foreign health organization. The hearing shall be held at least ten days following the issuance of the notice.

(d) If a foreign health organization experiences a mandatory control level event and no receiver has been appointed under the rehabilitation and liquidation statute of the jurisdiction of domicile of the foreign health organization, the commissioner may apply to the Commonwealth Court for a receiver under sections 553 and 554. The occurrence of the mandatory control level event shall be adequate grounds for the application under sections 553(a) and 554(a):

(503-B added June 22, 2000, P.L.457, No.62)

Section 504-B. Calculation of RBC.--(a) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions.

(b) The formula shall use and may adjust for the covariance between the following risks determined in each case by applying the factors in the RBC instructions:

- (1) Asset risk.
- (2) Credit risk.
- (3) Underwriting risk.

(4) All business and other risks set forth in the RBC instructions.

(504-B added June 22, 2000, P.L.457, No.62)

Section 505-B. Company Action Level Event.--(a) In the event of a company action level event, a health organization shall submit an RBC plan to the department to include, at a minimum, all of the following:

(1) Identification of the conditions that contributed to the company action level event.

(2) Proposed corrective actions to eliminate the company action level event.

(3) Projections of the health organization's financial results for the current year and at least the four succeeding years, with and without the proposed corrective actions, to include projections of statutory balance sheets, operating income, net income, capital, surplus and RBC levels. Projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense and benefit component.

(4) The key assumptions impacting the projections under paragraph (3) and the sensitivity of the projections to the assumptions.

(5) The quality of and problems associated with the health organization's business, including assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance.

(b) An RBC plan under subsection (a) shall be submitted within forty-five days after the occurrence of the company action level event.

(c) Within sixty days of the submission of an RBC plan under subsection (a), the department shall notify the health organization whether the RBC plan should be implemented or that the plan is unsatisfactory. The notification shall set forth the specific reasons for a determination that the plan is unsatisfactory and may include revisions that will make the RBC plan satisfactory to the department.

(d) Upon notification under subsection (c) that the RBC plan is unsatisfactory, the health organization shall prepare a revised RBC plan which may include revisions proposed by the department. Except as provided in subsection (e), the revised RBC plan shall be submitted within forty-five days after notification that the plan is unsatisfactory.

(e) The department may specify that the notification under subsection (c) constitutes a regulatory action level event. In the alternative, the department may take any other action necessary to place the health organization under regulatory control pursuant to Article V.

(f) Every domestic health organization that files an RBC plan or revised RBC plan under this section shall file a copy with the chief insurance regulatory official of any jurisdiction in which the health organization is authorized to do business if:

(1) The jurisdiction has an RBC provision substantially similar to section 511-B(a) and (b).

(2) The chief insurance regulatory official of the jurisdiction has provided a written request to the health organization for a copy of the RBC plan or revised RBC plan. Upon receipt of the written request, the health organization shall file a copy of the RBC plan or revised RBC plan within fifteen days of the receipt of notice or by the date the RBC plan or revised RBC plan is filed under this section, whichever is later.

(505-B added June 22, 2000, P.L.457, No.62)

Section 506-B. Regulatory Action Level Event.--(a) In the event of a regulatory action level event, the department:

(1) may require the health organization to submit an RBC plan or, if applicable, a revised RBC plan; and

(2) shall perform an examination under Article IX or an analysis as necessary of assets, liabilities and operations of the health organization, including, if applicable, a review of the RBC plan or revised RBC plan, and issue an order specifying any corrective actions deemed appropriate.

(b) In order to determine appropriate corrective actions under subsection (a)(2), the department may consider the results of any sensitivity test undertaken pursuant to the RBC instructions.

(c) The RBC plan or revised RBC plan required under subsection (a) shall be submitted within forty-five days after the occurrence of the regulatory action level event.

(d) The department may retain actuaries, investment experts, attorneys, appraisers, certified public accountants and other individuals as the department deems necessary to:

(1) review the health organization's RBC plan or revised RBC plan;

(2) examine or analyze the assets, liabilities and operations of the health organization, including contractual relationships; and

(3) formulate corrective actions.

(e) Fees, costs and expenses related to individuals retained under subsection (d) shall be charged to and paid by the health organization or other party as directed by the commissioner.

(506-B added June 22, 2000, P.L.457, No.62)

Section 507-B. Authorized Control Level Event.--In the event of an authorized control level event, the department shall:

(1) Take all action required under section 506-B for a regulatory action level event.

(2) If the commissioner deems it to be in the best interest of the policyholders and creditors of the health organization and the public, take action necessary to place the health organization under regulatory control under Article V. The authorized control level event shall be sufficient grounds to place the health organization under regulatory control under Article V.

(507-B added June 22, 2000, P.L.457, No.62)

Section 508-B. Mandatory Control Level Event.--(a) In the event of a mandatory control level event, the department shall take action necessary to place the health organization under regulatory control under sections 512 through 563. If the health organization is writing no business, the department may allow the health organization to run off its existing business under the supervision of the commissioner.

(b) The mandatory control level event shall be sufficient grounds for an order of rehabilitation under section 514.

(c) The commissioner may forego action to place the health organization under regulatory control under subsection (a) for up to ninety days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(508-B added June 22, 2000, P.L.457, No.62)

Section 509-B Hearings.--(a) A health organization shall have the right to a confidential departmental hearing to challenge a determination or action regarding any of the following events:

(1) A final order accepting an adjusted RBC report under section 502-B(c).

(2) Notification of a corrective order.

(b) A health organization shall notify the department of its request for a hearing within five days after the receipt of an order or notification under subsection (a). Upon receipt of the request, the department shall set a date for the hearing, which shall be no sooner than ten days nor later than thirty days after the date of the health organization's request.

(509-B added June 22, 2000, P.L.457, No.62)

Section 510-B. Notices.--(a) Notices under this article which may result in regulatory action shall be effective on the date of transmission by certified mail or other form of delivery that requires signature upon receipt.

(b) Notices under this article transmitted other than as provided in subsection (a) shall be effective upon the receipt of the notice.

(510-B added June 22, 2000, P.L.457, No.62)

Section 511-B. Confidentiality; Prohibition on Announcements, Prohibition on Use in Ratemaking.--(a) The following information filed with the department shall constitute information that may be damaging to a health organization if made available to its competitors and shall be confidential:

(1) RBC reports to the extent the information in the report is not required to be included in a publicly available annual statement schedule.

(2) RBC plans, including the results of reports of any examination or analysis of a health organization performed under this article.

(3) A corrective order issued pursuant to examination or analysis with respect to a domestic health organization or foreign health organization.

(b) Except for insurance or other regulatory officials of the Commonwealth or other jurisdictions, information under subsection (a) shall be confidential and may not be subject to subpoena by any Federal, State or other jurisdiction or made public by the department or any other person without the prior written consent of the health organization unless the commissioner makes the information public for purposes of Article V.

(c) The following shall apply to publication of RBC levels:

(1) Except as required by this article, the publication, dissemination, circulation or placement before the public, or directly or indirectly causing the publication, dissemination, circulation or placement before the public, of an assertion, representation or statement with regard to the RBC levels or component derived in the calculation of RBC levels of a health organization, including assertions, representations or statements intended or used to rank health organizations, by an insurer, agent, broker or other person in a newspaper, magazine or other publication, notice, pamphlet, letter or other printed matter or by broadcast or electronic transmission, is prohibited.

(2) Notwithstanding the provisions of paragraph (1), if a health organization is able to demonstrate to the commissioner with substantial proof that a materially false statement regarding the comparison of a health organization's total adjusted capital to its RBC levels or an inappropriate comparison of any other amount to the health organization's RBC levels has been published in writing, the health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false or inappropriate statement.

(d) The RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the department to monitor the solvency of health organizations and to determine the need for corrective action and shall not be used for ratemaking nor used as evidence in any rate proceeding nor to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which a health organization or any affiliate is authorized to write.

(511-B added June 22, 2000, P.L.457, No.62)

Section 512-B. Exemptions.--The department may exempt a domestic health organization that has been transacting business for less than three years from this article upon making a specific finding that application of this article is not necessary for the department to carry out statutory responsibilities.

(512-B added June 22, 2000, P.L.462, No.62)

Section 513-B. Supplemental Provisions; Rules.--(a) The provisions of this article are supplemental to any other provisions of the laws of this Commonwealth and shall not preclude or limit any other powers or duties of the commissioner under those laws, including, but not limited to, Article V and 31 Pa. Code Ch. 160 (relating to standards to define insurers deemed to be in hazardous financial condition).

(b) The department may adopt regulations necessary for the implementation of this article.

(513-B added June 22, 2000, P.L.452, No.62)

Section 514-B. Additional Penalties.--A health organization that fails to file an RBC report or adjusted RBC report within the time required under this article shall, in addition to any other penalties provided by law, forfeit a sum not to exceed two hundred dollars (\$200) for each day during which the health organization fails to file.

(514-B added June 22, 2000, P.L.457, No.62)

Section 515-B. Phase-In Provisions.--(a) This article shall apply to RBC reports required for the year ending December 31, 1999, and each year thereafter.

(b) Notwithstanding the provisions of sections 505-B, 506-B, 507-B and 508-B, the following provisions shall apply to domestic health organizations with respect to RBC reports filed with the department for the year ending December 31, 1999:

(1) In the event of a company action level event, the commissioner shall take no regulatory action under this article.

(2) In the event of a regulatory action level event as defined in paragraphs (1) and (2) of the definition of "regulatory action level event" in section 501-B, the department and the health organization shall take the actions required under section 505-B.

(3) In the event of a regulatory action level event as defined in paragraph (3), (4), (5) or (6) of the definition of "regulatory action level event" in section 501-B, the department shall take the actions required under section 506-B.

(4) In the event of a mandatory control level event, the department shall take the actions required under section 507-B.

(515-B added June 22, 2000, P.L.457, No.62)