# Tennessee
# Laws & Regulations
# Every Agent Should Know

# TENNESSEE
# Laws & Regulations

Eleventh Edition (July, 2016)

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## Useful Information

This document contains laws that have been copied and pasted. If you use the document on a PC that is always connected to the internet you will find many links to web sites and pages on the internet. There are also many links to information contained in this document. The links are in blue. Many of the important sections of the laws are highlighted in yellow. We feel these sections are particularly important to agents. There are several NOTES that attempt to give a simple explanation of what the Insurors think the section means. These NOTES are in red.

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Link to Agent Licensing Procedures

Link to Insurance Department

Link to Department of Labor & Workforce Development – WC Bureau

Link to Tennessee General Assembly

Link to Tennessee Code

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Link to Virtual University

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Law on Determining Independent Contractor/Employee Status

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# GENERAL

## Commissioner’s Powers

**56-1-204. Inquisitorial power given commissioner and deputies**

Inquisitorial power is given to the commissioner or the commissioner's deputies to inquire into any violation of the provisions of this title, and to examine any person under oath, and to compel production of books, records, or papers relative to the inquiry.

## Penalties for Law Violations

**56-1-801. Violation of insurance laws - General penalty**

A violation of any provision of this chapter and chapters 2-4, 7, 11 and 32 of this title, the penalty of which is not specifically provided therein, is a Class C misdemeanor.

## Penalties for Unauthorized Insurers

**56-2-105. Certificate of authority required – Exceptions.**

It is unlawful for any company to enter into a contract of insurance as an insurer or to transact insurance business in this state without a certificate of authority from the commissioner; provided, that this section shall not apply to:

(1) Contracts procured by agents or brokers under the authority of the Surplus Lines Insurance Act, compiled in chapter 14 of this title;

(2) Contracts of reinsurance;

(3) Transactions in this state involving policies lawfully solicited, written and delivered outside of this state covering only subjects of insurance not resident, located or expressly to be performed in this state at the time of issuance or covering property in the course of transportation by land, air or water, to, from or through this state and including any preparation or storage incidental thereto, and which transactions are subsequent to the issuance of those policies;

(4) Transactions in this state involving group or blanket insurance and group annuities where the master policy of the groups was lawfully issued and delivered in a state in which the company was authorized to transact insurance business;

(5) Transactions in this state involving a policy issued prior to April 3, 1968;

(6) Any life insurance or annuity company that holds a certificate of exemption from the commissioner as provided in § 56-2-106; or

(7) (A) The procuring of contracts of insurance issued to an industrial insured;

(B) For the purposes of subdivision (7)(A), an "industrial insured" is an insured:

(i) Who procures the insurance of any risk or risks by use of the services of a full-time employee acting as an insurance manager or buyer;

(ii) Whose aggregate annual premiums for insurance on all risks total at least twenty-five thousand dollars ($25,000); and

(iii) Who has at least twenty-five (25) full-time employees.

**56-2-108. Violation of § 56-2-105 – Penalty**

(a) Any company that violates § 56-2-105 is subject to a fine and/or a civil penalty of not less than one hundred dollars ($100) nor more than five thousand dollars ($5,000) for each violation.

(b) Each day in which a violation occurs constitutes a separate violation.

**56-2-305. Violations -- Commissioner's orders -- Penalties.**

**(a)** If, after providing notice consistent with the process established by § 4-5-320(c) and providing the opportunity for a contested case hearing held in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, the commissioner finds that any insurer, person, or entity required to be licensed, permitted, or authorized by the division of insurance has violated any statute, rule or order, the commissioner may, at the commissioner's discretion, order:

**(1)** The insurer, person, or entity to cease and desist from engaging in the act or practice giving rise to the violation;

**(2)** Payment of a monetary penalty of not more than one thousand dollars ($1,000) for each violation, but not to exceed an aggregate penalty of one hundred thousand dollars ($100,000), unless the insurer, person, or entity knowingly violates a statute, rule or order, in which case the penalty shall not be more than twenty-five thousand dollars ($25,000) for each violation, not to exceed an aggregate penalty of two hundred fifty thousand dollars ($250,000). This subdivision (a)(2) shall not apply where a statute or rule specifically provides for other civil penalties for the violation. For purposes of this subdivision (a)(2), each day of continued violation shall constitute a separate violation; and

**(3)** The suspension or revocation of the insurer's, person's, or entity's license.

**(b)** In determining the amount of penalty to assess under this section, or in determining whether the violation was a knowing violation for the purpose of subdivision (a)(2), the commissioner shall consider any evidence relative to the following criteria:

**(1)** Whether the insurer, person or entity could reasonably have interpreted its actions to be in compliance with the obligations required by a statute, rule or order;

**(2)** Whether the amount imposed will be a substantial economic deterrent to the violator;

**(3)** Whether the amount imposed would put the violator in a hazardous financial condition;

**(4)** The circumstances leading to the violation;

**(5)** The severity of the violation and the risk of harm to the public;

**(6)** The economic benefits gained by the violator as a result of noncompliance;

**(7)** The interest of the public; and

**(8)** The insurer's, person's, or entity's efforts to cure the violation.

**(c)** Notwithstanding the limitations set forth in subdivision (a)(2), no aggregate penalty limits shall apply to the following:

**(1)** Failure to file audited statements required pursuant to § 56-1-501(h) and rules promulgated under § 56-1-501(h);

**(2)** Failure to file quarterly financial statements as required by statute or regulation;

**(3)** Failure to file actuarial opinions pursuant to § 56-1-501(d) and rules promulgated under § 56-1-501(d);

**(4)** Failure to file annual reports pursuant to §§ 56-19-119, 56-28-111, 56-29-113, 56-30-117, 56-31-116, 56-43-108, and 56-44-104;

**(5)** Failure to file a risk-based capital report pursuant to § 56-46-103; and

**(6)** Violations of orders issued after a contested case hearing held in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, part 3, and pursuant to subdivision (a)(1).

**(d)** This section does not apply to individual or business entity insurance producers licensed pursuant to chapter 6, part 1 of this title.

**(e) (1)** Notwithstanding any law to the contrary, civil penalties received under the authority of this section shall be utilized by the department, at the discretion of the commissioner, to:

**(A)** Defray its expenses related to the liquidation of insurance companies as provided by chapter 9 of this title;

**(B)** Promote consumer awareness of insurance; or

**(C)** Provide training or educational opportunities to employees of the division of insurance.

**(2)** Any subaccount currently used by the department for training and education may also be used for the promotion of consumer awareness.

**(f) (1)** If, at any time following the certification of the vehicle insurance verification program under § 55-12-212, the commissioner of commerce and insurance finds that an automobile liability insurer, as defined in§ 55-12-203, has intentionally violated § 56-7-1118, then the commissioner may, after providing the opportunity for a contested case hearing held in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, assess a civil penalty against the automobile liability insurer of up to two hundred fifty dollars ($250) for each day the insurer fails to comply with § 56-7-1118. The commissioner may excuse or reduce the civil penalty under this subdivision (f)(1) for good cause.

**(2)** Until the certification of the program occurs, the commissioner shall not assess any civil penalty or convene a contested case hearing for an alleged violation of§ 56-7-1118 by an automobile liability insurer.

## Mortgagee/Lender “Anti-Piracy” Law

**47-23-101. Insurance information confidential**

**(a) (1)** When a borrower is required to keep real estate insured and to furnish evidence of such insurance to a lender as a condition for obtaining or keeping the loan, then the lender, mortgagee, assignee, or creditor is prohibited from disclosing to other persons or parties, directly or indirectly, information with respect to the expiration dates of such insurance or other insurance policy information so as to enable any person or party to solicit the insurance or any renewal thereof, without first obtaining the written consent of the policyholder for such disclosure to be made.

**(2)** No other person or party shall request the disclosure of such information, so as to facilitate solicitations of the insurance or any renewal thereof, without first obtaining the written consent of the policyholder.

**(3)** No lender, mortgagee, assignee, or creditor shall use any of the information contained in a policy of insurance for the purpose of soliciting insurance business with respect to the insured real property from the borrower.

**(b)** These prohibitions do not apply when the lender, mortgagee, assignee, or creditor has been advised in writing by the insurer or its agent that the insurance on the property will be cancelled or will not be renewed.

**(c)** A willful violation of this section by any lender, mortgagee, assignee, or creditor or by any other person or party who may request the disclosure of such information from such lender, mortgagee, assignee, or creditor is a Class A misdemeanor.

# PRODUCERS

**TENNESSEE INSURANCE PRODUCER LICENSING ACT OF 2002 WITH 2008 AMENDMENTS**

**56-6-101. Purpose and scope.**

(a) This part shall be known and may be cited as the "Tennessee Insurance Producer Licensing Act of 2002."

(b) This part governs the qualifications and procedures for the licensing of insurance producers. It simplifies and organizes some statutory language to improve efficiency, permits the use of new technology and reduces costs associated with issuing and renewing insurance licenses.

(c) This part does not apply to surplus lines agents licensed pursuant to the Surplus Lines Insurance Act, compiled in chapter 14 of this title, except as provided in §§ 56-6-108 and 56-6-118(b).

**56-6-102. Part definitions.**

As used in this part, unless the context otherwise requires:

(1) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity;

(2) "Commissioner" means the commissioner of the Tennessee department of commerce and insurance;

(3) "Department" means the department of commerce and insurance;

(4) "Home state" means any state or territory of the United States and the District of Columbia in which an insurance producer maintains a principal place of residence or principal place of business and is licensed to act as an insurance producer;

(5) "Insurance" means any of the lines of authority in § 56-2-201;

(6) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance;

(7) "Insurer" means any insurance company authorized to transact insurance business in this state;

(8) "License" means a document issued by this state's commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier;

(9) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the commissioner determines should be designated a form of limited line credit insurance;

(10) "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy;

(11) "Limited lines insurance" means those lines of insurance defined in § 56-6-110 or any other line of insurance that the commissioner deems necessary to recognize for the purposes of complying with § 56-6-108(e);

(12) "Limited lines producer" means a person authorized by the commissioner to sell, solicit or negotiate limited lines insurance;

(13) "NAIC" means the National Association of Insurance Commissioners;

(14) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract; provided, that the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers;

(15) "Person" means an individual or a business entity;

(16) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company;

(17) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company;

(18) "Surplus lines producer" means a person authorized by the commissioner to sell, solicit or negotiate surplus lines insurance pursuant to the Surplus Lines Insurance Act, compiled in chapter 14 of this title. The person shall have the same authority given to a surplus lines agent licensed under the Surplus Lines Insurance Act;

(19) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance;

(20) "Uniform application" means the current version of the NAIC uniform application for resident and nonresident producer licensing; and

(21) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

**56-6-103. License required.**

A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this part.

NOTE: Click here for a link to the Department web site that contains information from an administrative hearing relative to what an unlicensed person can and cannot do.

**56-6-104. Exceptions to licensing.**

(a) Nothing in this part shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

(b) A license as an insurance producer shall not be required of the following:

(1) An officer, director or employee of an insurer or of an insurance producer; provided, that the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(A) The officer, director or employee's activities are executive, administrative,

managerial, clerical or a combination of these, and are only indirectly related to the sale, solicitation or negotiation of insurance;

(B) The officer, director or employee's function relates to underwriting, loss control, inspection or the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(2) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance; or for the purpose of enrolling individuals under plans, issuing certificates under plans or otherwise assisting in administering plans, or performs administrative services related to mass marketed property and casualty insurance, where no commission is paid to the person for the service;

(3) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, director or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(4) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risks, or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(5) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state; provided, that the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(6) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; provided, that the person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state;

(7) A salaried full-time employee who counsels or advises an employer relative to the

insurance interests of the employer or of the subsidiaries or business affiliates of the employer; provided, that the employee does not sell or solicit insurance or receive a commission;

(8) Any regular salaried officer, employee or member of a fraternal benefit society that provides benefits in case of death or disability, resulting solely from accident, and that does not obligate the officer, employee or member to pay natural death or sick benefits, the officers, employees or members procuring other members and receiving no compensation for the procurement other than awards or merchandise nominal in value;

(9) An officer, director, or employee of a vehicle rental company engaged in the sale, solicitation, or negotiation of optional insurance sold in connection with and incidental to a motor vehicle rental agreement for a period not to exceed ninety (90) days;

(A) The insurance that may be offered pursuant to this subdivision (b)(9) is limited to:

(i) Personal accident coverage that provides protection for renters and other rental vehicle occupants for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs during the rental period;

(ii) Liability coverage that provides protection to renters and to other authorized drivers of the rental motor vehicle for liability arising from the operation of the motor vehicle during the rental period. The liability protection, when purchased by a renter, shall be deemed to be primary over any other coverages that may be available to the renter or other authorized driver of the rental vehicle to the extent of the protection provided;

(iii) Personal effects coverage that provides protection to renters and other motor vehicle occupants for loss of, or damage to, personal effects in the rental motor vehicle during the rental period; and

(iv) Roadside assistance coverage;

(B) As used in subdivision (b)(9)(A), "motor vehicle" or "rental vehicle" means a private passenger motor vehicle, including passenger vans, mini vans, and sport utility vehicles, and a cargo motor vehicle, including cargo vans, pickup trucks, and trucks with a gross vehicle weight of less than twenty-six thousand pounds (26,000 lbs.);

(C) Each person engaged in the sale of optional insurance products pursuant to this subdivision (b)(9) shall give each renter who purchases the coverage brochures or other written materials that:

(i) Summarize, clearly and correctly, the material terms and conditions of coverage offered to renters;

(ii) Identify the insurer;

(iii) Describe the process for filing a claim in the event the renter elects to purchase coverage;

(iv) State that the purchase of the coverage is not required in order to rent a vehicle;

(v) Disclose that the coverage offered by the rental agreement may provide a duplication of coverage already provided by a renter's personal automobile policy or by another source of coverage; and

(vi) Itemize the cost for the coverage separately;

(D) The commissioner may seek the sanctions provided in former § 56-6-112(e) [repealed] against a vehicle rental company upon a finding that an officer, director, or employee of a vehicle rental company has violated § 56-6-112(a)(2), (4), (5), (7), (8), or (10) in connection with the sale, solicitation, or negotiation of optional insurance sold in connection with and incidental to a motor vehicle rental agreement for a period not to exceed ninety (90) days; or

(10) An officer, director, employee, or authorized representative of a business entity engaged in the sale, solicitation, or negotiation of portable electronics insurance licensed pursuant to and acting in compliance with part 11 of this chapter.

**56-6-105. Application for examination.**

(a) A resident individual applying for an insurance producer license shall pass a written examination unless exempt pursuant to § 56-6-109. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Each individual wishing to take the state insurance examination shall first complete either an on-site or on-line preparation program approved by the commission. A person seeking an insurance producer license shall also meet the following prelicensing requirements:

(1) All applicants for an insurance producer license, unless otherwise exempted by law, are required to register and complete either an on-line or classroom study program approved by the commissioner;

(2) Applicants for a license shall be at least eighteen (18) years of age or older; and

(3) All other requirements for an insurance license shall be developed and conducted under rules and regulations prescribed by the commissioner.

(b) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting the nonrefundable examination fee.

(c) An individual who fails to appear for the examination as scheduled or fails to pass the examination, shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

**56-6-106. Application for license.**

(a) An individual residing in this state applying for an insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that the individual:

(1) Is at least eighteen (18) years of age;
(2) Has not committed any act that is a ground for denial, suspension or revocation set forth in § 56-6-112;
(3) *Has completed a prelicensing course of study for the lines of authority for which the person has applied;* Has completed a prelicensing course of study for the lines of authority for which the person has applied that consists of a minimum of twenty (20) hours of coursework for life, accident and health, property, casualty, personal lines or title insurance; Language in *italics* deleted effective April 8, 2014. Public Chapter 650.
(4) Has paid the fees set forth in § 56-6-121; and:
(5) Has successfully passed the examinations for the lines of authority for which the person has applied.

(b) A business entity may obtain an insurance producer's license; however, only an individual licensed producer or limited lines producer shall sell, solicit or negotiate a contract of insurance in this state. Application shall be made using the uniform business entity application. An individual authorized and acting on behalf of the business entity shall declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that

(1) The business entity has paid the applicable fees set forth in § 56-6-121; and

(2) The business entity has designated a principal or officer who also holds a current producer license responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(c) The commissioner may require any documents reasonably necessary to verify the information contained in an application

NOTE: Paragraph (b) allows, but does not require, your agency to get a business entity license. Many other states require your agency to have a license before you can get or renew a non-resident agent's license. Go to

http://www.tn.gov/assets/entities/commerce/attachments/BusinessEntityUniformAppPkt.pdf to get instructions and forms.

**56-6-107. License.**

(a) Unless denied licensure pursuant to § 56-6-112, persons who have met the requirements of §§ 56-6-105 and 56-6-106 shall be issued an insurance producer license. A resident insurance producer may receive a license in one or more of the following lines of insurance: (1) Life — insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;

(2) Accident and health or sickness — insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income;

(3) Property — insurance coverage for the direct or consequential loss or damage to property of every kind;

(4) Casualty — insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property;

(5) Variable life and variable annuity products — insurance coverage provided under variable life insurance contracts and variable annuities;

(6) Personal lines — property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes;

(7) Credit — limited line credit insurance; and

(8) Any other line of insurance permitted under this title or regulations promulgated under this title.

(b) (1) For licenses issued or renewed on or after January 1, 2007, the licenses shall remain in effect for twenty-four (24) months from the last day of the licensee's birth month.

(2) Business entity licenses will expire biennially on March 1.

(c) At the end of the twenty-four (24) months, the insurance producer license may be renewed, subject to the limitations set forth in § 56-6-112, by paying the applicable fee set forth in § 56-6-121, and submitting the renewal form prescribed by the commissioner. In addition to the foregoing, and subject to the exception found in § 56-6-118, an insurance producer license will not be renewed unless the insurance producer has completed all continuing education requirements, as established by rule. However, the continuing education requirements shall not apply to the following: (d) An insurance producer who allows the license to lapse may, within twelve (12) months from the due date of the renewal fee, reinstate the same license without the necessity of passing a

written examination. However, a penalty in the amount of double the unpaid renewal fee shall be required for any renewal fee received after the due date.(e) A licensed insurance producer who is unable to comply with the license renewal procedures of this section due to military service or some other extenuating circumstance (e.g., a long-term medical disability) may request a waiver of such license renewal procedures. The producer may also request a waiver of any examination requirement or any other sanction imposed for failure to comply with such renewal procedures.(f) The license shall contain the licensee's name, address, insurance producer number, and the date of issuance, the lines of authority, the expiration date and any other information the commissioner deems necessary.(g) A licensed insurance producer shall inform the commissioner by any means acceptable to the commissioner of a change of address within thirty (30) days of the change. Failure to timely inform the commissioner of a change in legal name or address may result in a disciplinary action pursuant to § 56-6-112.

NOTE: Link to Change of Address Form.

(h) In order to assist in the performance of the commissioner's duties, the commissioner may contract with non-governmental entities, including the NAIC or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the commissioner and the non-governmental entity may deem appropriate.

(i) In the commissioner's discretion, the commissioner shall have the authority to waive any continuing education requirements imposed by this section

**56-6-108. Nonresident licensing.**

(a)Unless denied licensure pursuant to § 56-6-112, a nonresident person shall receive an insurance producer license if(1) The person is currently licensed as a resident insurance producer and is in good standing in the person's home state;(2)The person has submitted the proper request for licensure and has paid the applicable fees required by § 56-6-121;(3) The person has submitted or transmitted to the commissioner the application for licensure that the person submitted to the person's home state, or in lieu of the same, a completed uniform application; and(4) The person's home state awards insurance producer licenses to residents of this state on the same basis.(b) The commissioner may verify the insurance producer's licensing status through any producer database maintained by the NAIC, its affiliates or subsidiaries.(c) A nonresident insurance producer who moves from one state to another state or a resident insurance producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.(d) Notwithstanding any other provision of this part, a person licensed as a surplus lines producer in the person's home state shall receive a surplus lines producer license in this state pursuant to subsection (a). Except as provided in subsection (a), nothing in this section otherwise amends or supersedes any provision of the Surplus Lines Insurance Act, compiled in chapter 14 of this title.

(e) Notwithstanding any other provision of this part, a person licensed as a limited line credit insurance producer or any other type of limited lines insurance producer in the person's home state shall receive a nonresident limited lines producer license, pursuant to subsection (a), as long as such a license is granted to residents of this state. Such license shall grant the nonresident the same scope of authority as granted a resident insurance producer holding such a license in this state.

**56-6-109. Exemption from examination.**

(a) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety (90) days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the NAIC, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(b) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee pursuant to § 56-6-106. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the commissioner determines otherwise by regulation.

**56-6-110. Limited lines producers.**

An individual who has met the requirements of § 56-6-106 shall be entitled to a limited lines producer license without examination in one (1) or more of the following limited lines:

(1) Travel Insurance.

(2) Credit life, credit accident and health insurance, or involuntary unemployment credit insurance;

(3) Mortgage guaranty insurance;

(4) Personal property insurance sold to a debtor under a master group policy issued to a creditor;

(5) Crop hail insurance;

(6) Title insurance; provided, that the limited lines producer is an attorney, duly licensed in this state, who acts as a title insurance agent as an ancillary part of the attorney's practice of law;

(7) Any other lines that the commissioner finds by rule are essential for the transaction of business in this state and do not require the professional competency demanded by an insurance producer's license; or

(8) Portable electronics insurance.

**56-6-111. Temporary licensing.**

(a) The commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(1) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business;

(2) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(3) To the designee of a licensed insurance producer entering active service in the armed forces of the United States of America; or

(4) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

(b) The commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. A temporary license issued under this part may also be suspended or revoked pursuant to § 56-6-112. A temporary license may not continue after the owner or the personal representative disposes of the business.

**56-6-112. License denial, nonrenewal, suspension or revocation.**

(a) The commissioner may place on probation, suspend, revoke or refuse to issue or renew a license issued under this part or may levy a civil penalty in accordance with this section or take any combination of those actions, for any one (1) or more of the following causes:

(1) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(2) Violating any law, rule, regulation, subpoena or order of the commissioner or of another state's commissioner;

(3) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(4) Improperly withholding, misappropriating or converting any moneys or properties received in the course of doing insurance business;

(5) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(6) Having been convicted of a felony;

(7) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(8) Using fraudulent, coercive, or dishonest practices, or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(9) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(10) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(11) Improperly using notes or any other reference material to complete an examination for an insurance license;

(12) Knowingly directing any person to submit an application for health care benefits through the TennCare program at a time when the person is covered by a group policy or when the policy is being renewed, and then quoting a rate for a group health insurance policy if the insurance producer knows the person would otherwise have been eligible to participate or continue participation in the group policy;

(13) Knowingly accepting insurance business from an individual who is not licensed;

(14) Selling, soliciting or negotiating insurance for a company that is not authorized to transact the business of insurance in this state; and

(15) Violating the unfair trade practices as enumerated in § 56-6-125.

(b) Any action by the commissioner to put on probation, suspend, revoke or deny the

renewal of a license pursuant to this section shall be governed by the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(c) In the event that the action by the commissioner is to deny an application for a license, the commissioner shall notify the applicant and advise, in writing, the applicant of the denial of the applicant's application within thirty (30) days.

(d) The license of a business entity may be suspended or revoked if the commissioner finds, after a hearing, that an individual licensee's violation was known or should have been known by one (1) or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the commissioner nor corrective action taken.

(e) The commissioner shall retain the authority to enforce this part and impose any penalty or remedy authorized by this part and this title against any person who is under investigation for or charged with a violation of this part or this title, even if the person's license has been surrendered or has lapsed by operation of law.

(f) The commissioner may serve a notice or order in any action arising under this part by registered or certified mail to the insurance producer or applicant at the address of record in the files of the department. Notwithstanding any law to the contrary, service in the manner set forth in this subsection (g) shall be deemed to constitute actual service on the insurance producer or applicant.

(g) If, after providing notice consistent with the process established by § 4-5-320(c), and providing the opportunity for a contested case hearing held in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, the commissioner finds that any person required to be licensed, permitted, or authorized by the division of insurance pursuant to this chapter has violated any statute, rule or order, the commissioner may, at the commissioner's discretion, order:

(1) The person to cease and desist from engaging in the act or practice giving rise to the violation;

(2) Payment of a monetary penalty of not more than one thousand dollars ($1,000) for each violation, but not to exceed an aggregate penalty of one hundred thousand dollars ($100,000). This subdivision (g)(2) shall not apply where a statute or rule specifically provides for other civil penalties for the violation. For purposes of this subdivision (g)(2), each day of continued violation shall constitute a separate violation; and

(3) The suspension or revocation of the person's license.

(h) In determining the amount of penalty to assess under this section, the commissioner shall consider:

(1) Whether the person could reasonably have interpreted such person's actions to be in

compliance with the obligations required by a statute, rule or order;

(2) Whether the amount imposed will be a substantial economic deterrent to the violator;

(3) The circumstances leading to the violation;

(4) The severity of the violation and the risk of harm to the public;

(5) The economic benefits gained by the violator as a result of noncompliance;

(6) The interest of the public; and

(7) The person's efforts to cure the violation.

**56-6-113. Commissions.**

(a) An insurer or insurance producer shall not pay a commission, service fee, brokerage fee or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this part and is not so licensed.

(b) A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this part and is not so licensed.

(c) Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under this part at the time of the sale, solicitation or negotiation and was so licensed at that time.

(d) An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state, unless the payment would violate § 56-8-104(8).

(e) An unlicensed person may make a referral to a licensed producer; provided that the person does not discuss the specific insurance policy terms and conditions. Except as prohibited by federal law, the unlicensed person may be compensated for the referral; however, an unlicensed person who is neither employed by nor affiliated with the insurance producer may be compensated only if the compensation is a fixed dollar amount, not to exceed twenty-five dollars ($25.00) or such lesser amount as the commissioner may establish by rule, for each referral. An unlicensed person who is either employed by or affiliated with the insurance producer may be compensated only if the compensation is a fixed nominal dollar amount. In either event, the referral compensation

shall not depend on whether the referred customer purchases an insurance product from the licensed producer.

**56-6-114. Sale of Unauthorized Insurance**

(a) A person shall be personally liable for any premiums paid for, or valid claims made on, all contracts of insurance unlawfully sold within this state by or through the person directly or indirectly, for or on behalf of an insurance company not authorized to do business in this state.

(b) A person who sells insurance in this state for an insurance company not authorized to do business in this state commits a fraudulent insurance act as defined by § 56-53-102.

**56-6-115. Appointments.**

(a) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(b) An insurance producer who solicits or negotiates an application for insurance shall be regarded, in any controversy arising from the application for insurance or any policy issued in connection therewith between the insured or insured's beneficiary and the insurer, as the agent of the insurer and not the insured or insured's beneficiary. This provision shall not affect the apparent authority of an agent.

(c) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(d) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer within five (5) days of the determination.

(e) An insurer shall pay an appointment fee, in the amount set forth in § 56-6-121, for each insurance producer appointed by the insurer. The fees under this section may be paid by the insurer on a quarterly basis.

(f) Any insurance producer may place excess or rejected risks with an insurer lawfully doing business within this state, and shall not be required to enter into an agency contract or agreement with the insurer accepting such excess or rejected risks or be appointed by such insurer; provided, that only that portion of the risk in excess of the limits which such insurer will write may be placed as an excess risk, and:

(1) The insurance producer has an agency contract or agreement with an insurer that actually engages in the writing of such insurance; and

(2) Such insurer has deemed such risk to be in excess of, or in noncompliance with, its underwriting standards.

(g) No insurance producer may place an application for insurance with any "residual market mechanism," as defined by § 56-5-302, unless such insurance producer:

(1) Has an agency contract or agreement with an insurer that actually engages in the writing of such insurance; and

(2) Makes a diligent effort to place such application for insurance with such insurer.

(h) It is unlawful for any insurer to accept applications from, or pay commissions to, an insurance producer or limited lines producer except in accordance with the provisions of this section. Any insurer who unlawfully accepts applications from, or pays commissions to, any insurance producer shall be deemed to have accepted and acknowledged such person as its insurance producer or limited lines producer.

(i) An individual not duly licensed as an insurance producer or limited lines producer who solicits a policy of insurance on behalf of an insurer shall thereby become liable for all the duties, requirements, liabilities and penalties to which an insurance producer of such insurer is subject.

**56-6-116 Fiduciary duty**.

Any money which an insurance producer receives for soliciting, negotiating or selling insurance shall be held in a fiduciary capacity, and shall not be misappropriated, converted or improperly withheld. Any violation of this section shall be considered grounds for the denial, suspension, or revocation of the insurance producer's license and shall subject the insurance producer to the sanctions and penalties set forth under § 56-6-112.

This section only requires that agents hold money in a "fiduciary capacity". Tennessee has no law requiring that funds for admitted companies be maintained in a separate account.

**56-6-117. Notification to commissioner of termination.**

**(a) Termination for Cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the commissioner, if the reason for termination is one of the reasons set forth in § 56-6-112 or the insurer has knowledge the producer was found by a court, government body, or

self-regulatory organization authorized by law to have engaged in any of the activities described in § 56-6-112. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

**(b) Termination Without Cause.** An insurer or authorized representative of the insurer that terminates the appointment, employment, or contract with a producer for any reason not set forth in § 56-6-112 shall notify the commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the commissioner. Upon written request of the commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

**(c) Termination of Appointment Fee.** An insurer shall pay a termination of appointment fee, in the amount set forth in § 56-6-121, for each insurance producer appointment terminated by the insurer.

**(d) Ongoing Notification Requirement.** The insurer or the authorized representative of the insurer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner in accordance with subsection (a) had the insurer known of its existence at the time the insurer initially notified the commissioner.

**(e) Copy of Notification to be Provided to Producer.** **(1)** Within fifteen (15) days after making the notification required by subsections (a), (b) and (d), the insurer shall mail a copy of the notification to the producer at the producer's last known address. If the producer is terminated for cause for any of the reasons listed in § 56-6-112, the insurer shall provide a copy of the notification to the producer at the producer's last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

**(2)** Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (g).

**(f) Immunities.** **(1)** In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the commissioner, or an organization of which the commissioner is a member and that compiles the information and makes it available to other commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided pursuant to this section or any information relating to any

statement that may be requested in writing by the commissioner from an insurer or producer; or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (a) was reported to the commissioner; provided, that the propriety of any termination for cause under subsection (a) is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

**(2)** In any action brought against a person that may have immunity under subdivision (f)(1) for making any statement required by this section or providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that subdivision (f)(1) does not apply because the person making the statement or providing the information did so with actual malice.

**(3)** Subdivision (f)(1) or (f)(2) shall not abrogate or modify any existing statutory or common law privileges or immunities.

**(g) Confidentiality. (1) (A)** All testimony, documents, other information in the control or possession of the department that is obtained by the commissioner in an investigation pursuant to this section shall, except as provided in subdivision (g)(1)(B), be confidential and absolutely privileged and shall not be:

**(i)** Subject to § 10-7-503(a) or § 56-1-602;

**(ii)** Subject to subpoena;

**(iii)** Subject to discovery; or

**(iv)** Admissible as evidence in any private civil action.

**(B)** Notwithstanding subdivision (g)(1)(A), the commissioner is authorized to use the testimony, documents, and other information in the control or possession of the department in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

**(2)** Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subdivision (g)(1).

**(3)** In order to assist in the performance of the commissioner's duties under this part, the commissioner may:

**(A)** Share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subdivision (g)(1), with other state, federal, and international regulatory agencies, with the NAIC, its affiliates or

subsidiaries, and with state, federal, and international law enforcement authorities; provided, that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

**(B)** Receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC, its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

**(C)** Enter into agreements governing sharing and use of information consistent with this subsection (g).

**(4)** No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subdivision (g)(3).

**(5)** Nothing in this part shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to § 10-7-503(a) to a database or other clearinghouse service maintained by the NAIC, its affiliates or subsidiaries.

**(h) Penalties for Failing to Report.** An insurer or the authorized representative of the insurer, or a producer that fails to report as required under this section or that is found to have falsely reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked. In addition to or in lieu of the suspension or revocation of a license or certificate of authority, the commissioner may subject violators of this part to a civil penalty in an amount not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each violation.

**56-6-118. Reciprocity.**

(a) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from the applicant's home state, except the requirements imposed by § 56-6-108, if the applicant's home state awards nonresident licenses to residents of this state on the same basis. Notwithstanding any other provision of this part, after a public hearing the commissioner may waive any of the limitations or requirements imposed by § 56-6-108 if the applicant's home state awards nonresident licenses to residents of this state on the same basis. However, nothing contained in this subsection (a) shall prevent the commissioner from denying, suspending or revoking a license issued under this part pursuant to § 56-6-112.

(b) A nonresident producer's satisfaction of the producer's home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the non-resident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

**56-6-119. Reporting of actions.**

(a) A producer shall report to the commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of any order entered or other relevant legal documents.

(b) Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the commissioner any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

**56-6-120. Investigations.**

**(a)** The commissioner may make investigations necessary for the proper administration of this part. For the purpose of making the investigations, the commissioner shall have inquisitorial powers and shall be empowered to subpoena witnesses and examine them under oath; provided that:

**(1)** Any investigatory action be reasonable in scope and relevant to the administration of this part;

**(2)** In the course of an investigation conducted pursuant to this section, the commissioner shall be given access to all business records of a person licensed or required to be licensed under this part. The department shall endeavor to conduct its investigation in a manner that is least obtrusive to the ongoing business of the person; and

**(3)** **(A)** All testimony, documents, other information in the control or possession of the commissioner that is obtained in an investigation pursuant to this section shall, except as provided in subdivision (a)(3)(B), be confidential and absolutely privileged and shall not be:

**(i)** Subject to § 10-7-503(a) or § 56-1-602;

**(ii)** Subject to subpoena;

**(iii)** Subject to discovery; or

**(iv)** Admissible as evidence in any private civil action;

**(B) (i)** The commissioner is authorized to use the testimony, documents, and other information in the control or possession of the department in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties;

**(ii)** Subject to subsection (b), a person being investigated pursuant to this section, or counsel for such person, may obtain from the commissioner a copy of each and any inquisitorial order and complaint filed against the person. Further, upon initiation of a formal proceeding against any person, the person shall be entitled to any and all discovery rights available under the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, or the Tennessee Rules of Civil Procedure.

**(b) (1)** Upon issuance by the commissioner of an inquisitorial order or upon receipt by the department of a written complaint against a person, the department shall provide the person with a copy of the inquisitorial order or complaint within thirty (30) days of issuance of the order or receipt of the complaint.

**(2)** Before seeking a statement from a person being investigated, the department shall notify the person that any statement may be used in an investigation or become evidence in a hearing. Failure of the department to comply with subdivision (b)(1) shall render any statement provided to the department prior to its compliance with subdivision (b)(1) inadmissible in any administrative actions against such person. However, failure to comply with subdivision (b)(1) shall not prevent the department from proceeding with any actions arising from such order or complaint. Further, nothing in this section shall prevent the department from taking a statement from a person being investigated prior to giving the notice required by subdivision (b)(1) as long as it is taken within thirty (30) days of the receipt of the complaint or the entry of the inquisitorial order.

**(c)** Upon receiving notice under subdivision (b)(1), the person being investigated may obtain a copy of any written, formal or recorded statements made by such person. The department shall produce such information requested pursuant to this subsection (c) within thirty (30) days of the request.

**(d)** In the course of an investigation conducted pursuant to this section, the commissioner shall have the right to take under oath the testimony of any person involved in the business of insurance. Such person shall be given no less than fourteen (14) days' written notice of the commissioner's intent to take testimony and the place where the testimony will be taken. Upon good cause shown, and in the commissioner's sole discretion, the commissioner may provide additional time to the requester.

**(e)** If the commissioner requests a person to produce records, originals or copies, in conjunction with an investigation conducted pursuant to this section, and the person from whom the documents have been requested believes the request is overbroad and will not lead to the discovery of facts relevant to the commissioner's investigation, that person may seek review of the commissioner's request by application to an administrative judge, including seeking entry of a protective order. The cost of document production pursuant

to this section shall be borne by the person from whom the documents are sought; provided, however, that all other costs of investigation shall be borne by the department.

**(f)** No later than thirty (30) days after completion of an investigation, or closure of a complaint file, the commissioner shall provide notice of such completion or closure to the person being investigated or against whom the complaint was filed.

**(g)** In the commissioner's annual report made pursuant to § 56-1-601, the department shall identify the total number of open investigations, the number of investigations opened in the year covered by the report, and the number of investigations closed in the year covered by the report.

**(h)** Any investigation initiated under this part shall be completed within two (2) years of receiving a complaint, or the entry of an inquisitorial order, whichever comes first. The filing of an action under subsection (e) shall toll this limitation until such time as there is a final order issued pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, and there is no judicial order staying the effectiveness of the final order. All actions shall be commenced within five (5) years of the date that the commissioner knew or reasonably should have known of the cause of action. Nothing in this subsection (h) shall prevent the department from taking action based upon an order previously entered by another state or the federal government or a felony conviction, regardless of the date of such order or conviction. Any investigation initiated prior to July 1, 2011, shall be completed or closed, or a contested case action shall be filed as of July 1, 2013.

**(i)** Any notices required by the department pursuant to this section may be transmitted electronically.

**56-6-121. Fees.**

In addition to any other fees that may be required elsewhere in this title, the following are the nonrefundable fees that will be paid to the commissioner under this part:

(1) Except as provided in subdivision (5), fifty dollars ($50.00) for the filing of an application for an insurance producer license or limited lines producer license;

(2) Sixty dollars ($60.00) for the renewal of an insurance producer license;

(3) Thirty dollars ($30.00) for the renewal of a limited lines producer license;

(4) Fifteen dollars ($15.00) for the appointment or termination of appointment of an insurance producer or limited lines producer by an insurer; and

(5) Seven hundred fifty dollars ($750) for the filing of an initial application or renewal application as a travel insurance supervising entity pursuant to the Travel Insurance Producer Limited License Act, compiled in part 14 of this chapter.

**56-6-122. Countersignatures.**

Notwithstanding any other provision of law to the contrary, there shall be no requirement that an insurance producer who is a resident of this state must countersign a policy of insurance written by an insurance company.

**56-6-123. Assumed names.**

An insurance producer doing business under any name other than the producer's legal name is required to notify the commissioner prior to using the assumed name.

**56-6-124. Regulations.**

(a) The commissioner may, in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, promulgate reasonable regulations as are necessary or proper to carry out the purposes of this part.

(b) The commissioner shall have the authority to promulgate any public necessity rules necessary to implement this part; provided, that permanent rules shall be implemented pursuant to the requirements of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(c) The commissioner shall promulgate continuing education requirements for individuals licensed under this part in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**56-6-125. Unfair Trade Practices.**

(a) It is an unfair trade practice for an insurance producer to:

(1) Hold the insurance producer out, directly or indirectly, to the public as a financial planner, investment adviser, consultant, financial counselor, risk manager or any other specialist engaged in the business of giving financial planning, risk management or advice relating to investments, insurance, real estate, tax matters or trust and estate matters when the person is in fact engaged only in the sale of insurance policies. This subdivision (a)(1) does not preclude persons who hold some form of formal recognized financial planning, risk management or consultant certification or designation from using this certification or designation when they are only selling insurance;

(2) Engage in the business of financial planning without disclosing to the client prior to the execution of the agreement provided for in subdivision (a)(3), or solicitation of the sale of a product or service, that:

(A) The person is also an insurance salesperson; and

(B) That a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this subsection (a) may be met by including it in any disclosure required by federal or state securities law; or

(3) Charge fees for the sale, solicitation or negotiation of insurance not authorized by a written agreement with an insurer, and, where applicable, incorporated in the insurer's rate filing. An insurance producer may charge fees for services not connected with the sale, solicitation and negotiation of insurance by the insurance producer if the fees are based upon a qualified written agreement, signed by the party to be charged in advance of the performance of the services under the agreement. A copy of the qualifying agreement must be provided to the party to be charged at the time the agreement is signed by the party. The agreement shall be considered as qualifying if it includes:

(A) The services for which the fee is to be charged;

(B) The amount of the fee to be charged or how it will be determined or calculated; and

(C) A disclosure stating that the client is under no obligation to purchase any insurance product through the insurance producer or consultant. The insurance producer shall retain a copy of the agreement for not less than three (3) years after completion of services, and a copy shall be available to the commissioner upon request.

(b) Notwithstanding subsection (a), nothing in this section shall be construed as permitting persons to charge an additional fee for services that are customarily associated with the sale, solicitation, negotiation or servicing of insurance policies.

**56-6-126. Severability.**

If any provisions of this part, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the part, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

# Surplus Lines Law

Department Bulletin on Filing for Single and Multi-State Policies.  Effective 10-1-14

**56-14-101. Short title -- Applicability.**

This part shall be known and may be cited as the "Surplus Lines Insurance Act." This part shall apply to surplus lines transactions where the insured's home state, as defined by§ 56-14-102, is this state.

**56-14-102. Part definitions.**

As used in this part, unless the context otherwise requires:

**(1)** "Admitted company" or "authorized company" means an insurance company qualified and licensed to transact business under this title;

**(2)** "Affiliate" means, with respect to an insured, any entity that controls the insured, is controlled by the insured or is under common control with the insured;

**(3)** "Affiliated group" means a group of entities in which each entity, with respect to an insured, controls the insured, is controlled by the insured, or is under common control with the insured;

**(4)** "Alien insurance company" means an insurance company incorporated or formed under the laws of any country other than the United States;

**(5)** "Commissioner" means the commissioner of commerce and insurance;

**(6)** "Control" means:

**(A)** To own, control, or have the power of an entity directly, indirectly, or acting through one or more other persons to vote twenty-five percent (25%) or more of any class of voting securities of another entity; or

**(B)** To direct, by an entity, in any manner, the election of a majority of the directors or trustees of another entity;

**(7)** "Department" means the department of commerce and insurance;

**(8)** **(A)** "Exempt commercial purchaser" means any person purchasing commercial insurance that, at the time of placement, meets the following requirements:

**(i)** The person employs or retains a qualified risk manager to negotiate insurance coverage;

**(ii)** The person has paid aggregate nationwide commercial property and casualty insurance premiums in excess of one hundred thousand dollars ($100,000) in the immediately preceding twelve (12) months; and

**(iii)** The person meets at least one (1) of the following criteria:

**(a)** The person possesses a net worth in excess of twenty million dollars ($20,000,000), as such amount is adjusted pursuant to subdivision (7)(B);

**(b)** The person generates annual revenue in excess of fifty million dollars

($50,000,000), as such amount is adjusted pursuant to subdivision (7)(B);

**(c)** The person employs more than five hundred (500) full-time or full-time equivalent employees per individual insured or is a member of an affiliated group employing more than one thousand (1,000) employees in the aggregate;

**(d)** The person is a not-for-profit organization or public entity generating annual budgeted expenditures of at least thirty million dollars ($30,000,000), as such amount is adjusted pursuant to subdivision (7)(B); or

**(e)** The person is a local governmental entity with a population in excess of fifty thousand (50,000) inhabitants;

**(B)** Beginning on the fifth occurrence of January 1 after June 10, 2011, and each fifth occurrence of January 1 thereafter, the amounts in subdivisions (7)(A)(iii)(*a*), (*b*), and (*d*) shall be adjusted to reflect the percentage change for such five-year period in the consumer price index for all urban consumers published by the federal bureau of labor statistics;

**(9)** "Foreign" has the same meaning as in § 56-1-102;

**(10)** **(A)** "Home state," except as provided in subdivision (9)(B) should be 10(B), means, with respect to an insured:

**(i)** The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

**(ii)** If one hundred percent (100%) of the insured risk is located out of the state referred to in subdivision (9)(A)(i), the state to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated;

**(B)** If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, "home state" means the home state, as determined pursuant to subdivision (9)(A), of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract;

**(C)** When determining the home state of the insured, the principal place of business is the state in which the insured maintains its headquarters and where the insured's high-level officers direct, control, and coordinate the business activities of the insured;

**(11)** "Insurance company" has the same meaning as in § 56-1-102;

**(12)** "Nonadmitted company" or "unauthorized company" means an insurance company not licensed to transact business in this state under this title;

**(13)** "Nonadmitted insurance" or "surplus lines insurance" means any insurance

coverage permitted by § 56-14-105 to be placed directly or through surplus lines agents with a nonadmitted insurer eligible pursuant to § 56-14-108;

**(14)** "Nonadmitted insurer" means, with respect to a state, an insurer not licensed to engage in the business of insurance in such state; provided, however, such term does not include a risk retention group, as defined in 15 U.S.C. § 3901(a)(4);

**(15)** "Qualified risk manager" means, with respect to a policyholder of commercial insurance, a person who meets the following requirements:

**(A)** The person is an employee of, or third-party consultant retained by, the commercial policyholder;

**(B)** The person provides skilled services in loss prevention, loss reduction, or risk and insurance coverage analysis, and purchase of insurance; and

**(C)** The person meets the standards set out in one (1) of the following categories:

**(i)** The person has:

**(a)** A bachelor's degree or higher from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management; and

**(b)** Either of the following:

**(1)** Three (3) years of experience in risk financing, claims administration, loss prevention, risk and insurance analysis or purchasing commercial lines of insurance; or

**(2)** A designation as a Chartered Property and Casualty Underwriter issued by the American Institute for Chartered Property and Casualty Underwriter, Insurance Institute of America;

**(3)** A designation as an Associate in Risk Management issued by the American Institute for Chartered Property and Casualty Underwriter, Insurance Institute of America;

**(4)** A designation as a Certified Risk Manager issued by the National Alliance for Insurance Education and Research;

**(5)** A designation as a RIMS Fellow issued by the Global Risk Management Institute; or

**(6)** Any other designation, certification, or license determined by a state insurance commissioner or other state insurance regulatory official or entity to

demonstrate minimum competency in risk management;

**(ii)** The person has:

**(a)** At least seven (7) years of experience in risk financing, claims administration, loss prevention, risk and insurance coverage analysis, or purchasing commercial lines of insurance; and

**(b)** Any one (1) of the designations set out in subdivision (15)(C)(i)(*b*);

**(iii)** The person has at least ten (10) years of experience in risk financing, claims administration, loss prevention risk and insurance coverage analysis, or purchasing commercial lines of insurance; or

**(iv)** The person has a graduate degree from an accredited college or university in risk management, business administration, finance, economics, or any other field determined by a state insurance commissioner or other state regulatory official or entity to demonstrate minimum competence in risk management;

**(16)** "State" includes any state in the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Northern Mariana Islands, the Virgin Islands, and American Samoa;

**(17)** "Surplus lines agent" means an agent who is licensed under chapter 6, part 1 of this title who is granted a surplus lines license in accordance with this part;

**(18)** "Surplus lines insurer" means an unauthorized company in which a nonadmitted insurance coverage is placed or may be placed under this part; and

**(19)** "Writing agent" means the licensed insurance agent who accepts the application for nonadmitted insurance directly or indirectly from the prospective insured.

**56-14-103. Surplus lines insurance authorized.**

(a) If insurance coverages of insureds, whose home state is this state, cannot be procured from admitted companies after diligent effort, except if an exempt commercial purchaser, the coverages, designated as surplus lines insurance, may be procured from unauthorized companies, subject to the following conditions:

(1) The insurance must be eligible for surplus lines under§ 56-14-105;

(2) The insurer must be an eligible surplus lines insurer under §56-14-109;

(3) The writing agent must be a licensed surplus lines agent; and

(4) Any other applicable provisions of this part must be followed.

(b) Any surplus lines insurance of an insured, whose home state is this state, shall be deemed to be insurance procured, or continued or renewed in this state for purposes of subsection (a).

**56-14-104. Surplus lines agent's license.**

(a) The commissioner may issue a surplus lines license to any agent licensed pursuant to title 56, chapter 6. Such licensee shall grant the agent authority to procure the kinds of insurance provided for in this part from unauthorized companies in this state under the conditions prescribed in this part.

(b) Every license issued pursuant to this section shall be for a twenty-four month term. A license fee in the amount of one hundred and twenty dollars ($120) shall be paid to the commissioner in advance of issuance or renewal of a license. Licenses expiring on December 31. 2011, shall be extended until the next scheduled renewal of a producer's license issued under title 56, chapter 6 and may be renewed biennially thereafter. New licenses issued on or after January 1, 2012, may be renewed for ensuing periods of twenty-four months expiring on the last day of the producer's birth month.

(c) Before the commissioner may issue or renew a license, the agent seeking licensure or renewal of a license shall file an application in a form that the commissioner prescribes.

(d) Before a license is issued, the applicant shall hold a valid license from the department authorizing the applicant to write the coverages provided for in this part with a company licensed to transact business in this state. The commissioner may participate in the NAIC producer licensing database.

**56-14-105. Eligibility for surplus lines insurance.**

(a) No insurance coverage shall be eligible for surplus lines insurance unless the full amount of insurance required is not procurable, after a diligent effort has been made to do so, from among the authorized companies licensed to transact and actually writing such kind and class of insurance in this state, and the amount of insurance eligible for surplus lines shall be only the amount in excess of the amount procurable from licensed insurers.

(b) Subsection (a) shall not apply to exempt commercial purchasers if the surplus lines agent procuring or placing the policy has disclosed to the exempt commercial purchaser that such insurance may or may not be available from admitted companies that may provide greater protection with more regulatory oversight, and the exempt commercial purchaser has subsequently requested in writing that the surplus lines agent procure or place such insurance from a nonadmitted company.

(c) Policy or contract forms shall not be eligible unless the use:

(1) Is reasonably necessary for the principal purposes of the coverage;

(2) Would not be contrary to the purposes of the coverage; or

(3) Would not be contrary to the purposes of this part with respect to the reasonable protection of authorized companies from unwarranted competition by unauthorized companies.

(d) The following kinds of insurance shall not be eligible for surplus lines insurance:

( 1) Primary personal automobile liability;

(2) Surety; and

(3) Workers' compensation, except as provided in subsection (a).

**56-14-106. Verified report of surplus lines insurance transactions -- Procedure for effecting surplus lines contracts.**

(a) On an annual basis, the surplus lines agent shall promptly file with the commissioner on March 1 of each year, on forms prescribed by the commissioner, a verified report of all surplus lines insurance transactions during the proceeding period placed, procured, or effected for, or on behalf of, an insured whose home state is this state, showing:

(1) Aggregate gross premiums written;

(2) Aggregate return premiums;

(3) Amount of tax remitted to this state; and

(4) Except for insurance placed or procured on behalf of an exempt commercial purchaser, a sworn statement by the agent with regard to the coverages described in the report that, to the best of the agent's knowledge and belief, the agent could not reasonably procure such coverages from an admitted insurer.

Policies written for an exempt commercial purchaser do not have to be included in the annual report.

(b) Within thirty (30) days of the end of each calendar month, the surplus lines agent shall make an affidavit for every new or renewed surplus lines insurance contract placed, procured or effected for, or on behalf of, an insured whose home state is this state within such calendar month, in the form prescribed by the commissioner. The affidavit shall be promptly filed with the commissioner and shall include an affirmation that the agent is, after diligent effort, unable to procure from an admitted company or admitted companies the full amount of insurance required to protect the interest of the insured for each surplus lines insurance transaction except those procured or placed for exempt commercial purchasers.

(c) Upon placing a new or renewed surplus lines insurance coverage, the surplus lines agent shall promptly issue and deliver to the insured evidence of the insurance consisting either of the policy as issued by the insurer or, if the policy is not then available, a certificate, cover note, or other confirmation of insurance.

(d) No surplus lines agent shall deliver the document required by subsection (c), or purport to insure or represent that insurance will be or has been granted by any unauthorized insurer, unless:

> (1) The agent has prior written authority from the insurer for the insurance;
>
> (2) The agent has received information from the insurer in the regular course of business that the insurance has been granted; or
>
> (3) An insurance policy providing the insurance actually has been issued by the insurer and delivered to the insured.

(e) If, after the delivery of the document required by subsection (c), there is any change as to the identity of the insurers, or the proportion of the direct risk assumed by the insurer as stated in the original certificate, cover note, or confirmation, or in any other material respect as to the insurance coverage evidenced by the document, the surplus lines agent shall promptly deliver to the insured a substitute certificate, cover note, confirmation, or endorsement for the original document, accurately showing the current status of the coverage and the insurers responsible under the coverage. No such change shall result in a coverage or insurance contract that would be in violation of this part if originally issued on that basis.

(f) If a policy issued by the insurer is not available upon placement of the insurance and the surplus lines agent has delivered a certificate, cover note, or confirmation upon request by the insured, the surplus lines agent shall as soon as reasonably possible procure from the insurer its policy evidencing the insurance and deliver the policy to the insured in replacement of the certificate, cover note, or confirmation that was previously issued.

**56-14-107. Requirements for surplus lines contracts.**

(a) For each insured whose home state is Tennessee, every new or renewed insurance contract certificate, cover note, or other confirmation of insurance procured and delivered as a surplus line insurance coverage pursuant to this part shall bear the name and address of the writing agent and shall have stamped, affixed, or printed upon it the following:

> This insurance contract is with an insurer not licensed to transact insurance in this state and is issued and delivered as a surplus lines coverage pursuant to the Tennessee insurance statutes.

(b) The document shall show the description and location of the subject of the insurance, coverage, conditions, and term of the insurance, the premium and rate charged and premium taxes to be collected from the insured, and the name and address of the insured and insurer. If the direct risk is assumed by more than one (1) insurer, the document shall state the name and address and proportion of the entire direct risk assumed by each insurer.

**56-14-108. Eligibility of surplus lines insurers.**

(a) An insurer shall not engage in the transaction of insurance unless authorized to do so pursuant to a valid license, exempted by this part or otherwise exempted by the insurance laws of this state.

(b) A person who does not have a valid license as required by subsection (a) shall not engage in the transaction of insurance or act in this state directly or indirectly as agent for, or otherwise represent or aid on behalf of another, a nonadmitted insurer in the solicitation, negotiation, procurement, or effectuation of insurance, or renewals thereof, or forwarding of applications, delivery of policies or contracts, inspection of risks, fixing of rates, investigation or adjustment of claims or losses, collection or forwarding of premiums, or in any other manner represent or assist the insurer in the transaction of insurance.

(c) A person who represents or aids a nonadmitted insurer in violation of this section shall be subject to the penalties set forth in § 56-14-117. No insurance contract entered into in violation of this section shall preclude the insured from enforcing his or her rights under the contract in accordance with the terms and provisions of the contract of insurance and the laws of this state, to the same degree those rights would have been enforceable had the contract been lawfully procured.

(d) This section shall not apply to a person, properly licensed as an agent or broker in this state who, for a fee and pursuant to a written agreement, is engaged solely to offer the insured advice, counsel or opinion, or service with respect to the benefits, advantages or disadvantages promised under any proposed or in-force policy of insurance if the person does not, directly or indirectly, participate in the solicitation, negotiation, or procurement of insurance on behalf of the insured.

(e) This section shall not apply to a person acting in material compliance with the insurance laws of this state in the placement of the types of insurance identified in the following subdivisions:

> (1) Surplus lines insurance as provided in§ 56-14-103. For the purposes of this subsection (e), a license shall be deemed to be in material compliance with the insurance laws of this state, unless the licensee committed a violation of§ 56-14-103 that proximately caused loss to the insured;

(2) Transactions for which a certificate of authority to do business is not required of an insurer under the insurance laws of this state;

(3) Reinsurance, unless the commissioner waives the requirements of this subdivision:

(A) The assuming insurer is authorized to engage in an insurance or reinsurance business by its domiciliary jurisdiction and is authorized to write the type of reinsurance in its domiciliary jurisdiction; and

(B) The assuming insurer satisfies all legal requirements for such reinsurance in the state of domicile of the ceding insurer;

(4) The property and operation of railroads or aircraft engaged in interstate or foreign commerce, wet marine, and transportation insurance; and

(5) Transactions subsequent to issuance of a policy not covering properties risks or exposures located, or to be performed in this state at the time of issuance, and lawfully solicited, written or delivered outside this state.

**56-14-109. Unauthorized insurers.**

**(a)** No surplus lines agent shall place any coverage with a unauthorized insurer that is not an eligible surplus lines insurer as provided under this section.

**(b)** No unauthorized insurer shall be or become an eligible surplus lines insurer, unless:

**(1)** The unauthorized insurer is a United States domiciled insurer and it is authorized to write the type of insurance in its domiciliary jurisdiction and one of the following criteria is met:

**(A)** The unauthorized insurer has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which equals the greater of:

**(i)** The minimum capital and surplus requirements under the law of this state; or

**(ii)** Fifteen million dollars ($15,000,000); or

**(B)** If the unauthorized insurer does not satisfy the requirements of subdivision (b)(1)(A), the commissioner makes an affirmative finding that the unauthorized insurer is acceptable. The commissioner's finding shall be based upon such facts as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the unauthorized insurer's capital and surplus is less than four million five hundred thousand dollars ($4,500,000); or

**(2)** The unauthorized insurer is not a United States domiciled insurer but is listed by the NAIC International Insurers Department.

**(c)** If, at any time the commissioner has reason to believe that any unauthorized insurer then on the list of eligible surplus lines insurers no longer meets conditions of eligibility, has willfully violated the laws of this state or does not conduct a proper claims practice, the commissioner may declare it ineligible.

**(d)** The commissioner shall promptly mail notice of all declarations made pursuant to subsection (c) to each surplus lines agent at the agent's most recent address that is on record with the commissioner.

**56-14-110. Validity of contracts.**

(a) Insurance contracts procured as surplus line insurance coverage from unauthorized companies in accordance with this part shall be fully valid and enforceable as to all parties, and shall be given recognition in ail matters and respects to the same effect and extent as like contracts issued by authorized companies.

(b) A contract of insurance placed in effect by an unauthorized company in violation of this part is unenforceable by the company. The insured shall not be precluded from enforcing the insured's rights in accordance with the terms and provisions of the contract.

**56-14-111. Liability of surplus lines insurer for losses and unearned premiums.**

(a) If an unauthorized company has assumed the risk in accordance with this part, and if the premium for the insurance has been received by the surplus lines agent who placed the insurance, then in all questions thereafter arising under the coverage as between the insurance company and the insured, the insurance company shall be deemed to have received the premium due to it for the coverage. The insurance company shall be liable to the insured as to losses covered by the insurance, and for unearned premiums that may become payable to the insured upon cancellation of the insurance, whether or not, in fact, the surplus lines agent is indebted to the insurer with respect to the insurance, or for any other cause.

(b) Each unauthorized company assuming a surplus lines insurance risk under this part shall be deemed to have subjected itself to the requirements of this section.

**56-14-112. Actions against insurer -- Service of process.**

(a) An unauthorized company may be sued upon any cause of action arising in this state under any surplus lines insurance contract issued by it or certificate, cover note, or other confirmation of the insurance issued by the surplus lines agent, pursuant to the same procedure as is provided for unauthorized insurers in title 56, chapter 2, part 6 and§ 56-7-105(b). The policy issued by the insurer, or any certificate of insurance issued by the

surplus lines agent, shall contain a provision stating the substance of this section and designating the person to whom the commissioner shall mail process.

(b) Each unauthorized company assuming a surplus lines insurance risk pursuant to this part shall be deemed to have subjected itself to the requirements of this section.

(c) This section shall be cumulative to any other methods that may be provided by law for service of process upon the insurer.

**56-14-113. Premiums subject to a gross premium tax -- Amount.**

**(a)** The premiums charged for surplus lines insurance are subject to a gross premium tax in an amount to be determined by subsection (b).

**(b)** **(1)** In addition to the full amount of gross premiums charged by the insurer for the insurance, every person licensed pursuant to § 56-14-104 shall collect and pay to the commissioner a sum based on the total gross premiums charged, less any return premiums, for surplus lines insurance provided by the surplus lines agent pursuant to the license. Where the insurance covers an insured whose home state is this state, the sum payable shall be computed based on an amount equal to five percent (5%) on the gross premiums, less the amount of gross premiums allocated to this state and returned to the insured.

**(2)** The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the surplus lines agent shall be returned to the policyholder directly by the surplus lines agent or through the producing broker, if any.

**(3)** The surplus lines agent is prohibited from rebating, for any reason, any part of the tax.

**(4)** The commissioner is authorized to contract or compact with other states for the purpose of collecting and disbursing to reciprocal states, defined as those participating in such contract or compact, any funds collected pursuant to subsection (a) that are applicable to other properties, risks, or exposures located or to be performed outside of this state. To the extent that other states where portions of the properties, risks, or exposures reside have failed to enter into compact or reciprocal allocation procedures with this state, the net premium tax collected shall be retained by this state.

**(5)** On March 1 of each year, at the time of filing the report as set forth in § 56-14-106, each surplus lines licensee shall pay the premium tax due for the policies written during the period covered by the report.

**(6)** For the purposes of this section, "premium" includes all premiums, membership fees, assessments, dues, or any other consideration for insurance collected under this section.

**(7)** The tax collected under this section shall be in lieu of all other insurance taxes.

**(8)** The surplus lines agent shall collect from the insured the amount of the tax at the time of delivery of the cover note, certificate of insurance, policy, or other initial confirmation of insurance, in addition to the full amount of the gross premium charged by the insurer for the insurance. No agent shall absorb the tax nor shall any agent, as an inducement for insurance or for any other reason, rebate all or any part of the tax or the agent's commission.

**(c)** All surplus lines premium taxes collected by a surplus lines agent under this section are trust funds in the agent's hands and the property of this state. Any surplus lines agent who fails or refuses to pay over to the state the surplus lines premium tax at the time required in this section, or who fraudulently withholds or appropriates or otherwise uses the money or any portions of the money belonging to the state, commits theft and shall be punished as provided by title 39, chapter 14, part 1, regardless of whether the surplus lines agent has or claims to have any interest in the money so received.

**(d)** **(1)** Any surplus lines agent or writing agent, holding the premium tax funds in trust, who fails and neglects to make returns and payments promptly and correctly as provided by subdivision (b)(5) shall forfeit and pay to the state, in addition to the amount of these taxes, an amount equal to five percent (5%) for the first month or fractional part of the first month of delinquency; provided, that should the period of delinquency exceed one (1) month, the rate of penalty will be an additional five percent (5%) for the second month or fractional part of the second month and penalty thereafter at the rate of one half of one percent (0.5%) per month of the amount of tax due, the maximum penalty not to exceed ten thousand dollars ($10,000) for any agent not more than three (3) days delinquent. All delinquencies shall bear interest at the rate of ten percent (10%) per annum from the date the amount was due until paid. The penalty and interest shall apply to any part of the tax unpaid by the due date.

**(2)** The commissioner has the discretion, for good cause shown, upon application made in advance of the delinquency date, to grant an extension of time not to exceed sixty (60) days, to the surplus lines agent or writing agent, holding the premium tax funds in trust, to file the premium tax returns and pay the tax imposed in this part, without penalty attached, but the tax shall bear interest as provided in subdivision (d)(1) from the date the amount was due.

**(3)** Any surplus lines agent or writing agent, holding the premium tax funds in trust, failing to pay the tax due plus penalty and interest for sixty (60) days beyond the due date may thereafter be debarred from transacting any business of insurance in the state until these taxes and penalties are fully paid, and the commissioner shall revoke the license of the surplus lines agent or writing agent.

**(4)** The commissioner is authorized to promulgate rules that provide for a convenience fee to cover the cost of accepting electronic monthly affidavits, annual reports and tax payments. Any fee set by rule under the authority of this subdivision (d)(4) may be

assessed in addition to any applicable penalty and interest. In no event shall the convenience fee exceed the actual costs incurred by the department in accepting electronic monthly affidavits, annual reports and tax payments. Any convenience fee may be collected from the insured in addition to the premium and tax.

**(e)** If the property of any surplus lines agent is seized upon any mesne or final process in any court in this state, or when the business of any surplus lines agent is suspended by the action of creditors or put into the hands of any assignee, receiver or trustee, all surplus lines premium tax money and penalties due the state from the surplus lines agent shall be considered preferred claims, and the state shall be a preferred creditor and shall be paid in full.

**(f)** The attorney general and reporter, upon request of the commissioner, shall proceed in the courts of this or any other state or in any federal court or agency to recover the tax not paid within the time prescribed in this section.

**56-14-114. Advertising.**

Any agent who is granted a surplus lines license in accordance with this part may bring announcements or statements before the public in respect to the agent's ability to place surplus lines insurance as may be permitted by this part.

**56-14-115. Commissions.**

Agents licensed in accordance with this part may not pay the whole or any part of the commission on surplus lines insurance to any person, except that the commissions may be shared or divided with any other person licensed by the commissioner as a surplus lines agent.

**56-14-116. Keeping of records.**

**(a)** Each surplus lines agent shall keep in the agent's office in this state a full and true record of each surplus lines contract procured by the agent for or on behalf of an insured whose home state is the state of Tennessee, including a copy of the daily report, if any, and showing such of the following items as may be applicable:

**(1)** Amount of the insurance and perils insured against;

**(2)** Brief general description of property insured and where located;

**(3)** Gross premium charged;

**(4)** Return premium paid, if any;

**(5)** Rate of premium charged upon the several items of property;

**(6)** Effective date of the contract and its terms;

**(7)** Name and post office address of the insured;

**(8)** Name and home office address of the insurer;

**(9)** Amount collected from the insured; and

**(10)** Other information as required by the commissioner.

**(b)** The record shall at all times be open to examination by the commissioner without notice, and shall be kept available and open to the commissioner for three (3) years next following expiration or cancellation of the contract.

**56-14-117. Violations and penalties.**

Any violation of this part shall subject the agent to the revocation or suspension of the surplus lines agent's license for a period of not less than one (1) year and a fine of not more than five hundred dollars ($500).

# RATES & POLICIES

**56-5-301. Application of part.**

This part applies to all kinds of insurance written on risks in this state by any insurer authorized to do business in this state, except:

(1) Life insurance;

(2) Annuities;

(3) Disability insurance;

(4) Ocean marine insurance;

(5) Reinsurance;

(6) Aircraft liability and aircraft hull insurance;

(7) Title insurance;

(8) Credit life insurance; and

(9) Credit accident and health insurance.

**56-5-302. Part definitions.**

As used in this part, unless the context otherwise requires:

(1) "Advisory organization" means any person or organization, other than a rate service organization, that assists insurers as authorized by § 56-5-311;

(2) "Advisory prospective loss costs" means historical aggregate losses and loss adjustment expenses projected through development to their ultimate value and through trending to a future point in time. "Advisory prospective loss costs" does not include provisions for profit or for expenses other than loss adjustment expenses;

(3) "Commercial risk insurance" means insurance within the scope of this part that is not personal risk insurance;

NOTE: The Commercial Risk Cancellation Law applies to risk defined in this section which is all lines except those lines listed in 56-5-301 and Personal Risk Insurance as defined in this section.

(4) "Commissioner" means the commissioner of commerce and insurance;

(5) "Joint underwriting" means a voluntary arrangement established on an ad hoc basis to provide insurance coverage for a commercial risk pursuant to which two (2) or more insurers separately contract with the insured at a price and under policy terms agreed upon between the insurers;

(6) "Multiplier" means a workers' compensation insurance company's determination of the profits and expenses, other than loss expense and loss adjustment expense, all other applicable rating factors, including, but not limited to, schedule rating, experience rating and small deductible credits, and deviation from advisory prospective loss costs associated with writing workers' compensation insurance, which shall be expressed as a single multiplicative factor to be applied equally and uniformly to the advisory prospective loss costs approved by the commissioner in making rates for all classification of risks utilized by the company;

NOTE: Paragraph 6 means that for WC, a company can have only one LCM. See 56-5-306(c)

(7) "Personal risk insurance" means property and casualty insurance that provides:

(A) Insurance on one (1) to four (4) family dwelling units, including mobile homes;

(B) Individual insurance on household goods in dwellings, mobile homes, apartments, or other residential facilities;

(C) Insurance on every kind of farm property or farm risk, including farm premises, buildings, machinery, equipment, motor vehicles, livestock, and other personal property used in farming operations;

(D) Insurance on private passenger non-fleet motor-driven vehicles, not used for hire, which are used for personal, farm or family needs. The motor-driven vehicles include pickups, station wagons, vans, and vehicles with fewer than four (4) wheels;

(E) Insurance on pleasure watercraft that are used for personal, farm or family needs; and

(F) Insurance sold in connection with and incidental to rental agreements for a period not to exceed ninety (90) days;

(8) “Pool” means a voluntary arrangement other than a residual market mechanism, established on an on-going basis, pursuant to which two (2) or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement;

(9) “Rate” includes advisory prospective loss costs;

(10) “Rate service organization” means any person or organization that assists insurers in ratemaking or filing as authorized by § 56-5-310;

(11) “Rate service organization” and “advisory organization” do not include joint underwriting organizations, actuarial, legal or other consultants, a single insurer, any employees of an insurer, or insurers under common control or management or their employees or managers;

(12) “Residual market mechanism” means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance that may be afforded applicants who are unable to obtain insurance through ordinary methods;

(13) “Supplementary rate information” includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, loss adjustment expense, including defense costs incurred for any reason under the policy, and any other similar information needed to determine the applicable rate in effect or to be in effect; and

(14) “Supporting information” means:

(A) The experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer;

(B) The interpretation of any statistical data relied upon by the filer;

(C) A description of methods used in making the rates; and

(D) Other similar information relied upon by the filer.

**56-5-305. Filing by personal risk insurers.**

(a) Every insurer of personal risk insurance shall file with the commissioner all rates, supplementary rate information, supporting information, policy forms, and endorsements at least thirty (30) days before the proposed effective date.

(b) The commissioner may give written notice, within thirty (30) days of the receipt of the filing, that the commissioner needs additional time, not to exceed thirty (30) days from the date of such notice, to consider the filing.

(c) Upon written application by the insurer, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof.

(d) (1) A filing shall be deemed to meet the requirements of this part and to become effective unless disapproved by the commissioner before the expiration of the waiting period or an extension thereof.

(2) Whenever a filing made pursuant to this section is not accompanied by sufficient supporting information, the commissioner shall inform the insurer as to what information is required to complete the filing.

(3) The filing shall not be deemed to be made until such information is furnished.

**56-5-306. Filing by commercial risk insurers.**

(a) (1) Except as provided in subsections (b) and (c), every insurer of commercial risk insurance shall file with the commissioner all rates, supplementary rate information, policy forms and endorsements, not later than fifteen (15) days after the effective date; provided, that such rates, supplementary rate information, policy forms and endorsements need not be filed for inland marine risks which by general custom of the business are not written according to manual rules of rating plans. Upon request of the commissioner, supporting information shall also be filed.

(2) The commissioner may, after a hearing providing not less than twenty (20) days' written notice to the insurer, disapprove any policy form or endorsement already in effect if it does not comply with the law or with rules adopted pursuant to this part or if it contains any provision which is unfair, deceptive or misleading. Any such disapproval order shall specify the reasons for the commissioner's findings and the date, not less than thirty (30) days after issuance of the order, when the disapproval is effective, and it shall thereafter be unlawful for the insurer to use the form or endorsement in this state.

(b) With respect to workers' compensation insurance, a rate service organization designated by one (1) or more insurers shall develop and file for approval with the commissioner in accordance with the provisions of this section, a filing on behalf of authorized insurers containing advisory prospective loss costs and supporting actuarial and statistical data for workers' compensation insurance. An advisory prospective loss costs filing shall become effective only when approved pursuant to § 50-6-402.

(c) Each workers' compensation insurer, or group of insurers under common ownership, shall individually file with the commissioner the multiplier and supporting information not later than fifteen (15) days after the effective date, and at least annually thereafter on March 1. Multipliers shall apply to the most recently approved, currently effective advisory prospective loss cost.

NOTE: This means the LCM must apply to the currently approved loss cost for the NCCI. Company does not have the option to not adopt NCCI loss cost filings. A carrier may change LCM as often as they want as long as they file it with department. They are supposed to refile every March 1 regardless of whether they have filed changes or not.

(d) All multipliers filed pursuant to subsection (c) shall be actuarially justified and shall be certified by a member in good standing of the Casualty Actuarial Society.

**56-5-307. Inspection of filings - Surcharges - Residual market mechanisms - Alternative filings**

**(a) Filings Open to Inspection.** All rates, supplementary rate information, policy forms, endorsements, and any supporting information filed under this part shall, as soon as filed, be open to public inspection at any reasonable time, except any information that is a trade secret under the Uniform Trade Secrets Act, compiled in title 47, chapter 25, part 17, as determined by the commissioner in the commissioner's sole discretion. The insurer or filer shall have the burden of asserting to the commissioner that the information is a trade secret. Insurers may file certain information with the commissioner for a determination as to whether it would be held to be a trade secret under this subsection (a). Such information shall not be made public during the pendency of the review. Should it be determined that such information is not trade secret information, then the commissioner shall return such information to the insurer or filer. Copies of public information may be obtained by any person on request and upon payment of a reasonable charge.

**(b) Consent to Rate**. Notwithstanding any other provisions of this part, upon written application of an insured, stating specific reasons why a risk requires higher than standard rates on file by an insurer, a rate in excess of that provided by a filing otherwise applicable may be used on a specific risk. An endorsement shall be attached to the policy, giving the reasons and the percentage of surcharge. A copy of the endorsement shall be kept by the insurer and its agent. The copies shall be made available to the commissioner

upon request for review to determine that the rates are not excessive, inadequate or unfairly discriminatory.

**(c) Residual Market Mechanism.** No filing, whether personal or commercial risk, shall be used for a residual market mechanism until it has become effective pursuant to § 56-5-305.

**(d) Rate Service Organization Filings.**

(1) (A) The filings required by §§ 56-5-305 and 56-5-306, except § 56-5-306(c), including advisory prospective loss costs, other than rates for policies issued pursuant to any residual market mechanism for workers' compensation insurance established under § 56-5-314, may be made by a rate service organization designated by an insurer.

(B) The filings required by § 56-5-306 for rates for polices issued pursuant to any residual market mechanism established under § 56-5-314 for workers' compensation insurance shall be made by a rate service organization designated by the commissioner.

(2) An insurer may make a filing, for lines other than workers' compensation, in compliance with §§ 56-5-305 and 56-5-306 and by giving written notice to the commissioner that the insurer is following rates as filed by a rate service organization in a particular line with any exceptions clearly set forth as are necessary to fully inform the commissioner.

**(e) Reference Filings**. An insurer may file by reference to rates, supplementary rate information, supporting information, and policy forms and endorsements filed by and effective for another insurer or a rate service organization.

**(f) Number of Rate Filings.** A company shall not be limited in the number of rate filings which a company may file in any one (1) calendar year; however, should a company make more than one (1) rate filing in one (1) calendar year for a single type of insurance coverage, the company shall pay to the commissioner for each additional rate filing the fee of two hundred and fifty dollars ($250) as well as all costs incurred by the commissioner for an actuarial review of the rate filing. The fee provided for by this subsection (f) and cost requirements shall not apply to advisory prospective loss cost filings by the commissioner's designated rate service organization.

**56-5-309. Information for insureds -- Review for aggrieved persons -- Civil penalty -- Rule-making authority.**

(a) **Information to Be Furnished Insureds.** Every insurer or rate service organization shall, within a reasonable time after receipt of a written request and upon payment of a reasonable charge, furnish to any insured affected by a rate published by it, all pertinent information as to such rate.

(b) **Aggrieved Persons**. Every insurer and rate service organization shall provide within this state reasonable means whereby any person aggrieved by the application of its rating system may be heard on written request to review the manner in which such rating system has been applied in connection with the insurance afforded. If the insurer fails to grant or reject such request within thirty (30) days, the applicant may proceed in the same manner as if the application had been rejected. Any party affected by the action of such insurer on such request may, within thirty (30) days after written notice of such action, appeal to the commissioner who, after a hearing held upon not less than ten (10) days' written notice to the appellant and to such insurer, may affirm, modify, or reverse such action.

**(c)** After notice and hearing in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, the commissioner may impose a civil penalty of up to ten thousand dollars ($10,000) per occurrence, upon a finding that a workers' compensation insurer, without any lawful basis, has assessed an employer premium:

**(1)** For individuals who are not employees; or

**(2)** On the basis of improper classification of employees

**(d)** The commissioner shall have the authority to promulgate rules, including public necessity rules, to effectuate the provisions of this section. Such rules may provide the commissioner with the authority to assess the charges of the administrative procedures division of the office of the secretary of state for any administrative hearing conducted under this section.

**56-5-314. Joint underwriting, pools, residual market mechanisms, and workers' compensation assigned risk plans.**

(a) Authorization. Notwithstanding § 56-5-313(a), insurers participating in joint underwriting, pools or residual market mechanisms may, in connection with the activity, act in cooperation with each other in the making of rates, supplementary rate information, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss and expense statistics or other information, and in the conduct of research. Joint underwriting, pools and residual market mechanisms shall not be deemed rate service or advisory organizations.

(b) Regulation. (1) Except to the extent modified by this section, insurers participating in joint underwriting, pool or residual market mechanisms are subject to this part.

(2) Every pool shall file with the commissioner:

(A) A copy of its constitution, articles of association or incorporation, bylaws, and any other rules or regulations governing its activities;

(B) A list of its members;

(C) The name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served; and

(D) Any changes in the filings under subdivisions (b)(2)(A)-(C).

(3) Any residual market mechanism, plan or agreement to implement the mechanism, and any amendments to the mechanism, plan or agreement, shall be submitted in writing to the commissioner for approval, together with such information as the commissioner may reasonably require.

(4) If, after a hearing, the commissioner finds that any activity or practice of insurers participating in joint underwriting, pool or residual market mechanisms is unfair, unreasonable or otherwise inconsistent with this part, the commissioner shall issue a written order specifying in what respects the activity or practice is unfair, unreasonable or otherwise inconsistent with this part and require the discontinuance of the activity or practice.

(c) (1) The commissioner shall implement a plan as soon as possible for the equitable apportionment among insurers of applicants for workers' compensation insurance who are in good faith entitled to such insurance, but who are unable to procure it through ordinary methods. The plan shall provide reasonable rules governing the equitable distribution of risks by direct assignment, reinsurance, or otherwise, and their assignment to insurers, and shall provide a method whereby applicants for insurance, insured, and insurers may have a hearing on grievances and the right of appeal to the commissioner.

(2) Notwithstanding § 56-5-313(a), every insurer, except those entities under § 50-6-405(a)(2) and (c) that qualify under § 50-6-401 or § 50-6-405, and those entities under title 50, chapter 6, part 6, undertaking to transact in this state the business of either workers' compensation or employer's liability insurance, or both, and every rating organization that files rates or prospective loss costs for such insurance shall participate in the plan. No insurer shall thereafter issue a policy of workers' compensation or employer's liability insurance or undertake to transact that business in this state unless the insurer participates in the plan.

(3) (A) No later than July 1 of each year, the commissioner shall determine whether the membership of the assigned risk pool, created pursuant to this subsection (c), for the prior calendar year exceeds fifteen percent (15%) of the membership of the eligible employer market, as based on premium, excluding self-insured employers and self-insured groups. For any period in which it is determined the membership of the assigned risk pool exceeds fifteen percent (15%) of the membership of the eligible employer market, the commissioner shall issue a report to the advisory council on workers' compensation setting forth the percentage of the eligible employer market insured through the assigned risk pool and the reasons contributing to increased membership of the pool. The report shall include recommendations as to whether:

(i) The competitive state workers' compensation insurance fund, established by title 50, chapter 6, part 6, should be activated;

(ii) A plan of direct assignment on a randomized basis of all assigned risk plan policies to insurers offering workers' compensation insurance subject to subdivision (c)(4) should be implemented;

(iii) Other actions should be taken; or

(iv) No action should be taken.

(B) The advisory council shall have ninety (90) days to provide written comments to the commissioner regarding the report and recommendations. After receipt of the advisory council's comments and recommendations, the commissioner shall take action deemed appropriate; provided, that the commissioner shall hold a hearing before electing to activate the competitive state workers' compensation insurance fund or to institute a plan of direct assignment.

(4) If a direct assignment plan becomes operational, pursuant to this section, then the commissioner shall structure the randomized assignment so that small insurers do not bear a disproportionate share of risk in the market. A plan of direct assignment shall include provisions to provide that insurers who depopulated the assigned risk pool in the preceding five (5) years receive applicable take out credits to be used in determining the appropriate level of policies to be assigned to the insurers.

(5) If the commissioner elects to make the competitive state workers' compensation fund operational pursuant to subdivision (c)(3), then the fund shall not be required to meet the reserve requirements for a domestic insurance company for the first seven (7) years of operation as otherwise required by §§ 50-6-601 and 50-6-603. The commissioner shall promptly notify the governor, and the speakers of the senate and the house of representatives of the election.

(6) (A) (i) On and after January 1, 1997, the plan developed under this subsection (c) shall assign an insured in this plan to one (1) of three (3) subplans. Those subplans are:

(a) The small employer plan, for insureds not eligible for experience rating;

(b) The special risk plan, for insureds that are employers whose experience modifications are one and ten hundredths (1.10) or less; and

(c) The safety incentive plan, for all other risks.

(ii) The commissioner is authorized to establish increasing levels of premium surcharges for employers with experience modification factors in excess of one and ten hundredths (1.10). The surcharges may not exceed fifty percent (50%) for employers with modification factors in excess of two and zero hundredths (2.00).

(B) The advisory prospective loss cost for subdivisions (c)(6)(A)(i)(a) and (b) may not exceed that approved by the commissioner for the voluntary market. The commissioner shall annually establish the multiplier to be applied to the advisory prospective loss cost for the assigned risk plan. In establishing the multiplier, the commissioner shall consider the estimated cost of providing required services pursuant to this subsection (c) and the level of the multipliers in the voluntary market. (7)(A) The commissioner shall not approve a plan pursuant to this subsection which does not provide for the making available of a list of the employers insured under this subsection on request to interested persons for a reasonable fee or to the department. A reasonable fee shall only include the cost of production and mailing such list.

(B) As part of the application for insurance coverage, an employer shall elect whether to be excluded from the list provided for by this subsection. Every application for the assigned risk plan shall include the following language:

THE INSURED ELECTS TO BE EXCLUDED FROM THE LIST OF EMPLOYERS IN THE ASSIGNED RISK PLAN:

________ YES ________ NO

NOTE: For WC assigned risk, you must check YES on the application in order to keep your clients name, address, governing class code, and estimated annual premium from being public.

**56-5-320. Designated rate service organizations - Uniform statistical plan - Workers' compensation insurers - Membership - Policy forms - Uniform classification scheme - Uniform experience rating plan.**

(a) The commissioner may designate a rate service organization to assist in gathering, compiling and reporting relevant workers' compensation insurance statistical information. If the commissioner makes such a designation, every workers' compensation insurer shall record and report its workers' compensation insurance experience to such designated rate service organization as set forth in the uniform statistical plan approved by the commissioner and if requested shall file a copy of the report with the commissioner.

(b) Each workers' compensation insurer shall be a member of the workers' compensation insurance rate service organization. Each workers' compensation insurer shall adhere to the policy forms and rating rules filed by such designated rate service organization.

(c) Every workers' compensation insurer shall adhere to a uniform classification system and uniform experience and retrospective rating plans that have been filed with the commissioner by such designated rate service organization and approved by the commissioner.

(d) Subject to the approval of the commissioner, the rate service organization shall develop and file rules reasonably related to the recording and reporting of data pursuant to the uniform statistical plan, uniform experience rating plan and the uniform classification system.

(e) For workers' compensation insurance provided in the voluntary market, no schedule rating plan shall limit its application to any risk based on premium size or eligibility for experience rating; provided, that the application for such plan to any individual risk shall not result in the premium for such risk being less than the classification minimum premium established for workers' compensation insurance.

**56-5-322 Exempt Commercial Risks**

(a) For purposes of this section:

(1) "Exempt commercial risk policyholder" means an insured that either employs the services of an insurance producer licensed in property or casualty lines of authority or procures commercial risk insurance with the services of a full-time risk manager, and:

(A) Is a city, county, or metropolitan government with a population of at least fifty thousand (50,000), according to the 2010 federal census or any subsequent census;

(B) Is this state;

(C) Is a not-for-profit organization or a public entity with an annual budget of at least twenty-five million dollars ($25,000,000) in the preceding fiscal year; or

(D) Is a commercial risk policyholder that annually certifies to the department on a form designated by the department that the policyholder:

(i) Possesses a net worth of more than ten million dollars ($10,000,000) at the time the policy of insurance is issued;

(ii) Generated net revenue or sales of more than fifteen million dollars ($15,000,000) in the preceding fiscal year;

(iii) Employs more than twenty-five (25) employees per individual company or fifty (50) employees per holding company at the time the policy of insurance is issued; and

(iv) Paid annual aggregate insurance premiums of more than two hundred fifty thousand dollars ($250,000) in the preceding fiscal year of commercial risk insurance as defined in § 56-5-302, excluding any premiums paid for accident and health insurance and workers' compensation and employer's liability insurance as defined in § 56-2-201; and

(2) "Risk manager" means a person who:

(A) Holds an Accredited Advisor in Insurance (AAI) or Associate in Risk Management (ARM) designation for property and casualty lines of authority;

(B) Holds a risk management in insurance degree from an accredited college or university for property and casualty lines of authority; or

(C) Is qualified by experience, as determined by the commissioner.

(b) Section 56-5-306(a) does not apply to a commercial risk policy issued to an exempt commercial risk policyholder by an insurer of commercial risk insurance.

(c) An insurer of commercial risk insurance is subject to the penalties provided in § 56-2-305 if the:

(1) Insurer does not comply with § 56-5-306(a) relative to a commercial risk insurance policy issued to a commercial risk policyholder; and

(2) Policyholder has not filed a certification as required by subdivision (a)(1)(D).

(d) The certification form filed by a commercial risk policyholder pursuant to subdivision (a)(1)(D) shall be confidential and not subject to title 10, chapter 7, part 5.

(e) Any application or policy issued to an exempt commercial risk policyholder shall contain a disclaimer in language the same as or substantially similar to the following:

The rate provided for in this policy and all forms utilized are exempt from the filing requirements of Tenn. Code Ann. § 56-5-306. The forms which make up this policy contract are exempt from the filing requirements of Tenn. Code Ann. § 56-5-306.

**56-5-323. Workers' compensation insurer's obligation to furnish loss run history to insured.**

(a) Within ten (10) business days of receipt of a written request from an insured or an insured's designee, a commercial lines insurer shall furnish directly to the person designated in the request, a copy of the insured's loss run history for up to the previous three (3) years, or complete loss run history with the insurer if the history is less than three (3) years. A written request includes communications made by email or fax. For the purposes of this section, "receipt" means receipt by an individual or entity designated by an insurer to receive loss run history requests.

(b) If the insurer fails to provide the requested information within the time allowed in this section, the failure shall be a violation of the Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009, compiled in chapter 8, part 1, of this title, and any requestor may seek enforcement and any remedies allowed pursuant to that chapter. The commissioner may take action in accordance with § 56-2-305 for the violation of

subsection.

(c) Notwithstanding this part to the contrary, no insurer shall charge any fees to prepare and furnish one (1) three-year loss run history. However, if the insurer provides the loss run history via electronic means, then the insurer may charge a reasonable fee to provide a hard copy of the same report.

## Contract Interpretation

### 56-7-102. Policies to contain entire contract - Exceptions - Construed as Tennessee contracts.

Every policy of insurance, issued to or for the benefit of any citizen or resident of this state on or after July 1, 1907, by any insurance company or association doing business in this state, except fraternal beneficiary associations and mutual insurance companies or associations operating on the assessment plan, or policies of industrial insurance, shall contain the entire contract of insurance between the parties to the contract, and every such contract so issued shall be held as made in this state and construed solely according to the laws of this state.

**Insurer's Bad Faith Penalty for Failure to Pay Promptly**

### 56-7-105. Additional liability upon insurers and bonding companies for bad-faith failure to pay promptly.

(a) The insurance companies of this state, and foreign insurance companies and other persons or corporations doing an insurance or fidelity bonding business in this state, in all cases when a loss occurs and they refuse to pay the loss within sixty (60) days after a demand has been made by the holder of the policy or fidelity bond on which the loss occurred, shall be liable to pay the holder of the policy or fidelity bond, in addition to the loss and interest thereon, a sum not exceeding twenty-five percent (25%) on the liability for the loss; provided, that it is made to appear to the court or jury trying the case that the refusal to pay the loss was not in good faith, and that such failure to pay inflicted additional expense, loss, or injury including attorney fees upon the holder of the policy or fidelity bond; and provided further, that such additional liability, within the limit prescribed, shall, in the discretion of the court or jury trying the case, be measured by the additional expense, loss, and injury including attorney fees thus entailed.

(b) In any action against an unauthorized foreign or alien insurer or bonding company upon a contract of insurance or fidelity bond issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein if the insurer or bonding company has failed for thirty (30) days after demand prior to commencement of the action to make payment in accordance with the terms of the contract or fidelity bond, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twelve and one-

half percent (12.5%) of the amount which the court or jury finds the plaintiff is entitled to recover against the insurer or bonding company, but in no event shall such fee be less than twenty-five dollars ($25.00). Failure of an insurer or bonding company to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

**Insured's Bad Faith Penalty for Actions Against Insurer**

**56-7-106. Liability on policyholders when action not brought in good faith.**

In the event it is made to appear to the court or jury trying the cause that the action of the policyholder in bringing the suit was not in good faith, and recovery under the policy is not had, the policyholder shall be liable to such insurance company, corporation, firm, or person in a sum not exceeding twenty-five percent (25%) of the amount of the loss claimed under the policy; provided, that such liability, within the limits prescribed, shall, in the discretion of the court or jury trying the cause, be measured by the additional expense, loss, or injury inflicted upon the defendant by reason of the suit.

**General Contractor as a Payee**

**56-7-111. Property or casualty insurance - General contractor as a payee.**

When insured property losses in excess of one thousand dollars ($1,000) accrue to the owners of dwellings or other structures insured under policies of property or casualty insurance as defined in § 56-2-201, the insurance company shall name the general contractor, as defined in § 62-6-102, of any uncompleted construction or building contract as a payee on the draft to the owner covering payment for the loss. The insurance company shall name the general contractor as payee on such draft pursuant to this section regardless of whether the work which was performed or is yet to be performed is less than twenty-five thousand dollars ($25,000).

**Notice of Premium Increase**

**56-7-118. Notice of premium increase.**

Any insurance company which increases its premiums shall give thirty (30) days notice of any increase to a customer who has an account paid by bank draft or pre-authorized check.

**56-7-135. Rebuttable presumption.**

(a) The signature of an applicant for or party to an insurance contract on an application, amendment, or other document stating the type, amount, or terms and conditions of coverage, shall create a rebuttable presumption that the statements provided by the person bind all insureds under the contract and that the person signing such document has read, understands, and accepts the contents of such document.

(b) The payment of premium for an insurance contract, or amendment thereto, by an insured shall create a rebuttable presumption that the coverage provided has been accepted by all insureds under the contract.

**56-7-136 Cancellation of Property Insurance after Consumer Inquiry**

(a) For purposes of this section:

(1) "Cancel" means to terminate a homeowner's insurance policy prior to the expiration of the policy period;

(2) "Claim":

(A) Means an oral, written, or electronic submission for payment filed by an insured, on behalf of the insured, or by a third party whereby an insurance company accepts the submission for payment in accordance with the insurance company's reasonable submission standards; and

(B) Does not mean an inquiry by an insured or by an insurance producer on behalf of an insured;

(3) "Inquiry" means any communication to an insurance company by an insured, or by an insurance producer on behalf of an insured, regarding general terms and conditions of a homeowner's insurance policy, including a communication concerning whether a homeowner's insurance policy provides coverage for a type of event or the process for filing a claim; and

(4) "Insurance company" has the same meaning as defined in§ 56-1-102.

(b) No insurance company shall increase a premium or cancel a homeowner's insurance policy solely on the basis of an inquiry or inquiries by an insured regarding the insured's homeowner's insurance policy or a loss under the policy.

(c) Notwithstanding the foregoing, if a communication by an insured to an insurance company necessitates an investigation by the insurance company which results in a written finding that there has been a change in a known condition or use of the premises or a fraudulent act by the consumer, then the insurance company may consider the communication to be either a claim or an inquiry.

(d) A violation of this section shall be considered an unfair trade practice under title 56, chapter 8.

# Restrictions on Use of Credit Scores

**56-5-401. Part definitions.**

As used in this part, unless the context otherwise requires:

(1) "Adverse action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of, any insurance, existing or applied for, in connection with the underwriting of personal insurance. An offer of placement with an affiliate insurer does not constitute adverse action, a refusal to insure, cancellation or nonrenewal of coverage;

(2) "Affiliate" means any company that controls, is controlled by, or is under common control with another company;

(3) "Consumer" means an insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy;

(4) "Consumer reporting agency" means any entity that, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties;

(5) "Credit information" means any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score;

(6) "Credit report" means any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's creditworthiness, credit standing or credit capacity that is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement;

(7) "Insurance score" means a number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured; and

(8) "Personal insurance", for the purposes of this part, means private passenger automobile, homeowners, motorcycle, manufactured home owners, noncommercial dwelling fire insurance, boat, personal watercraft, and recreational vehicle policies when those policies are individually underwritten for personal, family or household use.

**56-5-402. Restrictions on use of credit scores.**

An insurer authorized to do business in Tennessee that uses credit information to underwrite or rate risks for personal insurance, shall not:

(1) Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within ninety (90) days from the date the personal insurance policy is first written or renewal is issued;

(2) Use credit information unless no later than thirty-six (36) months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. The insurer is not required to comply with this subdivision (2) if:

(A) The insured is in the most favorably-priced tier of the insurer or within a group of affiliated insurers, for the type of policy covering the insured;

(B) If the insurer has determined not to use credit information in its re-evaluation of the insured upon renewal; or

(C) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within thirty (30) days of one another, unless only one (1) inquiry is considered,

(D) Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within thirty (30) days from one another, unless only one (1) inquiry is considered; or

(E) Collection accounts with a medical industry code, if so identified on the consumer's credit report;

(4) Deny, cancel or nonrenew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information;

(5) Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information;

(6) Take an adverse action against a consumer solely because the consumer does not have a credit account, without consideration of any other applicable factor independent of credit information;

(7) Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer either treats the consumer as if the consumer had neutral credit information as defined by the insurer or unless the insurer treats the consumer in a manner otherwise approved by the commissioner of commerce and insurance; and

(8) Use an insurance score that is calculated using income, gender, address, ethnic group, religion, marital status, nationality, education, or occupation of the consumer as a factor. Nothing in this subdivision (8) shall preclude an insurer from underwriting personal insurance on the basis of information in the insurance application that is not credit information.

**56-5-403. Notice to consumer of adverse action.**

If an insurer takes an adverse action based on factors that include credit information, the insurer must provide notice to the consumer that an adverse action has been taken. That notice must contain the reason or reasons for the adverse action, described in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. The notice must include a description of up to four (4) factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" does not meet the explanation requirements of this section. Standardized credit explanations provided by consumer reporting agencies or other third party vendors are deemed to comply with this section.

**56-5-404. Indemnification.**

An insurer shall indemnify, defend, and hold an insurance producer harmless from and against all liability, fees and costs arising out of or relating to the actions, errors or omissions of an insurance producer who obtains or uses credit history or insurance scores, or both, for an insurer, provided the insurance producer follows the instructions of or procedures established by the insurer and complies with any applicable law or act. Nothing in this section shall be construed to provide an applicant or insured with a cause of action that does not exist in the absence of this section.

**56-5-405. Filing of credit scoring models.**

Insurers that use insurance scores to underwrite or rate risks must file their scoring models or other scoring processes with the department of commerce and insurance. A filing that includes insurance scoring shall include loss experience justifying the use of credit information. Such filings shall be kept confidential by the commissioner of commerce and insurance and shall not be construed to be a public record pursuant to title 10, chapter 7.

**56-5-406. Incorrect or incomplete credit information.**

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 U.S.C. § 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within thirty (30) days of receiving the

notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid the premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last twelve (12) months of coverage or the actual policy period.

**56-5-407. Disclosure of intention to use credit information.**

(a) If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

(b) Use of the following example disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

# Valued Policy Law

NOTE: Valued Policy Law means that if there is a total loss by fire and the policy is more than ninety (90) days old or is a renewal the company must pay the face amount of the policy unless the policyholder is agreeable to something else. There is an Attorney General opinion that mobile homes that are permanently affixed on a foundation are covered by the Valued Policy Law. Contact the Insurors if you need more information on this law.

**56-7-801. Inspection of property insured against fire - No insurance exceeding fair value of property.**

(a) Within ninety (90) days after making or writing any contract of fire insurance on any building or structure in this state, the company, its designee or agent, shall cause the building or structure to be inspected.

(b) No company, agent or insurance producer shall knowingly issue, negotiate, continue or renew, or cause the permit to be issued, negotiated, continued or renewed any fire insurance policy upon property or interests in the property within this state of an amount that, with any existing insurance on the property, exceeds the fair value of the property.

**56-7-802. Measure of damages for loss by fire - Insured reimbursed for excess premiums.**

If buildings within the state insured against loss by fire are totally destroyed by fire, the company shall not be liable beyond the actual value of the insured property at the time of the loss or damage; and if it appears that the insured has paid premiums on an amount in excess of the actual value, the insured shall be reimbursed the proportionate excess or premiums paid on the difference between the amount named in the policy and the actual value, with interest at six percent (6%) per annum from the date of issue; and the excess of premiums, and interest on the premiums, shall be allowed the insured from the time any companies carrying the insurance at the time of the loss have continuously carried the insurance on the destroyed buildings, whether under policies existing at the time of the loss or under previous policies in the same companies.

**56-7-803. Measure of damages in case of agent's failure to inspect property.**

If the company, its designee or agent, fails to place a reasonable value on any insured property within the ninety-day period provided in § 56-7-801, and that is agreed to by the insured, and a loss occurs, then the value as shown by the policy or application is conclusively presumed to be reasonable, and settlement shall be made on that basis..

**Mortgagee Clause**

**56-7-804. Policies protecting trustees, mortgagees, assignees and like parties.**

When any person shall, as trustee, mortgagee, assignee, or otherwise, possess or have any fire insurance policy on realty made payable to such person, or other person as that person's interest may appear, then such insurance as to the interest of the trustee, mortgagee, assignee or other person therein named shall not be invalidated by an act or neglect of the mortgagor owner of the property so insured, nor by any foreclosure or other proceedings or notice of sale relating to the property, nor by change in title or ownership of the property, nor by occupation of the premises for purposes more hazardous than are permitted by such policy; provided, that in case the mortgagor or owner neglect to pay any premium due under such policy, the mortgagee, trustee, assignee, or other person shall on demand, pay same; and provided further, that the mortgagee, trustee, assignee, or other such person shall notify the insurance company of any change of ownership or occupancy or increase of hazard which shall come to the knowledge of the mortgagee, trustee, assignee, or other such person, and, unless permitted by the policy, it shall be noted thereon, and the mortgagee, trustee, assignee, or other person shall, on demand, pay the premium for such increased hazard for the term of the use thereof, or otherwise the policy shall be null and void; and provided further, that in the event the insurer concludes to cancel its policy under its terms, then ten (10) days' notice of such determination shall be given to the mortgagee, trustee, assignee, or other person so interested.

# Property & Casualty Guaranty Fund

**56-12-103. Scope.**

This part shall apply to all kinds of direct insurance, but shall not be applicable to:

**(1)** Life, annuity, health or disability insurance;

**2)** Mortgage guaranty, financial guaranty or other forms of insurance offering protection against investment risks;

**(3)** Fidelity or surety bonds, or any other bonding obligations;

**(4)** Credit insurance, vendors' single interest insurance, or other collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor-debtor transaction;

**(5)** Insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear or provides reimbursement for the liability incurred by the issuer of the agreements or service contracts that provide such benefits;

**(6)** Title insurance;

**(7)** Ocean marine insurance;

**(8)** Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk;

**(9)** Any insurance provided by or guaranteed by government;

**(10)** Any insurance issued on a limited or unlimited assessable basis; or

**(11)** Excess insurance.

**56-12-104. Definitions.**

As used in this part, unless the context otherwise requires:

**(7) (A)** “Covered claim” means an unpaid claim, including one for unearned premiums, submitted by a claimant, which arises out of and is within the coverage and is subject to

the applicable limits of an insurance policy to which this part applies and was issued by an insurer which is insolvent, if such insurer becomes an insolvent insurer after March 31, 1999 and:

(i) The claimant or insured is a resident of this state when the insured event occurs; provided, that for an entity other than an individual, the residence of a claimant, insured or policyholder is the state in which its principal place of business is located when the insured event occurs; or

(ii) The claim is a first-party claim for damage to property with a permanent location in this state.

(B) “Covered claim” does not include:

(i) Any amount awarded as punitive or exemplary damages;

(ii) Any amount sought as a return of premium under any retrospective rating plan;

(iii) Any amount due any reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, reinsurance recoveries, contribution, indemnification or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, or underwriting association may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the association's obligations and limitations set forth in this part or policy limits of the insured whichever amount is greater;

(iv) Any first party claim by an insured whose net worth exceeds ten million dollars ($10,000,000) on December 31 of the year next preceding the date the insurer becomes an insolvent insurer. An insured's net worth on such date is deemed to include the aggregate net worth of the insured and all of its subsidiaries as calculated on a consolidated basis; and

(v) Any first-party claims by an insured which is an affiliate of the insolvent insurer

**56-12-107. Powers and duties of association.**

(a) The association shall:

(1) (A) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or on request effects cancellation, if the insured does so within thirty (30) days of the determination, but the obligation shall include only that amount of each covered claim that is in excess of one hundred dollars ($100) and is less than one hundred thousand dollars ($100,000), except that the

association shall pay the full amount of any covered claim arising out of a workers' compensation policy. In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises;

**56-12-120. Unearned premium claims. —**

**(a)** All obligations for unearned premium claims shall include only that amount of each covered claim which is in excess of two hundred fifty dollars ($250) and is less than ten thousand dollars ($10,000).

**(b)** **(1)** Unearned premium claims arising out of workers' compensation policies shall be subject to the limitations of subsection (a).

**(2)** Unearned premium claims shall not include credit adjustments developed under retrospective rating plans.

Contact information for Property and Casualty Guaranty Fund

Ms. Jane Murphy , Administrator
Tennessee Insurance Guaranty Association
3100 West End Avenue, Suite 670
Nashville, TN 37203-5805

Phone 615-242-6839
Fax: (615) 255-4471 or (615) 255-4960

Web site: http://www.tiga.net/

# Life and Health Guaranty Association

**56-12-202. Purpose.**

**(a)** The purpose of this part is to protect, subject to certain limitations, the persons listed in § 56-12-204(a) against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in § 56-12-204(b), because of the impairment or insolvency of the member insurer that issued the policies or contracts.

**(b)** To provide this protection, an association of insurers is hereby created to pay benefits and to continue coverages as limited herein.

(c) Members of the association are subject to assessment to provide funds to carry out the purpose of this part, and shall provide such services as are necessary to implement the protections accorded to policyholders by this part.

**56-12-203. Part definitions.**

As used in this part, unless the context otherwise requires;

(5) "Covered policy" means a policy or contract, or a portion of a policy or contract, for which coverage is provided under § 56-12-204;

(6) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs;

(7) "Health insurance benefits" means benefits payable under any form of accident and health insurance policy;

(8) "Impaired insurer" means a member insurer which, after July 1, 1989, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

(9) "Insolvent insurer" means a member insurer which after July 1, 1989, is placed under an order of liquidation by a court of competent jurisdiction with a **finding of** insolvency;

**56-12-204. Applicability — Limitations on liability.**

(a) This part shall provide coverage for the policies and contracts specified in subsection (b):

(1) To persons who, regardless of where they reside except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees of persons covered under subdivision (a)(2);

(2) To persons who are owners of or certificate holders under the policies or contracts, other structured settlement annuities, and who:

(A) Are residents; or

(B) Are not residents, but only under all of the following conditions:

(i) The insurer that issued the policies or contracts is domiciled in this state;

(ii) The states in which the persons reside have associations similar to the association created by this part; and

(iii) The persons are not eligible for coverage by an association in any other state due to the fact that the insurer was not licensed in the state at the time specified in the state's guaranty association law;

(3) For structured settlement annuities specified in subsection (b), subdivisions (a)(1) and (a)(2) shall not apply, and this part shall, except as provided in subdivisions (a)(4) and (a)(5), provide coverage to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(A) Is a resident, regardless of where the contract owner resides; or

(B) Is not a resident, but only under both of the following conditions:

(i) (a) The contract owner of the structured settlement annuity is a resident; or

(b) The contract owner of the structured settlement annuity is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this part; and

(ii) Neither the payee, or the beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides;

(4) This part shall not provide coverage to a person who is a payee or the beneficiary of a contract owner resident of this state if the payee or beneficiary is afforded any coverage by the association of another state; or

(5) This part is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, such person shall not be provided coverage under this part. In determining the application of the provisions of this subdivision (a)(5) in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, beneficiary or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(b) (1) This part shall provide coverage to the persons specified in subsection (a) for direct, non-group life, accident and health, or annuity policies or contracts and supplemental contracts to any of these and for certificates under direct group policies and contracts, except as limited by this part. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities, and any immediate or deferred annuity contracts.

(2) This part shall not provide coverage for:

(A) A portion of a policy or contract not guaranteed by the insurer, or under which the risk is borne by the policy or contract owner;

(B) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(C) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(i) Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier; and

(ii) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(D) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

(i) A multiple employer welfare arrangement as defined in 29 U.S.C. § 1144;

(ii) A minimum premium group insurance plan;

(iii) A stop-loss group insurance plan; or

(iv) An administrative services only contract;

(E) A portion of a policy or contract to the extent that it provides for:

(i) Dividends or experience rating credits;

(ii) Voting rights; or

(iii) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(F) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

(G) A portion of a policy or contract to the extent that the assessments required by § 56-12-208 with respect to the policy or contract are preempted by federal or state law;

(H) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including without limitation:

(i) Claims based on marketing materials;

(ii) Claims based on side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements;

(iii) Misrepresentations of or regarding policy benefits;

(iv) Extra-contractual claims; or

(v) A claim for penalties or consequential or incidental damages;

(I) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(J) An unallocated annuity contract;

(K) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this part, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision (b)(2)(K), the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; or

(L) A policy or contract providing any hospital, medical, prescription drug or other healthcare benefits pursuant to part C or part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code, commonly known as Medicare part C & D, or any regulations issued pursuant thereto.

(c) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(1) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(2) (A) With respect to one (1) life, regardless of the number of policies or contracts:

(i) Three hundred thousand dollars ($300,000) in life insurance death benefits, but not more than one hundred thousand dollars ($100,000) in net cash surrender and net cash withdrawal values for life insurance;

(ii) One hundred thousand dollars ($100,000) in health insurance benefits; provided, for policies or contracts issued by a member insurer that becomes insolvent after January 1, 2010, the limits for health insurance benefits shall be as follows:

(a) One hundred thousand dollars ($100,000) for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values;

(b) Three hundred thousand dollars ($300,000) for disability insurance and three hundred thousand dollars ($300,000) for long term care insurance;

(c) Five hundred thousand dollars ($500,000) for basic hospital, medical and surgical insurance or major medical insurance;

(iii) Two hundred fifty thousand dollars ($250,000) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(B) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, two hundred fifty thousand dollars ($250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(C) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of three hundred thousand dollars ($300,000) in benefits with respect to any one (1) life under paragraphs (c)(2)(A) and (B) except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance under subdivision (c)(2)(A)(ii)(c) , in which case the aggregate liability of the association shall not exceed five hundred thousand dollars ($500,000) with respect to any one (1) individual; or

(ii) With respect to one (1) owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars ($5,000,000) in benefits, regardless of the number of policies and contracts held by the owner;

(D) The limitations set forth in this subsection (c) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this part may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(3) As used in this subsection (c):

(A) "Disability insurance" means insurance that provides stated benefits upon the disability of the insured as defined in the policy;

(B) "Long term care insurance" has the same meaning as set forth in § 56-42-103(5); and

(C) "Basic hospital, medical and surgical insurance or major medical insurance" means insurance that provides coverage for medical expenses incurred because of injury or illness, but does not include disability insurance, long term care insurance, Medicare supplement insurance, hospital confinement indemnity insurance, accident only insurance, specified disease insurance, loss of limb or body function insurance, or other limited benefit or supplemental health insurance excluded from the definition of health insurance in § 56-1-105.

(d) In performing its obligations to provide coverage under § 56-12-207, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Tennessee Life and Health Insurance Guaranty Association contact information.

Renee Birdwell, Assistant to the Administrator
615-242-8758
Email: tlhiga@edge.net

Web Site: http://www.tnlifega.org/contactus.cfm

Mailing address: 1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219-2433

# AUTO INSURANCE

# Financial Responsibility

**55-10-106. Immediate notice of accident.**

**(a)** The driver of a vehicle involved in an accident resulting in injury to or death of any person or property damage to an apparent extent of fifty dollars ($50.00) or more shall immediately, by the quickest means of communication, give notice of the accident to the local police department if the accident occurs within a municipality, otherwise to the office of the county sheriff or the nearest office of the state highway patrol.

**(b)** The requirements in subsection (a) shall apply to accidents occurring upon highways and the premises of any shopping center, trailer park or any apartment house complex, or any other premises that are generally frequented by the public at large.

**55-12-102. Chapter definitions.**

As used in this chapter, unless the context otherwise requires:

(12) "Proof of financial responsibility" or "proof of financial security" means:

(B)

(i) If proof is required after December 31, 2008, but prior to January 1, 2017, proof means:

(a) A written proof of liability insurance coverage provided by a single limit policy with a limit of not less than sixty thousand dollars ($60,000) applicable to one (1) accident;

(b) A split-limit policy with a limit of not less than twenty-five thousand dollars ($25,000) for bodily injury to or death of one (1) person, not less than fifty thousand dollars ($50,000) for bodily injury to or death of two (2) or more persons in any one (1) accident, and not less than fifteen thousand dollars ($15,000) for damage to property in any one (1) accident;

(c) A deposit of cash with the commissioner in the amount of sixty thousand dollars ($60,000); or

(d) The execution and filing of a bond with the commissioner in the amount of sixty thousand dollars ($60,000).

(ii) An insured holding a policy that complies with the insurance requirements of the financial responsibility law on December 31, 2008, will not be deemed to be in violation of the law if the policy meets the limits specified in subdivision (12)(B)(i)(a)-(d) as of the first renewal after December 31, 2008;

(C)

(i) If proof is required after December 31, 2016, proof means:

(a) A written proof of liability insurance coverage provided by a single limit policy with a limit of not less than sixty-five thousand dollars ($65,000) applicable to one (1) accident;

(b) A split-limit policy with a limit of not less than twenty-five thousand dollars ($25,000) for bodily injury to or death of one (1) person, not less than fifty thousand dollars ($50,000) for bodily injury to or death of two (2) or more persons in any one (1) accident, and not less than fifteen thousand dollars ($15,000) for damage to property in any one (1) accident;

(c) A deposit of cash with the commissioner in the amount of sixty-five thousand dollars ($65,000); or

(d) The execution and filing of a bond with the commissioner in the amount of sixty-five thousand dollars ($65,000).

(ii) An insured holding a policy that complies with the insurance requirements of the financial responsibility law on December 31, 2016, will not be deemed to be in violation of the law if the policy meets the limits specified in subdivision (12)(C)(i)(a)-(d) as of the first renewal after December 31, 2016;

**55-12-106. Exceptions to requirement of security and revocation -- Additional acceptable proof of financial security.**

The requirements of security and revocation contained in this chapter shall not apply to:

(1) An operator or owner, if the owner had in effect at the time of the accident, an automobile liability policy or bond with respect to the vehicle involved in the accident, except that an operator shall not be exempt under this subdivision (1) if, at the time of the accident, the vehicle was being operated without the owner's permission, either expressed or implied;

(2) An operator who is not the owner of the vehicle involved in the accident, if there was, in effect at the time of the accident, an automobile liability policy or bond with respect to driving a vehicle not owned by the operator;

(3) An operator or owner whose liability for damages resulting from the accident is, in the judgment of the commissioner, covered by another form of liability insurance policy or bond;

(4) Any owner qualifying as a self-insurer or to any operator of a vehicle owned by a person qualifying as a self-insurer as outlined in § 55-12-111;

(5) Any operator or owner of a motor vehicle involved in an accident wherein no injury

or damage was caused to the person or property of anyone other than the operator or owner;

(6) An owner of a motor vehicle, if at the time of the accident the vehicle was being operated without the owner's permission, either expressed or implied, or was parked by a person who had been operating the motor vehicle without permission;

(7) Any owner or operator who shall submit, on or before the date of revocation, proof satisfactory to the commissioner of acceptance of liability for the accident and an agreement concerning the payment of damages satisfactory to all parties claiming damages. This exemption shall not apply, however, if the owner or operator fails to carry out the terms of the agreement. The commissioner may at any time within three (3) years after the accident, upon notice of such failure, take any action that might have been taken had the agreement not been made;

(8) Vehicles owned by the United States, this state or any political subdivision of this state or any municipality therein, or to the operator of any vehicle so owned, when the vehicle is involved in an accident;

(9) Any vehicle owned and operated by a carrier subject to the jurisdiction of the department of safety or the interstate commerce commission;

(10) Any person licensed and engaged in the business of renting or leasing motor vehicles to be operated on the public highways shall be required only to furnish proof of financial ability to satisfy any judgment or judgments rendered against the person in the person's capacity as owner of the motor vehicle, and shall not be required to furnish proof of its financial ability to satisfy any judgment or judgments rendered against the person to whom the motor vehicle was rented or leased at the time of the accident;

(11) A driver or owner of a vehicle that, at the time of the accident, was parked, unless the vehicle was parked at a place where parking at the time of the accident was prohibited by any applicable law or ordinance, or unless the vehicle was parked in an otherwise unlawful manner;

(12) Any person employed by the government of the United States, while the person is acting within the scope of the office or employment and is involved in a motor vehicle accident;

(13) An owner or operator of any vehicle where there is no physical contact with another vehicle or object or person, unless a judgment has been obtained;

(14) A driver or owner of a vehicle who has submitted to the commissioner on or before the date of revocation notarized releases executed by all parties who have previously filed claims with the department as a result of the accident; or

(15) Any person who has obtained a discharge in bankruptcy that discharged all claims

against the person because of the accident listed in the petition; provided, that the discharge shall not relieve the person from the requirements of giving and maintaining proof of financial responsibility as required by § 55-12-126, and the person must pay a restoration fee of sixty-five dollars ($65.00) and pass the driver license examination.

**55-12-107. Minimum requirements of insurance policy or bond for security - Acceptable proof of existence of insurance or bond.**

(a) No policy or bond shall be effective under § 55-12-106, unless issued by an insurance company or surety company licensed to do business in this state, except as provided in subsection (b), and unless such policy or bond provides security not less than the amounts specified in § 55-12-102.

(b) No policy or bond shall be effective under § 55-12-106 with respect to any motor vehicle which was not registered in this state or which was registered elsewhere as of the effective date of the policy or bond or the most recent renewal thereof, unless the policy or bond executes a power of attorney authorizing the commissioner to accept service on its behalf of notice or process of any action upon such policy or bond arising out of such accident.

(c) The commissioner may rely upon the accuracy of the information in the report of an accident as to the existence of insurance or a bond unless and until the commissioner has reason to believe that the information is erroneous.

NOTE: Subsection (a) would effectively keep a surplus carrier from issuing a commercial auto liability policy since it cannot be used as proof of financial responsibility. 56-14-105 specifically says surplus lines companies cannot write primary personal auto liability.

**55-12-136. The Tennessee automobile insurance plan.**

Link to AIPSO web site that handles auto assigned risk applications.

(a) For the purposes of this section:

(1) "Commissioner" means the commissioner of commerce and insurance;

(2) "Department" means the department of commerce and insurance; and

(3) "Plan" means the Tennessee automobile insurance plan.

(b) (1) There is created a nonprofit, unincorporated legal entity to be known as the Tennessee automobile insurance plan.

(2) All insurance companies licensed by the department to write direct automobile liability policies in this state shall be and remain members of the plan as a condition of the companies' authority to transact insurance in this state.

(3) The plan shall perform its functions under the plan of operation established and approved under subsection (e) and shall exercise its powers through the governing committee established under subsection (c).

(c) (1) The governing committee of the plan shall consist of eleven (11) individuals serving terms as established in the plan of operation. The members of the governing committee shall be appointed by the commissioner in accordance with procedures set forth in the plan. Each member of the governing committee so selected shall represent an insurer licensed by the department to do business in this state, except that two (2) members of the governing committee shall be insurance producers licensed by the department. Vacancies on the governing committee shall be filled for the remaining period of the term in the same manner as initial appointments.

(2) The members of the governing committee appointed under prior law and serving in that capacity on May 7, 2009, shall continue to serve on the governing committee for the purpose of forming the initial operating plan under subsections (d) and (e). Such members are eligible for reappointment to the governing committee upon approval of the initial operating plan by the commissioner.

(3) In making appointments to the governing committee, the commissioner shall consider, among other factors, whether all member insurers are fairly represented.

(d) (1) The plan shall:

(A) At a minimum, in a manner fair to the insurers and equitable to their policyholders, apportion among the member insurers those applicants for automobile liability policies who are in good faith entitled to, but are unable to, procure automobile liability policies through ordinary methods. All insurance companies licensed by the department to write automobile liability insurance in this state shall subscribe to and participate in the plan;

(B) Assess member insurers the amounts necessary to pay the obligations of the plan under this section;

(C) Employ or retain persons who are necessary to handle claims and perform other duties required by the plan;

(D) Negotiate and become a party to contracts that are necessary to carry out the purpose of this section;

(E) Establish procedures whereby nominations for the governing committee will be submitted to the commissioner; and

(F) Perform other acts that are necessary or proper to effectuate the purpose of this section.

(2) With respect to any suit involving the plan:

(A) Any action relating to or arising out of this section against the plan shall be brought in a court in this state. The court shall have exclusive jurisdiction over any action relating to or arising out of this section against the plan; and

(B) Exclusive venue in any action brought against the plan is in the circuit or chancery court in Davidson County; provided, that the plan may waive such venue as to a specific action.

(e) (1) The plan shall submit to the commissioner a plan of operation and any amendments to the plan of operation necessary or suitable to assure the fair, reasonable, and equitable administration of the plan. The plan of operation and any amendments to the plan of operation shall become effective upon approval in writing by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall establish the procedures through which all the powers and duties of the plan under this section shall be performed.

(4) The plan of operation may provide that any or all powers and duties of the plan shall be delegated to a corporation, association or other organization that performs or will perform functions similar to those of the plan or its equivalent in two (2) or more states.

(f) (1) Upon request of the governing committee, the commissioner shall provide the plan with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may after notice and hearing:

(A) Suspend or revoke the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or that fails to comply with the plan of operation; or

(B) Impose a civil penalty of not more than five percent (5%) of the unpaid assessment per month on any member insurer that fails to pay an assessment when due; provided, however, that no penalty shall be less than one hundred dollars ($100) per month.

(g) (1) The plan shall be subject to examination by the commissioner. The commissioner may impose an examination fee to cover the costs of administering the examination.

(2) The governing committee shall submit to the department, not later than September 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(3) The plan shall submit all rates, supplementary rate information, supporting information, policy forms and endorsements in compliance with all applicable standards set forth in title 56, chapter 5, part 3.

(h) The plan shall be exempt from payment of all fees, except examination fees under subdivision (g)(1) and all taxes levied by this state or any of its subdivisions, except taxes levied on real or personal property.

(i) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, the plan or its agents or employees, the governing committee or the commissioner or the commissioner's representatives for any action taken by them in the performance of their powers and duties under this section.

(j) Any insurance company that is aggrieved by any ruling or decision of the commissioner made pursuant to this section shall be entitled to a review of the decision in the manner provided by the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**55-12-137. Duty of insurance company to file written proof of insurance when required - Civil penalty for violation.**

(a) Whenever, under the provisions of this chapter, any person is required to file with the commissioner of safety acceptable evidence of security, proof of financial responsibility, and such requirement may be satisfied by written proof of insurance coverage in the amounts required by this chapter, and the person is so insured, it is the duty of the insurance company with whom the person has insurance to file, upon request of the insured, the necessary information with the commissioner on a certificate or form approved by the commissioner.

(b) If any company fails or refuses to file, within the time required by this chapter, such certificate or form upon the request of an insured, reasonably made, the company shall forfeit to the insured the amount of one hundred dollars ($100) and shall be liable for damages in the amount of any damages sustained by the insured on account of the failure or refusal of the company to file the required form or certificate, such sums to be recoverable at the suit of the insured.

NOTE: This section places the burden on the insurance company to file an SR-22 if requested by the insured and the person had insurance in force when incident occurred

**55-12-138. Certification of understanding of and compliance with financial responsibility law.**

The commissioner of safety, with each application for an operator's or chauffeur's license, shall include a brief summary of Tennessee's financial responsibility law and such summary shall contain the following or similar certification to be signed by the applicant: "I CERTIFY THAT I UNDERSTAND ABOUT TENNESSEE'S FINANCIAL RESPONSIBILITY LAW AND I AGREE TO ABIDE BY IT."

**55-12-139. Compliance with financial responsibility law required - Evidence of compliance - Issuance of citations by police service technicians.**

NOTE: Section (a) removes mobile equipment from having to comply with financial responsibility law. This change keeps coverage for mobile equipment under the CGL policy.

(a) This chapter shall apply to every vehicle subject to the registration and certificate of title provisions.

(b)

(1)

(A) At the time the driver of a motor vehicle is charged with any violation under chapters 8 and 10, parts 1-5, and chapter 50 of this title; any other local ordinance regulating traffic; or at the time of an accident for which notice is required under § 55-10-106, the officer shall request evidence of financial responsibility as required by this section.

(B) In case of an accident for which notice is required under§ 55-10-106, the officer shall request evidence of financial responsibility from all drivers involved in the accident without regard to apparent or actual fault.

(C) If the driver of a motor vehicle fails to show an officer evidence of financial responsibility, or provides the officer with evidence of a motor vehicle liability policy as evidence of financial responsibility, the officer shall utilize the vehicle insurance verification program as defined in § 55-12-203 and may rely on the information provided by the vehicle insurance verification program, for the purpose of verifying evidence of liability insurance coverage.

(2) For the purposes of this section, "financial responsibility" means:

(A) Documentation, such as the declaration page of an insurance policy, an insurance binder, or an insurance card from an insurance company authorized to do business in this state, whether in paper or electronic format, stating that a policy of insurance meeting the requirements of this chapter has been issued;

(B) A certificate, valid for one (1) year, issued by the commissioner of

safety, stating that:

(i) A cash deposit or bond in the amount required by this chapter has been paid or filed with the commissioner of revenue; or

(ii) The driver has qualified as a self-insurer under§ 55-12-111; or

(C) The motor vehicle being operated at the time of the violation was owned by a common carrier subject to the jurisdiction of the department of safety or the interstate commerce commission, or was owned by the United States, this state, or any political subdivision thereof, and that the motor vehicle was being operated with the owner's consent.

**(c) (1)** It is an offense to fail to provide evidence of financial responsibility pursuant to this section.

**(2)** Except as provided in subdivision (c)(3), a violation of subdivision (c)(1) is a Class C misdemeanor punishable only by a fine of not more than one three hundred dollars ($300).changes effective 7-1-15

**(3) (A)** A violation of subdivision (c)(1) is a Class A misdemeanor, if a person is not in compliance with the financial responsibility requirements of this chapter at the time of an accident resulting in bodily injury or death and such person was at fault for the accident.

**(B)** For purposes of subdivision (c)(3)(A), a person is at fault for an accident if the person acted with criminal negligence, as defined in § 39-11-106, in the operation of such person's motor vehicle.

**(C)** A violation of subdivision (c)(1) is a Class A misdemeanor, if a person acts to demonstrate financial responsibility as required by this section by providing proof of motor vehicle liability insurance that the person knows is not valid.

**(4)** If the driver of a motor vehicle fails to provide evidence of financial responsibility pursuant to this section, an officer may tow the motor vehicle as long as the officer's law enforcement agency has adopted a policy delineating the procedure for taking such action.

**(d)** The fines imposed by this section shall be in addition to any other fines imposed by this title for any other violation under this title.

**(e) (1)** On or before the court date, the person so charged may submit evidence of financial responsibility at the time of the violation. If it is the person's first violation of this section and the court is satisfied that the financial responsibility was in effect at the time of the violation, the charge of failure to provide evidence of financial responsibility shall be dismissed. Upon the person's second or subsequent violation of this section, if

the court is satisfied that the financial responsibility was in effect at the time of the violation, the charge of failure to provide evidence of financial responsibility may be dismissed. Any charge that is dismissed pursuant to this subsection (e) shall be dismissed without costs to the defendant and no litigation tax shall be due or collected, notwithstanding any law to the contrary.

(2) A person who did not have financial responsibility that was in effect at the time of being charged with a violation of subsection (c) shall not have that person's violation of subsection (c) dismissed.

(f) (1) Notwithstanding any law to the contrary, in any county having a population in excess of seven hundred fifty thousand (750,000), according to the 2000 federal census or any subsequent federal census, police service technicians are authorized to issue traffic citations in lieu of arrest pursuant to § 55-10-207.

(2) For the purposes of subdivision (f)(1) only, "police service technician" means a person appointed by the director of police services, who responds to requests for service at accident locations and obtains information, investigates accidents and provides other services to assist the police unit, fire unit, ambulance, emergency rescue and towing service.

(g) For purposes of this section, acceptable electronic formats include display of electronic images on a cellular phone or any other type of portable electronic device.

(h) If a person displays the evidence in an electronic format pursuant to this section, the person is not consenting for law enforcement to access any other contents of the electronic device.

**55-12-140. Renewal of vehicle registration.**

(a) The record of conviction of an offense under § 55-12-139(c) shall be promptly transmitted to the department of safety. For any such conviction occurring after July 1, 2009, upon request by the commissioner of safety, the commissioner of revenue shall not issue a renewal of registration for any vehicle for which evidence of financial responsibility is required under § 55-12-139 until the person who was convicted of violating § 55-12-139(c) furnishes proof of financial responsibility as defined in § 55-12-139(b).

(b) This section shall not apply to any person who was in compliance with this chapter, at the time of the citation under § 55-12-139(c) but was unable to produce evidence of compliance at the time of the citation.

**56-7-1101. Priority and applicability of coverages.**

(a) (1) In all cases arising out of the use of a motor vehicle on which the owner of the motor vehicle has any insurance coverages, the owner's policy is primary if the vehicle is

being operated with the permission of the owner and within the scope of the permission granted.

(2) Any other coverages which may be available to the permittee are not applicable unless and until the limits of all coverages provided by the owner's policy first are exhausted.

NOTE: Insurance of vehicle owner is primary EXCEPT when vehicle is owned by dealer. The garage policy is excess and the insurance of the person driving dealer's vehicle is primary.

(b) Any provision of subsection (a)(1) or (a)(2) to the contrary notwithstanding, where the only insurance coverage provided by the owner of such vehicle is under a garage policy, then any coverage which may be available to the permittee shall be primary and the coverage under the owner's garage policy shall not be applicable unless and until the limits of all coverage available to the permittee shall be first exhausted; provided, that when any nonowned vehicle is in the possession, custody or control of a person who is in the business of storing, parking, servicing or repairing vehicles, then any insurance available to the owner shall not be applicable unless and until all insurance that is available under a garage policy of such person in possession has been exhausted.

(c) When a claim arises out of the operation of a motor vehicle which is leased, under a written lease agreement, and pursuant to which agreement the lessee provides coverage for the vehicle, then any other coverage which may be available for the vehicle through the lessor is not applicable unless and until the limits of all coverage provided by the lessee for the vehicle first are exhausted.

**56-7-1106. Collision insurance purchased as a condition to financing automobile purchase.**

When a creditor or lender requires a borrower to purchase collision insurance as a condition to obtaining a loan to purchase an automobile, and sells collision, but not liability, insurance to such borrower, then the creditor or lender shall provide written notice to the borrower that no liability insurance is being sold. This written notice shall be signed by the borrower and explained to such borrower as a part of or together with the loan papers executed by such borrower.

**56-7-1110. Insurance coverage or collision damages waivers for rental cars.**

Any rental car company, offering for sale insurance coverage or collision damage waivers, shall state clearly on the front page of the rental contract that the purchaser of the insurance coverage or collision damage waiver offered may be covered for such claims on the purchaser's personal motor vehicle insurance policy, and that if such insurance coverage exists under the renter's personal insurance policy, and the coverage is confirmed, the renter may require the rental car company to submit any claims to the renter's personal insurance carrier as the renter's agent. The rental car company shall not

make any written or oral representations that it will not present claims or negotiate with the renter's insurance carrier. As used in this section, "confirmation of coverage" includes telephone confirmation from an insurance company representative.

**56-7-1111. Antique automobiles - Valuation.**

(a) If, at the request of the insurer, an appraisal of personal property to be insured under an automobile policy insuring an antique automobile is made, then, in the absence of fraud, the appraised value of such property shall be binding on the insurer if the insurer:

(1) Charges and accepts a premium for such policy (or endorsement thereto) which is based on the amount of the appraised value; and

(2) Issues such a policy (or endorsement thereto) which provides coverage of the property in the amount of the appraised value.

**56-7-1118 Compliance of automobile liability insurers with requirements of James Lee Atwood Jr. Law. Effective 1/1/2016**

(a) Automobile liability insurers, as defined in§ 55-12-203, shall comply with any requirements set forth in the James Lee Atwood Jr. Law, compiled in title 55, chapter 12, part 2, and any rules promulgated thereto.

(b) Automobile liability insurers, as defined in§ 55-12-203, shall also comply with the following requirements:

(1) Cooperate with the department of revenue or its designated agent, the department of safety, and the department of commerce and insurance in establishing, operating, and maintaining the vehicle insurance verification program, as defined in§ 55-12-203;

(2) Maintain the data necessary to verify the existence of financial responsibility, including liability insurance coverage provided to its customers pursuant to the required time period established by the department of revenue, for the vehicle insurance verification program;

(3) Maintain Internet service, pursuant to the requirements established under the James Lee Atwood Jr. Law, through which online insurance verification can take place, including responding to authorized inquiries from the department of revenue or its designated agent of the vehicle insurance verification program; and

(4) Provide security consistent with accepted insurance industry and United States motor vehicle agency standards related to the transmission of personal data.

(c) Automobile liability insurers that make a good faith effort to comply with the requirements described in subsections (a) and (b), shall have immunity from civil and administrative liability as to any action related to the good faith effort.

# James Lee Atwood, Jr. Law Effective 1/1/2016

**55-12-201 Short title.**
This part shall be known and may be cited as the "James Lee Atwood Jr. Law."

**55-12-202 Purpose of part.**

The purpose of this part is to develop and implement an efficient insurance verification program that utilizes the online verification system and data transfer standards for transmitting a full book of business specifications, model, and guide of the Insurance Industry Committee on Motor Vehicle Administration in order to verify whether the financial responsibility requirements of this chapter have been met with a motor vehicle liability insurance policy, and to provide the commissioner of revenue with the authority to develop, implement, and administer the program.

**5-12-203 Part definitions.**

As used in this part, unless the context otherwise requires:

(1) "Automobile liability insurer," "insurer," or "carrier" means an insurance carrier licensed under title 56 to provide vehicle insurance, as defined in § 56-2-201, in this state;

(2) "Commercial automobile coverage" means any coverage provided to an insured, regardless of the number of vehicles or entities covered, under a commercial coverage form and rated from a commercial manual approved by the department of commerce and insurance;

(3) "Designated agent" means a third-party vendor that the department of revenue may contract with to develop, implement, and administer the program;

(4) "Full book of business" means a business record download of an automobile liability insurer made in accordance with IICMVA Insurance Data Transfer Guide Specifications that contains the data elements described in§ 55-12-207(c)(1);

(5) "IICMVA" means the Insurance Industry Committee on Motor Vehicle Administration;

(6) "IICMVA Model" means the online insurance verification system model created by the IICMVA;

(7) "NAIC" means the National Association of Insurance Commissioners;

(8) "Unknown carrier request" means an electronic request for insurance coverage verification on a specific vehicle sent in accordance with IICMVA standards by the department of revenue or its designated agent to a carrier or carriers when the identity of

the vehicle's carrier or the insurance policy number for the vehicle is unknown; and

(9) "Vehicle insurance verification program" or "program" means an insurance verification program that is created in compliance with the online verification system and data transfer standards, specifications, model, and guide of the IICMVA, and developed, implemented, and administered by the department of revenue in compliance with this part.

**55-12-204 Development of insurance verification program -- Consultation with certain entities required.**

(a) The commissioner of revenue shall develop, implement, and administer an insurance verification program to electronically verify whether the financial responsibility requirements of this chapter have been met with a motor vehicle liability insurance policy; provided, the commissioner may contract with a designated agent to develop, implement, and administer the program.

(b) Prior to issuance of a request for proposal for the services of a designated agent or prior to developing and implementing the program, the department of revenue or, if applicable, its designated agent shall consult with the following entities to determine the details and deadlines related to the program:

(1) Automobile liability insurers;

(2) Private service providers who have successfully developed and implemented similar verification systems in other states;

(3) The department of safety; and

(4) The department of commerce and insurance.

**55-12-205 Requirements of program.**

The program shall:

(1) Be an accessible common carrier based system for on line electronic verification and data transfers of proof of motor vehicle liability insurance in accordance with IICMVA specifications and standards;

(2) Verify, on an on-demand basis minus reasonable downtime for system maintenance as agreed upon by the department of revenue, or its designated agent, and the insurer, the liability insurance status of a motor vehicle, whose status is determined:

(A) As of the time of the inquiry; or

(B) At other times not exceeding six (6) months prior to the inquiry unless otherwise agreed upon by the commissioner of revenue, or its designated agent, and the insurer;

(3)

(A) In an effort to confirm the liability insurance status of a motor vehicle in instances where the program is unable to verify the liability insurance status, require automobile liability insurers that choose only to utilize the IICMVA model to:

(i) Accept unknown carrier requests; or

(ii) Provide upon request either:

(a) A full book of business as described in § 55-12-207, current to the date of the request; or

(b) A list of vehicle identification numbers of all vehicles currently insured by the automobile liability insurer.

(B) The information in subdivision (3)(A)(ii) shall be requested no more frequently than quarterly and the automobile liability insurer may freely choose between the options described in subdivisions (3)(A)(ii)(a) and (b).

(4) Use, as warranted, multiple data elements to make insurance verification inquiries more accurately by utilizing:

(A) The automobile liability insurer's NAIC code;

(B) Vehicle identification numbers;

(C) Insurance policy numbers or policy key;

(D) The date of the verification request; and

(E) Other data elements as set forth in the most recent version of the IICMVA Model User Guide for Implementing Online Insurance Verification;

(5) Provide sufficient measures for the security and integrity of data collected by the program;

(6) Limit the usage of the information obtained through the operation of the program to the department of revenue, the department of safety, the department of commerce and insurance, law enforcement, and the judiciary to effectuate the purposes of this chapter;

(7) Utilize open data and data transmission standards as determined by the department of revenue by rule;

(8) Send requests to automobile liability insurers for verification of evidence of financial responsibility via online services established by the automobile liability insurers, or offered through a similar proprietary or common carrier electronic system in compliance with the specifications and standards of the IICMVA;

(9) Respond to a verification request within a time period established by the department of revenue, or its designated agent, and consistent with the most recent version of the IICMVA Model User Guide for Implementing Online Insurance Verification; and

(10) Work in conjunction with existing state programs and systems related to this title if necessary to carry out this part.

**55-12-206 Duties of department of revenue and/or designated agent with respect to developing and implementing program.**

In developing and implementing the program, the department of revenue and, if applicable, its designated agent shall:

(1) Consult and cooperate with automobile liability insurers in establishing and operating the program;

(2) Designate and maintain a contact person for automobile liability insurers during the development, implementation, and administration of the program;

(3) Publish a detailed guide of the program;

(4) Establish and maintain the systems necessary to make verification requests to insurers using the data elements that the department of revenue, or its designated agent, and automobile liability insurers have agreed upon and are necessary to receive accurate responses from automobile liability insurers;

(5) Implement and maintain, for all information transmitted and received, strict system and data security measures consistent with applicable industry standards as determined by the department of revenue by rule; provided, data secured by the department of revenue, or its designated agent, via the program shall not be shared with any party other than those permitted by state or federal privacy laws, including, but not limited to, the federal Driver's Privacy Protection Act of 1994 (18 U.S.C. §§ 2721 et seq.);

(6) If applicable, be responsible for keeping the designated agent informed on the implementation status, functionality, and planned or unplanned service interruptions; and

(7) Provide alternative methods of reporting for automobile liability insurers writing fewer than five hundred (500) noncommercial motor vehicle policies in this state as determined by the department of revenue.

**55-12-207 Requirements for automobile liability insurer not utilizing the IICMVA model.**

(a) If an automobile liability insurer chooses not to utilize the IICMVA model, the automobile liability insurer shall provide to the department of revenue, or its designated agent, a full book of business by the seventh day of each calendar month.

(b)

(1) Subsection (a) does not apply if the policy covers a motor vehicle that is registered as a vehicle of a political subdivision or of this state, or as a vehicle registered pursuant to§ 55-4-122 or§ 55-4-502.

(2) Subsection (a) does not preclude an automobile liability insurer from more frequent reporting.

(c)

(1)The full book of business provided pursuant to subsection (a) shall include:

(A) The vehicle identification number of each insured motor vehicle; and

(B) The automobile liability insurer's NAIC code, policy number, and effective date of each policy.

(2) Each automobile liability insurer that chooses not to utilize the IICMVA model pursuant to subsection (a) shall transmit the information described in this subsection (c) by either electronic means or by another means of transmission acceptable to the department of revenue or its designated agent.

**55-12-208 Insurer may use both IICMVA model and full book of business download process.**

Nothing in this part precludes an automobile liability insurer from utilizing both the IICMVA model and the full book of business download process described in § 55-12-207.

**55-12-209 Confidentiality of information -- Utilization of program by law enforcement officers -- Insurers permitted to utilize third-party vendors --**

**Application to vehicles insured under commercial automobile coverage -- Annual report.**

(a) Any information obtained by the department of revenue, or its designated agent, from the program is for the sole use of the department of revenue, the department of safety, the department of commerce and insurance, law enforcement, and the judiciary to effectuate this chapter and is not a public record for purposes of title 10, chapter 7, nor discoverable in the course of legal proceedings.

(b) The department of safety shall cooperate with the department of revenue in developing, implementing, and maintaining the program.

(c) A law enforcement officer from a jurisdiction that has reasonable access to the program shall utilize the program to verify proof of financial responsibility as required by§ 55-12-139.

(d) Nothing in this part precludes a law enforcement officer from a jurisdiction that does not have reasonable access to the program from utilizing the program to verify proof of financial responsibility as required by § 55-12-139.

(e) Nothing in this part prohibits an automobile liability insurer from using the services of a third-party vendor to comply with this part.

(f) This part shall not apply to motor vehicles insured under commercial automobile coverage; however, insurers of those vehicles may participate on a voluntary basis. Automobile liability insurers shall provide commercial automobile customers with evidence reflecting that the vehicle is insured under a commercial automobile policy. Sufficient evidence may include an insurance identification card that clearly identifies the policy as providing commercial automobile coverage.

(g) No later than January 1, 2019, and annually thereafter, the department of revenue and the department of safety shall issue a joint report to the general assembly, evidencing:

(1) The costs of the program to the department of revenue, insurers, and the public;

(2) The effectiveness of the program in reducing the number of uninsured motor vehicles;

(3) The number of persons complying with the financial responsibility requirements of this chapter through means other than motor vehicle liability insurance;

(4) The number of persons convicted per year for failing to show evidence of financial responsibility pursuant to § 55-12-139, and

(5) If available, the number of motor vehicle accidents involving an uninsured motorist on an annual basis since January 1, 2016.

**55-12-210 Notice to motor vehicle owner of noncompliance -- Penalties for failure to comply within specified time -- Prohibition against false or fraudulent statements -- Part does not affect other actions or penalties -- Eligibility for notice.**

(a)

(1) If there is evidence based on either the IICMVA model or the full book of business download process described in § 55-12-207 that a motor vehicle is not insured, the department of revenue shall, or shall direct its designated agent to, provide notice to the owner of the motor vehicle that the owner has fifteen (15) days from the date of the notice to provide to the department of revenue:

(A) The owner or operator's proof of financial security in a form approved by the department of revenue;

(B) Proof of exemption from the owner or operator's financial security requirements under this chapter;

(C) Proof that the motor vehicle is no longer in the owner's possession; or

(D) A statement, under penalty of perjury, that the vehicle is not in use on any public road.

(2) The notice described in subdivision (a)(1) shall include a statement that if the owner of the motor vehicle fails to comply with the requirements set forth in the notice, the owner of the motor vehicle shall be subject to a twenty-five-dollar coverage failure fee. The department of revenue or its designated agent shall transmit the notice to the owner of the motor vehicle by mailing the notice to the most recent street address or electronic mail address provided to the department of revenue by the owner.

(b)

(1) If an owner of a motor vehicle fails to provide satisfactory proof or a statement as described in subsection (a), the department of revenue shall:

(A) Impose on the owner of the motor vehicle a twenty-five-dollar coverage failure fee. Of this fee, five dollars ($5.00) shall be distributed to the county clerk of the county in which the motor vehicle is registered, five dollars ($5.00) shall be distributed to the department of safety, and the remainder shall be deposited into the uninsured motorist identification restricted fund created in § 55-12-213; and

(B) Provide a notice to the owner of the motor vehicle stating that the owner must pay the coverage failure fee described in subdivision (b)(1)(A) and provide satisfactory proof or a statement as described in subsection (a) within thirty (30) days of the date of the notice.

(2) The notice described in subdivision (b)(1)(8) shall include a statement that if the owner of the motor vehicle fails to comply with the requirements set forth in the notice, the owner of the motor vehicle shall be subject to a one hundred-dollar continued coverage failure fee and suspension or revocation of the owner's motor vehicle registration.

(c) If the owner of the motor vehicle fails to comply with the notice described in subdivision (b)(1)(8), the department of revenue:

(1) Shall impose on the owner of the motor vehicle a one hundred-dollar continued coverage failure fee, which shall be in addition to the coverage failure fee imposed under subdivision (b)(1)(A). Of this continued coverage failure fee, ten dollars ($10.00) shall be distributed to the county clerk of the county in which the motor vehicle is registered, five dollars ($5.00) shall be distributed to the department of safety, and the remainder shall be deposited into the uninsured motorist identification restricted fund created in § 55-12-213;

(2) Shall suspend or revoke the motor vehicle owner's registration; and

(3)

(A) Shall provide notice to the motor vehicle owner of the legal consequences of operating a motor vehicle with a suspended or revoked registration and without owner or operator's proof of financial security as required by this chapter, and instructions on how to effect the reinstatement of the motor vehicle owner's registration; or

(B) May direct a designated agent to provide the notice and instructions described in this subdivision (c)(3).

(d) Any action by the department of revenue to suspend or revoke the registration of a motor vehicle under this section may be in addition to an action by a law enforcement agency to impose penalties under this chapter.

(e)

(1) A person shall not provide a false or fraudulent statement to the department of revenue or its designated agent.

(2) In addition to any other penalties, a violation of subdivision (e)(1) is a

Class 8 misdemeanor.

(f) This part does not affect other actions or penalties that may be taken or imposed for violation of the owner or operator's financial security requirements of this chapter.

(g) If the vehicle is no longer insured by the automobile liability insurer of record and no other insurance company using the IICMVA model indicates coverage after an unknown carrier request under§ 55-12-205(3), the owner of the motor vehicle becomes eligible for notice as described in subsections (a) and (b).

**55-12-211 Requirements for reinstatement or renewal of registration after suspension or revocation.**

(a) The department of revenue shall not process an application for reinstatement or renewal of registration of a motor vehicle after a suspension or revocation of the registration under§ 55-12-210 until:

(1) The applicant pays all fees owed pursuant to§ 55-12-210; and

(2) The applicant pays any applicable county reinstatement fee pursuant to subsection (b).

(b) A county legislative body may vote to impose a county reinstatement fee for reinstatement or renewal of registration of a motor vehicle after a suspension or revocation of the registration under § 55-12-210. This reinstatement fee shall be in addition to any other fee imposed under this chapter and shall not exceed twenty-five dollars ($25.00).

(c) The commissioner of revenue may waive the fees imposed under§ 55-12-210 and the county clerk of the county in which the vehicle is to be registered may waive the county reinstatement fee under subsection (b), if applicable, if:

(1) The registration was suspended or revoked under§ 55-12-210; and

(2) The applicant provides proof acceptable to the department of revenue that the applicant had an owner or operator's financial security in effect for the vehicle on the date the suspension or revocation went into effect.

**55-12-212 Certification that program installed and fully operational.**

The program shall be installed and fully operational upon certification by the commissioner of revenue that the program has been successfully tested and is ready for implementation, but not later than January 1, 2017. Until such certification occurs, no law enforcement action shall be taken based on the program.

**55-12-213 Uninsured motorist identification restricted fund established.**

(a) There is established within the general fund an account to be known as the "uninsured motorist identification restricted fund."

(b) The fund shall consist of money generated from this part, less any amount distributed to the county clerks and the department of safety, and funds appropriated by the general assembly. The commissioner of revenue shall use only the money in the fund in administering this part.

(c) Any unencumbered moneys and any unexpended balance of the fund remaining at the end of any fiscal year shall not revert to the general fund, but shall be carried forward and maintained in separate accounts until expended in accordance with this part.

(d) Moneys in the fund shall be invested by the state treasurer for the benefit of the fund pursuant to § 9-4-603. Interest accruing on investments and deposits of the fund shall be returned to the fund and remain a part of the fund. The fund shall be administered by the commissioner of revenue.

**55-12-214 Effect of part on existing financial responsibility requirements.**

Nothing in this part shall alter the existing financial responsibility requirements in this chapter.

**55-12-215 No fee or surcharge to be levied on automobile liability insurers.**

Nothing in this part shall allow the department of revenue or its designated agent to levy any fee or surcharge on automobile liability insurers.

# UNINSURED MOTOR VEHICLE LAW

**56-7-1201. Requirements and types of coverage - Presumptions - Limitations of liability.**

a) Every automobile liability insurance policy delivered, issued for delivery or renewed in this state, covering liability arising out of the ownership, maintenance, or use of any motor vehicle designed for use primarily on public roads and registered or principally garaged in this state, shall include uninsured motorist coverage, subject to provisions filed with and approved by the commissioner, for the protection of persons insured under the policy who are legally entitled to recover compensatory damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness or disease, including death, resulting from injury, sickness or disease.

(1) The limits of the uninsured motorist coverage shall be equal to the bodily injury liability limits stated in the policy.

(2) However, any named insured may reject in writing the uninsured motorist coverage completely or select lower limits of the coverage but not less than the minimum coverage limits in § 55-12-107. Any document signed by the named insured or legal representative that initially rejects the coverage or selects lower limits shall be binding upon every insured to whom the policy applies, and shall be conclusively presumed to become a part of the policy or contract when issued or delivered, regardless of whether physically attached to the policy or contract. Unless the named insured subsequently requests the coverage in writing, the rejected coverage need not be included in or supplemental to any continuation, renewal, reinstatement, or replacement of the policy, or the transfer of vehicles insured under the policy, where the named insured had rejected the coverage in connection with a policy previously issued by the same insurer; provided, that whenever a new application is submitted in connection with any renewal, reinstatement or replacement transaction, this section shall apply in the same manner as when a new policy is being issued

NOTE: All auto liability policies must include UMBI at same limits as BI unless the insured rejects the coverage or selects a lower limit in writing. There is an Attorney General opinion that says if insured buys UMBI then same options must apply to UMPD. That is, they have UMPD unless rejected in writing. If rejected in writing, the rejection applies to all renewals.

(3) No uninsured or underinsured motorist coverage need be provided in this state by an excess or umbrella policy of insurance.

(b) (1) With respect to bodily injury to an insured, at a time when such insured is not occupying any motor vehicle, the insurance on the vehicle under which the injured party is an insured with the highest limits of uninsured motorist coverage shall apply, and no other uninsured motorist coverage shall apply. In no instance shall uninsured motorist coverage from more than one (1) policy be available as primary coverage, nor shall the injured party be an occupant of more than one (1) vehicle at one (1) time.

(2) With respect to bodily injury to an insured while occupying a motor vehicle owned by such insured, only the limits of uninsured motorist coverage on the vehicle in which the insured was an occupant shall apply. The limits of uninsured motorist coverage shall not be increased because of multiple motor vehicles whether covered under a single policy or multiple policies, and in no event shall the total amount of recovery from all policies and bonds, including any amount recovered under the insured's uninsured motorist coverage, exceed the limits of the insured's uninsured motorist coverage.

(3) With respect to bodily injury to an insured while occupying an automobile not owned by the insured, the following priorities of recovery under uninsured motorist coverage apply:

(A) The uninsured motorist coverage on the vehicle in which the insured was an occupant shall be the primary uninsured motorist coverage;

(B) If uninsured motorist coverage on the vehicle in which the insured was an occupant is exhausted due to the extent of compensatory damages, then the uninsured motorist coverage provided by a policy under which the insured is a named insured shall be applicable as excess coverage to the policy described in subdivision (b)(1); provided, that if the insured is covered as a named insured under more than one (1) policy, then only such policy with the highest limits of uninsured motorist coverage shall apply;

(C) If the uninsured motorist coverage provided under the policies described in subdivisions (b)(3)(A) and (B), if applicable, is exhausted due to the extent of compensatory damages, then the uninsured motorist coverage provided by a policy under which the insured is covered other than as a named insured shall be applicable as excess coverage to the policies listed in subdivisions (b)(3)(A) and (B); provided, that if the insured is covered by more than one (1) such policy, then only such policy with the highest limits of uninsured motorist coverage shall apply; and

(D) In no instance shall the insured be entitled to receive total benefits from all policies listed in subdivisions (b)(3)(A)-(C) in an amount greater than the limits of the policy providing the highest limits of uninsured motorist coverage.

(c) **(1)** Every insured purchasing uninsured motorist bodily injury coverage shall be provided an opportunity to include uninsured motorist property damage coverage, subject to provisions filed with and approved by the commissioner, applicable to losses in excess of two hundred dollars ($200). However, the deductible of two hundred dollars ($200) shall not apply if:

(A) The vehicle involved in the accident is insured by the same insurer for both collision and uninsured motorist property damage coverage; and

(B) The operator of the other vehicle has been positively identified and is solely at fault.

(2) No insurer shall be required to offer limits of such property damage coverage greater in amount than the property damage liability limits purchased by the insured. After such uninsured motorist property damage coverage has been made available to an insured one (1) time and has been rejected in writing, it need not again be made available in any continuation, renewal, reinstatement, or replacement of such policy, or the transfer of vehicles insured thereunder, unless the insured makes a written request for such coverage; provided, that whenever a new application is submitted in connection with any renewal, reinstatement, or replacement transaction, the provisions of this section shall apply in the same manner as when a new policy is being issued. As used in this section, "property damage" means damage to either the insured vehicle or property owned by an insured while in the insured vehicle.

NOTE: UMPD covers only the vehicle and owned property in the vehicle. UMPD on owned property in car is excess over any other coverage. UMPD does not cover rental of a car when insured vehicle is damaged.

(d) The limit of liability for an insurer providing uninsured motorist coverage under this section is the amount of that coverage as specified in the policy less the sum of the limits collectible under all liability and/or primary uninsured motorist insurance policies, bonds, and securities applicable to the bodily injury or death of the insured. With regard to a claim against a governmental unit, political subdivision or agency thereof, the limitations of liability established under applicable law shall be considered as limits collectible under a liability insurance policy.

(e) If the owner or operator of any motor vehicle that causes bodily injury or property damage to the insured is unknown, the insured shall have no right to recover under the uninsured motorist provision unless:

(1) (A) Actual physical contact has occurred between the motor vehicle owned or operated by the unknown person and the person or property of the insured; or

(B) The existence of the unknown motorist is established by clear and convincing evidence, other than any evidence provided by occupants in the insured vehicle;

(2) The insured or someone in the insured's behalf has reported the accident to the appropriate law enforcement agency within a reasonable time after its occurrence; and

(3) The insured was not negligent in failing to determine the identity of the other vehicle and the owner or operator of the other vehicle at the time of the accident

(f) No insurer shall increase the automobile insurance rate or premium of an insured with uninsured motorist coverage nor cancel such coverage due solely to the payment of any claim under uninsured motorist coverage.

(g) Failure of the motorist from whom the insured is legally entitled to recover damages to file the appropriate forms required by the department of safety pursuant to the Financial Responsibility Law, compiled in title 55, chapter 12, within ninety (90) days of the accident date shall create a rebuttable presumption that such motorist was uninsured at the time of such accident. After the ninety (90) days and upon paying a fee as set by the department, the commissioner shall issue a certified affidavit indicating whether such forms have been filed.

(h) An insurer's proof of compliance with the provisions of this section may be accomplished by the capture of the named insured's signature or initials, or that of the insured's legal representative, by means of electronic imaging. However, the provisions of this subsection shall not be construed to authorize utilization of an electronic image of such signature or initials for any purpose other than demonstrating insurer compliance with the requirements of this section. In accordance with the Uniform Administrative

Procedures Act, compiled in title 4, chapter 5, the commissioner of commerce and insurance shall promulgate rules prescribing fines and/or other disciplinary actions to be imposed for insurer misuse of an electronic image of such signature or initials.

**56-7-1202. "Uninsured motor vehicle" defined - Coverage of government vehicles.**

(a) (1) For the purpose of uninsured motor vehicle coverage, "uninsured motor vehicle" means a motor vehicle whose ownership, maintenance, or use has resulted in the bodily injury, death, or damage to property of an insured, and for which the sum of the limits of liability available to the insured under all valid and collectible insurance policies, bonds, and securities applicable to the bodily injury, death, or damage to property is less than the applicable limits of uninsured motorist coverage provided to the insured under the policy against which the claim is made; and

NOTE: The "sum of the limits of liability available" provides "underinsured motorists coverage". Tennessee coverage is better than "underinsured motorist" because the liability limits of the at fault party do not matter; it is the limits of liability available to the injured party that trig UM coverage. For example, policy covering injured party has $100,000 UMBI limit and at fault party has $500,000 BI limits. At faulty party hits school bus and injuries a bus load of kids with damages far in excess of his $500,000 BI limit. After court doles out BI limits your insureds kid gets only $50,000. They can collect remaining $50,000 from UMBI even though at fault party had higher BI limits than insured's UMBI limit. In our example the only limits available to our insured were $50,000.

(2) "Uninsured motor vehicle" does not include a motor vehicle:

(A) Insured under the liability coverage of the same policy of which the uninsured motor vehicle coverage is a part;

(B) Owned by, or furnished for the regular use of, the insured or any resident spouse or resident relative in the same household;

(C) Self-insured within the meaning of the Tennessee Financial Responsibility Law, compiled in title 55, chapter 12, or any similar state or federal law;

(D) Designed for use mainly off public roads except while on public roads; or

(E) While located for use as premises.

(b) Notwithstanding any other law, the applicable limits of liability for a governmental unit, political subdivision or agency thereof for claims arising out of the operation of a motor vehicle shall be considered as liability coverage available under a valid and collectible insurance policy.

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**56-7-1203. Insolvency protection limitation - More favorable protection not precluded.**

An insurer's insolvency protection shall be applicable only to accidents occurring during a policy period in which its insured's uninsured motorist coverage is in effect where the liability insurer of the tortfeasor becomes insolvent within one (1) year after the accident. Nothing in this section shall be construed to prevent any insurer from affording insolvency protection under terms and conditions more favorable to its insureds than is provided in this section.

**56-7-1204. Payment by insurer - Subrogation.**

(a) In the event of payment to any person under the coverage required by this part, and subject to the terms and conditions of such coverage, the insurer making such payment shall, to the extent thereof, be subrogated to all of the rights of the person to whom such payment has been made, and shall be entitled to the proceeds of any settlement or judgment resulting from the exercise of any rights of recovery of such person against any person or organization legally responsible for the bodily injury or property damage for which such payment is made, including the proceeds recoverable from the assets of an insolvent insurer.

(b) Payment by an insurer under the coverage required by this part shall not constitute a satisfaction of the liability of the party or parties responsible for such bodily injury or property damage under the financial responsibility laws of this state.

**56-7-1205. Minimum policy limits not increased.**

Nothing contained in this part shall be construed as requiring the forms of coverage provided pursuant to this part, whether alone or in combination with similar coverage afforded under other automobile liability policies, to afford limits in excess of those that would be afforded had the insured thereunder been involved in an accident with a motorist who was insured under a policy of liability insurance with the minimum limits described in § 55-12-107, or the uninsured motorist liability limits of the insured's policy if such limits are higher than the limits described in § 55-12-107 Such forms of coverage may include such terms, exclusions, limitations, conditions, and offsets, which are designed to avoid duplication of insurance and other benefits.

NOTE: This section prevents stacking of UM limits.

**56-7-1206. Service of process - Actions by insurers - John Doe warrants - Arbitration.**

(a) Any insured intending to rely on the coverage required by this part shall, if any action is instituted against the owner and operator of an uninsured motor vehicle, serve a copy of the process upon the insurance company issuing the policy in the manner prescribed by law, as though such insurance company were a party defendant. Such company shall

thereafter have the right to file pleadings and take other action allowable by law in the name of the owner and operator of the uninsured motor vehicle or in its own name; provided, that nothing in this subsection shall prevent such owner or operator from employing counsel of the owner's own choice; and provided further, that the evidence of service upon the insurance carrier shall not be made a part of the record.

(b) If the owner or operator of any motor vehicle which causes bodily injury or property damage to a person insured under this part is unknown and if such insured satisfies all of the requirements of § 56-7-1201(e), should suit be instituted the insured shall issue a John Doe warrant against the unknown owner or operator in order to come within the coverage of the owner's uninsured motorist policy. If the uninsured motorist's identity and whereabouts are discovered during the pendency of the proceeding, the provisions of subsection (e) shall govern the proper course of action following such discovery.

(c) The uninsured motorist provision shall not require arbitration of any claim arising thereunder nor shall the insured be restricted or prevented in any manner from employing legal counsel or instituting legal proceedings.

(d) In the event that service of process against the uninsured motorist, which was issued to the motorist's last known address, is re turned by the sheriff or other process server marked, "Not to be found in my county," or words to that effect, or if service of process is being made upon the secretary of state for a nonresident uninsured motorist and the registered notice to the last known address is returned without service on the uninsured motorist, the service of process against the uninsured motorist carrier, pursuant to this section, shall be sufficient for the court to require the insurer to proceed as if it is the only defendant in such a case.

(e) In the event the uninsured motorist's whereabouts is discovered during the pendency of the proceedings, an alias process may issue against the uninsured motorist. In such a case, the uninsured motorist shall be allowed a reasonable time within which to plead to the original process, and then the case may proceed against the uninsured motorist as if the motorist was served with process in the first instance.

(f) Notwithstanding subsection (c), if a party or parties alleged to be liable for the bodily injury or death of the insured offers the limits of all liability insurance policies available to such party or parties in settlement of the insured's claim, the insured or the insured's personal representative may accept the offer, execute a full release of the party or parties on whose behalf the offer is made and preserve the right to seek additional compensation from the insured's uninsured motorist insurance carrier upon agreement of the insured or the insured's personal representative to submit the insured's uninsured motorist claim to binding arbitration of all issues of tort liability and damages, provided:

(1) (A) The offer must be for the sum of the limits of all liability insurance policies providing coverage to the party or parties on whose behalf the offer is made and in an aggregate amount which is less than the uninsured motorist coverage applicable to the bodily injury or death of the insured; or

(B) If, by payments to other injure d parties, the limits of all liability insurance policies providing coverage to the party or parties on whose behalf the offer is made have been reduced to an amount which is less than the limits of the insured's uninsured motorist coverage, the offer must be for the total amount of coverage that remains available to the party or parties on whose behalf the offer is made; and

(2) If the settlement does not release all parties alleged to be liable to the insured, arbitration of the uninsured motorist claim shall not be conducted until the claims against all such other parties have been fully and finally disposed of by settlement, final judgment or otherwise.

(g) Parties proposing to accomplish a settlement pursuant to this section shall comply with the following requirements and conditions:

(1) Upon request, the insured or the insured's personal representative or attorney shall provide the liability insurance company or companies providing coverage to the party or parties to be released, the name and address of the insurance company or companies providing the insured with uninsured motorist coverage, the policy number or numbers and the limits of uninsured motorist coverage available to the insured;

(2) The liability insurance company or companies providing coverage to the party or parties to be released shall give written notice of the offer to the insured's uninsured motorist insurance carrier or its attorney, provide verification of the coverage upon request and confirm to the uninsured motorist insurance carrier or its attorney that the party or parties to be released will agree in writing to cooperate with the uninsured motorist insurance carrier in connection with the arbitration of the uninsured motorist claim; provided, that the uninsured motorist insurance carrier will agree to waive its subrogation rights against the party or parties to be released;

(3) The insured or the insured's personal representative or attorney shall give written notice to the uninsured motorist insurance carrier or its attorney of the insured's intent to accept the offer and agreement to submit the uninsured motorist claim to binding arbitration;

(4) After receipt of both of the notices referred to in subdivisions (g)(2) and (3), the uninsured motorist insurance carrier shall have thirty (30) days to give notice to its insured or the insured's personal representative or attorney and the liability insurance carrier or carriers or their attorneys that it consents to the settlement; that it will agree to binding arbitration of the insured's uninsured motorist claim and will waive its subrogation rights against the party or parties to be released in exchange for their written agreement to cooperate in connection with the arbitration;

(5) Upon receipt of the notice required by subdivision (g)(4), the insured may proceed to execute a release of the party or parties on whose behalf the offer was made and upon execution of the release, receive payment of the settlement proceeds; and

(6) The notices required by subdivisions (g)(2), (3) and (4) shall be given by certified mail, return receipt requested, or by some other method pursuant to which the sender receives written verification that the notice was received.

(h) (1) The arbitration provided for in this section shall be conducted pursuant to this section and, pursuant to the Uniform Arbitration Act, compiled in title 4, chapter 5, part 3 and the provision in title 29, chapter 5, parts 1 and 3.

(2) The arbitrator shall be selected by agreement of the parties. Notwithstanding § 29-5-304, if the parties are unable to agree, either party may request a judge of a court of record in the county in which the arbitration is pending to designate three (3) potential arbitrators. The parties shall then agree upon one (1) of the three (3) arbitrators so designated.

(3) Unless the parties agree otherwise, the arbitration will take place in the county in which the insured resides and the rules of evidence applicable to the state courts where the arbitration is conducted shall apply.

(4) The arbitrator shall not be informed as to the amount or amounts collected by the insured by way of settlement or judgment prior to the conclusion of the arbitration. Disclosure of such information prior to the conclusion of the arbitration will result in disqualification of the arbitrator.

(5) Coverage issues shall be decided by a court of competent jurisdiction. The arbitrator shall decide issues of tort liability and damages only. The arbitrator shall first decide issues of liability and the apportionment of fault and, if fault is found, the amount of damages sustained by the insured.

(6) If the arbitrator's award to the insured is less than or equal to the total amount collected by the insured by way of settlements or judgments plus the amount of any settlement offer made by the uninsured motorist carrier at least fifteen (15) days prior to the arbitration, the insured will pay the arbitrator's fee. In the event the arbitrator's award to the insured exceeds the total amount collected by the insured by way of settlements or judgments plus the amount of any settlement offer made by the uninsured motorist carrier at least fifteen (15) days prior to the arbitration, the uninsured motorist insurance carrier will pay the arbitrator's fee.

(i) The uninsured motorist insurance carrier shall be entitled to credit for the total amount of damages collected by the insured from all parties alleged to be liable for the bodily injury or death of the insured whether obtained by settlement or judgment and whether characterized as compensatory or punitive damages.

(j) Nothing contained in this sect ion shall prohibit or preclude the uninsured motorist insurance carrier and the insured or the insured's personal representative from settling the

insured's uninsured motorist claim at any time and upon such terms and conditions as are acceptable to the parties.

(k) Notwithstanding the provisions of this section relating to binding arbitration, after receipt of both of the notices referred to in subdivisions (g)(2) and (3), the uninsured motorist insurance carrier, at its option, may elect to decline binding arbitration and preserve its subrogation rights; provided, that within thirty (30) days after receipt of both of the notices it pays the insured the full amount of the offer made by the liability insurance company or companies providing coverage to the party or parties seeking the release. Acceptance of the amount by the insured shall not operate as a release of the liability insurance carrier's insureds, nor shall it prevent or preclude the insured from seeking additional compensation from the insured's uninsured motorist insurance carrier. Upon acceptance by the insured, the uninsured motorist insurance carrier shall be subrogated to the extent of its payment and further subrogated to the extent it is required to make further payments of compensatory damages under the uninsured motorist coverage of its policy. Upon final disposition of the case, the liability insurance carrier or carrier, shall reimburse the uninsured motorist insurance carrier in the amount of policy limits applicable to the defendant or defendants on whose behalf the offer was made or in the amount of the judgment rendered against the defendant or defendants, whichever is less. In the event the judgment is in favor of the defendant or defendants, the uninsured motorist insurance carrier shall not be entitled to reimbursement for any amounts paid its insured pursuant to this subsection. In the event the judgment exceeds the liability insurance coverage available to the defendant or defendants, the uninsured motorist insurance carrier shall be subrogated against the defendant or defendants to the extent of payments it is required to make in excess of such liability insurance coverage . The uninsured motorist insurance carrier shall be entitled to credit for the total amount of damages collected by the insured from all parties alleged to be liable for the bodily injury or death of the insured whether obtained by settlement or judgment and whether characterized as compensatory or punitive damages.

# Cancellation of Auto Policy

**56-7-1301. Definitions - Application of part.**

(a) As used in this part:

(1) "Nonpayment of premium" means failure of the named insured to discharge when due any obligations in connection with the payment of premiums on a policy of automobile liability insurance or any installment of such premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit; and

(2) "Private passenger automobile liability insurance policy" means a policy delivered or issued for delivery in this state, insuring a natural person as named insured, or one (1) or

more related individuals resident of the same household, and under which the insured vehicles therein designated are of the following types only:

(A) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(B) Any other four (4) wheel motor vehicle with a load capacity of one thousand five hundred pounds (1,500 lbs.) or less which is not used in the occupation, profession or business of the insured, other than driving to and from the insured's place of employment or used in the occupation of farming.

(b) This part does not apply to:

(1) Policies of automobile liability insurance issued under an automobile assigned risk plan;

(2) Any policy insuring more than four (4) automobiles;

(3) Any policy covering garage, automobile sales agency, repair shop, service station or public parking place operation hazards; or

(4) Any policy of insurance issued principally to cover personal or premises liability of an insured even though such insurance may also provide some incidental coverage for liability arising out of the ownership, maintenance or use of a motor vehicle on the premises of such insured or on the ways immediately adjoining such premises.

(c) This part applies only to that portion of an automobile liability policy insuring against bodily injury and property damage liability and to the provisions therein, if any, relating to medical payments and/or uninsured motorist coverage.

**56-7-1302. Cancellation of automobile insurance policies - Grounds.**

(a) Every private passenger automobile liability insurance policy shall hereafter be subject to the provisions of this part.

(b) Unless the policy has been in effect less than sixty (60) days at the time notice of cancellation is mailed, and it is not a renewal policy, the company shall not exercise its right to cancel the insurance afforded in the policy unless such cancellation is based on one (1) or more of the following reasons:

(1) Nonpayment of premium;

(2) (A) The policy was obtained through a material misrepresentation;

(B) The named insured failed to disclose fully the insured's motor vehicle accidents and moving traffic violations for the preceding thirty-six (36) months if called for in the application; or

(C) The named insured failed to disclose in the written application or in response to inquiry by the insured's broker or by the insurer or its agent information necessary for the acceptance or proper rating of the risk;

(3) (A) Any insured violated any of the terms or conditions of the policy;

(B) Any insured made a false or fraudulent claim or knowingly aided or abetted another in the presentation of such a claim; or

(C) If, after the effective date of the insurance, the policy is extended, with or without charge, to provide coverage for the operation of an automobile by a person or persons not listed on the original application, or a supplement thereto, the company shall be allowed sixty (60) days, after written request to the company for insurance on such driver or drivers, to accept or reject the additional risk and, if the additional risk is not acceptable to the company, the policy may be cancelled; provided, that notice shall be mailed within sixty (60) days from the date of such request;

(4) The named insured or any other operator, either resident in the same household, or who customarily operates an automobile insured under the policy:

(A) Has had a driver's license or motor vehicle registration suspended or revoked within the thirty-six (36) months prior to notice of cancellation;

(B) Is or becomes subject to epilepsy or heart attacks, and cannot produce a certificate from a physician testifying to such person's unqualified ability to operate a motor vehicle; or

(C) Is or has been convicted of or forfeits bail, during the thirty-six (36) months immediately preceding the effective date of the policy or during the policy period, for:

(i) Any felony;

(ii) Criminal negligence resulting in death, homicide or assault, arising out of the operation of a motor vehicle;

(iii) Operating a motor vehicle while in an intoxicated condition or while under the influence of drugs;

(iv) Leaving the scene of an accident without stopping to report;

(v) Theft of a motor vehicle;

(vi) Making false statements in an application for a driver license; or

(vii) A third violation, committed within a period of thirty-six (36) months, of:

(a) Any ordinance, law or regulation limiting the speed of motor vehicles; or

(b) Any of the provisions in the motor vehicle laws of any state, the violation of which constitutes a misdemeanor, whether or not the violations were repetitions of the same offense or were different offenses; or

(5) The insured automobile is:

(A) Altered so as to increase the risk substantially;

(B) Used as an authorized emergency vehicle; or

(C) Subject to an inspection law and has not been inspected or, if inspected, has failed to qualify.

(c) No automobile liability insurance policy may be cancelled solely because the driver was involved in a collision not adjudicated the driver's fault.

NOTE: While the law lists reasons it basically does not apply since most PPA policies limit right to cancel after sixty days or if policy has renewed to nonpayment of premium, revocation of driver's license, or if the policy was obtained through material misrepresentation. Mailing of notice is sufficient proof of notice.

**56-7-1303. Notice of cancellation.**

**(a)** **(1)** No notice of cancellation of a policy shall be effective unless mailed or delivered by the insurer, its authorized agent or employee, to the named insured as shown in the policy declarations at the address shown in the declarations, stating when not less than twenty (20) days thereafter the cancellation shall be effective; provided, the policy may be cancelled by the company by mailing to the insured written notice stating when not less than ten (10) days thereafter the cancellation shall be effective, if:

**(A)** The cancellation is due to nonpayment of premium; or

**(B)** The policy has been in effect less than sixty (60) days and is not a renewal policy.

**(2)** The mailing of the notice shall be sufficient proof of notice.

**(3)** The effective date and hour of cancellation stated in the notice shall become the end of the policy period, unless the insured surrenders the policy and requests cancellation prior to the date and hour specified in the cancellation notice.

**(4)** Delivery of the written notice either by the insured or by the company shall be equivalent to mailing.

**(b)** **(1)** If the reason or reasons for cancellation are not included in the notice of cancellation, then at the written request of the named insured, mailed or delivered to the insurer not later than fifteen (15) days subsequent to the effective date of cancellation, the insurer shall specify any and all reasons for the cancellation. This subdivision (b)(1) only applies to policies that have been in force sixty (60) days beyond the initial effective date.

**(2)** Every renewal policy shall be presumed to be in effect for at least sixty (60) days. Any notice of cancellation shall advise the insured that the insured may request the reasons for cancellation by written request mailed or delivered to the insurer not later than fifteen (15) days subsequent to the effective date of cancellation.

**(c)** There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to the reason for cancellation, for any statement made by any of them in any written notice of cancellation, for the providing of information pertaining to the cancellation, or for statements made or evidence submitted at any hearings conducted in connection with the cancellation.

**56-7-1304. Notice of intention not to renew.**

(a) Nothing in this part applies to nonrenewal, except that in the event the company does not intend to renew the contract, it shall mail or deliver to the named insured, at the address shown in the policy, not less than thirty (30) days' notice of its intention not to renew. Proof of mailing of notice shall be sufficient proof of notice.

(b) Unless the nonrenewal notice contains a reason for such nonrenewal action, such notice shall advise the insured that upon written request of the named insured, mailed or delivered to the insurer not later than fifteen (15) days after the effective date of the nonrenewal, the insurer will within twenty (20) days mail to the named insured a written statement specifying a reason for such nonrenewal action. There shall be no liability on the part of and no cause of action of any nature shall arise against any insurer, its authorized representative, its agents, its employees, or against any firm, person or corporation furnishing information to the insurer, as to reason for nonrenewal.

NOTE: A company may non-renew a PPA policy for any reason by giving at least thirty (30) days notice. Again proof of mailing of notice is sufficient proof of notice. If the reason for non-renewable is not given in the notice the notice must advise the insured that upon written request received not later than fifteen (15) days after the effective date of non-renewal the insurer will mail the insured a written statement specifying a reason. They insured cannot do anything but they will know the reason for nonrenewal.

**56-7-1305. Notice of eligibility for assigned risk plan.**

When a policy of automobile liability insurance is cancelled, other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance, the insurer shall notify the named insured of the insured's possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

# CANCELLATION OF PERSONAL RISK INSURANCE

**56-7-1901. Notice of intention not to renew.**

Except as provided in § 56-7-1304, if an insurance company does not intend to renew a contract of any kind of personal risk insurance identified in § 56-5-302, the company shall mail or deliver to the named insured, at the address shown in the policy, notice of its intention not to renew at least thirty (30) days prior to the expiration of the policy.

**56-7-1902. Statement of reasons for nonrenewal - Liability of information providers.**

(a) Unless the nonrenewal notice contains a reason for such nonrenewal action, such notice shall advise the insured that upon written request of the named insured, mailed or delivered to the insurer not later than fifteen (15) days after the effective date of the nonrenewal, the insurer will within twenty (20) days mail to the named insured a written statement specifying a reason for such nonrenewal action.

(b) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer, its authorized representative, its agents, its employees, or against any firm, person or corporation furnishing information to the insurer, as to the reason for nonrenewal.

# Cancellation of Commercial Insurance and Notification of Rate Increase

**56-7-1801. Short title.**

This part shall be known and may be cited as the "Cancellation of Commercial Risk Insurance Act."

**56-7-1802. Definitions.**

As used in this part, unless the context otherwise requires:

(1) (A) "Commercial risk insurance" means insurance within the scope of this part which is not "personal risk insurance," as defined in § 56-5-302, and subject to the exclusions set out in § 56-5-301; and

(B) "Commercial risk insurance" does not include fidelity and surety bonds, or insurance written by a surplus lines insurer; and

(2) "Nonpayment of premium" means failure of the named insured to discharge when due any of its obligations in connection with the payment of premiums on a policy of commercial risk insurance or any installment of such premium, whether the premium is payable directly to the insurer or its agents or indirectly under any premium finance plan or extension of credit.

**56-7-1803. Prerequisites for effective notice of cancellation.**

After a commercial risk insurance policy has been in effect for sixty (60) days, or, if the policy is a renewal, effective immediately, no notice of cancellation shall be effective unless it is based on the occurrence, after the effective date of the policy, of one (1) or more of the following:

(1) Nonpayment of premium, including nonpayment of any additional premiums, calculated in accordance with the current rating manual of the insurer, justified by a physical change in the insured property or a change in its occupancy or use;

NOTE: This section does not allow a company to cancel a current policy for nonpayment of an audit on a policy that has expired.

(2) Conviction of the named insured of a crime having as one of its necessary elements an act increasing any hazard insured against;

(3) Discovery of fraud or material misrepresentation on the part of either of the following:

(A) The insured or the insured's representative in obtaining the insurance; or

(B) The named insured in pursuing a claim under the policy;

(4) Failure to comply with written loss control recommendations;

(5) Material change in the risk which increases the risk of loss after insurance coverage has been issued or renewed;

NOTE: The fact that company finds out about a material change is not grounds for cancellation. The material change must occur during the policy period.

(6) Determination by the commissioner that the continuation of the policy would jeopardize a company's solvency or would place the insurer in violation of the insurance laws of this state or any other state;

(7) Violation or breach by the insured of any policy terms or conditions; or

(8) Such other reasons that are approved by the commissioner.

**56-7-1804. Prerequisites for effective notice of cancellation - Contents of notices of cancellation - Delivery of notice.**

(a) No notice of cancellation of a commercial risk insurance policy shall be effective unless mailed by the insurer, its authorized agent, or employee, to the named insured as shown in the policy declarations at the address shown in such declarations.

(b) If the cancellation is due to any of the items set forth in § 56-7-1803, or if the policy has been in effect less than sixty (60) days and is not a renewal policy, such cancellation shall be effective not less than ten (10) days after the date of mailing.

(c) The mailing of notice shall be sufficient proof of notice. The effective date and hour of cancellation stated in the notice shall become the end of the policy period unless the insured shall surrender the policy and request cancellation prior to the date and hour specified in the cancellation notice.

(d) Delivery of such written notice either by the agent or by the company shall be the equivalent of mailing.

(e) All notices of cancellation shall state which of the grounds set forth in § 56-7-1803 are relied upon, and that upon written request of the named insured, the insurer shall furnish the facts on which the cancellation is based.

(f) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer, its authorized representative, its agents, its employees, or any firm, person or corporation furnishing to the insurer information as to reason for cancellation, for any statement made by any of them in any written notice of cancellation, for the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

**56-7-1805. Failure to comply with notice requirements - Policy extension - When notice of non-renewable not required.**

(a) Unless the insurer, at least sixty (60) days in advance of the end of the policy period, mails or delivers to the named insured and agent at the address shown in the policy, notice of its intention not to renew the commercial risk policy or to condition its renewal on reduction of limits or elimination of coverages, the insurer is required to extend the existing policy sixty (60) days from the date such notice is provided. The premium for the policy provided in such circumstances shall be no more than a pro rata basis of the

existing policy.  Any commercial risk policy written for a term of less than one (1) year shall be considered as if written for a term of one (1) year. Any commercial risk policy written for a term longer than one (1) year, or any commercial risk policy with no fixed expiration date, shall be considered as if written for specific policy periods or terms of one (1) year.

(b) Notice of non-renewable is not required if:

(1) The insurer has offered to issue a renewal policy; or

(2) Where the named insured has obtained replacement coverage or has agreed in writing to obtain replacement coverage.

(c) If an insurer provides the notice described in this section, and thereafter the insurer extends the policy for ninety (90) days or less, an additional notice of nonrenewal is not required with respect to the extension.

**56-7-1806. Revision of rates.**

(a) In the event an insurance company intends to increase the premiums of a commercial risk policy by an amount which is more than twenty-five percent (25%) and the increase in premium is the result of comparing policies of equivalent exposures, the insurance company shall mail or deliver to the named insured and producer at the address shown on the policy not less than sixty (60) days prior notice of its intention to increase the premiums specifying the percentage of the increase.

(b) Unless notice is provided as described above, the insurer is required to extend the existing policy sixty (60) days from the date such notice is provided.

(c) The premium for the policy provided in such circumstances shall be not more than a pro rata basis of the existing policy.

**56-7-1807. Noncompliance with provisions.**

Failure to comply with the provisions of this part shall be considered to be an unfair trade practice under § 56-8-104.

**56-7-1808. Promulgation of rules and regulations by commissioner.**

(a) The commissioner may, after notice and hearing, promulgate rules and regulations to carry out the provisions of this part.

(b) The rulemaking authority includes the power to increase or decrease the time within which notice is required by this part.

# SINKHOLE COVERAGE

**56-7-130. Sinkholes Losses**

(a) As used in this section, unless the context otherwise requires:

(1) "ANSI" means the American National Standards Institute;

(2) "Building stabilization or foundation repairs" means techniques performed at, to, or attached to the existing foundation of a building with the intention to repair, re-level, or stabilize the building or foundation of a covered ~~building~~ structure;

(3) "Covered structure" means any structure, including the personal property contained in the structure, to the extent covered under the terms of the policy;

(4) "Engineer" means a person meeting the qualifications under title 62, chapter 2, part 4 who has at least a bachelor's degree in engineering, and relevant experience and expertise in the identification of sinkhole activity, as well as other potential subterranean causes of structural damage;

(5) "Homeowner property insurance" means an insurance policy that includes coverage for a residential dwelling;

(6) "Land stabilization" means any repair technique intended to replace, rebuild, stabilize, or restore the land including any repair technique designed to compensate for or prevent land instability;

(7) "Primary structural member" means a structural element designed to support and stabilize the vertical or lateral loads of the overall structure;

(8) "Primary structural system" means an assemblage of primary structural members;

(9) "Professional geologist" means a person meeting the qualifications of title 62, chapter 36, part 1, who has at least a bachelor's degree in geology or a related earth science with expertise in the geology of this state, as well as having relevant geological experience and expertise identifying sinkhole activity, as well as other potential geologic causes of structural damage;

(10) "Sinkhole" means a subterranean void created by the dissolution of limestone or dolostone strata resulting from groundwater erosion causing a surface subsidence of soil, sediment, or rock;

(11) "Sinkhole activity" means settlement or systematic weakening of the earth supporting a covered structure, only if the settlement or systematic weakening results from contemporaneous movement or raveling of soils, sediments, or rock materials into subterranean voids created by the effect of groundwater erosion on a limestone or similar rock formation;

(12) "Sinkhole loss":

(A) Means structural damage to a covered structure caused by the sudden collapse of the earth supporting the covered structure as the result of sinkhole activity; and

(B) Does not include:

(i) Land stabilization or costs associated with land stabilization; or

(ii) In the absence of structural damages to the covered ~~building~~ structure, cracking, shrinking, expansion, deterioration, or similar damages; and

(13) "Structural damage" means foundation displacement or deflection caused by a sinkhole after completion of initial construction of the covered ~~building~~ structure, resulting in:

(A) Interior floor displacement or deflection:

(i) In excess of variances acceptable under building standards for residential construction approved by ANSI; and

(ii) To the extent that the interior building structure or members are unfit for service or represent a safety hazard;

(B) Damage to primary structural members or primary structural systems that:

(i) Results in such members or systems failing to meet the strength and performance requirements set forth in building standards for residential construction approved by ANSI; and

(ii) Renders such structural members or structural systems unfit for service or a safety hazard; or

(C) Occupancy of the covered structure has been prohibited by a governmental agency because of unsafe conditions.

The reference in this subdivision to building standards approved by ANSI shall not require the original construction of a covered ~~building~~ structure to be in compliance with such standards, but is solely for the purpose of defining the extent of damage required in order to be considered structural damage.

(b) Every insurer offering homeowner property insurance in this state shall make coverage available for insurable sinkhole losses, including contents of personal property

contained in the dwelling. The insurer may require an inspection of the property before issuance of sinkhole loss coverage. Nothing in this section mandates that sinkhole loss coverage be included in any homeowner property insurance policy, but only that insurers offering homeowner property insurance make such coverage available for optional purchase on request by policyholders.

(c) Every insurer offering homeowner property insurance in this state shall make a proper filing with the department to comply with this section. The insurer may make sinkhole loss coverage available in the homeowner policy itself, by endorsement, or through other coverage that the insurer may arrange, and the insurer may make an additional charge for the coverage.

(d) Upon receipt of a claim for a sinkhole loss under a policy providing sinkhole loss coverage, an insurer must meet the following standards in investigating the claim:

(1) The insurer shall make an inspection of the insured's premises to determine if there has been structural damage to the covered ~~building~~ structure resulting from possible sinkhole activity;

(2) If, upon the investigation pursuant to subdivision (d)(1), the insurer determines that there is no sinkhole loss, the insurer may deny the claim;

(3) If, the insurer concludes that structural damage to a covered ~~building~~ structure is inconsistent with sinkhole activity, then prior to denying the claim, the insurer shall obtain a written certification from an engineer, a professional geologist, or other qualified individual stating that:

(A) An analysis was conducted of sufficient scope to provide an opinion within a reasonable professional probability on the cause of the observed structural damage; and

(B) (B)Sinkhole activity did not cause the observed structural damage; and

(4) If the insurer obtains, pursuant to subdivision (d)(3), written certification that the cause of the structural damage was not sinkhole activity, and if the policyholder has submitted the sinkhole claim without good faith grounds for submitting the claim, the policyholder shall reimburse the insurer for fifty percent (50%) of the cost of the analysis under subdivision (d)(3); provided, however, that a policyholder is not required to reimburse an insurer more than two thousand five hundred dollars ($2,500) with respect to any claim. A policyholder is required to pay reimbursement under this subdivision (d)(4), only if the insurer, prior to ordering the analysis pursuant to subdivision (d)(3), informs the policyholder of the policyholder's potential liability for reimbursement and gives the policyholder the opportunity to withdraw the claim.

(e)(1) If a covered sinkhole loss is verified by the insurer, the conduct of the insurer and policyholder is governed by this subsection (e), subject to the terms and conditions of the policy or endorsement.

(2) ·The insurer may limit its total claims payment for damages to the covered structure to the actual cash value of the sinkhole loss to the covered building structure, excluding costs associated with building stabilization or foundation repair, until the policyholder enters into a contract for the performance of building stabilization or foundation repairs in accordance with the recommendations of the engineer retained or approved by the insurer.

(3) To be eligible to receive payment for building stabilization or foundation repairs, or any other loss to the covered structure in excess of the actual cash value of the sinkhole loss to the covered structure, the insured must repair such damage or loss in accordance with a plan of repair approved by the insurer.

(4) In order to prevent additional damage to the building or structure, the policyholder must enter into a contract for the performance of building stabilization and foundation repairs within ninety (90) days after the insurance company confirms coverage for the sinkhole loss and notifies the policyholder of such confirmation.

(5) After the policyholder enters into the contract for the performance of building stabilization and foundation repairs as set forth in this subsection (e) and subject to the terms and conditions of the policy, the insurer shall pay the amounts necessary to begin and perform such repairs as the work is performed and expenses are incurred. The insurer may not require the policyholder to advance payment for covered repairs.

(6) Without the prior written consent of the insurer, the policyholder may not accept anything of value from any person proposing to perform the repairs specified in this section as an inducement to contract with such person for the repairs.

(7) The stabilization and all other repairs to the structure and contents must be completed within twelve (12) months after entering into the contract for repairs described in subdivision (e)(3) unless:

(A) There is a mutual agreement between the insurer and the policyholder;

(B) The claim is in litigation;

(C) The claim is under appraisal or mediation; or

(D) Repairs are undertaken but cannot be completed within twelve (12) months because of reasons beyond the control of the policyholder.

(8) If the covered structure cannot be repaired or if the cost of repair exceeds policy limits, the terms and conditions of the policy or endorsement relative to losses in excess of policy limits shall apply.

(f) This subsection shall not be construed as limiting an insurer's right to cancel, decline to renew, or decline to issue homeowner property insurance; provided, however, an insurer may cancel, decline to renew, or decline to issue any homeowner property insurance on a structure that has been the subject of a sinkhole loss claim if the structure:

(1) Has not been repaired in accordance with the plan of repair approved by the insurer and within the time constraints set forth in subdivision (e)(?); or

(2) Is subject to the risk of future sinkhole damage because of unstable land.

(g) Nothing in this section:

(1) Requires an insurer to pay more than one (1) policy limit for one (1) policy loss due to a covered sinkhole loss;

(2) Prohibits an insurer from inspecting property or engaging in other underwriting practices in connection with making available coverage for sinkhole losses;

(3) Prohibits an insurer from offering coverage that is broader or more extensive than the offer of coverage required by this section;

(4) Prohibits an insurer from including in a policy or endorsement terms and conditions that are not contrary to this section; or

(5) Limits or creates any rights or obligations except as explicitly stated in this section.

{h) The commissioner may promulgate rules and regulations for the purpose of implementing this section.

Links to Department Bulletins on sinkhole coverage.

Offer of Sinkhole Coverage Required by Tenn. Code Ann. § 56-7-129
Code section has been changed from 56-7-129 to 56-7-130.

Defining Sinkhole Statutes "Make Available" Provision

Sinkhole Coverage for Residential Properties

# UNFAIR TRADE PRACTICES

The Tennessee Unfair Trade Practices and Unfair Claims Settlement Act of 2009 becomes effective January1, 2009. Click on this link to view/print the 19 page Public Chapter 1079. Part of the new law is incorporated into the sections below.

## Unfair Competition or Deceptive Acts

**56-8-104. Unfair trade practices defined.**

The following practices are defined as unfair trade practices in the business of insurance by any person:

**(1) Misrepresentations and False Advertising of Insurance Policies.** Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

**(A)** Misrepresents the benefits, advantages, conditions or terms of any policy;

**(B)** Misrepresents the dividends or share of the surplus to be received on any policy;

**(C)** Makes a false or misleading statement as to the dividends or share of surplus previously paid on any policy;

**(D)** Is misleading or is a misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates;

**(E)** Uses any name or title of any policy or class of policies misrepresenting the true nature of the policy or class of policies;

**(F)** Is a misrepresentation, including any intentional misquote of premium rate, for the purpose of inducing or tending to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of any policy;

**(G)** Is a misrepresentation for the purpose of effecting a pledge or assignment of or effecting a loan against any policy; or

**(H)** Misrepresents any policy as being shares of stock;

**(2) False Information and Advertising Generally.** 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 any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any insurer in the

conduct of its insurance business, that is untrue, deceptive or misleading;

**(3) Defamation.** Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature that is false, or maliciously critical of or derogatory to the financial condition of any insurer, and that is calculated to injure the insurer;

**(4) Boycott, Coercion and Intimidation.** **(A)** Entering into any agreement to commit, or by any concerted action committing, any act or boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of or monopoly in, the business of insurance; or

**(B)** By any act of boycott, coercion or intimidation, monopolizing or attempting to monopolize any part of the business of insurance; provided, that nothing in this subdivision (4)(B) shall be interpreted as defining or determining as an unfair method of competition or any unfair or deceptive act or practice in the business of insurance any act of boycott, coercion or intimidation on the part of any person, unless the act is committed in connection with an intention on the part of the person to monopolize, or attempt to monopolize, any material part of the business of insurance; and provided further, that no insurance company shall be held to have violated this subdivision (4)(B) because of any act of a producer of that company, which act has not been authorized or approved or acquiesced in by the company;

**(5) False Statements and Entries.** **(A)** Knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating or delivering to any person, or placing before the public, or knowingly causing, directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of an insurer; or

**(B)** Knowingly making any false entry of a material fact in any book, report or statement of any insurer or knowingly omitting to make a true entry of any material fact pertaining to the business of the insurer in any book, report or statement of the insurer, or knowingly making any false material statement to any insurance department official;

**(6) Stock Operations and Advisory Board Contracts.** Issuing or delivering or permitting agents, officers or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any common law corporation, or securities or any special or advisory board contracts or other contracts of any kind promising returns and profits as an inducement to purchase insurance;

**(7) Unfair Discrimination.** **(A)** Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any life insurance policy or annuity or in the dividends or other benefits payable on any policy or annuity, or in any other of the terms and conditions of the policy;

**(B)** **(i)** Refusing life insurance to, refusing to continue life insurance of, or limiting the amount, extent, or kind of life insurance coverage available to an individual based on the individual's past lawful travel experiences; or

**(ii)** **(a)** Refusing life insurance to, refusing to continue life insurance of, limiting the amount, extent, or kind of life insurance available to an individual, or determining the premium of life insurance based on the individual's future lawful travel plans unless:

**(1)** The risk of loss for individuals who travel to a specified destination at a specified time is reasonably anticipated to be greater than if the individuals did not travel to that destination at that time; and

**(2)** The risk classification is based on sound actuarial principles and actual or reasonably anticipated experience;

**(b)** An action shall be deemed to meet the requirements for exemption under subdivision (7)(B)(ii)(*a*) if it is taken because either one (1) of the following is true with respect to the travel destination:

**(1)** The director of the centers for disease control and prevention of the department of health and human services has issued alerts or warnings regarding serious health-related conditions or an epidemic or pandemic alert or response; or

**(2)** There is an ongoing armed conflict involving the military of a sovereign nation foreign to the destination;

**(iii)** **(a)** The commissioner is authorized to promulgate rules necessary to implement this subdivision (7)(B) and is authorized to provide for limited exceptions that are based upon national or international emergency conditions that affect the public health, safety, and welfare and that are consistent with public policy;

**(b)** An insurer shall make any pertinent underwriting guidelines and supporting analyses available to the commissioner on request;

**(C)** Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable under any accident or health insurance policy, or in any of the terms or conditions of the policy, or in any other manner;

**(D)** Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazard by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on a property or casualty risk solely because of the geographic location of the risk, unless the action is the result of the application of sound underwriting and actuarial principles related to actual or reasonably

anticipated loss experience;

**(E)** Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to insure, refusing to renew, canceling or limiting the amount of insurance coverage on the residential property risk, or the personal property contained in the residential property, solely because of the age of the residential property;

**(F)** Refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual because of the sex, race, religion, national origin, marital status, income, or educational background of the individual; however, nothing in this subdivision (7) shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependent benefits and nothing shall prohibit price distinctions between persons pursuant to underwriting and actuarial principles;

**(G)** To terminate, or to modify coverage or to refuse to issue or refuse to renew any property or casualty policy solely because the applicant or insured or any employee of either is mentally or physically impaired; provided, that this subdivision (7) shall not apply to health care liability insurance or accident and health insurance sold by a casualty insurer; and, provided further, that this subdivision (7) shall not be interpreted to modify any other provision of law relating to the termination, modification, issuance or renewal of any insurance policy or contract; or

**(H)** Refusing to insure solely because another insurer has refused to write a policy, or has canceled or has refused to renew an existing policy in which that person was the named insured. Nothing contained in this subdivision (7)(H) shall prevent the termination of an excess insurance policy on account of the failure of the insured to maintain any required underlying insurance;

**(8) Rebates.** **(A)** Except as otherwise expressly provided by law, knowingly permitting or offering to make or making any policy of insurance, including, but not limited to, any life insurance policy or annuity, or accident and health insurance or other insurance, or agreement as to the contract other than as plainly expressed in the policy issued thereon, or paying or allowing, or giving or offering to pay, allow, or give, directly or indirectly, as inducement to the policy, any rebate of premiums payable on the policy, or any special favor or advantage in the dividends or other benefits thereon, or any valuable consideration or inducement whatever not specified in the policy; or giving, or selling, or purchasing or offering to give, sell, or purchase as inducement to the policy or annuity or in connection with the policy or annuity, any stocks, bonds or other securities of any insurance company or other corporation, association or partnership, or any dividends or profits accrued thereon, or anything of value whatsoever not specified in the policy;

**(B)** Nothing in subdivision (7) or this subdivision (8)(A) shall be construed as including within the definition of discrimination or rebates any of the following practices:

**(i)** In the case of life insurance policies or annuities, paying bonuses to

policyholders or otherwise abating their premiums in whole or in part out of surplus accumulated from nonparticipating insurance, provided that any such bonuses or abatement of premiums shall be fair and equitable to policyholders and for the best interests of the company and its policyholders;

**(ii)** In the case of life insurance policies issued on the industrial debit plan, making allowance to policyholders who have continuously, for a specified period, made premium payments directly to an office of the insurer in an amount that fairly represents the saving in collection expenses;

**(iii)** Readjusting the rate of premium for a group insurance policy based on the loss or expense under the group insurance policy, at the end of the first or any subsequent policy year of insurance under the group insurance policy, that may be made retroactive only for the policy year; or

**(iv)** Offering a child passenger restraint system or a discount in premium equal to the amount of the purchase price of a child passenger restraint system to policyholders, when the purpose of the restraint system is the safety of a child and complies with § 55-9-602;

**(9) Prohibited Group Enrollments.** No insurer shall offer more than one (1) group policy of insurance through any person unless the person is licensed, at a minimum, as a limited lines producer; however, this prohibition shall not apply to employer/employee relationships, nor to any such enrollments;

**(10) Failure to Maintain Marketing and Performance Records.** Failure of an insurer to maintain its books, records, documents and other business records in such an order that data regarding claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner. Data for at least the current calendar year and the two (2) preceding years shall be maintained;

**(11) Failure to Maintain Complaint Handling Procedures.** Failure of any insurer to maintain a complete record of all the complaints it received since the date of its last examination under § 56-1-408. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. For purposes of this subdivision (11), "complaint" means a written communication expressing dissatisfaction or disagreement with the decision or action of an insurer; provided, however, that a communication submitted as part of the insurer's usual and customary claims process shall not be considered as a complaint;

**(12) Misrepresentation in Insurance Applications.** Making false or fraudulent statements or representations on or relative to an application for a policy, for the purpose of obtaining a fee, commission, money or other benefit from any provider or individual person;

**(13) Failure to File or to Certify Information Regarding the Endorsement or Sale of Long-term Care Insurance.** Failure of any insurer to:

**(A)** File with the insurance department the following material:

**(i)** The policy and certificate;

**(ii)** A corresponding outline of coverage; and

**(iii)** All advertisements requested by the insurance department; or

**(B)** Certify annually that the association has complied with the responsibilities for disclosure, advertising, compensation arrangements, or other information required by the commissioner, as set forth by rule;

**(14) Failure to Provide Claims History.** **(A)** Failure of a company issuing property and casualty insurance to provide the following loss information for the three (3) previous policy years to the first named insured within thirty (30) days of receipt of the first named insured's written request:

**(i)** On all claims, date and description of occurrence, and total amount of payments; and

**(ii)** For any occurrence not included in subdivision (14)(A)(i), the date and description of occurrence;

**(B)** Should the first named insured be requested by a prospective insurer to provide detailed loss information in addition to that required under subdivision (14)(A), the first named insured may mail or deliver a written request to the insurer for the additional information. No prospective insurer shall request more detailed loss information than reasonably required to underwrite the same line or class of insurance. The insurer shall provide information under this subdivision (14)(B) to the first named insured as soon as possible, but in no event later than twenty (20) days of receipt of the written request. Notwithstanding any other provision of this section, no insurer shall be required to provide loss reserve information, and no prospective insurer may refuse to insure an applicant solely because the prospective insurer is unable to obtain loss reserve information;

**(C)** The commissioner is authorized to promulgate rules to exclude the provision of the loss information as outlined in subdivision (14)(A) for any line or class of insurance where it can be shown that the information is not needed for that line or class of insurance, or where the provision of loss information otherwise is required by law;

**(D)** Information provided under subdivision (14)(B) shall not be subject to discovery by any party other than the insured, the insurer and the prospective insurer;

**(15) Unfair Replacement Transaction Practices.** Replacing a life insurance policy or an annuity contract in a manner contrary to rules promulgated by the commissioner pursuant to this part;

**(16) Unfair Utilization of Proprietary Information.** With respect to any policy of insurance underwritten in a pool, residual market mechanism, joint underwriting authority or assigned risk plan or through a plan depopulation initiative or other similar program, any information contained in a policy application or obtained in the servicing of such a policy of insurance cannot be used in any manner by the servicing carrier or its representatives for the purpose of soliciting any form of insurance, except when permission to use the information is granted by the commissioner on any specific risk;

**(17) Changing Classification and Rate After Policy Expiration or Renewal.** With respect to commercial risk insurance, making a change in the classification or rates either more than one (1) year after the policy's renewal date or the expiration date if the policy was not renewed without the written consent of the insured; provided, that no consent is necessary if the change is in the favor of the insured. This subdivision (17) does not apply where the insured has failed to cooperate, given misleading information, or made material misrepresentations or omissions;

**(18) Preferences or Distinctions in Certain Insurance Transactions prohibited.** **(A)** Making, offering to make, or permitting any preference or distinction in property, marine, casualty, or surety insurance as to form or policy, certificate, premium, rate, benefits, or conditions of insurance, based upon membership, nonmembership, or employment of any person or persons by or in any particular group, association, corporation, or organization, or making the preference or distinction available in any event based upon any fictitious grouping of persons;

**(B)** The restrictions and limitations of this subdivision (18) do not extend or apply to life, health and accident, disability or workers' compensation insurance or to plans to provide legal services. Nothing in this subdivision (18) shall apply to any domestic company that confines its insurance business and operations to this state and to the provision of insurance solely for the benefit of its members, or members of its parent or sponsoring organization;

**(C)** Notwithstanding any other provision of this title, dues paid before or after March 22, 1996, to a nonprofit association, membership in which entitles the members to apply for insurance from insurance companies described in subdivision (18)(B), shall not be considered as gross premium or consideration for insurance;

**(D)** Notwithstanding any other provision of this title to the contrary, an insurer may make, offer to make, or permit a preference or distinction in property, marine, casualty or surety insurance as to form or policy, certificate, premium, rate, benefits or conditions of insurance based upon membership in an association of professionals with more than five thousand (5,000) dues-paying members in this state with members residing or practicing in at least eighty (80) counties within the state;

**(19) Disclosure of Nonpublic Personal Information. (A)** Disclosing nonpublic personal information contrary to Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102, compiled in 15 U.S.C. § 6801 et seq., or violating a rule lawfully promulgated under this part;

**(B) (i)** The commissioner shall not impose civil penalties against, or revoke or suspend the license of, a person who violates subdivision (19)(A), unless the violator intentionally violated subdivision (19)(A) or committed violations of subdivision (19)(A) in sufficient number as to indicate a lack of the use of due diligence on the part of the violator in complying with subdivision (19)(A);

**(ii)** For purposes of subdivision (19)(A):

**(a)** "Nonpublic personal information" means nonpublic personal information as defined in Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102; and

**(b)** "Person" means an entity or individual holding or required by law to hold a certificate of authority or license, or the functional equivalent of a certificate of authority or license, under this title;

**(C)** Any rules promulgated pursuant to this subdivision (19) shall be no more restrictive than Title V of the Gramm-Leach-Bliley Act of 1999, Pub. L. No. 106-102;

**(20) False, Misleading, Deceptive or Unfair Practices Concerning Sales to Members of the Armed Forces.** Notwithstanding any other provision in this title, the commissioner shall have the authority to adopt rules to protect service members of the United States armed forces from dishonest and predatory insurance sales practices by declaring certain identified practices to be false, misleading, deceptive or unfair; and

**(21) (A) Unauthorized Use of Lender Information.** It is unlawful for any person to make, publish, disseminate, circulate, or place before the public, or cause, 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 the Internet or any radio or television, or in any other way, an advertisement, announcement or statement containing any assertion, representation, or statement with respect to the sale, distribution, offering for sale or advertising of any loan, refinance, insurance or any other product or service that is untrue, deceptive, or misleading.

**(B)** It is unlawful for any person to commit any of the unlawful acts prohibited in § 45-2-1709(a)(1)(D) or (E).

**(C)** For purposes of this subdivision (21), "lender" means any bank, savings and loan association, savings bank, trust company, credit union, industrial loan and thrift company, mortgage company, mortgage broker, or any subsidiary or affiliate of a bank, savings and

loan association, savings bank, trust company, credit union, industrial loan and thrift company, mortgage company, or mortgage broker.

## Probation of Lenders Requiring Insurance Limits Greater Than Property Value

### 56-8-106. Lending of money, extension of credit, or renewal — Conditions prohibited — Disclosures.

(a) No person or depository institution, or affiliate of a depository institution, shall require as a condition precedent to the lending of money or extension of credit, or any renewal thereof, that the person to whom the money or credit is extended or whose obligation a creditor is to acquire or finance, negotiate any policy or renewal of any policy through a particular insurer or group of insurers or agent or broker or group of agents or brokers. Further, no person or depository institution, or affiliate of a depository institution, shall reject an insurance policy solely because the policy has been issued or underwritten by a person who is not associated with the depository institution or affiliate when insurance is required in connection with a loan or extension of credit. However, nothing in this subsection (a) shall be construed as prohibiting engaging in an arrangement that would not violate § 106 of the Bank Holding Company Act Amendments of 1972, codified in 12 U.S.C. § 1972, as interpreted by the board of governors of the federal reserve system, or § 5(q) of the Home Owners' Loan Act, codified in 12 U.S.C. § 1464(q).

(b) No person or depository institution, or affiliate of a depository institution, who lends money or extends credit shall:

(1) As a condition for extending credit or offering any product or service that is equivalent to an extension of credit, require that a customer obtain insurance from a depository institution or an affiliate of a depository institution, or a particular insurer or producer; however, this subdivision (b)(1) does not prohibit a person or depository institution, or affiliate of a depository institution, from informing a customer or prospective customer that insurance is required in order to obtain a loan or credit, that loan or credit approval is contingent upon the procurement by the customer of acceptable insurance or that insurance is available from the person or depository institution or affiliate of a depository institution;

(2) Unreasonably reject a policy furnished by the customer or borrower for the protection of the property securing the credit or lien. A rejection shall not be deemed unreasonable if it is based on reasonable standards, uniformly applied, relating to the extent of coverage required and the financial soundness and the services of an insurer. The standards shall not discriminate against any particular type of insurer, nor shall the standards call for rejection of a policy because it contains coverage in addition to that required in the credit transaction;

(3) Require that any customer, borrower, mortgagor, purchaser, insurer, broker or insurance producer pay a separate charge in connection with the handling of any policy required as security for a loan on real estate, or pay a separate charge to substitute the policy of one (1) insurer for that of another. This subdivision (b)(3) does not include the interest that may be charged on premium loans or premium advancements in accordance with the terms of the loan or credit document. Further, this subdivision (b)(3) does not apply to charges that would be required when the person or depository institution or affiliate of a depository institution is the licensed producer providing the insurance;

(4) Require any procedures or conditions of duly licensed producers or insurers not customarily required of those producers or insurers affiliated or in any way connected with the person who lends money or extends credit;

(5) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state is responsible for the insurance sales activity of, or stands behind the credit of, the person, depository institution or its affiliate;

(6) Use an advertisement or other insurance promotional material that would cause a reasonable person to mistakenly believe that the federal government or the state guarantees any returns on insurance products or is a source of payment on any insurance obligation of or sold by the person, depository institution or its affiliate;

(7) Act as a producer unless properly licensed in accordance with § 56-6-103;

(8) Pay or receive any commission, brokerage fee or other compensation as a producer, unless the person holds a valid producer's license for the applicable class of insurance. However, in addition to any other manner of compensation otherwise allowed by law, an unlicensed person may make a referral to a licensed producer; provided, that the person does not discuss specific insurance policy terms and conditions. Except as prohibited by federal law, the unlicensed person may be compensated for the referral; however, an unlicensed person who is neither employed by nor affiliated with the insurance producer may be compensated only if the compensation is a fixed dollar amount, not to exceed twenty-five dollars ($25) or such lesser amount as the commissioner may establish by rule, for each referral. An unlicensed person who is either employed by or affiliated with the insurance producer may be compensated only if the compensation is a fixed nominal dollar amount. Furthermore, any person who accepts deposits from the public in an area where such transactions are routinely conducted in the depository institution may receive for each customer referral no more than a one-time, nominal fee of a fixed dollar amount for each referral. In any event, the referral compensation shall not depend on whether the referred customer purchases an insurance product from the licensed producer;

(9) Solicit or sell insurance, other than credit insurance or flood insurance, unless the solicitation or sale is completed through documents separate from any credit transactions;

(10) Include the expense of insurance premiums, other than credit insurance premiums or flood insurance premiums, in the primary credit transaction without the express written consent of the customer;

(11) Solicit or sell insurance unless its insurance sales activities are, to the extent practicable, physically separated from areas where retail deposits are routinely accepted by depository institutions; or

(12) Solicit or sell insurance unless it maintains separate and distinct books and records relating to the insurance transactions, including all files relating to and reflecting consumer complaints.

(13) Require, in connection with a loan or extension of credit secured by real property, that the debtor procure insurance for the protection of the property for an amount that exceeds the replacement cost of the structures existing on the secured property at the time of the loan or extension of credit or, in the case of a construction or improvement loan, insurance that exceeds the replacement value the structures are expected to have upon completion of the construction or improvements;

(c) Every person or depository institution, or affiliate of a depository institution that lends money or extends credit and who solicits insurance primarily for personal, family or household purposes shall disclose to the customer in writing that the insurance related to the credit extension may be purchased from an insurer or producer of the customer's choice, subject only to the lender's right to reject a given insurer or agent as provided in subdivision (b)(2). Further, the disclosure shall inform the customer that the customer's choice of insurer or producer will not affect the credit decision or credit terms in any way, except that the depository institution may impose reasonable requirements concerning the creditworthiness of the insurer and the scope of coverage chosen as provided in subdivision (b)(2).

(d) (1) A depository institution that solicits, sells, advertises or offers insurance, and any person that solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall disclose to the customer in writing, where practicable and in a clear and conspicuous manner, prior to a sale, that the insurance:

(A) Is not a deposit;

(B) Is not insured by the federal deposit insurance corporation or any other federal government agency;

(C) Is not guaranteed by the depository institution, its affiliate, if applicable, or any person that is soliciting, selling, advertising or offering insurance, if applicable; and

(D) Where appropriate, involves investment risk, including the possible loss of value.

(2) For purposes of the requirements of subdivision (d)(1), an affiliate of a depository institution is subject to these requirements only to the extent that it sells, solicits, advertises, or offers insurance products or annuities at an office of a depository institution or on behalf of a depository institution. These requirements apply only when an individual purchases, applies to purchase, or is solicited to purchase insurance products or annuities primarily for personal, family or household purposes and only to the extent that the disclosure would be accurate.

(3) A depository institution that solicits, sells, advertises or offers insurance, and any person who solicits, sells, advertises or offers insurance on behalf of a depository institution or on the premises of a depository institution shall obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure or at the time of the initial purchase of the insurance policy. If the solicitation is conducted by telephone, the person or depository institution shall obtain an oral acknowledgement of receipt of the disclosure, maintain sufficient documentation to show that the acknowledgement was given by the customer and make reasonable efforts to obtain a written acknowledgement from the customer. If a customer affirmatively consents to receiving the disclosures electronically and if the disclosures are provided in a format that the customer may retain or obtain later, the person or depository institution may provide the disclosure and obtain acknowledgement of the receipt of the disclosure from the customer using electronic media.

(4) For the purposes of subdivision (d)(1), a person is selling, soliciting, advertising or offering insurance on behalf of a depository institution, whether at an office of the depository institution or another location, if at least one (1) of the following applies:

(A) The person represents to the customer that the sale, solicitation, advertisement or offer of the insurance is by or on behalf of the depository institution;

(B) The depository institution refers a customer to the person who sells insurance and the depository institution has a contractual arrangement to receive commissions or fees derived from the sale of insurance resulting from the referral; or

(C) Documents evidencing the sale, solicitation, advertisement or offer of insurance identify or refer to the depository institution.

(e) The commissioner shall have the power to examine and investigate those insurance activities of any person, depository institution, affiliate of a depository institution or insurer that the commissioner believes may be in violation of this section. The person, depository institution, affiliate of a depository institution or insurer shall make its insurance books and records available to the commissioner and the commissioner's staff for inspection upon reasonable notice.

(f) Nothing in this section shall prevent a person or depository institution, or affiliate of a depository institution, who lends money or extends credit from placing insurance on

real or personal property in the event the mortgagor, borrower or purchaser has failed to provide required insurance in accordance with the terms of the loan or credit document.

# PREMIUM FINANCING

**56-37-110. Cancellation – Notice.**

(a) When a premium finance agreement contains a power of attorney enabling the premium finance company to cancel any insurance contract or contracts listed in the agreement, the insurance contract or contracts shall not be cancelled by the premium finance company unless such cancellation is effectuated in accordance with this section.

(b) Not less than ten (10) days' written notice shall be mailed to the insured, at the insured's last known address as shown on the records of the premium finance company, of the intent of the premium finance company to cancel the insurance contract unless the default is cured within such ten-day period; provided, that if a default results from the refusal of a bank to honor a loan repayment check, such default shall be treated as a request of the insured for cancellation and the premium finance company shall not be required to provide an additional ten (10) days' written notice to such insured.

(c) After expiration of such ten-day period, the premium finance company may thereafter cancel such insurance contract or contracts by mailing to the insurer a notice of cancellation. The insurance contract shall be cancelled as if such notice of cancellation had been submitted by the insured, but without requiring the return of the insurance contract or contracts. The premium finance company shall also mail a notice of cancellation to the insured at the insured's last known address as shown on the records of the premium finance company.

(d) All statutory, regulatory and contractual restrictions providing that the insurance contract may not be cancelled unless notice is given to a governmental agency, mortgagee or other third party shall apply where cancellation is effected under the provisions of this section. The insurer shall give the prescribed notice on behalf of itself or the insured to any governmental agency, mortgagee or other third party on or before the second business day after the day it receives the notice of cancellation, taking into consideration the number of days' notice required to complete the cancellation.

**56-37-111. Refund of gross unearned premiums upon cancellation.**

(a) Whenever a financed insurance contract is cancelled, the insurer shall return whatever gross unearned premiums are due under the insurance contract directly to the premium finance company for the account of the insured or insureds as soon as reasonably possible, but in no event shall the period for payment exceed thirty (30) days after the effective date of cancellation. In the event that the crediting of return premiums to the account of the insured results in a surplus over the amount due from the insured, the premium finance company shall refund such excess to the insured within thirty (30) days; provided, that no such refund shall be required if it amounts to less than one dollar

($1.00). Failure by the insurer to remit the unearned premium to the finance company, as required by the provisions of this subsection, shall make the insurer liable for any interest or finance fees that are assessed against the policyholder as a result of the failure to timely remit unearned premiums after the required period to remit the refund.

(b) When cancellation of a financed insurance contract is requested by the premium finance company, the insurance company shall base the refund of the unearned premiums on a pro-rata basis.

**56-37-112. Perfected assignment and security interest. Effective April 12, 2013**

(a) A premium finance company, seller, building or savings and loan association, bank, trust company, industrial loan and thrift company or credit union authorized to do business in this state that finances insurance premiums, shall be deemed to have a perfected assignment and security interest in any premiums financed if the buyer or borrower signs a written agreement assigning a security interest in the premiums financed to the premium finance company, seller, seller's assignee, or lender. No filing or other recordation of the premium finance agreement or financing statement shall be necessary to perfect the validity of the agreement as a valid assignment and secured transaction as against creditors, subsequent purchasers, pledgees, encumbrancers, trustees in bankruptcy or any other insolvency proceeding under any law, or anyone having the status or power of the aforementioned or their successors or assigns.

# WORKERS' COMPENSATION

**50-6-102. Chapter definitions.** **[Applicable to injuries occurring on and after July 1, 2014.]**

As used in this chapter, unless the context otherwise requires:

**(1)** "Administrator" means the chief administrative officer of the bureau of workers' compensation of the department of labor and workforce development;

**(2)** "AMA guides" means the 6th edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, American Medical Association, until a new edition is designated by the general assembly in accordance with § 50-6-204(k)(2)(A). The edition that is in effect on the date the employee is injured is the edition that shall be applicable to the claim;

**(3)** **(A)** "Average weekly wages" means the earnings of the injured employee in the employment in which the injured employee was working at the time of the injury during the period of fifty-two (52) weeks immediately preceding the date of the injury divided by fifty-two (52); but if the injured employee lost more than seven (7) days during the period when the injured employee did not work, although not in the same week, then the earnings for the remainder of the fifty-two (52) weeks shall be divided by the number of weeks remaining after the time so lost has been deducted;

**(B)** Where the employment prior to the injury extended over a period of less than fifty-two (52) weeks, the method of dividing the earnings during that period by the number of weeks and parts of weeks during which the employee earned wages shall be followed; provided, that results just and fair to both parties will be obtained;

**(C)** Where, by reason of the shortness of the time during which the employee has been in the employment of the employer, it is impracticable to compute the average weekly wages as defined in this subdivision (3), regard shall be had to the average weekly amount that, during the first fifty-two (52) weeks prior to the injury or death, was being earned by a person in the same grade, employed at the same work by the same employer, and if there is no such person so employed, by a person in the same grade employed in the same class of employment in the same district;

**(D)** Wherever allowances of any character made to any employee in lieu of wages are specified as part of the wage contract, they shall be deemed a part of the employee's earnings;

NOTE: This is the reason for not including bonuses in WC payroll. Allowances in lieu of wages that are specified in the wage contract are included in the calculation of "average weekly wage" in determining amount of benefits. If allowances are not in lieu of wages and specified in wage contract they are not included in computing "average weekly wage"

**(4)** [Deleted by 2013 amendment, effective July 1, 2014.]

**(5)** "Bureau" or "bureau of workers' compensation" means the bureau of workers' compensation of the department of labor and workforce development;

**(6)** "Case management" means medical case management or the ongoing coordination of medical care services provided to an injured or disabled employee on all cases where medical care expenses are expected to exceed a threshold;

**(7)** "Commissioner" means the commissioner of labor and workforce development;

**(8)** "Construction design professional" means:

**(A)** Any person possessing a valid registration or license entitling that person to practice the technical profession of architecture, engineering, landscape architecture or land surveying in this state;

**(B)** Any corporation, partnership, firm or other legal entity authorized by law to engage in the technical profession of architecture, engineering, landscape architecture or land surveying in this state; or

**(C)** Any person, firm or corporation providing interior space planning or design in

this state;

**(9)** "Court of workers' compensation claims" means the adjudicative function within the bureau of workers' compensation;

**(10)** "Department" means the department of labor and workforce development;

**(11)** [Deleted by 2015 amendment, effective May 4, 2015.]

**(12)** **(A)** "Employee" includes every person, including a minor, whether lawfully or unlawfully employed, the president, any vice president, secretary, treasurer or other executive officer of a corporate employer without regard to the nature of the duties of the corporate officials, in the service of an employer, as employer is defined in subdivision (13), under any contract of hire or apprenticeship, written or implied. Any reference in this chapter to an employee who has been injured shall, where the employee is dead, also include the employee's legal representatives, dependents and other persons to whom compensation may be payable under this chapter;

NOTE: When counting number of employees you include part-time, spouse, kids and other kinfolks. You count any and everybody when determining if employer must purchase WC.

**(B)** "Employee" includes a sole proprietor, a partner, or a member of a limited liability company who devotes full time to the proprietorship, partnership, or limited liability company, respectively, and elects to be included in the definition of employee by filing written notice of the election with the bureau at least thirty (30) days before the occurrence of any injury or death, and may at any time withdraw the election by giving notice of the withdrawal to the bureau;

**(C)** The provisions of this subdivision (12) allowing a sole proprietor or a partner to elect to come under this chapter (Links to I-4 Election of be covered and I-5 Withdrawal of election These forms cannot be used for a Construction Service Provider.) shall not be construed to deny coverage of the sole proprietor or partner under any individual or group accident and sickness policy the sole proprietor or partner may have in effect, in cases where the sole proprietor or partner has elected not to be covered by this chapter, for injuries sustained by the sole proprietor or partner that would have been covered by this chapter had the election been made, notwithstanding any provision of the accident and sickness policy to the contrary. Nothing in this section shall require coverage of occupational injuries or sicknesses, if occupational injuries or sicknesses are not covered under the terms of the policy without reference to eligibility for workers' compensation benefits;

**(D)** **(i)** In a work relationship, in order to determine whether an individual is an "employee," or whether an individual is a "subcontractor" or an "independent contractor," the following factors shall be considered:

**(a)** The right to control the conduct of the work;

**(b)** The right of termination;

**(c)** The method of payment;

**(d)** The freedom to select and hire helpers;

**(e)** The furnishing of tools and equipment;

**(f)** Self-scheduling of working hours; and

**(g)** The freedom to offer services to other entities; and

**(ii)** A premium shall not be charged by an insurance company for any individual determined to be an independent contractor pursuant to this subdivision (12)(D);

NOTE: These are the seven things to be considered in determining if a person not in construction industry is an independent contractor or an employee. Notice that the list does not include liability insurance, contractor's license, Yellow Page ad, name on vehicle, or any of the various other criteria that companies make up. The Supreme Court has said that the right to control the work is the most important. It is a judgment call with no requirement as to how many of the seven factors must be satisfied.

The Department issued a Bulletin dated June 1, 2005 outlining the responsibility of insurance companies and employers in determining the existence of an independent contractor relationship. Click here to see/print the Bulletin.

**(E)** "Employee" does not include a construction services provider, as defined in § 50-6-901, if the construction services provider is:

**(i)** Listed on the registry established pursuant to part 9 of this chapter as having a workers' compensation exemption and is working in the service of the business entity through which the provider obtained such an exemption;

**(ii)** Not covered under a policy of workers' compensation insurance maintained by the person or entity for whom the provider is providing services; and

**(iii)** Rendering services on a construction project that:

**(a)** Is not a commercial construction project, as defined in § 50-6-901; or

**(b)** Is a commercial construction project, as defined in § 50-6-901, and the general contractor for whom the construction services provider renders construction services complies with § 50-6-914(b)(2);

**(13)** "Employer" includes any individual, firm, association or corporation, the receiver or trustee of the individual, firm, association or corporation, or the legal representative of a deceased employer, using the services of not less than five (5) persons for pay, except as provided in § 50-6-902, and, in the case of an employer engaged in the mining and production of coal, one (1) employee for pay. If the employer is insured, it shall include the employer's insurer, unless otherwise provided in this chapter;

**(14)** "Injury" and "personal injury" mean an injury by accident, a mental injury, occupational disease including diseases of the heart, lung and hypertension, or cumulative trauma conditions including hearing loss, carpal tunnel syndrome or any other repetitive motion conditions, arising primarily out of and in the course and scope of employment, that causes death, disablement or the need for medical treatment of the employee; provided, that:

**(A)** An injury is "accidental" only if the injury is caused by a specific incident, or set of incidents, arising primarily out of and in the course and scope of employment, and is identifiable by time and place of occurrence, and shall not include the aggravation of a preexisting disease, condition or ailment unless it can be shown to a reasonable degree of medical certainty that the aggravation arose primarily out of and in the course and scope of employment;

**(B)** An injury "arises primarily out of and in the course and scope of employment" only if it has been shown by a preponderance of the evidence that the employment contributed more than fifty percent (50%) in causing the injury, considering all causes;

**(C)** An injury causes death, disablement or the need for medical treatment only if it has been shown to a reasonable degree of medical certainty that it contributed more than fifty percent (50%) in causing the death, disablement or need for medical treatment, considering all causes;

**(D)** "Shown to a reasonable degree of medical certainty" means that, in the opinion of the physician, it is more likely than not considering all causes, as opposed to speculation or possibility;

**(E)** The opinion of the treating physician, selected by the employee from the employer's designated panel of physicians pursuant to § 50-6-204(a)(3), shall be presumed correct on the issue of causation but this presumption shall be rebuttable by a preponderance of the evidence;

**(15)** **(A)** "Maximum total benefit" means the sum of all weekly benefits to which a worker may be entitled;

**(B)** For injuries occurring on or after July 1, 1992, but before July 1, 2009, the maximum total benefit shall be four hundred (400) weeks times the maximum weekly benefit, except in instances of permanent total disability;

**(C)** For injuries occurring on or after July 1, 2009, but before July 1, 2014, the maximum total benefit shall be four hundred (400) weeks times one hundred percent (100%) of the state's average weekly wage, as determined pursuant to subdivision (15)(B), except in instances of permanent total disability. Temporary total disability benefits paid to the injured worker shall not be included in calculating the maximum total benefit;

**(D)** For injuries occurring on or after July 1, 2014, the maximum total benefit shall be four hundred fifty (450) weeks times one hundred percent (100%) of the state's average weekly wage, as determined pursuant to subdivision (15)(B), except in instances of permanent total disability. Temporary total disability benefits paid to the injured worker before the employee attains maximum medical improvement shall not be included in calculating the maximum total benefit;

**(16) (A) (i)** "Maximum weekly benefit" means the maximum compensation payable to the worker per week;

**(ii)** For injuries occurring between July 1, 1990, and June 30, 1991, the maximum weekly benefit shall be two hundred seventy-three dollars ($273) per week;

**(iii)** For injuries occurring on or after July 1, 1991, and before August 1, 1992, the maximum weekly benefit shall be two hundred ninety-four dollars ($294) per week;

**(iv)** For injuries occurring on or after August 1, 1992, and through June 30, 1993, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to seventy-eight percent (78%) of the state's average weekly wage, as determined by the department;

**(v)** For injuries occurring on or after July 1, 1993, and through June 30, 1994, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to eighty-two and four-tenths percent (82.4%) of the state's average weekly wage, as determined by the department;

**(vi)** For injuries occurring on or after July 1, 1994, and through June 30, 1995, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to eighty-six and eight-tenths percent (86.8%) of the state's average weekly wage, as determined by the department;

**(vii)** For injuries occurring on or after July 1, 1995, and through June 30, 1996, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to ninety-one and two-tenths percent (91.2%) of the state's average weekly wage, as determined by the department;

**(viii)** For injuries occurring on or after July 1, 1996, and through June 30, 1997, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to ninety-five and six-tenths percent (95.6%) of the

state's average weekly wage as determined by the department;

**(ix)** For injuries occurring on or after July 1, 1997, and through June 30, 2004, the maximum weekly benefit shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to one hundred percent (100%) of the state's average weekly wage as determined by the department;

**(x)** For injuries occurring on or after July 1, 2004, the maximum weekly benefit for permanent disability benefits shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to one hundred percent (100%) of the state's average weekly wage, as determined by the department; and

**(xi)** **(a)** For injuries occurring on or after July 1, 2004, through June 30, 2005, the maximum weekly benefit for temporary disability benefits shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to one hundred five percent (105%) of the state's average weekly wage, as determined by the department; and

**(b)** For injuries occurring on or after July 1, 2005, the maximum weekly benefit for temporary disability benefits shall be sixty-six and two thirds percent (66 2/3%) of the employee's average weekly wage up to one hundred ten percent (110%) of the state's average weekly wage, as determined by the department;

**(B)** As used in subdivision (15)(A), the state average weekly wage shall be determined as of the preceding January 1, and shall be adjusted annually using the data from the bureau and shall be effective on July 1 of each year;

**(17)** "Mental injury" means a loss of mental faculties or a mental or behavioral disorder, arising primarily out of a compensable physical injury or an identifiable work related event resulting in a sudden or unusual stimulus, and shall not include a psychological or psychiatric response due to the loss of employment or employment opportunities;

**(18)** "Minimum weekly benefit" means the minimum compensation per week payable to the worker, which shall be fifteen percent (15%) of the state's average weekly wage, as determined by the department;

**(19)** "Specialty practice group" means a group of Tennessee licensed physicians, surgeons, or chiropractors providing medical care services of the same or similar medical specialty as each other and operating out of the same physical location; and

**(20)** "Utilization review" means evaluation of the necessity, appropriateness, efficiency and quality of medical care services, including the prescribing of one (1) or more Schedule II, III, or IV controlled substances for pain management for a period of time exceeding ninety (90) days from the initial prescription of such controlled substances, provided to an injured or disabled employee based on medically accepted standards and an objective evaluation of those services provided; provided, that "utilization review"

does not include the establishment of approved payment levels, a review of medical charges or fees, or an initial evaluation of an injured or disabled employee by a physician specializing in pain management.

**(21)** [Deleted by 2013 amendment, effective July 1, 2014.]

**50-6-103. Scope of chapter.**

**(a)** Every employer and employee subject to this chapter, shall, respectively, pay and accept compensation for personal injury or death by accident arising primarily out of and in the course and scope of employment without regard to fault as a cause of the injury or death; provided, that any person who has an exemption pursuant to § 50-6-104 or part 9 of this chapter shall not be bound if the employee has given, prior to any accident resulting in injury or death, notice to be exempted from this chapter as provided in this part.

**50-6-104. Election of corporation officer to be exempt from chapter.**

**(a)** Any officer of a corporation may elect to be exempt from the operation of this chapter. Any officer who elects exemption and who, after electing exemption then revokes that exemption, shall give notice to that effect in accordance with a form prescribed by the bureau. Link to I-6 exemption I-7 revoke exemption These forms cannot be used for a Construction Service Provider.

**(b)** Notice given pursuant to subsection (a) shall be given thirty (30) days prior to any accident resulting in injury or death; provided, that if any injury or death occurs less than thirty (30) days after the date of employment, notice of the exemption or acceptance given at the time of employment shall be sufficient notice of exemption.

**(c)** The notice of election not to accept this chapter, shall be as follows: the employee shall give written or printed notice to the employer of the employee's election not to be bound by the Workers' Compensation Law and file with the bureau, a duplicate, with proof of service on the employer attached to the notice, together with an affidavit of the employee that the action of the employee in rejecting the Workers' Compensation Law was not advised, counseled or encouraged by the employer or by anyone acting for the employer.

**(d)** [Deleted by 2013 amendment, effective July 1, 2014.]

**(e)** The election by any employee, who is a corporate officer of the employer, to be exempted from this chapter, shall not reduce the number of employees of the employer for the purposes of determining the requirements of coverage of the employer under this chapter.

**(f)** Every employee who is a corporate officer and who elects not to operate under this chapter, in any action to recover damages for personal injury or death by accident brought against an employer who has elected to operate under this chapter, shall proceed

as at common law, and the employer may make use of all common law defenses. This section shall not apply to any officer of a corporation, member of a limited liability company, partner, or sole proprietor who is engaged in the construction industry, as defined by § 50-6-901; instead, part 9 of this chapter shall apply to such officer, member, partner or sole proprietor.

**50-6-106. Employments not covered.**

Link to I-8 Election of Exempt Employer to be Covered
Link to I-9 Notice to Withdraw Election

This chapter shall not apply to:

**(1)** **(A)** Any common carrier doing an interstate business while engaged in interstate commerce, which common carrier and the interstate business are already regulated as to employer's liability or workers' compensation by act of congress, it being the purpose of this law to regulate all such business that the congress has not regulated in the exercise of its jurisdiction to regulate interstate commerce; provided, that this chapter shall apply to those employees of the common carriers with respect to whom a rule of liability is not provided by act of congress; provided, further, that no common carrier by motor vehicle operating pursuant to a certificate of public convenience and necessity shall be deemed the employer of a leased-operator or owner-operator of a motor vehicle or vehicles under a contract to such a common carrier;

**(B)** Notwithstanding subdivision (1)(A), a leased operator or a leased owner/operator of a motor vehicle under contract to a common carrier may elect to be covered under any policy of workers' compensation insurance insuring the common carrier upon written agreement of the common carrier, by filing written notice of the contract, on a form prescribed by the administrator, with the bureau; provided, that the election shall in no way terminate or affect the independent contractor status of the leased operator or leased owner/operator for any other purpose than to permit workers' compensation coverage. The leased operator or leased owner/operator electing coverage as provided in this section shall establish the validity of and satisfy the terms and conditions of all contractual agreements between the parties prior to the payment of any claim for workers' compensation. The election of coverage may be terminated by the leased operator, leased owner/operator, or common carrier by providing written notice of the termination to the bureau and to all other parties consenting to the prior election. The termination shall be effective thirty (30) days from the date of the notice to all other parties consenting to the prior election and to the bureau;

**(C)** The venue of any dispute arising out of or connected with the validity of the contractual relationship or terms of the written agreement upon which the workers' compensation benefits are extended between the common carrier and a leased operator or leased owner/operator shall be the chancery court of the county where the contract was entered or the county of the principal place of business of the common carrier;

**(D)** Whenever the leased operator, the leased owner/operator or the carrier files a suit

to resolve a contract dispute pursuant to subdivision (C), the statute of limitations for filing a petition for benefit determination with the bureau shall be tolled for ninety (90) days after final judgment has been entered in the suit including all appeals. In cases where a leased operator or leased owner/operator has filed a petition for benefit determination before the leased operator, leased owner/operator or the carrier has filed a suit pursuant to subdivision (C) to resolve a contract dispute, the petition for benefit determination shall be held in abeyance by the bureau until final judgment, including all appeals, has been entered in the suit filed pursuant to subdivision (C).

**(2)** Any person whose employment at the time of injury is casual, that is, one who is not employed in the usual course of trade, business, profession or occupation of the employer;

**(3)** Domestic servants and employers of domestic servants;

**(4)** Farm or agricultural laborers and employers of those laborers;

**(5)** In cases where fewer than five (5) persons are regularly employed, except as provided in § 50-6-902; provided, that in those cases the employer may accept this chapter by filing written notice of the acceptance with the bureau at least thirty (30) days before the happening of any accident or death, and may at any time withdraw the acceptance by giving like notice of withdrawal;

**(6)** The state, counties of the state and municipal corporations; provided, that the state, any county or municipal corporation may accept this chapter by filing written notice of the acceptance with the bureau under the administrator, at least thirty (30) days before the happening of any accident or death, and may at any time withdraw the acceptance by giving like notice of the withdrawal. The state, any county or municipal corporation may accept this chapter as to any department or division of the state, county or municipal corporation by filing written notice of acceptance with the bureau under the administrator, at least thirty (30) days before the happening of any accident or death and may, at any time, withdraw acceptance for the division or department by giving like notice of the withdrawal, and the acceptance by the state, county or municipal corporation for any department or division of the state, county or municipal corporation shall have effect only of making the department or division designated subject to the terms of this chapter; or

**(7)** Any person performing voluntary service as a ski patrolperson who receives no compensation for the services other than meals, lodging or the use of ski tow or ski lift facilities or any combination of meals, lodging and the use of ski tow or ski lift facilities.

**50-6-107. Application to coal mine operators and employees.**

This chapter shall apply to coal mine operators and to their employees.

**50-6-108. Right to compensation exclusive.**

(a) The rights and remedies granted to an employee subject to this chapter, on account of personal injury or death by accident, including a minor whether lawfully or unlawfully employed, shall exclude all other rights and remedies of the employee, the employee's personal representative, dependents or next of kin, at common law or otherwise, on account of the injury or death.

(b) No employer who fails to secure payment of compensation as required by this chapter, shall be permitted to defend the suit upon any of the following grounds, in any suit brought against the employer by an employee covered by this chapter or by the dependent or dependents of the employee, to recover damages for personal injury or death arising from an accident:

(1) The employee was negligent;

(2) The injury was caused by the negligence of a fellow servant or fellow employee; or

(3) The employee had assumed the risk of the injury.

(c) This section shall not be construed to preclude third party indemnity actions against an employer who has expressly contracted to indemnify the third party.

**50-6-109. Nonperformance of statutory duty not relieved.**

Nothing in this chapter shall be construed to relieve any employer or employee from penalty for failure or neglect to perform any statutory duty.

**50-6-110. Injuries not covered - Drug and alcohol testing.**

(a) No compensation shall be allowed for an injury or death due to:

(1) The employee's willful misconduct;

(2) The employee's intentional self-inflicted injury;

(3) The employee's intoxication or illegal drug usage;

(4) The employee's willful failure or refusal to use a safety device;

(5) The employee's willful failure to perform a duty required by law; or

(6) The employee's voluntary participation in recreational, social, athletic or exercise activities, including, but not limited to, athletic events, competitions, parties, picnics, or exercise programs, whether or not the employer pays some or all of the costs of the activities unless:

(A) Participation was expressly or impliedly required by the employer;

**(B)** Participation produced a direct benefit to the employer beyond improvement in employee health and morale;

**(C)** Participation was during employee's work hours and was part of the employee's work-related duties; or

**(D)** The injury occurred due to an unsafe condition during voluntary participation using facilities designated by, furnished by or maintained by the employer on or off the employer's premises and the employer had actual knowledge of the unsafe condition and failed to curtail the activity or program or cure the unsafe condition.

**(b)** If the employer defends on the ground that the injury arose in any or all of the ways stated in subsection (a), the burden of proof shall be on the employer to establish the defense.

**(c)** **(1)** In cases where the employer has implemented a drug-free workplace pursuant to chapter 9 of this title, if the injured employee has, at the time of the injury, a blood alcohol concentration level equal to or greater than eight hundredths of one percent (.08%) for non-safety sensitive positions, or four hundredths of one percent (.04%) for safety-sensitive positions, as determined by blood or breath testing, or if the injured employee has a positive confirmation of a drug as defined in § 50-9-103, then it is presumed that the drug or alcohol was the proximate cause of the injury. This presumption may be rebutted by clear and convincing evidence that the drug or alcohol was not the proximate cause of injury. Percent by weight of alcohol in the blood must be based upon grams of alcohol per one hundred milliliters (100 mL) of blood. If the results are positive, the testing facility must maintain the specimen for a minimum of three hundred sixty-five (365) days at minus twenty degrees celsius (-20 degrees C.). Blood serum may be used for testing purposes under this chapter; provided, however, that if this test is used, the presumptions under this section do not arise unless the blood alcohol level is proved to be medically and scientifically equivalent to or greater than the comparable blood alcohol level that would have been obtained if the test were based on percent by weight of alcohol in the blood. However, if, before the accident, the employer had actual knowledge of and acquiesced in the employee's presence at the workplace while under the influence of alcohol or drugs, the employer retains the burden of proof in asserting any defense under subsections (a) and (b), and this subsection (c) does not apply.

**(2)** If the injured worker refuses to submit to a drug test, it shall be presumed, in the absence of clear and convincing evidence to the contrary, that the proximate cause of the injury was the influence of drugs, as defined in § 50-9-103.

**(3)** The administrator of the bureau of workers' compensation shall provide, by rule, for the authorization and regulation of drug testing policies, procedures and methods. Testing of injured employees pursuant to a drug-free workplace program under chapter 9 of this title shall not commence until the rules are adopted.

**50-6-111. Defenses not available to employer failing to secure payment of compensation.** [Applicable to injuries occurring prior to July 1, 2014.]

No employer who fails to secure payment of compensation as required by this chapter, shall, in any suit brought against the employer by an employee covered by this chapter or by the dependent or dependents of the employee, to recover damages for personal injury or death arising from an accident, be permitted to defend the suit upon any of the following grounds:

**(1)** The employee was negligent;

**(2)** The injury was caused by the negligence of a fellow servant or fellow employee; or

**(3)** The employee had assumed the risk of the injury.

**50-6-112. Actions against third persons — Attorney's fees — Distribution of recovery — Limitations period.**

**(a)** When the injury or death for which compensation is payable under this chapter was caused under circumstances creating a legal liability against some person other than the employer to pay damages, the injured worker, or the injured worker's dependents, shall have the right to take compensation under this chapter, and the injured worker, or those to whom the injured worker's right of action survives at law, may pursue the injured worker's or their remedy by proper action in a court of competent jurisdiction against the other person.

**(b)** In the event of a recovery from the other person by the worker, or those to whom the worker's right of action survives, by judgment, settlement or otherwise, the attorney representing the injured worker, or those to whom the injured worker's right of action survives, and effecting the recovery, shall be entitled to a reasonable fee for the attorney's services, and the attorney shall have a first lien for the fees against the recovery; provided, that if the employer has engaged other counsel to represent the employer in effecting recovery against the other person, then a court of competent jurisdiction shall, upon application, apportion the reasonable fee between the attorney for the worker and the attorney for the employer, in proportion to the services rendered.

**(c)** **(1)** In the event of a recovery against the third person by the worker, or by those to whom the worker's right of action survives, by judgment, settlement or otherwise, and the employer's maximum liability for workers' compensation under this chapter has been fully or partially paid and discharged, the employer shall have a subrogation lien against the recovery, and the employer may intervene in any action to protect and enforce the l.

**(2)** In the event the net recovery by the worker, or by those to whom the worker's right of action survives, exceeds the amount paid by the employer, and the employer has not, at the time, paid and discharged the employer's full maximum liability for workers' compensation under this chapter, the employer shall be entitled to a credit on the

employer's future liability, as it accrues, to the extent the net recovery collected exceeds the amount paid by the employer.

**(3)** In the event the worker, or those to whom such worker's right of action survives, effects a recovery, and collection thereof, from such other person, by judgment, settlement or otherwise, without intervention by the employer, the employer shall nevertheless be entitled to a credit on the employer's future liability for workers' compensation, as it accrues under this chapter, to the extent of the net recovery.

**(d)** **(1)** Such action against such other person by the injured worker, or those to whom such injured worker's right of action survives, must be instituted in all cases within one (1) year from the date of injury.

**(2)** Failure on the part of the injured worker, or those to whom the injured worker's right of action survives, to bring the action within the one-year period shall operate as an assignment to the employer of any cause of action in tort that the worker, or those to whom the worker's right of action survives, may have against any other person for the injury or death, and the employer may enforce the cause of action in the employer's own name or in the name of the worker, or those to whom the worker's right of action survives, for the employer's benefit, as the employer's interest may appear, and the employer shall have six (6) months after the assignment within which to commence the suit.

**(3)** If the cause of action described in subsection (a) arises in a jurisdiction other than this state and the other jurisdiction has a statute of limitations for personal injury and wrongful death greater than the one-year statute of limitations provided in this state, the court hearing the cause of action shall apply the statute of limitations that provides the injured worker, or those to whom the injured worker's right of action survives, the greatest amount of time in which to institute an action.

**(4)** Under no circumstances shall the negligent party described in subsection (a) benefit from this subsection (d).

**50-6-113. Liability of principal, intermediate contractor or subcontractor.**
**[Applicable to injuries occurring prior to July 1, 2014.]**

**(a)** A principal contractor, intermediate contractor or subcontractor shall be liable for compensation to any employee injured while in the employ of any of the subcontractors of the principal contractor, intermediate contractor or subcontractor and engaged upon the subject matter of the contract to the same extent as the immediate employer.

**(b)** Any principal contractor, intermediate contractor or subcontractor who pays compensation under subsection (a) may recover the amount paid from any person who, independently of this section, would have been liable to pay compensation to the injured employee, or from any intermediate contractor.

**(c)** Every claim for compensation under this section shall be in the first instance

presented to and instituted against the immediate employer, but the proceedings shall not constitute a waiver of the employee's rights to recover compensation under this chapter from the principal contractor or intermediate contractor; provided, that the collection of full compensation from one (1) employer shall bar recovery by the employee against any others, nor shall the employee collect from all a total compensation in excess of the amount for which any of the contractors is liable.

**(d)** This section applies only in cases where the injury occurred on, in, or about the premises on which the principal contractor has undertaken to execute work or that are otherwise under the principal contractor's control or management.

**(e)** A subcontractor under contract to a general contractor may elect to be covered under any policy of workers' compensation insurance insuring the contractor upon written agreement of the contractor, by filing written notice of the election, on a form prescribed by the administrator, with the bureau. It is the responsibility of the general contractor to file the written notice with the bureau. Failure of the general contractor to file the written notice shall not operate to relieve or alter the obligation of an insurance company to provide coverage to a subcontractor when the subcontractor can produce evidence of payment of premiums to the insurance company for the coverage. The election shall in no way terminate or affect the independent contractor status of the subcontractor for any other purpose than to permit workers' compensation coverage. The election of coverage may be terminated by the subcontractor or general contractor by providing written notice of the termination to the bureau and to all other parties consenting to the prior election. The termination shall be effective thirty (30) days from the date of the notice to all other parties consenting to the prior election and to the bureau. Link to Combined Form I-15 & I-17

**(f)** This section shall not apply to a construction services provider, as defined by § 50-6-901.

**50-6-114. Supremacy of chapter — Setoffs for payments by disability plan.**

**(a)** No contract or agreement, written or implied, or rule, regulation or other device, shall in any manner operate to relieve any employer, in whole or in part, of any obligation created by this chapter, except as provided in subsection (b).

**(b)** Any employer may set off from temporary total, temporary partial, permanent partial and permanent total disability benefits any payment made to an employee under an employer funded disability plan for the same injury; provided, that the disability plan permits such an offset. The offset from a disability plan may not result in an employee's receiving less than the employee would otherwise receive under this chapter. In the event that a collective bargaining agreement is in effect, this subsection (b) shall be subject to the agreement of both parties.

**50-6-115. Extraterritorial application of chapter.**

**(a)** For purposes of this section, an employee is considered to be temporarily in a state working for an employer if the employee is working for such employee's employer in a state other than the state where such employee is primarily employed for no more than fourteen (14) consecutive days, or no more than twenty-five (25) days total, during a calendar year.

**(b)** **(1)** If an employee in this state who is subject to this chapter temporarily leaves this state incidental to the employee's employment and receives an accidental injury arising out of and in the course and scope of the employee's employment, the employee, or the employee's beneficiaries in the case of an injury that results in the employee's death, shall be entitled to the benefits of this chapter as if the employee was injured in this state.

**(2)** If an employee, while working outside the territorial limits of this state other than temporarily, suffers an injury on account of which the employee, or, in the event of the employee's death, the employee's dependents, would have been entitled to the benefits provided by this chapter had the injury occurred within this state, the employee, or in the event of the employee's death resulting from the injury, the employee's dependents, shall be entitled to the benefits provided by this chapter; provided, that at the time of the injury:

**(A)** The employment was principally localized within this state;

**(B)** The contract of hire was made in this state; or

**(C)** If at the time of the injury the injured worker was a Tennessee resident and there existed a substantial connection between this state and the particular employer and employee relationship.

**(c)** **(1)** An employee from another state and the employee's employer are exempt from this chapter while the employee is temporarily in this state performing work for the employer if:

**(A)** The employer has furnished workers' compensation insurance coverage under the workers' compensation insurance or similar laws of the other state to cover the employee's employment while in this state;

**(B)** The extraterritorial provisions of this chapter are recognized in the other state; and

**(C)** Employees and employers who are covered in this state are likewise exempted from the application of the workers' compensation insurance or similar laws of the other state.

**(2)** The benefits under the workers' compensation insurance or similar laws of the other state, or other remedies under similar law, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the employee while

temporarily working for that employer in this state.

**(3)** A certificate from the duly authorized officer of the appropriate department of another state certifying that the employer of such other state is insured in that state and has provided extraterritorial coverage insuring employees while working in this state is prima facie evidence that the employer carries such workers' compensation insurance.

**(4)** Whenever in any appeal or other litigation the construction of the laws of another jurisdiction is required, the courts shall take judicial notice of such construction of the laws of the other jurisdiction.

**(5)** When an employee has a claim under the workers' compensation insurance laws of another state, territory, province, or foreign nation for the same injury or occupational disease as the claim filed in this state, the total amount of compensation paid or awarded under such other workers' compensation law shall be credited against the compensation due under this chapter.

**(d)** **(1)** Any employer who is insured in this state for workers' compensation under this chapter, and who has extraterritorial coverage under this chapter, for their employees while such employees are temporarily working outside this state within the meaning of subsection (a) may obtain a certificate evidencing such coverage at the time that the application for certification is made from the commissioner of commerce and insurance.

**(2)** In order to obtain a certificate under subdivision (d)(1), an employer shall:

**(A)** File an application with the commissioner of commerce and insurance, on a form that is approved by the commissioner of commerce and insurance;

**(B)** Pay a filing fee to the department of commerce and insurance in the amount of one hundred dollars ($100). The commissioner of commerce and insurance may change the amount of the filing fee required by this subdivision (d)(2)(B) by promulgating a rule pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, as necessary to ensure that the proceeds of such filing fees are sufficient to offset the cost of processing applications and issuing the certificates authorized by this subsection (d); and

**(C)** Submit to the commissioner of commerce and insurance a copy of the declaration page from the employer's workers' compensation insurance policy, or such proof as the commissioner of commerce and insurance may require to demonstrate that the employer is self insured for workers' compensation and the territorial limits of such coverage.

**(3)** The commissioner of commerce and insurance is authorized to issue a certificate that certifies that, at the time that the application for certification is made, the applicant employer in this state is insured for workers' compensation under this chapter, and that such employers have extraterritorial coverage under this chapter, for their employees while such employees are temporarily working outside this state within the meaning of subsection (a).

**50-6-116. Construction of chapter.**

For any claim for workers' compensation benefits for an injury, as defined in this chapter, when the date of injury is on or after July 1, 2014, this chapter shall not be remedially or liberally construed but shall be construed fairly, impartially, and in accordance with basic principles of statutory construction and this chapter shall not be construed in a manner favoring either the employee or the employer.

**50-6-117. Suits by corporation officer against employer.** **[Applicable to injuries occurring prior to July 1, 2014.]**

Every employee who is a corporate officer and who elects not to operate under this chapter, in any action to recover damages for personal injury or death by accident brought against an employer who has elected to operate under this chapter, shall proceed as at common law, and the employer in the suit may make use of all common law defenses. This section shall not apply to any officer of a corporation, member of a limited liability company, partner, or sole proprietor who is engaged in the construction industry, as defined by § 50-6-901; instead, part 9 of this chapter shall apply to such officer, member, partner or sole proprietor.

**50-6-118. Penalties.** **[Applicable to injuries occurring on and after July 1, 2014.]**

**(a)** The bureau of workers' compensation shall, by rule promulgated pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, establish and collect penalties for the following:

**(1)** Failure of a covered employer to provide workers' compensation coverage or qualify as a self-insurer;

**(2)** Late filing of accident reports;

**(3)** Bad faith denial of claims;

**(4)** Late filing of notice of denial of claim;

**(8)** Failure of any party to appear or to mediate in good faith at any alternative dispute resolution proceeding;

**(9)** Failure of any party to comply, within the designated timeframe, with any order or judgment issued by a workers' compensation judge;

**(10)** Performance of any enumerated action provided in § 29-9-102 in relation to any proceedings in the court of workers' compensation claims;

**(11)** Failure of any employer to timely provide medical treatment made

reasonably necessary by the accident and recommended by the authorized treating physician or operating physician;

**(12)** Failure of an employer to timely provide a panel of physicians that meets the statutory requirements of this chapter;

**(13)** Wrongful failure of an employer to pay an employee's claim for temporary total disability payments;

**(14)** Wrongful failure to satisfy the terms of an approved settlement; and

**(15)** Refusal to cooperate with the services provided by an ombudsman;

**(b)** All penalties collected by the department from an employer for failure to provide workers' compensation coverage or failure to qualify as a self-insurer shall be paid into and become a part of the uninsured employers fund. All other penalties collected by the department shall be paid into and become a part of the second injury fund.

**(c)** The bureau of workers' compensation may assess the penalties authorized by this chapter, upon providing notice and an opportunity for a hearing to an employer, an employee, an insurer, or a self-insured pool or trust. If a hearing is requested, the commissioner, commissioner's designee, or an agency member appointed by the commissioner shall have the authority to hear the matter as a contested case, and the authority to hear the administrative appeal of an agency decision, relating to the assessment of the penalties authorized by this chapter. When a hearing or review of an agency decision is requested, the requesting party shall have the burden of proving, by a preponderance of the evidence, that the penalized party was either not subject to this chapter, or that the penalties assessed pursuant to this chapter should not have been assessed. Any party assessed a penalty pursuant to this section shall have the right to appeal the penalty assessed by the bureau and affirmed by the commissioner, the commissioner's designee or an agency member in the manner provided in this subsection, pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**(d)** If an employee receives a settlement, judgment or decree under this chapter that includes the payment of medical expenses and the employer or workers' compensation carrier wrongfully fails to reimburse an employee for any medical expenses actually paid by the employee within sixty (60) days of the settlement, judgment or decree, or fails to provide reasonable and necessary medical expenses and treatment, including failure to reimburse for reasonable and necessary medical expenses, in bad faith after receiving reasonable notice of their obligation to provide the medical treatment, the employer or[Middle dot] workers' compensation carrier shall be liable, in the discretion of the court, to pay the employee, in addition to the amount due for medical expenses paid, a sum not exceeding twenty-five percent (25%) of the expenses; provided, that it is made to appear to the court that

the refusal to pay the claim was not in good faith and that the failure to pay inflicted additional expense, loss or injury upon the employee.

(16) Any violation of § 50-6-215 by an individual or entity not licensed by the department of commerce and insurance; (effective 7-1-16)

**50-6-119. Information awareness program.**

**(a)** In order to provide greater awareness among employers and employees of the rights and obligations of the workers' compensation laws, the bureau of workers' compensation shall institute an information awareness program. The program shall:

**(1)** Involve a statewide effort to consult with employers on the actions required;

**(2)** Provide that employers with frequent incidents of injuries be targeted for referral to appropriate agencies on accident prevention;

**(3)** Provide education and information aimed at preventing disputes and delays in the processing of claims, through the use of speakers' seminars and conferences;

**(4)** Provide a system to communicate developments in the law to interested groups;

**(5)** Provide injured employees with complete information on their rights to compensation and day-to-day assistance with problems on their claims;

**(6)** Develop general informational literature and audio-visual aids for both employees and employers; and

**(7)** Provide a toll-free number for employers and employees to receive information from and ask questions of the department.

**(b)** Any publications for distribution under this section must be published in accordance with the rules, regulations, policies and procedures of the state publications committee.

**50-6-120. Liability of construction design professionals.**

**(a)** No construction design professional, or any employee of the construction design professional, who is retained to perform professional services on a construction project, shall be liable for the personal injury or death of any nonemployee of the construction design professional, working on the construction project, unless the construction design professional or any employee of the construction design professional is guilty of negligence that is a proximate cause of the injury or death of the nonemployee.

**(b)** Nothing in this section shall be construed to affect the rights or responsibilities of any person under this chapter.

**(c)** Rule 11 of the Tennessee Rules of Civil Procedure shall apply in all actions against construction design professionals.

**50-6-121. Advisory council on workers' compensation.**

**(a) (1) (A)** There is created an advisory council on workers' compensation. There shall be seven (7) voting members of the council, with three (3) representing employers, three (3) representing employees, and one (1) member who shall serve as the chair and who shall be the state treasurer or the state treasurer's designee. There shall be ten (10) nonvoting members of the council. All members shall have a demonstrable working knowledge of the workers' compensation system.

**(B)** The chair shall preside at meetings of the council and, in consultation with the voting members of the council, shall supervise the work of the staff of the council. The council shall meet at the call of the chair or at the written call of four (4) voting members of the council which written call shall be delivered to the chair. The chair may vote only on matters related to the administration of the council or the council's research. The chair is not permitted to vote on any matter that constitutes the making of a policy recommendation to the governor or to the general assembly.

**(C)** The speaker of the house of representatives, the speaker of the senate and the governor shall each appoint one (1) employer and one (1) employee representative to the council, who shall be voting members. Representatives, officers and employees from labor organizations or business trade organizations are eligible for appointment. In making the appointments of the employer representatives, the appointing authorities shall strive to ensure a balance of a commercially insured employer, self-insured employer or an employer who operates a small business. At least one (1) employee representative shall be from organized labor. Proxy voting is prohibited by voting members of the council; provided, however, that in instances where a voting member will be absent from a vote of the council, the member's appointing authority is authorized to appoint an alternate or designee for the vote or votes.

**(D)** Voting members shall serve four-year terms and the terms shall be staggered so that the terms of only three (3) voting members shall terminate at the same time. All four-year terms shall begin on July 1 and terminate on June 30, four (4) years thereafter.

**(E) (i)** The governor shall also appoint ten (10) nonvoting members of the council as follows: one (1) to represent local governments, one (1) to represent insurance companies, five (5) to represent health care providers and three (3) attorneys. The nonvoting local government representative may be appointed from lists of qualified persons submitted by interested municipal and county organizations including, but not limited to, the Tennessee Municipal League and the Tennessee County Services Association. The nonvoting insurance company representative may be appointed from lists of qualified persons submitted by interested insurance organizations including, but not limited to, the Alliance of American Insurers and the American Insurance Association. One (1) nonvoting healthcare provider representative may be appointed from lists of qualified persons submitted by interested medical organizations including, but not limited to, the Tennessee Medical Association and one (1) nonvoting healthcare provider representative may be appointed from lists of qualified persons submitted by

interested hospital organizations including, but not limited to, the Tennessee Hospital Association. One (1) nonvoting health care provider representative shall be a chiropractor who is licensed in this state, one (1) nonvoting health care provider representative shall be a physical therapist who is licensed in this state, and one (1) nonvoting health care provider representative shall be an occupational therapist who is licensed in this state, and these members shall not receive reimbursement for travel expenses. The nonvoting attorney members shall be appointed as follows: one (1) who shall primarily represent injured workers' compensation claimants, who may be appointed from lists of qualified persons submitted by interested justice organizations including, but not limited to, the Tennessee Association for Justice; one (1) who shall primarily represent employers or workers' compensation insurers, who may be appointed from lists of qualified persons submitted by interested defense lawyer organizations including, but not limited to, the Tennessee Defense Lawyers Association; and one (1) who may be appointed from lists of qualified persons submitted by interested legal organizations including, but not limited to the Tennessee Bar Association.

**(ii)** The appointing authorities shall consult with interested groups including, but not limited to, the organizations listed in subdivision (a)(E)(i) to determine qualified persons to fill positions on the council.

**(F)** The nonvoting members shall be appointed to four-year terms that shall begin on July 1 and terminate on June 30, four (4) years thereafter.

**(G)** The chair of the commerce and labor committee of the senate, the chair of the consumer and human resources committee of the house of representatives, the administrator of the bureau of workers' compensation and the commissioner of commerce and insurance, or their designees, shall be ex officio, nonvoting members of the council.

**(2)** Each voting and nonvoting member of the advisory council on workers' compensation shall, upon the expiration of the member's term, be eligible for reappointment and shall serve until a successor is appointed. In the event a member resigns or becomes ineligible for service during the member's term, a successor shall be appointed by the appropriate appointing authority to serve the remainder of the term.

**(3)** No employer shall discriminate in any manner against an employee who serves on the advisory council because of the employee's service. Employees who serve on the advisory council shall not be denied any benefit from their employer because of the employee's service. Travel expenses of the employee representatives on the council shall be reimbursed pursuant to subsection (b); however, employers may choose to pay the travel expenses of their employees' service on the advisory council according to their own policies.

**(b)** **(1)** Notwithstanding § 3-6-304 or any other law to the contrary, and in addition to all other requirements for membership on the council:

**(A)** Any person registered as a lobbyist pursuant to the registration requirements of

title 3, chapter 6 who is subsequently appointed or otherwise named as a member of the council shall terminate all employment and business association as a lobbyist with any entity whose business endeavors or professional activities are regulated by the council, prior to serving as a member of the council. This subdivision (b)(1)(A) shall apply to all persons appointed or otherwise named to the council after July 1, 2010;

**(B)** No person who is a member of the council shall be permitted to register or otherwise serve as a lobbyist pursuant to title 3, chapter 6 for any entity whose business endeavors or professional activities are regulated by the council during such person's period of service as a member of the council. This subdivision (b)(1)(B) shall apply to all persons appointed or otherwise named to the council after July 1, 2010, and to all persons serving on the council on such date who are not registered as lobbyists; and

**(C)** No person who serves as a member of the council shall be employed as a lobbyist by any entity whose business endeavors or professional activities are regulated by the council for one (1) year following the date such person's service on the council ends. This subdivision (b)(1)(C) shall apply to persons serving on the council as of July 1, 2010, and to persons appointed to the council subsequent to such date.

**(2)** A person who violates this subsection (b) shall be subject to the penalties prescribed in title 3, chapter 6.

**(3)** The bureau of ethics and campaign finance is authorized to promulgate rules and regulations to effectuate the purposes of this subsection (b). All such rules and regulations shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, and in accordance with the procedure for initiating and proposing rules by the ethics commission to the bureau of ethics and campaign finance as prescribed in § 4-55-103.

**(c)** In addition to all other requirements for membership on the council, all persons appointed or otherwise named to serve as members of the council after July 1, 2010, shall be residents of this state.

**(d)** Members of the council shall not be paid but may be reimbursed for travel expenses. All reimbursement for travel expenses shall be in accordance with the comprehensive travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

**(e)** The council shall meet at least twice each year. It shall annually review workers' compensation in the state and shall issue a report of its findings and conclusions on or before July 1 of each year. The annual report shall be sent to the governor, the speakers of the house of representatives and the senate, the chair and vice-chair of the special joint committee on workers' compensation, the administrator of the bureau of workers' compensation, the commissioner of commerce and insurance and the clerks of the house of representatives and senate. Notice of the publication of the annual report and all other reports published by the council shall be provided to all members of the general assembly

pursuant to § 3-1-114.

**(f)** In performing its responsibilities, the council's role shall be strictly advisory, but it may:

**(1)** Make recommendations to the governor, the general assembly, the special joint committee on workers' compensation, the standing committees of each house that review the status of the workers' compensation system, the administrator of the bureau of workers' compensation and the commissioner of commerce and insurance relating to the promulgation or adoption of legislation or rules;

**(2)** Make recommendations to the administrator of the bureau of workers' compensation and the commissioner of commerce and insurance regarding the method and form of statistical data collections; and

**(3)** Monitor the performance of the workers' compensation system in the implementation of legislative directives.

**(g)** The chair, in consultation with the voting members of the council, is authorized to retain staff and professional assistance, such as consultants and actuaries, as the chair deems necessary for the work of the council, subject to budgetary approval in the general appropriations act. For administrative purposes, the council shall be attached to the department of treasury for all administrative matters relating to receipts, disbursements, expense accounts, budget, audit and other related items. The state treasurer shall have administrative and supervisory control over the staff assigned to assist the council. Employees of the council shall not have the status of preferred service employees pursuant to title 8. The autonomy of the council and its authority are not affected by this subsection (g).

**(h)** The council may develop evaluations, statistical reports and other information from which the general assembly may evaluate the impact of the legislative changes to workers' compensation law, including, but not limited to, the Reform Act of 2004 and subsequent statutory changes to this chapter.

**(i)** The advisory council shall issue an annual report that includes a summary of significant supreme court decisions relating to workers' compensation, including an explanation of their impact on existing policy. The report shall be due on or before January 15 of each year and shall include, to the extent possible, the decisions that were issued during the preceding calendar year. This annual report shall be sent to the governor, the speaker of the house of representatives, the speaker of the senate, the chair of the consumer and human resources committee of the house of representatives, the chair of the commerce and labor committee of the senate, and the chair and co-chair of the special joint committee on workers' compensation. Notice of the publication of the report shall be provided to all members of the general assembly pursuant to § 3-1-114.

**(j)** The advisory council on workers' compensation shall, within ten (10) business days of

each meeting it conducts, provide a summary of the meeting and a report of all actions taken and all actions recommended to be taken to each member of the consumer and human resources committee of the house of representatives and the commerce and labor committee of the senate.

**(k)** Whenever any bill is introduced in the general assembly proposing to amend this chapter or to make any change in workers' compensation law, or to make any change in the law that may have a financial or other substantive impact on the administration of workers' compensation law, the standing committee to which the bill is referred may refer the bill to the council. The council's review of bills relating to workers' compensation should include, but not be limited to, bills that propose to amend chapters 3, 6, 7, and 9 of this title, and title 56, chapters 5 and 47. All bills referred to the council shall be reported back to the standing committee to which they were assigned as quickly as reasonably possible. Notwithstanding the absence of a report from the council, the standing committee is free to consider the bill at any time. The chair making the referral shall immediately notify the prime sponsors of the referral and the council shall not review and comment on the proposed legislation until the prime sponsors have been notified. The comments of the council shall describe the potential effects of the proposed legislation on the workers' compensation system and its operations and any other information or suggestions that the council may think helpful to the sponsors, the standing committees or the general assembly. The comments of the council may include recommendations for or against passage of the proposed legislation. Other than reporting the recommendations for or against passage of proposed legislation and responding to any questions that the legislators may have, no staff of the advisory council shall lobby or advocate for or against passage of proposed legislation.

**(l)** The council shall study and report on the occupational health and safety of employment in Tennessee and make recommendations for safe employment education and training and promote the development of employer-sponsored health and safety programs.

**50-6-122. Case management and utilization review - Use of HMOs and PPOs - Legislative intent - Claims by health care providers - Collection agencies - Reports to credit bureau.**

(a) (1) It is the intent of the general assembly that quality medical care services shall be available to injured and disabled employees. It is also the legislative intent to control increasing medical costs in workers' compensation matters by establishing cost control mechanisms to ensure cost-effective delivery of medical care services by employing a program of medical case management and a program to review the utilization and quality of medical care services.

(2) In order to assure that in workers' compensation cases quality medical care is rendered and to control medical care costs, an employer is authorized to use, but is not required to use, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). An HMO or PPO may contract with medical care providers as permitted by law. The contracts are authorized to use, but are not limited to the use of, the

following managed care methodologies:

(A) Medical bill review;

(B) Establishment of medical practice guidelines;

(C) Case management, subject to § 50-6-123;

(D) Utilization review, subject to § 50-6-124; and

(E) Peer review programs.

(3) Section 50-6-204(a)(3), relative to medical care, shall apply to any managed care methodology employed pursuant to this section. For the purposes of § 50-6-204(a)(3), physicians and surgeons in the same HMO or PPO are considered to be associated in practice together if they share a common employer for purposes of their clinical practice, or are associated together in a group practice.

(b) A health care provider shall not pursue a private claim against a workers' compensation claimant for all or part of the costs of health care services provided to the claimant by the provider unless:

(1) The injury is finally adjudicated not to be compensable under this chapter;

(2) The physician or surgeon, as provided in § 50-6-204, who was not authorized by the employer at the time the services were rendered, knew that the physician or surgeon was not an authorized physician or surgeon; or

(3) The employee knew that the physician or surgeon was not an authorized physician or surgeon; provided, that subdivision (b)(2) and this subdivision (b)(3) do not apply to emergency care.

**50-6-128. Penalty for employer causing compensable claim to be paid by insurance or failing to provide necessary medical treatment.**

If any employer knowingly, willfully, and intentionally causes a medical or wage loss claim to be paid under health or sickness and accident insurance, or fails to provide reasonable and necessary medical treatment, including a failure to reimburse when the employer knew that the claim arose out of a compensable work-related injury and should have been submitted under its workers' compensation insurance coverage, then a civil penalty of five hundred dollars ($500) shall be assessed against the employer, and the employer may not offset any sickness and accident income benefit paid to the employee against its temporary total disability benefit payment liability due to the employee pursuant to this chapter. The administrator of the bureau of workers' compensation has the authority to assess and collect the civil penalty.

**50-6-131. Confidentiality of medical records.**

Medical records provided to the bureau of workers' compensation in the course of its activities and the review of settlements pursuant to this chapter shall remain confidential and shall not be considered to be public records.

**50-6-132. Report of employers failing to provide coverage.**

No later than December 31 of each year, the bureau of workers' compensation shall produce a report that includes a listing of the name of each covered employer that failed, during the preceding state fiscal year, to provide workers' compensation coverage or qualify as a self-insured employer as required by law. Only those employers whose failure resulted in periods of non-coverage shall be included within the report. The report shall also include the penalty assessed by the bureau and the payment status of the penalty. The report shall be provided to the advisory council on workers' compensation, the oversight committee on workers' compensation, and the chairs of the senate commerce, labor and agriculture committee and the consumer and employee affairs committee of the house of representatives.

**50-6-134. Annual review.**

The bureau shall, on or before July 1, 2015, and annually thereafter, review the impact of the Workers' Compensation Reform Act of 2013 on the workers' compensation system in this state and deliver a report of its findings to each member of the general assembly.

**50-6-135. Medical advisory committee.**

**(a)** **(1)** The administrator shall appoint a medical advisory committee comprised of practitioners in the medical community having experience in the treatment of workers' compensation injuries, representatives of the insurance industry, employer representatives, and employee representatives to assist the administrator in the development of treatment guidelines and advise the administrator on issues relating to medical care in the workers' compensation system.

**(2)** The medical director shall serve as a nonvoting ex-officio member of the committee.

**(b)** In making appointments, the administrator shall strive to achieve a geographic balance and, in the case of the physician members of the committee, shall assure, to the extent possible, that the membership of the committee reflects the diversity of specialties involved in the medical treatment and management of workers' compensation claimants.

**(c)** Members of the committee shall serve without compensation but, when engaged in the conduct of their official duties as members of the committee, shall be entitled to reimbursement for travel expenses in accordance with uniform regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

**(d)** Each member appointed shall serve a term of four (4) years and may be reappointed by the administrator. If a member leaves the position prior to the expiration of the term, the administrator shall appoint an individual meeting the qualifications of this section to serve the unexpired portion of the term. The individual may be reappointed by the administrator upon expiration of the term.

**50-6-201. Notice of injury.**

**(a) (1)** Every injured employee or the injured employee's representative shall, immediately upon the occurrence of an injury, or as soon thereafter as is reasonable and practicable, give or cause to be given to the employer who has no actual notice, written notice of the injury, and the employee shall not be entitled to physician's fees or to any compensation that may have accrued under this chapter, from the date of the accident to the giving of notice, unless it can be shown that the employer had actual knowledge of the accident. No compensation shall be payable under this chapter, unless the written notice is given the employer within ~~thirty (30)~~ fifteen (15) days after the occurrence of the accident, unless reasonable excuse for failure to give the notice is made to the satisfaction of the tribunal to which the claim for compensation may be presented.

**(2)** The notice of the occurrence of an accident by the employee required to be given to the employer shall state in plain and simple language the name and address of the employee and the time, place, nature, and cause of the accident resulting in injury or death. The notice shall be signed by the claimant or by some person authorized to sign on the claimant's behalf, or by any one (1) or more of the claimant's dependents if the accident resulted in death to the employee.

**(3)** No defect or inaccuracy in the notice shall be a bar to compensation, unless the employer can show, to the satisfaction of the workers' compensation judge before which the matter is pending, that the employer was prejudiced by the failure to give the proper notice, and then only to the extent of the prejudice.

**(4)** The notice shall be given personally to the employer or to the employer's agent or agents having charge of the business at which the injury was sustained by the employee.

**(b)** In those cases where the injuries occur as the result of gradual or cumulative events or trauma, then the injured employee or the injured employee's representative shall provide notice of the injury to the employer within ~~thirty (30)~~ fifteen (15) days after the employee:

**(1)** Knows or reasonably should know that the employee has suffered a work-related injury that has resulted in permanent physical impairment; or

**(2)** Is rendered unable to continue to perform the employee's normal work activities as the result of the work-related injury and the employee knows or reasonably should know that the injury was caused by work-related activities.

**(c)** [Deleted by 2013 amendment, effective July 1, 2014.]

**50-6-202. Contents and service of notice.** **[Applicable to injuries occurring prior to July 1, 2014.]**

**(a)** **(1)** The notice required to be given of the occurrence of an accident to the employer shall state in plain and simple language the name and address of the employee, the time, place, and nature and cause of the accident resulting in injury or death, and shall be signed by the claimant or by some person in the claimant's behalf, or by any one (1) or more of the claimant's dependents if the accident resulted in death to the employee.

**(2)** No defect or inaccuracy in the notice shall be a bar to compensation, unless the employer can show to the satisfaction of the tribunal in which the matter is pending that the employer was prejudiced by the failure to give the proper notice, and then only to the extent of such prejudice.

**(b)** The notice shall be given personally to the employer or to the employer's agent or agents having charge of the business in working at which the injury was sustained by the employee.

**50-6-202. Electronic submission and processing of medical bills.**

**(a)** On or after July 1, 2014, the administrator, in cooperation with the commissioner of commerce and insurance, shall adopt rules regarding the electronic submission and processing of medical bills by health care providers to insurance carriers.

(b) Insurance carriers shall accept medical bills submitted electronically by health care providers in accordance with the administrator's rules.

(c) The administrator shall establish by rule the criteria for granting exceptions to insurance carriers and health care providers who are unable to submit or accept medical bills electronically.

**50-6-203. Limitation of time, claims and actions.** **[Applicable to injuries occurring on and after July 1, 2014.]**

**(a)** No request for a hearing by a workers' compensation judge under this chapter shall be filed with the court of workers' compensation claims, other than a request for settlement approval, until a workers' compensation mediator has issued a dispute certification notice certifying issues in dispute for hearing before a workers' compensation judge.

**(b)** **(1)** In instances when the employer has not paid workers' compensation benefits to or on behalf of the employee, the right to compensation under this chapter shall be forever barred, unless the notice required by § 50-6-201 is given to the employer and a petition for benefit determination is filed with the bureau on a form prescribed by the administrator within one (1) year after the accident resulting in injury.

(2) In instances when the employer has voluntarily paid workers' compensation benefits, within one (1) year following the accident resulting in injury, the right to compensation is forever barred, unless a petition for benefit determination is filed with the bureau on a form prescribed by the administrator within one (1) year from the latter of the date of the last authorized treatment or the time the employer ceased to make payments of compensation to or on behalf of the employee.

(c) For purposes of this section, the issuing date of the last payment of compensation by the employer, not the date of its receipt, shall constitute the time the employer ceased making payments and an employer or its insurer shall provide the date on request.

(d) In case of physical or mental incapacity, other than minority, of the injured person or the injured person's dependents to perform or cause to be performed any action required within the time specified in this section, then the period of limitation in the case shall be extended for one (1) year from the date when the incapacity ceases.

(e) (1) Unless a claim for death benefits is settled or voluntarily paid, the dependent or dependents of a deceased employee shall file a petition for benefit determination on a form prescribed by the administrator within one (1) year after the date of the employee's death.

(2) In the event the deceased employee was a native of a foreign country and leaves no known dependent or dependents within the United States, it shall be the duty of the administrator to give written notice forthwith of the death to the duly accredited consular officer of the country of which the beneficiaries are citizens.

(f) If the employee fails to appear and participate in alternative dispute resolution as scheduled by the bureau, a workers' compensation judge shall have the authority to dismiss the employee's claim by sending a copy of the order of dismissal by certified mail with return receipt requested to the employee's last known address. The order of dismissal for failure to participate in alternative dispute resolution shall become final and the claim shall be forever barred, unless the employee contacts the bureau to schedule mediation and attends mediation within sixty (60) days after the date on which the workers' compensation judge enters the order of dismissal. If the employee complies with the requirements of this subsection within the timeframe provided, the workers' compensation judge shall rescind the order dismissing the employee's claim for failure to participate in alternative dispute resolution.

(g) [Deleted by 2013 amendment, effective July 1, 2014.]

(h) [Deleted by 2013 amendment, effective July 1, 2014.]

(i) Proceedings to obtain a judgment in the case of the failure of the employer for thirty (30) days to pay any compensation due under any settlement or determination shall be filed within one (1) year after the default.

(j) In any case where an employer has paid permanent partial disability benefits to an

employee in an attempt to settle a claim for workers' compensation benefits but the employee and employer have not entered into a settlement agreement that has been approved by a workers' compensation judge, the statute of limitations for filing a claim to recover workers' compensation benefits pursuant to this chapter shall be extended for two (2) years from the date the last payment of permanent partial disability benefits was made to the employee.

**50-6-212. Hernia or rupture.**

(a) In all claims for compensation for hernia or rupture, resulting from injury by accident arising primarily out of and in the course and scope of the employee's employment, it must be definitely proven to the satisfaction of the court that:

(1) There was an injury resulting in hernia or rupture;

(2) The hernia or rupture appeared suddenly;

(3) It was accompanied by pain;

(4) The hernia or rupture immediately followed the accident; and

(5) The hernia or rupture did not exist prior to the accident for which compensation is claimed.

(b) All hernia or rupture, inguinal, femoral or otherwise, so proven to be the result of an injury by accident arising primarily out of and in the course and scope of the employment, shall be treated in a surgical manner by a radical operation. If death results from the operation, the death shall be considered as the result of the injury, and compensation paid in accordance with this chapter.

(c) (1) In case the injured employee refuses to undergo the radical operation for the cure of the hernia or rupture, no compensation will be allowed during the time the refusal continues.

(2) If, however, it is shown that the employee has some chronic disease, or is otherwise in such physical condition that the court finds it unsafe for the employee to undergo the operation, the employee shall be paid compensation in accordance with this chapter.

**50-6-213. Epileptics - Election not to be covered by certain provisions - Revocation.**

**(a)** Epileptics may elect not to be subject to this part for injuries resulting because of epilepsy and still remain subject to its provisions for all other injuries.

**(b)** This election shall be made by giving notice to the employer in writing on a form to be furnished by the bureau of workers' compensation and filing a copy of the notice with the bureau. Link to Combined I-10, I-11and I-12

**(c)** An election may be revoked by giving written notice to the employer of revocation, and the revocation shall be effective upon filing copy of the notice with the bureau.
Link to I-13 Withdrawal of Waiver

**50-6-216. Ombudsman program.**

**(a)** The administrator shall establish a workers' compensation ombudsman program to assist injured or disabled employees, persons claiming death benefits, employers, and other persons in protecting their rights, resolving disputes, and obtaining information available under workers' compensation laws. The ombudsman program shall be available only to those individuals or organizations that are not represented by an attorney in the claim for workers' compensation benefits.

**(b)** No statement, discussion, evidence, allegation or other matter of legal significance that occurs in the presence of an ombudsman shall be admissible as evidence in any other proceeding.

**(c)** The administrator may adopt rules and regulations consistent with this chapter in order to fulfill the purposes of this section in an orderly and efficient manner.

**(d)** The bureau shall have authority to assess a civil penalty against any person or organization, with the exception of the state or a representative of the state, that refuses to cooperate with the services provided by an ombudsman as provided in § 50-6-118.

**(e)** **(1)** Any party that is not represented by legal counsel may request the services of a workers' compensation ombudsman by contacting the office of mediation services.

**(2)** The ombudsman's authority shall include, but not be limited to, the following:

**(A)** Meet with and provide information to unrepresented parties about the unrepresented party's rights and responsibilities under the law;

**(B)** Explain the administrative process for resolving workers' compensation claims;

**(C)** Investigate claims and attempt to resolve disputes without resort to alternative dispute resolution and court proceedings;

**(D)** Communicate with all parties and providers in the claim;

**(E)** Assist the parties in the completion of forms; and

**(F)** Facilitate the exchange of medical records.

**(3)** An ombudsman who is not a licensed attorney shall not provide legal advice; however, an ombudsman who is a licensed attorney may provide limited legal advice but shall not represent any party as the party's attorney. No ombudsman shall make attorney referrals.

**(4)** An ombudsman shall not be called to testify in any proceeding and no statement or representation made to an ombudsman shall be considered by a workers' compensation judge for any purpose.

**(5)** An unrepresented party has a right to consult with an ombudsman and receive services under this subsection. If the party receiving the services of an ombudsman obtains legal counsel pertaining to the case or dispute for which the services of an ombudsman were engaged, the party, or the party's counsel, shall immediately notify the bureau and the office of mediation services. Upon receipt of notice that the party has retained counsel, the ombudsman shall terminate all services.

### 50-6-217. Workers' compensation appeals board. [Applicable to injuries occurring on and after July 1, 2014.]

**(a)** (1) The administrator shall establish a workers' compensation appeals board, which shall be wholly separate from the court of workers' compensation claims, to review interlocutory and final orders entered by workers' compensation judges upon application of any party to a workers' compensation claim.

**(2)** Any party aggrieved by an order issued by a workers' compensation judge may appeal the order to the workers' compensation appeals board by filing a notice of appeal on a form prescribed by the administrator. Review shall be accomplished in the following manner:

> **(A)** Within seven (7) business days after issuance of an interlocutory order, either party may appeal the interlocutory order by filing a notice of appeal with the clerk of the court of workers' compensation claims. Following the expiration of the time established by bureau rules for the parties to file a transcript prepared by a licensed court reporter or a statement of the evidence, along with briefs or position statements specifying the issues presented for review and supporting arguments, the record on appeal shall be submitted by the clerk of the court of workers' compensation claims to the clerk of the workers' compensation appeals board. Within seven (7) business days of the receipt of the record on appeal, the workers' compensation appeals board shall issue a decision affirming, reversing, or modifying and remanding the interlocutory order of the workers' compensation judge. The decision of the workers' compensation appeals board shall not be subject to further review; and
>
> **(B)** Within thirty (30) calendar days after issuance of a compensation order pursuant to § 50-6-239(c)(2), either party may appeal the compensation order by filing a notice of appeal with the clerk of the court of workers' compensation claims. The appealing party shall have fifteen (15) calendar days after the record is filed with the clerk of the workers' compensation appeals board to file a brief. A brief in response, if any, shall be filed within fifteen (15) calendar days of the filing of the appellant's brief. No later than forty-five (45) calendar days after the expiration of the fifteen-day period for a responsive brief

to be filed, the workers' compensation appeals board shall issue a decision affirming, reversing, modifying the compensation order and/or remanding the case. For purposes of further appellate review, the workers' compensation appeals board shall certify as final the order of the court of workers' compensation claims as affirmed, reversed, modified, or remanded. The decision of the workers' compensation appeals board shall be appealable to the Tennessee Supreme Court as provided for in the Tennessee Rules of Appellate Procedure. If a compensation order is timely appealed to the workers' compensation appeals board, the order issued by the workers' compensation judge shall not become final, as provided in § 50-6-239(c)(7), until the workers' compensation appeals board issues a written decision certifying the order as a final order.

**(3)** The workers' compensation appeals board may reverse or modify and remand the decision of the workers' compensation judge if the rights of any party have been prejudiced because findings, inferences, conclusions, or decisions of a workers' compensation judge:

**(A)** Violate constitutional or statutory provisions;

**(B)** Exceed the statutory authority of the workers' compensation judge;

**(C)** Do not comply with lawful procedure;

**(D)** Are arbitrary, capricious, characterized by abuse of discretion, or clearly an unwarranted exercise of discretion; or

**(E)** Are not supported by evidence that is both substantial and material in the light of the entire record.

**(b) T**his section shall have no effect on the procedures established for filing a claim for workers' compensation benefits in the division of claims administration, pursuant to § 9-8-402, or in the claims commission, pursuant to § 9-8-307. The workers' compensation appeals board shall have no jurisdiction over an appeal of a decision of a commissioner of the claims commission.

**(c) T**he decisions of the workers' compensation appeals board shall not be subject to judicial review pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**(d) (1) I**n the appeal of an interlocutory order, with the exception of the filing of the notice of appeal, when an act is required to be performed within a specified time, the workers' compensation appeals board may extend the specified time only in exceptional circumstances not to exceed five (5) additional business days, either upon its own motion or upon motion of any party. In the appeal of a compensation order, with the exception of the filing of the notice of appeal, when an act is required to be performed within a specified time, the workers' compensation appeals board may extend the specified time

only in exceptional circumstances not to exceed twenty-one (21) additional calendar days, either upon its own motion or upon motion of any party.

**(2) T**he administrator shall have the authority to assess filing fees sufficient to offset the costs of administering this chapter.

**50-6-304. Last employer liable.**

When an employee has an occupational disease, the employer in whose employment the employee was last injuriously exposed to the hazards of the disease, and the employer's insurance carrier, if any, at the time of the exposure, shall alone be liable, for the occupational disease, without right to contribution from any prior employer or insurance carrier.

**50-6-307. Waiver of compensation for aggravation of condition.** [Applicable to injuries occurring both prior to and on and after July 1, 2014.]

**(a) (1)** When an employee, or prospective employee, though not incapacitated for work, is found to be affected by or susceptible to a specific occupational disease, the employee or prospective employee may, subject to the approval of the workers' compensation bureau of the department of labor and workforce development, be permitted to waive in writing compensation for any aggravation of the employee's or prospective employee's condition that may result from the employee's or prospective employee's working or continuing to work in the same or similar occupation for the same employer or for another employer; provided, that this provision shall not apply to specific occupational diseases on which waivers are prohibited by the federal Coal Mine Health and Safety Act of 1969, compiled in 30 U.S.C. § 901 et seq.

**(2)** All provisions of this chapter, with respect to accidents shall be applicable to the coverage provided in this part for occupational diseases, except as otherwise provided in this part.

**(b)** When an employee or prospective employee has a prior history of heart disease, heart attack or coronary failure or occlusion, the employee or prospective employee may be permitted to waive in writing compensation from the employee's or prospective employee's employer or future employer for claims growing out of an aggravation or repetition of the condition, the waiver to be evidenced by filing with the administrator a written instrument to which shall be attached a copy of a medical statement giving the prior history of the condition, and in all those cases claims for workers' compensation benefits growing out of an aggravation or repetition of the condition by the employee or the employee's dependents shall be barred.

**(c)** No employer shall require the execution of a waiver by any employee who was at work on March 17, 1961, unless the employee subsequently suffers a heart condition.

**50-6-401. Authority to write insurance-- Tax**

**(a) (1) (A)** Every person, partnership, association, organization or corporation, whether organized under the laws of this or any other state or country, that has or may hereafter comply with the laws of this state and is authorized to write accident or indemnity insurance in this state shall be authorized and empowered to write workers' compensation insurance under the terms and provisions of this part, and likewise every reciprocal and mutual insurance association or corporation shall have the same privileges; provided, that any such entity offering workers' compensation insurance shall be required to offer medical benefits coverage for paid-on-call and volunteer firefighters.

**(B)** For purposes of this subdivision (a)(1), "volunteer firefighter" means any member or personnel of a fire department, volunteer fire department, rescue squad or volunteer rescue squad, including, but not limited to, a junior member, a board member or an auxiliary member of the department or squad.

**(2)** An entity offering workers' compensation insurance shall offer coverage for members of rescue squads on similar terms and conditions as coverage available to full-time paid firefighters or emergency medical services personnel.

**(b) (1)** All insurance carriers provided for by this section shall be subject to a tax of four percent (4%) on premiums collected for workers' compensation insurance, and a surcharge of four tenths of one percent (0.4%) of the premiums, the surcharge to be earmarked for the administration of the Tennessee Occupational Safety and Health Act, compiled in chapter 3 of this title, and this shall be in lieu of any other tax on premiums for the writing of the business of workers' compensation insurance now provided for by law.

**(2)** The surcharge of four tenths of one percent (0.4%) on the tax on workers' compensation insurance premiums levied by this section shall not apply to any employer who employs ten (10) or fewer employees unless the employer is in the business of construction or manufacturing.

**(c)** Of the funds collected pursuant to subsection (b), a sum sufficient shall be allocated from and equal to an amount not greater than fifty percent (50%) of the revenues derived from the premium tax levied pursuant to this section, and shall be paid into the second injury fund created in § 50-6-208, to provide payments for the benefits provided in § 50-6-208.

**50-6-402. Classification of risks and premiums - Filing - Approval**

**(a)** In determining classifications of risks and premiums relating thereto, the insurer may include allowances of any character made to any employee, only when such allowances are in lieu of wages, and are specified as part of the wage contract.

NOTE: Section (a) is the reason for the bonus rule in the NCCI manual. Both conditions must be satisfied before a company can include bonuses. It makes no difference that

other states include bonuses, or that bonuses are regularly paid, or that they are large bonuses. The test is are they both (1) in lieu of wages and (2) specified in the wage contract.

**(b)** Before approving any workers' compensation loss cost filing made by the designated rate service organization pursuant to this part or title 56, the commissioner of commerce and insurance shall consult with the advisory council on workers' compensation concerning the filing. The council shall have sixty (60) days to provide written comment on the filing. The council shall meet to provide the comment. The commissioner of commerce and insurance shall approve, disapprove or modify the filing within ninety (90) days of receiving the filing. If the commissioner of commerce and insurance modifies the filing, the modification shall be within the range established by the recommendation of the rate service organization in its filing and the recommendation of the advisory council on workers' compensation. In instances when the commissioner of commerce and insurance modifies the filing, the rate service organization shall develop a plan that reflects the commissioner's modification, unless the organization appeals the modification pursuant to § 56-5-308. The commissioner shall report the action taken on the filing to the special joint committee on workers' compensation and to the speakers of the senate and the house of representatives.

**(c)** Prior to the commissioner of commerce and insurance establishing the multiplier to be applied to the assigned risk plan, as provided in § 56-5-314(c), the commissioner shall provide notice of the intended action, including supporting rationale therefor, to the advisory council on workers' compensation. The council may, within fifteen (15) days of receipt of such notice, provide written comment and recommendation to the commissioner related to the intended action. After the fifteen-day period has expired the commissioner shall establish the multiplier, by order, as provided in § 56-5-314(c).

**(d)** The commissioner of commerce and insurance shall report quarterly to the advisory council on workers' compensation concerning all workers' compensation filings made by the designated rate service organization received by the department of commerce and insurance that were not referred to the council as set out in subsection (b) since the last report.

**50-6-407. Certificate of compliance with insurance provisions.**

Every individual, firm, association, or corporation using the services of one (1) or more persons for pay shall post and maintain in a conspicuous place on the business premises a printed notice regarding workers' compensation as prescribed by the administrator of the bureau of workers' compensation. The notice shall include, at a minimum, a general description of the duties and obligations of both the employer and the employee under the law; the name, address and telephone number of the individual to notify in the event of a work-related injury; a toll-free number and address for the department of labor and workforce development at which employers or employees may obtain additional information; and the name, address and telephone number of a representative of the employer who can confirm whether the individual, firm, association, or corporation is

subject to this chapter; and other information required through rules promulgated by the administrator of the bureau of workers' compensation.

**50-6-414. Experience modification factors - Notification of employers - Failure to give timely notification.**

**(a)** Any employer who is assigned an experience modification factor for the purpose of determining its workers' compensation premium shall be sent annually, at no charge to the employer, a copy of any information relative to its experience modification factor that is available to an insurance company.

**(b)** If the experience modification factor notification is not received by the employer prior to the policy renewal date, or the policy anniversary date if different, the experience modification factor shall not be used for premium purposes if its use results in a higher premium for the employer. The mailing of the experience modification factor worksheet shall be sufficient proof of notice, provided the mailing is by certified mail, return receipt requested.

NOTE: This section requires the experience modification worksheet to be sent annually to the employer via of certified mail return receipt requested. If the employer does not get the notification prior to renewal a higher modification factor cannot be applied to the policy. If the mod goes down and is late it must be used.

**50-6-417. Dispute of experience modification factor.**

In cases where an employer disputes an experience modification factor assigned to the employer, the insurer shall notify the employer of the employer's right to submit a request for review and to appeal to the commissioner of commerce and insurance pursuant to § 56-5-309(b).

**50-6-418. Rating plans based on drug-free workplace program participation.** **[Applicable to injuries occurring on and after July 1, 2014.]**

**(a)** **(1)** The department of commerce and insurance shall approve rating plans for workers' compensation insurance that give specific identifiable consideration in the setting of rates to employers that implement a drug-free workplace program pursuant to rules adopted by the bureau of workers' compensation of the department of labor and workforce development. The plans must take effect January 1, 1997, must be actuarially sound, and must state the savings anticipated to result from the drug testing. The credit shall be at least five percent (5%) unless the commissioner of commerce and insurance determines that five percent (5%) is actuarially unsound.

**(2)** The commissioner is also authorized to develop a schedule of premium credits for workers' compensation insurance for employers who have safety programs that attain certain criteria for safety programs. The commissioner shall consult with the administrator of the bureau of workers' compensation in setting the criteria.

**(b)** The department of commerce and insurance shall apply the drug-free workplace program credit separately to each individual company for an employer having more than one (1) company under one (1) workers' compensation insurance policy. However, no credit given to an individual company may be combined with any credit given to any other company of the common employer or to the common employer itself.

**50-6-421. Requesting and obtaining information on employer workers' compensation insurance policies to ensure compliance with law -- Confidentiality -- What constitutes public record. [Applicable to injuries occurring on and after July 1, 2014.]**

**(a)** The administrator of the bureau of workers' compensation may request and obtain information regarding employer workers' compensation insurance policies in order to ensure compliance with the law. Except as otherwise provided in subsection (b), any information relating to workers' compensation insurance policies obtained by the administrator pursuant to this subsection (a) shall be deemed confidential and shall not constitute a public record, as defined in § 10-7-503; provided, such information may be used by any state agency, or vendor designated by the state, for the purpose of ensuring compliance with the law.

**(b)** The following information obtained by the administrator pursuant to subsection (a) shall constitute a public record, as defined in § 10-7-503, and shall be open for personal inspection by any citizen of this state:

**(1)** Employer name and business address;

**(2)** Workers' compensation insurance carrier name and business address; and

**(3)** Workers' compensation insurance policy number, policy effective date, policy expiration date, policy cancellation date, and policy reinstatement date.

## Safe Employment Practices

**50-6-501. Establishment of safety committees - Reporting by insurance companies - Civil penalty.**

**(a)** In order to promote health and safety in places of employment in this state, every public or private employer that is subject to this chapter, shall establish and administer a safety committee in accordance with rules adopted pursuant to § 50-6-502, if the administrator of the workers' compensation bureau finds that the employer has an experience modification factor or rate applied to the premium greater than or equal to one and twenty hundredths (1.20).

**(b)** In making determinations under subsection (a), the administrator of the workers' compensation bureau shall utilize the most recent statistics regarding experience modification rates.

**(c) (1)** Every insurance company authorized to write workers' compensation insurance shall submit its modification factors or rates for each of its workers' compensation insureds to the commissioner of commerce and insurance, when requested by the commissioner. On request from the administrator of the workers' compensation bureau, the commissioner of commerce and insurance shall provide the bureau of workers' compensation with the information.

**(2)** The administrator of the workers' compensation bureau shall establish safety committee requirements for self-insured employers pursuant to rules promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

**(3)** The commissioner of commerce and insurance may assess a civil penalty of up to two thousand dollars ($2,000) per incident for failure to comply with subdivision (c)(1).

**50-6-502. Rules governing committees - Duties of committees - Training - Operation under collective bargaining agreement.**

**(a)** In carrying out § 50-6-501, the administrator of the workers' compensation bureau shall promulgate rules that include, but are not limited to, provisions:

**(1) P**rescribing the membership of the committees to ensure equal numbers of hourly employees and employer representatives as well as specifying the frequency of meetings;

**(2) R**equiring employers to make adequate written records of each meeting and to maintain the records subject to inspection by Tennessee occupational safety and health administration representatives; and

**(3)** Requiring employers to compensate employee representatives on safety committees at the regular hourly wage while the employees are engaged in safety committee training or are attending safety committee meetings.

**(b)** The duties and functions of the safety committee shall include, but are not limited to:

**(1)** Assisting in establishing procedures for workplace safety inspections by the committee;

**(2)** Assisting in establishing procedures for investigating all safety incidents, accidents, illnesses and deaths; and

**(3)** Assisting in evaluating accident and illness prevention programs.

**(c)** The employer shall provide training for safety committee members in their duties and responsibilities provided in subsection (b).

**(d)** An employer operating under a collective bargaining agreement that contains provisions regulating the formation and operation of a safety committee that meets or exceeds the minimum requirements of this section and § 50-6-501 may apply to the administrator of the workers' compensation bureau for a determination that the employer meets the requirements of this section and § 50-6-501.

**50-6-505. Civil liability of labor organization.**

When an employee incurs an injury compensable under this chapter, the discussion or furnishing, or failure to discuss or furnish, or failure to enforce any safety or health provision, shall not subject a labor organization representing the injured employee to any civil liability for the injury.

**CONSTRUCTION SERVICES PROVIDERS**

**50-6-901. Part definitions.**

For purposes of this part, unless the context otherwise requires:

(1) "Active and in good standing as reflected in the records of the secretary of state" means a corporation, limited liability company, or partnership that is in existence, registered or authorized to transact business in this state as reflected in the records of the secretary of state; and in the case of a corporation, limited liability company, limited liability partnership, or limited partnership, such entity is in good standing with the Tennessee department of revenue;

(2) "Board" means the state board for licensing contractors;

(3) "Commercial construction project" means any construction project that is not:

(A) The construction, erection, remodeling, repair, improvement, alteration or demolition of one (1), two (2), three (3) or four (4) family unit residences not exceeding three (3) stories in height or accessory use structures in connection with the residences;

(B) The construction, erection, remodeling, repair, improvement, alteration or demolition of any building or structure for use and occupancy by the general public which, pursuant to § 62-6-112(f)(2), a small commercial building contractor is authorized to bid on and contract for; or

(C) Performed by any person, municipality, county, metropolitan government, cooperative, board, commission, district, or any entity created or authorized by public act, private act or general law to provide electricity, natural gas, water, waste water services, telephone service, telecommunications service, cable service, or Internet service or any combination thereof, for sale to consumers in any particular service area;

(4) “Construction project” means the construction, erection, remodeling, repair, improvement, alteration or demolition of a building, structure or other undertaking; provided, that if a general contractor contracts to erect, remodel, repair, improve, alter or demolish multiple buildings, structures or undertakings in one (1) contract, all such buildings, structures or undertakings described in such contract shall constitute one (1) construction project;

(5) “Construction services provider” or “provider” means any person or entity engaged in the construction industry;

(6) “Corporate officer” or “officer of a corporation” means any person who fills an office provided for in the corporate charter or articles of incorporation of a corporation that in the case of a domestic corporation is formed under the laws of this state pursuant to title 48, chapters 11-68, or in the case of a foreign corporation is authorized to transact business in this state pursuant to title 48, chapters 11-68; provided, that a domestic or foreign corporation is active and in good standing as reflected in the records of the secretary of state;

(7) “Direct labor” means the performance of any activity that would be assigned to the contracting group as those classifications are designated by the rate service organization designated by the commissioner of commerce and insurance as provided in § 56-5-320, but does not include:

(A) Classification code 5604, or any subsequent classification code, for construction executives, supervisors, or foremen that are responsible only for the oversight of laborers; or

(B) Classification code 5606, or any subsequent classification code, for project managers, construction executives, construction managers and construction superintendents having only administrative or managerial responsibilities for construction projects by exercising operational control indirectly through job supervisors or foremen;

(8) "Engaged in the construction industry" means any person or entity assigned to the contracting group as those classifications are designated by the rate service organization designated by the commissioner of commerce and insurance as provided in § 56-5-320; provided, where more than one (1) classification applies, the governing classification, as that term is defined by the rate service organization designated by the commissioner of commerce and insurance as provided in § 56-5-320, shall be used to determine whether the person or entity is engaged in the construction industry;

(9) “Family-owned business” means a business entity in which members of the same family of the applicant have an aggregate of at least ninety-five percent (95%) ownership of such business;

(10) “General contractor” means the person or entity responsible to the owner or developer for the supervision or performance of substantially all of the work, labor, and

the furnishing of materials in furtherance of the construction, erection, remodeling, repair, improvement, alteration or demolition of a building, structure or other undertaking and who contracts directly with the owner or developer of the building, structure or other undertaking; “general contractor” includes a prime contractor;

(11) “Good standing with the Tennessee department of revenue” means the secretary of state has received and verified through electronic confirmation or a certificate of tax clearance issued by the commissioner of revenue that a corporation, limited liability company, limited liability partnership, or limited partnership is current on all fees, taxes, and penalties to the satisfaction of the commissioner;

(12) “Member of a limited liability company” means any member of a limited liability company formed pursuant to title 48, chapters 201-249 that is active and in good standing as reflected in the records of the secretary of state;

(13) “Members of the same family of the applicant” means parents, children, siblings, grandparents, grandchildren, stepparents, stepchildren, stepsiblings, or spouses of such, and includes adoptive relationships;

(14) “Partner” means any person who is a member of an association that is formed by two (2) or more persons to carry on as co-owners of a business or other undertaking for profit and such association is active and in good standing as reflected in the records of the secretary of state;

(15) “Person” means only a natural person and does not include a business entity;

(16) “Registry” means the construction services provider workers' compensation exemption registry established pursuant to this part and maintained by the secretary of state; and

(17) “Sole proprietor” means one (1) person who owns a form of business in which that person owns all the assets of such business.

**50-6-902. Requirement that construction services providers carry workers' compensation insurance — Exemptions — Election by subcontractor.**

**(a)** Except as provided in subsection (b), all construction services providers shall be required to carry workers' compensation insurance on themselves. The requirement set out in this subsection (a) shall apply whether or not the provider employs fewer than five (5) employees.

**(b)** To the extent there is no restriction on applying for an exemption pursuant to § 50-6-903, a construction services provider shall be exempt from subsection (a) if the provider:

**(1)** Is a construction services provider rendering services on a construction project that

is not a commercial construction project and is listed on the registry;

**(2)** Is a construction services provider rendering services on a commercial construction project, is listed on the registry and such provider is rendering services to a person or entity that complies with § 50-6-914(b)(2);

**(3)** Is covered under a policy of workers' compensation insurance maintained by the person or entity for whom the provider is providing services;

**(4)** Is a construction services provider performing work directly for the owner of the property; provided, however, that this subdivision (b)(4) shall not apply to a construction services provider who acts as a general or intermediate contractor and who subsequently subcontracts any of the work contracted to be performed on behalf of the owner;

**(5)** Is a construction services provider building a dwelling or other structure, or performing maintenance, repairs, or making additions to structures, on the construction service provider's own property; or

**(6)** Is a provider whose employment at the time of injury is casual as provided in § 50-6-106.

**(c)** A subcontractor engaged in the construction industry under contract to a general contractor engaged in the construction industry may elect to be covered under any policy of workers' compensation insurance insuring the general contractor upon written agreement of the general contractor, regardless of whether such subcontractor is on the registry established pursuant to this part, by filing written notice of the election, on a form prescribed by the administrator of the workers' compensation bureau, with the bureau. It is the responsibility of the general contractor to file the written notice with the department. Failure of the general contractor to file the written notice shall not operate to relieve or alter the obligation of an insurance company to provide coverage to a subcontractor when the subcontractor can produce evidence of payment of premiums to the insurance company for the coverage. The election shall in no way terminate or affect the independent contractor status of the subcontractor for any other purpose than to permit workers' compensation coverage. The election of coverage may be terminated by the subcontractor or general contractor by providing written notice of the termination to the department and to all other parties consenting to the prior election. The termination shall be effective thirty (30) days from the date of the notice to all other parties consenting to the prior election and to the department.

**(d)** Nothing in this part shall be construed as exempting or preventing a construction services provider from carrying workers' compensation insurance for any of its employees. The requirement set out in this subsection (d) shall apply whether or not the provider employs fewer than five (5) employees.

**50-6-903. Criteria for applying for exemption**

**(a)** Any construction services provider who meets one (1) of the following criteria may apply for an exemption from § 50-6-902(a):

**(1)** An officer of a corporation who is engaged in the construction industry; provided, that no more than five (5) officers of one (1) corporation shall be eligible for an exemption;

**(2)** A member of a limited liability company who is engaged in the construction industry if such member owns at least twenty percent (20%) of such company;

**(3)** A partner in a limited partnership, limited liability partnership or a general partnership who is engaged in the construction industry if such partner owns at least twenty percent (20%) of such partnership;

**(4)** A sole proprietor engaged in the construction industry; or

**(5)** An owner of any business entity listed in subdivisions (a)(1)-(3) that is family-owned; provided, that no more than five (5) owners of one (1) family-owned business may be exempt from § 50-6-902(a).

**(b)** A construction services provider may be eligible for and may utilize multiple exemptions if the construction services provider meets the requirements set out in subsection (a) for each such exemption and complies with § 50-6-904 for each such exemption in which the construction services provider seeks to obtain; provided, however, that a construction services provider applying for a second or subsequent exemption shall not be required to pay the fees set out in § 50-6-912(a)(1) and (2), but shall instead pay the fee set out in § 50-6-912(a)(9) for each subsequent workers' compensation exemption registration and shall pay the fee set out in § 50-6-912(a)(10) for each subsequent registration renewal.

**(c)** **(1)** A construction services provider who is an individual and who does not meet the criteria established in subsection (a), but who is a member of a recognized religious sect or division and is an adherent of established tenets or teachers of such sect or division by reason of which such construction services provider is conscientiously opposed to acceptance of the benefits provided by this chapter may apply for an exemption from § 50-6-902(a); provided, however, that no more than five (5) individuals associated with one business entity may be exempt from § 50-6-902(a).

**(2)** Any applicant applying for an exemption from § 50-6-902(a) pursuant to subdivision (c)(1) shall provide an affidavit from the leader of the recognized religious sect or division stating that the individual filing the application for an exemption is a member of the recognized religious sect or division and is exempt, as evidenced by the Internal Revenue Service Form 4029, or similar form used by the internal revenue service. The leader of the recognized religious sect or division shall notify the secretary of state and department, in writing, if the member of the recognized religious sect or division who obtains an exemption from § 50-6-902(a) leaves or withdraws membership

from the recognized religious sect or division.

**(3)** Each individual employee of a construction services provider who meets the religious exemption requirements pursuant to this subsection (c) shall pay the fees set out in § 50-6-912(a)(1) and (a)(2). Any collected fees shall be deposited into the employee misclassification education and enforcement fund, pursuant to § 50-6-913.

**50-6-904. Application for construction services provider registration.**

**(a) (1) (A)** Any construction services provider applying for an exemption from § 50-6-902(a) who has not been issued a license by the board shall obtain a construction services provider registration from the secretary of state at the same time such provider applies for such exemption.

**(B)** The secretary of state is authorized and directed to issue the construction services provider registration on behalf of the board. The secretary of state shall issue an identification number assigned to the provider's registration. The board shall obtain such identification number and other identifying information from the secretary of state.

**(2)** Any construction services provider requesting exemption from § 50-6-902(a) shall submit an application along with the required filing fees to the secretary of state. The applicant shall provide sufficient documentation for the secretary of state to assure that such applicant meets the requirements set out in § 50-6-902, including, but not limited to:

**(A)** The applicant's full legal name;

**(B)** The applicant's birth month;

**(C)** The applicant's physical address; provided, that the applicant may provide a post office box number for purposes of receiving mail from the secretary of state, as long as the applicant also provides a physical address for the business entity for which the applicant is an officer, member, partner or owner;

**(D)** A telephone number through which the applicant can be reached;

**(E)** The name of the business entity through which the applicant is seeking the workers' compensation exemption;

**(F)** The federal employer identification number issued to the applicant if a sole proprietor or a business entity for which the applicant is an officer, member, partner or owner seeking exemption pursuant to § 50-6-903, and the last four (4) digits of the applicant's social security number; provided, however, that if an applicant seeks an exemption pursuant to § 50-6-903(c), the applicant may provide the last four (4) digits of a control number issued to the applicant by the social security administration instead of the last four (4) digits of the applicant's social security number;

**(G)** The contractor license number issued by the board to such applicant or the construction services provider registration number issued by the secretary of state to such applicant;

**(H)** A current license issued by a local government pursuant to § 67-4-723, if the business entity through which the applicant is seeking the workers' compensation exemption is required by law to obtain such license;

**(I)** Any other information the secretary of state deems necessary to identify such applicant; and

**(J)** If the construction services provider is applying for an exemption pursuant to the criteria set out in § 50-6-903(c), the provider shall submit a copy of an approved Internal Revenue Service Form 4029 or similar form used by the internal revenue service, to show that an application for exemption from social security and medicare taxes and waiver of benefits has been approved for such provider applying for an exemption pursuant to this part.

**(3)** The secretary of state shall verify that the applicant meets the qualifications set out in § 50-6-902 upon a review of its records and the records provided by such applicant.

**(b)** The application shall be on a form designed by the secretary of state and shall contain a statement that specifies the eligibility requirements for exemption, contain an attestation that the applicant meets the eligibility requirements and contain a statement that a false statement on such application is subject to the penalties of perjury set out in § 39-16-702.

**(c)** The application, as well as a process for submission of such application, shall be available through the secretary of state's web site or by contacting the secretary of state's office in person or by mail.

**50-6-905. Filing of application — Issuance of notice — Publication on registry — Correction of documents filed with secretary of state — Address and change of address.]**

**(a)** If a construction services provider's application delivered to the secretary of state meets the requirements of this part, as determined by the secretary of state, the secretary of state shall file the application and:

**(1)** Issue a notice to such provider that the provider is listed on the registry; and

**(2)** Publish on the registry, contained on the secretary of state's web site, the provider's name and other identifying information, including, but not limited to:

**(A)** The full legal name of the provider;

**(B)** The specific identification number issued to the provider by the secretary of state

upon filing the application;

**(C)** The period in which the provider is exempt, including the date and time in which such exemption expires; and

**(D)** Any other identifying information the secretary of state deems necessary for the public to identify such provider.

**(b)** The provider shall not be exempt from the requirement of § 50-6-902(a) until the provider's application is filed by the secretary of state and the applicant's name and other identifying information is published on the registry. If a provider's exemption is revoked pursuant to § 50-6-908, such revocation is effective upon the provider's name and other identifying information no longer appearing on the registry after being removed by the secretary of state pursuant to § 50-6-908.

**(c)** A provider listed on the registry may correct a document filed with the secretary of state if the document contains an incorrect statement or was defectively executed, attested, sealed, verified or acknowledged. A document shall be corrected in a manner established by the secretary of state.

**(d)** A provider listed on the registry shall maintain a current physical mailing address with the secretary of state. A change of address shall be made in a manner established by the secretary of state.

**50-6-906. Refusal by secretary of state to file application — Reversal or modification by court — Hearing — Appeal.**

**(a)** If the secretary of state refuses to file an application and list the construction services provider on the registry, the secretary of state shall return such application to the provider within ten (10) business days after the document was received for filing, together with a brief, written explanation of the reason for the secretary of state's refusal to file.

**(b)** If the secretary of state refuses to file an application and list a provider on the registry, the provider may appeal the refusal to the chancery court of Davidson County. The appeal shall be commenced by petitioning the court to compel listing such provider on the registry and shall attach to the petition the application and the secretary of state's explanation of the secretary of state's refusal to file.

**(c)** The court may reverse or modify the actions of the secretary of state if the rights of the provider have been prejudiced because the secretary of state's actions are:

**(1)** In violation of constitutional or statutory provisions;

**(2)** In excess of the statutory authority of the secretary of state;

**(3)** Made upon unlawful procedure; or

**(4)** Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

**(d)** After any hearing deemed necessary by the court, the court may summarily order the secretary of state to list such provider on the registry or take other action the court considers appropriate.

**(e)** The court's final decision may be appealed as in other civil proceedings.

**50-6-907. Term of validity of exemption — Renewal.**

**(a)** The exemption obtained pursuant to this part shall be valid for two (2) years from a date and time set by the secretary of state. No more than sixty (60) days prior to the expiration of the exemption period, a construction services provider may file an application to renew an exemption. Renewal of an exemption shall be made in a manner established by the secretary of state.

**(b)** The secretary of state shall remove the construction services provider's name from the registry at the close of business on the day the provider's exemption expires. If the exemption expires on a day that state offices are closed or the secretary of state's office is closed, the exemption shall expire at the close of business on the next business day.

**(c)** A construction services provider whose registration expires under this section may renew the exemption by following the procedure outlined in § 50-6-904.

**50-6-908. Revocation of exemption by provider or secretary of state.**

**(a)** **(1)** Any construction services provider who obtains an exemption and subsequently chooses to revoke such exemption shall:

**(A)** Give notice to the person or entity for whom the provider may currently be providing services of the revocation in accordance with a form prescribed by the secretary of state;

**(B)** Attest as to whether or not the provider has any employment related injuries at the time of such revocation that occurred while providing services to a person or entity that did not provide coverage under a policy of workers' compensation; and

**(C)** Within twenty-four (24) hours of such revocation, notify any person or entity for whom the provider is currently providing services that the provider has voluntarily revoked the provider's workers' compensation exemption.

**(2)** Upon filing such notice, the secretary of state shall remove the construction services provider's name from the registry.

**(3)** A construction services provider who revokes an exemption under this section may reapply for an exemption by following the procedure set forth in § 50-6-904.

**(b)** **(1)** In addition to the revocation set out in subsection (a), a workers' compensation exemption shall be revoked by the secretary of state upon:

**(A)** Notification from the board that the board has revoked or suspended any license issued to the construction services provider by the board, including a license issued to a business entity through which the construction services provider obtained such an exemption. For purposes of this subdivision (b)(1)(A), if a construction services provider's license is revoked, whether or not such license is in the provider's individual name or in the name of a business entity through which the provider obtained an exemption, then any exemption obtained through such business entity shall be revoked;

**(B)** Notification from the department of any violations of § 50-6-412 by the construction services provider, including any violation against a business entity through which the construction services provider obtained such an exemption. For purposes of this subdivision (b)(1)(B), if a construction services provider has violated § 50-6-412, whether or not such violation was committed by the individual or a business entity through which the provider obtained an exemption, then any exemption obtained through such business entity shall be revoked and all exemptions in the provider's name shall be subject to revocation;

**(C)** A determination by the secretary of state that the construction services provider no longer meets the requirements for an exemption established pursuant to this part; or

**(D)** A determination by the secretary of state that the construction services provider failed to renew prior to the expiration date of such exemption or the provider failed to pay any fees required to be paid pursuant to this part.

**(2)** Any notification of a violation made by the department pursuant to subdivision (b)(1)(B) shall include information indicating whether such violation requires a temporary or permanent revocation pursuant to § 50-6-412.

**(3)** If a provider's exemption is revoked pursuant to this section, the secretary of state shall:

**(A)** Remove the construction services provider's name from the registry within seven (7) days of receipt of notification from the department or the board, or upon making a determination as provided in subdivision (b)(1)(C) or (b)(1)(D); and

**(B)** Notify the construction services provider that such provider is required to notify, within twenty-four (24) hours of such revocation, any person or entity for whom the provider is currently providing services that the provider's workers' compensation exemption has been revoked.

**(4)** If a provider's exemption is revoked pursuant to subdivision (b)(1), the administrative and judicial procedures available to such provider shall be those procedures set out in § 50-6-906.

**(c)** If a construction services provider's exemption is revoked pursuant to this section, the construction services provider shall be required to carry workers' compensation insurance as provided in § 50-6-902(a); provided, that such construction services provider does not otherwise meet an exemption set out in § 50-6-902(b).

**(d)** A construction services provider whose exemption is revoked for any reason set out in this part shall be notified of such revocation in writing, and shall not be entitled to a refund of filing fees.

**50-6-909. Reinstatement of exemption.**

**(a)** Except as provided in § 50-6-412(h)(2), a construction services provider whose exemption is revoked pursuant to § 50-6-908 may apply to reinstate such exemption in the same manner as provided for in this part for an initial application.

**(b)** A construction services provider whose exemption is revoked under § 50-6-908(b) may only be granted a reinstatement of exemption:

**(1)** Upon notification to the secretary of state from the board that such provider's license is no longer revoked or suspended;

**(2)** Upon notification from the department of labor and workforce development to the secretary of state that the provider qualified for reinstatement pursuant to § 50-6-412(g); and

**(3)** If the secretary of state determines that the provider meets the requirements for an exemption established pursuant to this part.

**(c)** Upon verification by the secretary of state that the requirements of subsection (b) are met, the secretary of state shall file the application in accordance with § 50-6-905.

**50-6-910. Action to recover damages.**

**(a)** Any action to recover damages for injury, as defined by § 50-6-102, by a construction services provider shall proceed as at common law, and the defendant in the suit may make use of all common law defenses if, at the time of the injury, the construction services provider was:

**(1)** Listed on the registry as having a workers' compensation exemption and working in the service of a business entity through which the construction services provider obtained such an exemption;

**(2)** Not covered under a policy of workers' compensation insurance maintained by the person or entity for whom the provider was providing services at the time of such injury; and

**(3)** Eligible for an exemption pursuant to § 50-6-914(b)(2), if such eligibility requirements apply, at the time of such injury.

**(b)** Any construction services provider proceeding as at common law pursuant to subsection (a) shall forego the right to sue to establish or reestablish workers' compensation coverage.

**50-6-911. Notice to public of exemptions — Web site — Additions and deletions from registry.**

**(a)** **(1)** The secretary of state shall provide notice on its web site that the registry is for purposes of establishing providers who are exempt from workers' compensation coverage and in no way reflects licensing or certification of any construction services provider.

**(2)** The board, the department of commerce and insurance and the department of labor and workforce development shall each develop a notice provision to inform the public that any person or entity interested in determining whether a construction services provider is exempt from workers' compensation coverage shall review the secretary of state's web site. Such notice provision shall be prominently displayed on the web sites of the board, the department of commerce and insurance and the department of labor and workforce development.

**(b)** **(1)** The secretary of state shall provide notice to the department of labor and workforce development, the board and the department of commerce and insurance when a construction services provider is added to or removed from the registry.

**(2)** If any construction services provider has a license issued by the board, and such license is revoked or suspended, the board shall immediately notify the secretary of state, in order for the secretary of state to revoke such provider's exemption pursuant to § 50-6-908(b).

**50-6-912. Fees.**

**(a)** The secretary of state may charge the following maximum fees for each of the following:

**(1)** The issuance of a construction services provider registration to providers who have not been issued a license by the board ......................$50

**(2)** The issuance of a construction services provider workers' compensation exemption ......................$50

**(3)** The filing of correction information pursuant to § 50-6-905(c) ......................$20

**(4)** The filing of change of address information pursuant to § 50-6-905(d) ......................$20

**(5)** The filing of a construction services provider workers' compensation exemption renewal ......................$50

**(6)** The filing of a construction services provider registration renewal to providers who have not been issued a license by the board ......................$50

**(7)** The filling of a revocation pursuant to § 50-6-908(a) ......................$20

**(8)** The issuance of a copy of the notice issued pursuant to § 50-6-905(a)(1) ......................$20

**(9)** The issuance of a second or subsequent construction services provider workers' compensation exemption registration ......................$20 per registration

**(10)** The filing of a second or subsequent construction services provider workers' compensation exemption renewal ..................... $20 per renewal

**(b)** In addition to the maximum fees authorized in subsection (a), the secretary of state is authorized to charge an online transaction fee to cover costs associated with processing payments for applications submitted online.

**(c)** Except as provided in subsections (a) and (b), no other fees shall be charged by the secretary of state to administer this part.

**50-6-913. Creation of employee misclassification education and enforcement fund — Costs of administration.**

**(a)** There is created a fund to be known as the "employee misclassification education and enforcement fund." Any fee collected pursuant to § 50-6-912(a) shall be deposited in the employee misclassification education and enforcement fund. Moneys in the fund shall be invested by the state treasurer in accordance with the provisions of § 9-4-603. The fund shall be administered by the administrator of the workers' compensation bureau.

**(b)** All costs of the secretary of state associated with the administration of this part shall be paid by the administrator of the workers' compensation bureau from the employee misclassification education and enforcement fund. Moneys remaining in the fund after such payment may be expended, subject to appropriation by the general assembly, at the direction of the administrator of the workers' compensation bureau for the purchase of computer software and hardware designed to identify potential employee misclassification activity, for the hiring of additional employees to investigate potential

employee misclassification activity, for education of employers and employees regarding the requirements of this part and in support of the ongoing investigation and prosecution of employee misclassification.

**(c)** Any amount in the employee misclassification education and enforcement fund at the end of any fiscal year shall not revert to the general fund, but shall remain available for the purposes set forth in subsection (b). Interest accruing on investments and deposits of the employee misclassification education and enforcement fund shall be credited to such account, shall not revert to the general fund, and shall be carried forward into each subsequent fiscal year.

**50-6-914. Liability of general contractor, intermediate contractor or subcontractor for injured employee — Claims.**

**(a)** Except as provided for in subsection (b), a general contractor, intermediate contractor or subcontractor shall be liable for compensation to any employee injured while in the employ of any of the subcontractors of the general contractor, intermediate contractor or subcontractor and engaged upon the subject matter of the contract to the same extent as the immediate employer.

**(b)** **(1)** Notwithstanding subsection (a) and subject to subdivision (b)(2), a general contractor, intermediate contractor or subcontractor shall not be liable for workers' compensation to a construction services provider listed on the registry established pursuant to this part.

**(2)** **(A)** No more than three (3) construction services providers performing direct labor on a commercial construction project may be exempt from § 50-6-902(a).

**(B)** For purposes of subdivision (b)(2)(A), the three (3) construction services providers shall be selected by the general contractor. The limit of three (3) set out in subdivision (b)(2)(A) shall be three (3) individuals listed on the registry as having a workers' compensation exemption and working in the service of a business entity through which the construction services provider obtained such an exemption.

**(C)** If a general contractor allows a construction services provider to provide services on a commercial construction project while such provider is utilizing an exemption pursuant to this part, the general contractor shall:

**(i)** Notify each such construction services provider in writing that the provider has been chosen by the general contractor as one of the three (3) construction services providers performing direct labor who may be exempt from § 50-6-902(a); and

**(ii)** Maintain a record identifying each such construction services provider. The general contractor shall make the record maintained pursuant to this subdivision (b)(2)(C)(ii) available for inspection upon request by the general contractor's insurance provider, the department, and the department of commerce and insurance.

**(c)** Any general contractor, intermediate contractor or subcontractor who pays compensation under subsection (a) may recover the amount paid from any person or entity who, independently of this section, would have been liable to pay compensation to the injured employee, or from any subcontractor.

**(d)** Every claim for compensation under this section shall be presented first to and instituted against the immediate employer, but the proceedings shall not constitute a waiver of the employee's rights to recover compensation under this chapter from the general contractor, intermediate contractor or subcontractor; provided, that the collection of full compensation from one (1) employer shall bar recovery by the employee against any others, and the employee shall not collect from all employers a total compensation in excess of the amount for which any of the contractors is liable.

**(e)** This section applies only in cases where the injury occurred on, in, or about the premises on which the general contractor has undertaken to execute work or that are otherwise under the general contractor's control or management.

**50-6-915. Open records.**

Notwithstanding any law to the contrary, records maintained by the secretary of state relative to the construction services provider registration and to the workers' compensation exemption registration, other than records displayed on the registry established pursuant to this part, shall not constitute a public record as defined in § 10-7-503 and shall not be open for public inspection.

**50-6-916. Construction regarding requiring a certificate of workers' compensation insurance.**

Nothing in this part shall be construed as preventing or prohibiting any contractor from requiring a certificate of workers' compensation insurance from any of its subcontractors or any construction services providers providing services to such contractor.

**50-6-917. Coverage by a policy of workers' compensation issued through assigned risk plan.**

A policy of workers' compensation insurance issued through the assigned risk plan as provided in § 56-5-314 that insures a person engaged in the construction industry shall be governed by this part, and a state agency shall not impose requirements relative to this part on such a policy other than those imposed by this part.

**50-6-918. Annual recommendations regarding programs and services funded through the employee misclassification education and enforcement fund.**

Beginning with fiscal year 2012-2013, and each fiscal year thereafter, the employee misclassification advisory task force created pursuant to § 50-6-919 shall make recommendations to the general assembly regarding programs and services to be funded from the employee misclassification education and enforcement fund created pursuant to § 50-6-913.

**50-6-919. Employee misclassification advisory task force. Deleted**

**50-6-920. Offense — Violation.**

**(a)** It is an offense for any employer to knowingly:

**(1)** Coerce or attempt to coerce, as a precondition to employment or otherwise, a job applicant to obtain an exemption pursuant to this part; or

**(2)** Coerce, attempt to coerce, discharge or take any adverse employment action against an employee because the employee has failed to obtain an exemption pursuant to this part.

**(b)** A violation of subsection (a) is a Class A misdemeanor.

**50-6-921. Effective date of exemption — Maintaining exemption under prior law.**

The construction services provider workers' compensation exemption for any provider not exempt prior to March 1, 2011, who has been placed on the workers' compensation exemption registry by the secretary of state shall be in effect beginning at 12:00 a.m. on March 1, 2011, regardless of such provider's date of application; provided, that any person exempt under provisions of law in effect prior to March 1, 2011, shall maintain such exemption until March 1, 2011.

## DRUG-FREE WORKPLACE PROGRAM

Click HERE for link to Department of Labor & Workforce Development Web Site with Information on Drug Free Work Place.

**50-9-101. Legislative intent.**

**(a)** It is the intent of the general assembly to promote drug-free workplaces in order that employers in this state be afforded the opportunity to maximize their levels of productivity, enhance their competitive positions in the marketplace and reach their desired levels of success without experiencing the costs, delays and tragedies associated with work-related accidents resulting from drug or alcohol abuse by employees. It is also the intent of the general assembly that employers obtaining certification as a drug free workplace under rules promulgated by the bureau should be able to renew that certification on an annual basis without requiring repeated annual training of existing employees; provided, however, the employer certifies on a form prescribed by the bureau

that all existing employees have undergone training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy. It is further the intent of the general assembly that drug and alcohol abuse be discouraged and that employees who choose to engage in drug or alcohol abuse face the risk of unemployment and the forfeiture of workers' compensation benefits.

**(b)** If an employer implements a drug-free workplace program in accordance with this chapter, which includes notice, education and procedural requirements for testing for drugs and alcohol pursuant to rules developed by the bureau, the covered employer may require the employee to submit to a test for the presence of drugs or alcohol and, if a drug or alcohol is found to be present in the employee's system at a level prescribed by statute or by rule adopted pursuant to this chapter, the employee may be terminated and forfeits eligibility for workers' compensation medical and indemnity benefits. However, a drug-free workplace program must require the covered employer to notify all employees that it is a condition of employment for an employee to refrain from reporting to work or working with the presence of drugs or alcohol in the employee's body and, if an injured employee refuses to submit to a test for drugs or alcohol, the employee forfeits eligibility for workers' compensation medical and indemnity benefits.

**50-9-102. Applicability.**

Sections 50-9-103 -- 50-9-111 apply to a drug-free workplace program implemented pursuant to rules adopted by the administrator of the bureau of workers' compensation. The application of this chapter is subject to the provisions of any applicable collective bargaining agreement. Nothing in the program authorized by this chapter is intended to authorize any employer to test any applicant or employee for alcohol or drugs in any manner inconsistent with federal constitutional or statutory requirements, including those imposed by the Americans with Disabilities Act, compiled in 42 U.S.C. § 12101 et seq and the National Labor Relations Act, compiled in 29 U.S.C. § 131 et seq.

**50-9-103. Chapter Definitions.**

As used in this chapter, unless the context otherwise requires.

(1) "Alcohol" has the same meaning in this chapter when used in the federal regulations describing the procedures used for testing of alcohol by programs operating pursuant to the authority of the United States department of transportation, currently compiled at 49 C.F.R. part 40. It is intended that the definition shall change as the department of transportation's regulations are revised;

(2) "Alcohol test" means an analysis of breath, or blood, or any other analysis which determines the presence and level or absence of alcohol as authorized by the United States department of transportation in its rules and guidelines concerning alcohol testing and drug testing;

(3) "Chain of custody" refers to the methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial

collection to final disposition for all such materials or substances, and providing for accountability at each stage in handling, testing and storing specimens and reporting test results;

(4) "Confirmation test," "confirmed test" or "confirmed drug or alcohol test" means a second analytical procedure used to identify the presence of a specific drug or alcohol or metabolite in a specimen, which test must be different in scientific principle from that of the initial test procedure and must be capable of providing requisite specificity, sensitivity and quantitative accuracy;

(5) "Covered employer" means a person or entity that employs a person, is covered by the Workers' Compensation Law, maintains a drug-free workplace pursuant to this chapter and includes on the posting required by § 50-9-105 a specific statement that the policy is being implemented pursuant to the provisions of this chapter. This chapter shall have no effect on employers who do not meet this definition;

(6) "Drug" means any controlled substance subject to testing pursuant to drug testing regulations adopted by the United States department of transportation. A covered employer shall test an individual for all such drugs in accordance with the provisions of this chapter. The commissioner of labor and workforce development may add additional drugs by rule in accordance with § 50-9-111;

(7) "Drug or alcohol rehabilitation program" means a service provider that provides confidential, timely and expert identification, assessment and resolution of employee drug or alcohol abuse;

(8) "Drug test" or "test" means any chemical, biological or physical instrumental analysis administered by a laboratory authorized to do so pursuant to this chapter, for the purpose of determining the presence or absence of a drug or its metabolites pursuant to regulations governing drug testing adopted by the United States department of transportation or such other recognized authority approved by rule by the commissioner of labor and workforce development;

(9) "Employee" means any person who works for salary, wages or other remuneration for a covered employer;

(10) "Employee assistance program" means an established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug or alcohol abuse; referrals of employees for appropriate diagnosis, treatment and assistance; and follow-up services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by the program

(11) "Employer" means a person or entity that employs a person and that is covered by the Workers' Compensation Law;

(12) "Initial drug or alcohol test" means a procedure that qualifies as a "screening test" or "initial test" pursuant to regulations governing drug or alcohol testing adopted by the United States department of transportation or such other recognized authority approved by rule by the administrator of the bureau of workers' compensation;

(13) "Job applicant" means a person who has applied for a position with a covered employer and who has been offered employment conditioned upon successfully passing a drug or alcohol test, and may have begun work pending the results of the drug or alcohol test;

(14) "Medical review officer" or "MRO" means a licensed physician, employed with or contracted with a covered employer, who has knowledge of substance abuse disorders, laboratory testing procedures and chain of custody collection procedures; who verifies positive, confirmed test results; and who has the necessary medical training to interpret and evaluate an employee's positive test result in relation to the employee's medical history or any other relevant biomedical information;

(15) "Reasonable-suspicion drug testing" means drug or alcohol testing based on a belief that an employee is using or has used drugs or alcohol in violation of the covered employer's policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon:

(A) Observable phenomena while at work, such as direct observation of drug or alcohol use or of the physical symptoms or manifestations of being under the influence of a drug or alcohol;

(B) Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance;

(C) A report of drug or alcohol use, provided by a reliable and credible source;

(D) Evidence that an individual has tampered with a drug or alcohol test during employment with the current covered employer;

(E) Information that an employee has caused, contributed to or been involved in an accident while at work; or

(F) Evidence that an employee has used, possessed, sold, solicited or transferred drugs or used alcohol while working or while on the covered employer's premises or while operating the covered employer's vehicle, machinery or equipment;

(16) "Safety-sensitive position" means a position involving a safety-sensitive function pursuant to regulations governing drug or alcohol testing adopted by the United States department of transportation. For drug-free workplaces, the commissioner is authorized,

with the approval of the advisory council on workers' compensation, to promulgate rules expanding the scope of safety-sensitive position to cases where impairment may present a clear and present risk to co-workers or other persons. "Safety-sensitive position" means, with respect to any employer, a position in which a drug or alcohol impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to carry a firearm, perform life-threatening procedures, work with confidential information or documents pertaining to criminal investigations or work with controlled substances; or a position in which a momentary lapse in attention could result in injury or death to another person; and

(17) "Specimen" means tissue, fluid or a product of the human body capable of revealing the presence of alcohol or drugs or their metabolites.

**50-9-104. Testing for drugs or alcohol authorized - Conditions for testing - Effect of failure to comply.**

(a) A covered employer may test a job applicant for alcohol or for any drug described in § 50-9-103; provided, that for public employees such testing shall be limited to the extent permitted by the Tennessee and federal constitutions. A covered employer may test an employee for any drug defined in § 50-9-103(6) and at any time set out in § 50-9-106. An employee who is not in a "safety-sensitive position," as defined in § 50-9-103(16), may be tested for alcohol only when the test is based upon "reasonable suspicion," as defined in § 50-9-103(15). An employee in a safety-sensitive position may be tested for alcohol use at any occasion described in § 50-9-106(a)(2)-(5), inclusive. In order to qualify as having established a drug-free workplace program which affords a covered employer the ability to qualify for the discounts provided under § 50-6-418 and deny workers' compensation medical and indemnity benefits and shift the burden of proof under § 50-6-110(c), all drug or alcohol testing conducted by covered employers shall be in conformity with the standards and procedures established in this chapter and all applicable rules adopted pursuant to this chapter. If a covered employer fails to maintain a drug-free workplace program in accordance with the standards and procedures established in this section and in applicable rules, the covered employer shall not be eligible for:

(1) Discounts under § 50-6-418;

(2) A shift in the burden of proof pursuant to § 50-6-110(c); or

(3) Denial of workers' compensation medical and indemnity benefits pursuant to this chapter. All covered employers qualifying for and receiving discounts provided under § 50-6-418 must be reported annually by the insurer to the bureau.

(b) The commissioner of labor and workforce development shall adopt a form pursuant to rulemaking authority, which form shall be used by the employer to certify compliance with the provisions of this chapter. Substantial compliance in completing and filing the form with the commissioner shall create a rebuttable presumption that the employer has

established a drug-free workplace program and is entitled to the protection and benefit of this chapter. Prior to granting any premium credit to an employer pursuant to § 50-6-418, all insurers and self-insured pools under chapter 6, part 4 of this title, shall obtain such form from the employer. Not less than monthly insurers and self-insured pools shall submit such forms to the department of labor and workforce development. Any other employer desiring to establish a drug-free workplace shall file such form with the department.

(c) It is intended that any employer required to test its employees pursuant to the requirements of any federal statute or regulation shall be deemed to be in conformity with this section as to the employees it is required to test by those standards and procedures designated in that federal statute or regulation. All other employees of such employer shall be subject to testing as provided in this chapter in order for such employer to qualify as having a drug-free workplace program.

**50-9-105. Written policy statement.**

(a) One (1) time only, prior to testing, a covered employer shall give all employees and job applicants for employment a written policy statement which contains:

(1) A general statement of the covered employer's policy on employee drug or alcohol use, which must identify:

(A) The types of drug or alcohol testing an employee or job applicant may be required to submit to, including reasonable-suspicion drug or alcohol testing or drug or alcohol testing conducted on any other basis; and

(B) The actions the covered employer may take against an employee or job applicant on the basis of a positive confirmed drug or alcohol test result;

(2) A statement advising the employee or job applicant of the existence of this section;

(3) A general statement concerning confidentiality;

(4) Procedures for employees and job applicants to confidentially report to a medical review officer the use of prescription or nonprescription medications to a medical review officer after being tested, but only if the testing process has revealed a positive result for the presence of alcohol or drug use;

(5) The consequences of refusing to submit to a drug or alcohol test;

(6) A representative sampling of names, addresses and telephone numbers of employee assistance programs and local drug or alcohol rehabilitation programs;

(7) A statement that an employee or job applicant who receives a positive confirmed test result may contest or explain the result to the medical review officer within five (5)

working days after receiving written notification of the test result; that if an employee's or job applicant's explanation or challenge is unsatisfactory to the medical review officer, the medical review officer shall report a positive test result back to the covered employer; and that a person may contest the drug or alcohol test result pursuant to rules adopted by the department of labor and workforce development;

(8) A statement informing the employee or job applicant of the employee's responsibility to notify the laboratory of any administrative or civil action brought pursuant to this section;

(9) A list of all drug classes for which the employer may test;

(10) A statement regarding any applicable collective bargaining agreement or contract and any right to appeal to the applicable court;

(11) A statement notifying employees and job applicants of their right to consult with a medical review officer for technical information regarding prescription or nonprescription medication; and

(12) A statement complying with the requirements for notice under § 50-9-101(b).

(b) A covered employer shall ensure that at least sixty (60) days elapse between a general one-time notice to all employees that a drug-free workplace program is being implemented and the effective date of the program. Such notice shall also indicate that on the effective date of the program that § 50-6-110(c) will apply to that employer.

(c) A covered employer shall include notice of drug and alcohol testing on vacancy announcements for positions for which drug or alcohol testing is required. A notice of the covered employer's drug and alcohol testing policy must also be posted in an appropriate and conspicuous location on the covered employer's premises, and copies of the policy must be made available for inspection by the employees or job applicants of the covered employer during regular business hours in the covered employer's personnel office or other suitable locations.

(d) Subject to any applicable provisions of a collective bargaining agreement or any applicable labor law, a covered employer may rescind its coverage under this chapter by posting a written and dated notice in an appropriate and conspicuous location on its premises. The notice shall state that the policy will no longer be conducted pursuant to this chapter. The employer shall also provide sixty (60) days' written notice to the employer's workers' compensation insurer of the rescission. As to employees and job applicants, the recession shall become effective no earlier than sixty (60) days after the date of the posted notice.

(e) The commissioner of labor and workforce development shall develop a model notice and policy for drug-free workplace programs.

(f) Any notice required by this section shall inform minors who are tested that the minor's parents or guardians will be notified of the results of tests conducted pursuant to this chapter.

**50-9-106. Required drug or alcohol tests.**

**(a)** To the extent permitted by law, a covered employer who establishes a drug-free workplace is required to conduct the following types of drug or alcohol tests:

**(1) Job Applicant Drug and Alcohol Testing.** A covered employer must, after a conditional offer of employment, require job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive confirmed drug test as a basis for refusing to hire a job applicant. An employer may, but is not required to, test job applicants, after a conditional offer of employment, for alcohol. Limited testing of applicants, only if it is based on a reasonable classification basis, is permissible in accordance with bureau rule;

**(2) Reasonable-Suspicion Drug and Alcohol Testing.** A covered employer must require an employee to submit to reasonable-suspicion drug or alcohol testing. A written record shall be made of the observations leading to a controlled substances reasonable suspicion test within twenty-four (24) hours of the observed behavior or before the results of the test are released, whichever is earlier. A copy of this documentation shall be given to the employee upon request, and the original documentation shall be kept confidential by the covered employer pursuant to § 50-9-109 and shall be retained by the covered employer for at least one (1) year;

**(3) Routine Fitness-For-Duty Drug Testing.** **(A)** A covered employer shall require an employee to undergo drug or alcohol testing if, as a part of the employer's written policy, the test is conducted as a routine part of a routinely scheduled employee fitness-for-duty medical examination, or is scheduled routinely for all members of an employment classification or group; provided, that a public employer may require scheduled, periodic testing only of employees who:

**(i)** Are police or peace officers;

**(ii)** Have drug interdiction responsibilities;

**(iii)** Are authorized to carry firearms;

**(iv)** Are engaged in activities that directly affect the safety of others;

**(v)** Work in direct contact with inmates in the custody of the department of correction; or

**(vi)** Work in direct contact with minors who have been adjudicated delinquent or who are in need of supervision in the custody of the department of children's services.

**(B)** This subdivision (a)(3) does not require a drug or alcohol test if a covered employer's personnel policy on July 1, 1998, does not include drug or alcohol testing as part of a routine fitness-for-duty medical examination. The test shall be conducted in a nondiscriminatory manner. Routine fitness-for-duty drug or alcohol testing of employees does not apply to volunteer employee health screenings, employee wellness programs, programs mandated by governmental agencies, or medical surveillance procedures that involve limited examinations targeted to a particular body part or function.

**(4) Follow-Up Drug Testing.** If the employee in the course of employment enters an employee assistance program for drug-related or alcohol-related problems, or a drug or alcohol rehabilitation program, the covered employer must require the employee to submit to a drug and alcohol test, as appropriate, as a follow-up to the program, unless the employee voluntarily entered the program. In those cases, the covered employer has the option to not require follow-up testing. If follow-up testing is required, it must be conducted at least once a year for a two-year period after completion of the program. Advance notice of a follow-up testing date must not be given to the employee to be tested; and

**(5) Post-Accident Testing.** After an accident that results in an injury, as defined in chapter 3 of this title, and the rules promulgated under chapter 3 of this title, the covered employer shall require the employee to submit to a drug or alcohol test in accordance with this chapter.

**(b)** This chapter does not preclude an employer from conducting any lawful testing of employees for drugs or alcohol that is in addition to the minimum testing required under this chapter.

Random drug testing IS NOT required.

**50-9-107. Testing subject to department of transportation procedures - Verification - Chain of custody procedures - Costs - Discrimination on grounds of voluntary treatment prohibited.**

(a) All specimen collection and testing for drugs and alcohol under this chapter shall be performed in accordance with the procedures provided for by the United States department of transportation rules for workplace drug and alcohol testing compiled at 49 C.F.R., Part 40.

(b) A covered employer may not discharge, discipline, refuse to hire, discriminate against or request or require rehabilitation of an employee or job applicant on the sole basis of a positive test result that has not been verified by a confirmation test and by a medical review officer.

(c) A covered employer that performs drug testing or specimen collection shall use chain-of-custody procedures established by regulations of the United States department of

transportation or such other recognized authority approved by rule by the commissioner of labor and workforce development governing drug testing.

(d) A covered employer shall pay the cost of all drug and alcohol tests, initial and confirmation, which the covered employer requires of employees. An employee or job applicant shall pay the costs of any additional drug or alcohol tests not required by the covered employer.

(e) A covered employer shall not discharge, discipline or discriminate against an employee solely upon the employee's voluntarily seeking treatment, while under the employ of the covered employer, for a drug-related or alcohol-related problem if the employee has not previously tested positive for drug or alcohol use, entered an employee assistance program for drug-related or alcohol-related problems or entered a drug or alcohol rehabilitation program. Unless otherwise provided by a collective bargaining agreement, a covered employer may select the employee assistance program or drug or alcohol rehabilitation program if the covered employer pays the cost of the employee's participation in the program. However, nothing in this chapter is intended to require any employer to permit or provide such a rehabilitation program.

(f) If drug or alcohol testing is conducted based on reasonable suspicion, the covered employer shall promptly detail in writing the circumstances which formed the basis of the determination that reasonable suspicion existed to warrant the testing. A copy of this documentation shall be given to the employee upon request and the original documentation shall be kept confidential by the covered employer pursuant to § 50-9-109, and shall be retained by the covered employer for at least one (1) year.

**50-9-108. Drug or alcohol use not "handicap" or "disability" - Drug or alcohol use "cause" for firing or failure to hire - Miscellaneous provisions.**

**(a)** An employee or job applicant whose drug or alcohol test result is confirmed as positive in accordance with this section shall not, by virtue of the result alone, be deemed to have a disability as defined under federal, state or local disability discrimination laws.

**(b)** A covered employer who discharges or disciplines an employee or refuses to hire a job applicant in compliance with this section is considered to have discharged, disciplined or refused to hire for cause.

**(c)** No physician-patient relationship is created between an employee or job applicant and a covered employer or any person performing or evaluating a drug or alcohol test, solely by the establishment, implementation or administration of a drug or alcohol testing program. This section in no way relieves the person performing the test from responsibility for acts of negligence in performing the tests.

**(d)** Nothing in this section shall be construed to prevent a covered employer from establishing reasonable work rules related to employee possession, use, sale or solicitation of drugs or alcohol, including convictions for offenses relating to drugs or

alcohol, and taking action based upon a violation of any of those rules.

**(e)** This section does not operate retroactively, and does not abrogate the right of an employer under state law to lawfully conduct drug or alcohol tests, or implement lawful employee drug-testing programs. This chapter shall not prohibit an employer from conducting any drug or alcohol testing of employees that is otherwise permitted by law.

**(f)** If an employee or job applicant refuses to submit to a drug or alcohol test, the covered employer is not barred from discharging or disciplining the employee or from refusing to hire the job applicant; however, this subsection (f) does not abrogate the rights and remedies of the employee or job applicant as otherwise provided in this section.

**(g)** This section does not prohibit an employer from conducting medical screening or other tests required, permitted or not disallowed by any statute, rule or regulation for the purpose of monitoring exposure of employees to toxic or other unhealthy substances in the workplace or in the performance of job responsibilities. The screening or testing is limited to the specific substances expressly identified in the applicable statute, rule or regulation, unless prior written consent of the employee is obtained for other tests. The screening or testing need not be in compliance with the rules adopted by the department of labor and workforce development and department of health. If applicable, the drug or alcohol testing must be specified in a collective bargaining agreement as negotiated by the appropriate certified bargaining agent before the testing is implemented.

**(h)** No cause of action shall arise in favor of any person based upon the failure of an employer to establish a program or policy for drug or alcohol testing.

**50-9-109. Confidentiality of records - Parental notification.**

**(a)** All information, interviews, reports, statements, memoranda and drug or alcohol test results, written or otherwise, received by the covered employer through a drug or alcohol testing program are confidential communications and may not be used or received in evidence, obtained in discovery or disclosed in any public or private proceedings, except in accordance with this section or in determining compensability under this chapter.

**(b)** Covered employers, laboratories, medical review officers, employee assistance programs, drug or alcohol rehabilitation programs and their agents who receive or have access to information concerning drug or alcohol test results shall keep all information confidential. Release of the information under any other circumstance is authorized solely pursuant to a written consent form signed voluntarily by the person tested, unless the release is compelled by a hearing officer or a court of competent jurisdiction pursuant to an appeal taken under this section, relevant to a legal claim asserted by the employee or is deemed appropriate by a professional or occupational licensing board in a related disciplinary proceeding. The consent form must contain, at a minimum:

**(1)** The name of the person who is authorized to obtain the information;

**(2)** The purpose of the disclosure;

**(3)** The precise information to be disclosed;

**(4)** The duration of the consent; and

**(5)** The signature of the person authorizing release of the information.

**(c)** Information on drug or alcohol test results for tests administered pursuant to this chapter shall not be released or used in any criminal proceeding against the employee or job applicant. Information released contrary to this section is inadmissible as evidence in the criminal proceeding.

**(d)** This section does not prohibit a covered employer, agent of the employer or laboratory conducting a drug or alcohol test from having access to employee drug or alcohol test information or using the information when consulting with legal counsel in connection with actions brought under or related to this section, or when the information is relevant to its defense in a civil or administrative matter. Neither is this section intended to prohibit disclosure among management as is reasonably necessary for making disciplinary decisions relating to violations of drug or alcohol standards of conduct adopted by an employer.

**(e)** A covered employer shall notify the parents or legal guardians of a minor of the results of any drug or alcohol testing program conducted pursuant to this chapter. Notwithstanding any other provisions of this section, an employer is authorized to disclose the results to parents and guardians and an employer shall not be liable for any disclosure permitted by this subsection (e).

**50-9-110. Prerequisites for processing test specimens - Licensure of testing laboratory.**

**(a)** A laboratory may not analyze initial or confirmation test specimens unless:

**(1)** The laboratory is licensed and approved by the department of health, using criteria established by the United States department of health and human services as guidelines for modeling the state drug-free testing program pursuant to this section, or the laboratory is certified by the United States department of health and human services, the College of American Pathologists or other recognized authority approved by rule by the commissioner of labor and workforce development; and

**(2)** The laboratory complies with the procedures established by the United States department of transportation for a workplace drug test program or other recognized authority approved by the commissioner of labor and workforce development.

**(b)** Confirmation tests may only be conducted by a laboratory that meets the requirements of subdivisions (a)(1) and (2) and is certified by either the Substance Abuse

and Mental Health Services Administration or the College of American Pathologists -- Forensic Urine Testing Programs.

**50-9-111. Rules and regulations - Guidelines for state testing program.**

(a) The administrator of the bureau of workers' compensation is authorized to adopt rules, using the rules and guidelines adopted by the department of health and criteria established by the United States department of health and human services and the United States department of transportation as guidelines for modeling the state drug and alcohol testing program, concerning, but not limited to:

(1) Standards for licensing drug and alcohol testing laboratories and suspension and revocation of the licenses;

(2) Body specimens and minimum specimen amounts that are appropriate for drug or alcohol testing;

(3) Methods of analysis and procedures to ensure reliable drug or alcohol testing results, including the use of breathalyzers and standards for initial tests and confirmation tests;

(4) Minimum cut-off detection levels for alcohol, each drug or metabolites of the drug for the purposes of determining a positive test result;

(5) Chain-of-custody procedures to ensure proper identification, labeling and handling of specimens tested; and

(6) Retention, storage and transportation procedures to ensure reliable results on confirmation tests and retests.

(b) The administrator of the bureau of workers' compensation is authorized to adopt relevant federal rules concerning drug and alcohol testing as a minimum standard for testing procedures and protections that the administrator may exceed. The rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(c) The administrator of the bureau of workers' compensation shall consider drug testing programs and laboratories operating as a part of the College of American Pathologists -- Forensic Urine Drug Testing Programs in issuing guidelines or promulgating rules relative to recognized authorities in drug testing.

(d) The administrator is authorized to set education program requirements for drug-free workplaces by rules promulgated in accordance with the requirements of the Uniform Administrative Procedures Act. The requirements shall not be more stringent than the federal requirements for workplaces regulated by the United States department of transportation rules. The requirements shall not require an employer to provide annual education or awareness training for each employee if all existing employees have

undergone such training at least once and have acknowledged annually in writing the existence of the employer's drug-free workplace policy.

**50-9-112. Temporary employment agencies exempt from drug-free workplace requirements.**

A temporary employment agency shall not be required by rule, regulation or policy of the department of labor and workforce development to implement a drug-free workplace pursuant to this chapter.

**50-9-113. State and local government construction contracts.**

**(a)** Each employer with five (5) or more employees receiving pay who contracts with the state or any local government to provide construction services or who is awarded a contract to provide construction services or who provides construction services to the state or local government shall submit an affidavit stating that the employer has a drug-free workplace program that complies with this chapter, in effect at the time of the submission of a bid at least to the extent required of governmental entities. Any private employer that certifies compliance with the drug-free workplace program, only to the extent required by this section, shall not receive any reduction in workers' compensation premiums and shall not be entitled to any other benefit provided by compliance with the drug-free workplace program set forth in this chapter. Nothing in this section shall be construed to reduce or diminish the rights or privileges of any private employer who has a drug-free workplace program that fully complies with this chapter. For purposes of compliance with this section, any private employer shall obtain a certificate of compliance with the applicable portions of the Drug-free Workplace Act from the department of labor and workforce development. No local government or state governmental entity shall enter into any contract or award a contract for construction services with an employer who does not comply with this section.

**(b)** If it is determined that an employer subject to this section has entered into a contract with a local government or state agency and the employer does not have a drug-free workplace pursuant to this section, the employer shall be prohibited from entering into another contract with any local government or state agency until the employer can prove compliance with the drug-free workplace program pursuant to this section. If the same employer again contracts with any local government or state agency and does not have a drug-free workplace program pursuant to this section, then the employer shall be prohibited from entering into another contract with any local government or state agency for not less than three (3) months from the date the violation was discovered and verified and shall be prohibited from entering into another contract until the employer complies with the drug-free workplace program pursuant to this section. If the same employer for a third time contracts with any local government or state agency and does not have a drug-free workplace program pursuant to this section, then the employer shall be prohibited from entering into another contract with any local government or state agency for not less than one (1) year from the date the violation was discovered and verified and shall be prohibited from entering into another contract until the employer complies with the drug-

free workplace program pursuant to this section.

**(c)** A written affidavit by the principal officer of a covered employer provided to a local government at the time the bid or contract is submitted stating that the employer is in compliance with this section shall absolve the local government of all further responsibility under this section and any liability arising from the employer's compliance or failure of compliance with this section.

**(d)** For the purposes of this section, "employer" does not include any utility or unit of local government. "Employer" includes any private company or corporation.
(d) A written affidavit by the principal officer of a covered employer provided to a local government at the time such bid or contract is submitted stating that the employer is in compliance with this section shall absolve the local government of all further responsibility under this section and any liability arising from the employer's compliance or failure of compliance with the provisions of this section.

**50-9-114. Information to be included within bid or procurement specifications for construction services - Contesting a contract.**

(a) The state or any local government, including departments, divisions, or agencies thereof, shall include within any bid or procurement specifications for construction services the following information:

(1) A statement as to whether the governmental entity issuing a construction service bid or other procurement specification operates a drug-free workplace program as certified under this chapter or operates any other programs which provide for testing of employees for workplace use of drugs or alcohol;

(2) If operating such a program, a statement which describes the government entity's drug-free workplace and/or alcohol and drug testing program; and

(3) A statement that all bidders or proposals for construction services are required to submit an affidavit as part of their bid, that attests that such bidder operates a drug-free workplace program or other drug or alcohol testing program with requirements at least as stringent as that of the program operated by the governmental entity.

(b) Unless suit is filed in chancery court, employers shall have seven (7) calendar days to contest a contract entered into by employers subject to the provisions of this section with a local government or state government. Employers that do not contest such contracts within seven (7) calendar days by filing suit in chancery court shall waive their rights to challenge such contracts for violating the provisions of this section. Such contracts shall be contested in chancery court in the county where the contract was entered. The trial of the alleged violation of the provisions of this section shall be expedited by giving it priority over all cases on the trial docket, except workers' compensation cases.

# MISCELLANEOUS

### 62-6-123. Indemnify or hold harmless agreement invalid.

A covenant promise, agreement or understanding in or in connection with or collateral to a contract or agreement relative to the construction, alteration, repair or maintenance of a building, structure, appurtenance and appliance, including moving, demolition and excavating connected therewith, purporting to indemnify or hold harmless the promisee against liability for damages arising out of bodily injury to persons or damage to property caused by or resulting from the sole negligence of the promisee, the promisee's agents or employees or indemnitee, is against public policy and is void and unenforceable.

## Dram Shop Law

### 57-10-101. Proximate cause.

The general assembly hereby finds and declares that the consumption of any alcoholic beverage or beer rather than the furnishing of any alcoholic beverage or beer is the proximate cause of injuries inflicted upon another by an intoxicated person.

### 57-10-102. Standard of proof.

Notwithstanding the provisions of § 57-10-101, no judge or jury may pronounce a judgment awarding damages to or on behalf of any party who has suffered personal injury or death against any person who has sold any alcoholic beverage or beer, unless such jury of twelve (12) persons has first ascertained beyond a reasonable doubt that the sale by such person of the alcoholic beverage or beer was the proximate cause of the personal injury or death sustained and that such person:

(1) Sold the alcoholic beverage or beer to a person known to be under the age of twenty-one (21) years and such person caused the personal injury or death as the direct result of the consumption of the alcoholic beverage or beer so sold; or

(2) Sold the alcoholic beverage or beer to an obviously intoxicated person and such person caused the personal injury or death as the direct result of the consumption of the alcoholic beverage or beer so sold.

## Conventions & Social Gatherings

### 57-4-203. Prohibited practices - Hours of sale - Authority of commission - Penalties

**Exterior Signs.** **(1)** No licensee shall place any sign of any description on the exterior of the licensee's hotel, convention center, premier type tourist resort, restaurant, or club which is not in compliance with all duly adopted local ordinances relative to such exterior signs.

**(2)** A violation of subdivision (a)(1) is a Class C misdemeanor.

**(b) Sales to Minors Prohibited.** **(1)** **(A)** Any licensee or other person who sells, furnishes, disposes of, gives, or causes to be sold, furnished, disposed of, or given, any alcoholic beverage to any person under twenty-one (21) years of age commits a Class A misdemeanor and shall be punished in accordance with § 39-15-404, as well as any other applicable section.

**(B)** Any licensee engaging in business regulated hereunder or any employee thereof who sells, furnishes, disposes of, gives, or causes to be sold, furnished, disposed of, or given any beer or malt beverage as defined in § 57-6-102 to any person under twenty-one (21) years of age is guilty of a Class A misdemeanor.

**(2)** Any person under the age of twenty-one (21) years who:

**(A)** Purchases, attempts to purchase, receives, or has in such person's possession in any public place, any alcoholic beverage, commits a Class A misdemeanor; or

**(B)** Knowingly makes a false statement or exhibits false identification to the effect that the licensee is twenty-one (21) years of age or older to any person engaged in the sale of alcoholic beverages for the purpose of purchasing or obtaining the same commits a Class A misdemeanor.

**(i)** If a person violating this subdivision (b)(2)(B) is less than eighteen (18) years of age, such person shall be punished by a fine of fifty dollars ($50.00) or not less than twenty (20) hours of community service work, which fine or penalty shall not be suspended or waived. The fine imposed by this subdivision (b)(2)(B)(i) shall apply regardless of whether the violator cooperates with law enforcement officers by telling them the place the alcohol was purchased or obtained or from whom it was purchased or obtained.

**(ii)** If the person violating this subdivision (b)(2)(B) is eighteen (18) years of age or older but less than twenty-one (21) years of age, such person shall be punished by a fine of not less than fifty dollars ($50.00) nor more than two hundred dollars ($200) or by imprisonment in the local jail or workhouse for not less than five (5) days nor more than thirty (30) days. The penalties imposed by this subdivision (b)(2)(B)(ii) apply regardless of whether the violator cooperates with law enforcement officers by telling them the place the alcohol was purchased or obtained or from whom it was purchased or obtained.

**(C)** **(i)** In addition to any criminal penalty established by this section, a court in which a person younger than twenty-one (21) years of age is convicted of the purchase, attempt to purchase or possession of alcoholic beverages, or the making of a false statement or exhibition of false identification for the purpose of purchasing or obtaining alcoholic beverages in violation of this section, shall prepare and send to the department of safety, driver control division, within five (5) working days of the conviction an order of denial of driving privileges for the offender.

**(ii)** The court and the department of safety shall follow the same procedures and utilize the same sanctions and costs for an offender younger than twenty-one (21) years of age but eighteen (18) years of age or older as provided in title 55, chapter 10, part 7, for offenders younger than eighteen (18) years of age but thirteen (13) years of age or older.

**(3)** This chapter does not prohibit any person eighteen (18) years of age or older from selling, transporting, possessing or dispensing alcoholic beverages in the course of such person's employment.

**(c) Other Prohibited Sales. (1)** It is unlawful for any licensee or other person to sell or furnish any alcoholic beverage to any person who is known to be insane or mentally defective, or to any person who is visibly intoxicated, or to any person who is known to habitually drink alcoholic beverages to excess, or to any person who is known to be an habitual user of narcotics or other habit-forming drugs.

**(2)** A violation of subdivision (c)(1) is a Class A misdemeanor.

**(d) Hours of Sale. (1)** Except as provided in subdivision (d)(5), hotels, clubs, zoological institutions, public aquariums, museums, motels, convention centers, restaurants, community theaters, theater, historic interpretive centers, sports authority facilities, and urban park centers, licensed as provided herein to sell alcoholic beverages, and/or malt beverages, and/or wine may not sell, or give away, alcoholic beverages and/or malt beverages and/or wine between the hours of three o'clock a.m. (3:00 a.m.) and eight o'clock a.m. (8:00 a.m.) on weekdays, or between the hours of three o'clock a.m. (3:00 a.m.) and twelve o'clock (12:00) noon on Sundays.

**(2)** Except as provided in subdivision (d)(5), hotels, motels and restaurants, licensed under § 57-4-102(26)(B) may not sell or give away alcoholic beverages, and/or malt beverages and/or wine between the hours of one o'clock a.m. (1:00 a.m.) and eight o'clock a.m. (8:00 a.m.) on weekdays or between the hours of one o'clock a.m. (1:00 a.m.) and twelve o'clock (12:00) noon on Sundays.

**(3)** Except as provided in subdivision (d)(5), establishments in a terminal building of a commercial air carrier airport and commercial airline travel clubs licensed as provided herein to sell alcoholic beverages, and/or malt beverages, and/or wine, may not sell, or give away, alcoholic beverages and/or malt beverages and/or wine between the hours of three o'clock a.m. (3:00 a.m.) and eight o'clock a.m. (8:00 a.m.) on weekdays or between the hours of three o'clock a.m. (3:00 a.m.) and twelve o'clock noon (12:00) on Sundays.

**(4)** Except as provided in subdivision (d)(5), licensees under § 57-4-102(27) may not sell or give away alcoholic beverages and/or malt beverages and/or wine between the hours of five o'clock a.m. (5:00 a.m.) and eight o'clock a.m. (8:00 a.m.) on weekdays or between the hours of five o'clock a.m. (5:00 a.m.) and twelve o'clock (12:00) noon on Sundays.

**(5)** The commission is authorized to extend the hours of sale in the jurisdictions which have approved the sale of liquor by the drink by referendum; provided, however, that such extension of hours as well as § 57-5-301(b)(5) shall apply to Sunday sales of beer within the area of the county outside a municipality which approves liquor by the drink by referendum unless the county legislative body by a two-thirds (2/3) vote sets the hours for Sunday sales of beer in accordance with § 57-5-301(b)(1) to apply within such area. Upon petition by any licensee or group of licensees under this chapter, the commission may, after conducting a rule-making hearing pursuant to the Uniform Administrative Procedures Act, compiled in title 4, chapter 5, adopt rules expanding the hours during which it is legal to sell or give away alcoholic beverages, malt beverages and wine, pursuant to this chapter. The commission is hereby directed to consider such factors as the hours of sales in contiguous states and the need to compete with jurisdictions elsewhere in the country for convention and tourism business. The governing body of any municipality or metropolitan government which has approved liquor by the drink by referendum may, at any time, opt out of any extension of hours adopted under this section by passage of a resolution. Further, any municipality or metropolitan government that has opted out may, at a later date, opt in by passage of a resolution.

**(e) Restrictions on Sealed or Unsealed Packages, or Gifts. (1)** No licensee hereunder shall sell any wine or other alcoholic beverage in any sealed or unsealed package to any patrons or customers for consumption off its premises. Notwithstanding the foregoing, a restaurant licensed under this chapter may permit a customer who purchases an unsealed package of wine in conjunction with a food purchase and consumes a portion of the wine on the premises to remove the partially filled package from the premises. In addition, a licensee holding a license issued pursuant to §§ 57-4-102(14) and (33) may sell and distribute alcoholic beverages and wine in unsealed containers to the occupant of a suite located within a sports authority facility or a convention center; provided, that such occupant is at least twenty-one (21) years of age, is authorized by the lessee of the suite to receive such alcoholic beverages and wine, and the alcoholic beverage or wine is not removed from the sports authority facility or convention center.

**(2)** No licensee shall give away any such sealed package or any drink of wine or alcoholic beverage to any patron or customer; provided, that any hotel licensed under this chapter may include as part of the accommodations to a registered guest the provision of four (4) seven hundred fifty milliliter (750 ml.) complimentary sealed packages of wine or alcoholic beverages which must have all appropriate taxes paid upon them.

**(3)** The tax required by chapter 4, part 3 of this title shall be paid upon the normal sales price of any such packages of wines provided under this subsection (e).

**(4)** A restaurant or limited service restaurant may sell beer for consumption off premises upon meeting the requirements of § 57-5-101(c)(1)(B).

**(f) Method of Sale.** Sales of wine and alcoholic beverages by licensees hereunder shall be conducted in the same manner as the sale of food is regularly conducted by such hotels, convention centers, premier type tourist resorts, restaurants, or clubs, except that

no curb service of such beverages is lawful.

**(g) Ownership of Alcoholic Beverages Sold.** **(1)** It is a Class C misdemeanor for any licensee hereunder to sell or serve on the licensee's premises any wine or other alcoholic beverage unless such beverage is owned outright by the licensee.

**(2)** It is unlawful for any person, firm or corporation to sell wine or other alcoholic beverage as authorized herein without complying with the applicable provisions of this chapter.

**(h) Restrictions on Employment.** No entity holding a license issued pursuant to § 57-4-101 shall employ any person in the serving of beer, wine or other alcoholic beverages who does not possess a server permit from the commission. It is made the duty of the licensee to see that each person dispensing or serving alcoholic beverages, wine or beer in the licensee's establishment possesses such a permit, which permit must be on the person of such employee or on the premises of the licensed establishment and subject to inspection by the commission or its duly authorized agent when the employee is engaged in the performance of that employee's duties for the licensee.

**(i) Premises Must Be Licensed -- Exception for Conventions, Social Gatherings and Catered Events.** **(1)** **(A)** Except with respect to a caterer licensed under this chapter, it is unlawful for any person, firm, corporation, partnership, or association to allow the dispensing of alcoholic beverages except sacramental wines and beer, in any establishment unless such establishment is licensed under this title.

**(B)** A violation of subdivision (i)(1)(A) is a Class B misdemeanor.

(2) Bona fide conventions or meetings, however, may bring their own alcoholic beverages onto the licensed premises if the same beverages are served to delegates or guests without cost. All other provisions of this chapter shall be applicable to such premises. This section has no application to social gatherings in a private home or a private place which is not of a commercial nature or where goods or services may be purchased or sold or any charge or rent or other thing of value is exchanged for the use thereof, excepting it be for sleeping quarters. Nothing herein shall preclude the serving of alcoholic beverages to guests without cost in rooms or suites or banquet rooms of a hotel or club licensed pursuant to this chapter.

**(3)** A restaurant, hotel, or caterer holding a valid catering license may sell or distribute wine, beer, and other alcoholic beverages at social or commercial events, catered by the restaurant, hotel, or caterer where the restaurant, hotel, or caterer is providing food service at such event; provided, that the restaurant, hotel, or caterer shall notify the commission as to the time, location and duration of the catered event before the commencement of the event. Nothing in this subdivision (i)(3) or chapter shall be interpreted to require a person who holds a valid caterer license under this chapter to also be licensed as a restaurant or hotel.

**(j) Penalties Invoked.** **(1)** Any person, firm or corporation who violates any provision of parts 1 and 2 of this chapter is guilty of a misdemeanor, and, upon conviction thereof, shall be fined not less than five hundred dollars ($500) nor more than one thousand dollars ($1,000); and, in the discretion of the court, imprisoned not less than thirty (30) days, nor more than six (6) months, and each violation constitutes a separate offense.

**(2)** Any person, firm or corporation who shall sell wine or other alcoholic beverages for consumption on its premises except as authorized by parts 1 and 2 of this chapter is guilty of a misdemeanor and punishable as provided in this section.

**(3)** Upon conviction of a second offense under this chapter, the permit of any licensee so convicted shall be automatically and permanently revoked.

**(4)** Upon the second conviction of any person, firm, or corporation for violation of subdivision (b)(1), such person, firm, or corporation is guilty of a Class E felony. In addition, upon the second such conviction, the permit of such licensee shall be automatically and permanently revoked regardless of any other punishment actually imposed.

**(k) Purchases by Special Occasion Licensees.** No charitable, nonprofit or political organization possessing a special occasion license shall purchase for sale or distribution under such license any alcoholic beverages from any source other than a licensee under § 57-3-204. This subsection (k) shall not apply to homemade wine made in the Swiss tradition by a member or members of a special occasion permit holder issued a license pursuant to § 57-4-102(32)(D). The member may supply the wine notwithstanding the limitations of § 57-3-207(e).

**(l) Commercial Airline Travel Clubs.** A commercial airline travel club licensed under this chapter may provide complimentary drinks of wine and alcoholic beverages to its patrons, customers, and guests. Such commercial airline travel club must have a separate area, other than the gate and ticket areas, designated as a club area for use by its members. The tax required by part 3 of this chapter shall be paid upon the normal sales price of all such complimentary drinks of wine and alcoholic beverages provided under this subsection (*l*).

**(m) Discounts.** Nothing in this chapter shall prohibit a licensee from offering a discount in such manner as the licensee deems appropriate as long as the discount being offered is not below the cost paid by the licensee to purchase the alcoholic beverages from the retailer.

## Employee Online Privacy Act of 2014

### 50-1-1001. Short title

This part shall be known and may be cited as the “Employee Online Privacy Act of 2014.”

**50-1-1002. Definitions**

As used in this part:

(1) “Adverse action” means to discharge, threaten, or otherwise discriminate against an employee in any manner that affects the employee's employment, including compensation, terms, conditions, location, rights, immunities, promotions, or privileges;

(2) “Applicant” means an individual who has applied for employment with an employer;

(3) “Employer” means a person or entity that employs one (1) or more employees and includes the state and its political subdivisions and an agent, representative, or designee of the employer;

(4) “Law enforcement agency” has the same meaning as defined in § 39-17-314; and

(5) “Personal Internet account”:

> (A) Means an online account that is used by an employee or applicant exclusively for personal communications unrelated to any business purpose of the employer; and includes any electronic medium or service where users may create, share or view content, including, emails, messages, instant messages, text messages, blogs, podcasts, photographs, videos or user-created profiles; and
>
> (B) Does not include an account created, maintained, used, or accessed by an employee or applicant for business-related communications or for a business purpose of the employer.

**50-1-1003. Employee's or applicant's personal Internet account; password; employer restrictions**

(a) An employer shall not:

> (1) Request or require an employee or an applicant to disclose a password that allows access to the employee's or applicant's personal Internet account;
>
> (2) Compel an employee or an applicant to add the employer or an employment agency to the employee's or applicant's list of contacts associated with a personal Internet account;
>
> (3) Compel an employee or an applicant to access a personal Internet account in the presence of the employer in a manner that enables the employer to observe the contents of the employee's or applicant's personal Internet account; or

(4) Take adverse action, fail to hire, or otherwise penalize an employee or applicant because of a failure to disclose information or take an action specified in subdivisions (a)(1)-(3).

(b) Unless otherwise provided by law, an employer is not prohibited from:

(1) Requesting or requiring an employee to disclose a username or password required only to gain access to:

(A) An electronic communications device supplied by or paid for wholly or in part by the employer; or

(B) An account or service provided by the employer that is obtained by virtue of the employee's employment relationship with the employer, or used for the employer's business purposes;

(2) Disciplining or discharging an employee for transferring the employer's proprietary or confidential information or financial data to an employee's personal Internet account without the employer's authorization;

(3) Conducting an investigation or requiring an employee to cooperate in an investigation if:

(A) There is specific information on the employee's personal Internet account regarding compliance with applicable laws, regulatory requirements, or prohibitions against work-related employee misconduct; or

(B) The employer has specific information about an unauthorized transfer of the employer's proprietary information, confidential information, or financial data to an employee's personal Internet account;

(4) Restricting or prohibiting an employee's access to certain web sites while using an electronic communications device supplied by or paid for wholly or in part by the employer or while using an employer's network or resources, in accordance with state and federal law;

(5) Monitoring, reviewing, accessing, or blocking electronic data stored on an electronic communications device supplied by or paid for wholly or in part by the employer, or stored on an employer's network, in accordance with state and federal law;

(6) Complying with a duty to screen employees or applicants before hiring or to monitor or retain employee communications:

(A) That is established under federal law or by a “self-regulatory organization”, as defined in the Securities and Exchange Act of 1934,15 U.S.C. § 78c(a);

(B) For purposes of law enforcement employment; or

(C) For purposes of an investigation into law enforcement officer conduct performed by a law enforcement agency; or

(7) Viewing, accessing, or using information about an employee or applicant that can be obtained without violating subsection (a) or information that is available in the public domain.

(c) Conducting an investigation or requiring an employee to cooperate in an investigation as specified in subdivision (b)(3) includes requiring the employee to share the reported content or information in order to make a factual determination.

(d)(1) This part does not create a duty for an employer to search or monitor the activity of a personal Internet account.

(2) An employer is not liable under this part for a failure to request or require that an employee or applicant grant access to, allow observation of, or disclose information that allows access to or observation of the employee's or applicant's personal Internet account.

**50-1-1004. Severability clause**

If any provision of this part or the application of any provision of this part to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the part that can be given effect without the invalid provision or application, and to that end, the provisions of this part are declared to be severable.