service of a copy of the application has been made on the candidate and proof of service is endorsed on the application being filed. Upon receipt of the proper filing fee, the clerk shall place the name of the candidate on the official ballot without partisan designation. The filing dates contained in this subdivision do not apply to any home rule charter city whose charter provides for earlier filing dates.

Approved May 6, 1987

CHAPTER 63—S.F.No. 324

An act relating to traffic regulations; removing exemptions regarding alcohol- or controlled substance-related activities of persons engaged in work upon the highway; amending Minnesota Statutes 1986, section 169.03, subdivision 6.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 169.03, subdivision 6, is amended to read:

Subd. 6. (a) The provisions of this chapter shall not apply to persons, motor vehicles, and other equipment while actually engaged in work upon the highway, ~~but~~ except as provided in paragraphs (b) and (c).

(b) This chapter shall apply to those persons and vehicles when traveling to or from such work, except that persons operating equipment owned, rented or hired by road authorities shall be exempt from the width, height and length provisions of sections 169.80 and 169.81 and shall be exempt from the weight limitations of this chapter while engaged in snow or ice removal and while engaged in flood control operations on behalf of the state or a local governmental unit.

(c) Sections 169.121 to 169.129 apply to persons while actually engaged in work upon the highway.

Approved May 6, 1987

CHAPTER 64—S.F.No. 341

An act relating to insurance; regulating unfair settlement practices of automobile insurers; requiring repairs with original equipment parts; providing an exception; regulating insurance appraisals; revising the truth-in-repairs act to require disclosure of whether new parts are original equipment parts; amending Minnesota Statutes 1986, sections 72A.20, subdivision 12a; 72B.091, subdivision 2; 325F.56, subdivision 8; and 325F.60, subdivision 1.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 1986, section 72A.20, subdivision 12a, is amended to read:

Subd. 12a. **CLAIMS SETTLEMENT.** (a) **ADMINISTRATIVE ENFORCEMENT.** The commissioner may, in accordance with chapter 14, adopt rules to insure the prompt, fair, and honest processing of claims and complaints. The commissioner may, in accordance with sections 72A.22 to 72A.25, seek and impose appropriate administrative remedies, including fines, for (1) a violation of this subdivision or the rules adopted pursuant to this subdivision; or (2) a violation of subdivision 12. The commissioner need not show a general business practice in taking an administrative action for these violations.

No individual violation constitutes an unfair, discriminatory, or unlawful practice in business, commerce, or trade for purposes of section 8.31.

(b) **CONSTRUCTION.** The policy of the department of commerce, in interpreting and enforcing this subdivision, will be to take into consideration all pertinent facts and circumstances in determining the severity and appropriateness of the action to be taken in regard to any violation of this subdivision.

The magnitude of the harm to the claimant or insured, and any actions by the insured, claimant, or insurer that mitigate or exacerbate the impact of the violation may be considered.

Actions of the claimant or insured which impeded the insurer in processing or settling the claim, and actions of the insurer which increased the detriment to the claimant or insured may also be considered in determining the appropriate administrative action to be taken.

(c) **DEFINITIONS.** For the purposes of this subdivision, the following terms have the meanings given them.

(1) Adjuster or adjusters. "Adjuster" or "adjusters" is as defined in section 72B.02.

(2) Agent. "Agent" means insurance agents or insurance agencies licensed pursuant to section 60A.17, and representatives of these agents or agencies.

(3) Claim. "Claim" means a request or demand made with an insurer for the payment of funds or the provision of services under the terms of any policy, certificate, contract of insurance, binder, or other contracts of temporary insurance. The term does not include a claim under a health insurance policy made by a participating provider with an insurer in accordance with the participating provider's service agreement with the insurer which has been filed with the commissioner of commerce prior to its use.

(4) Claim settlement. "Claim settlement" means all activities of an insurer related directly or indirectly to the determination of the extent of liabilities due

or potentially due under coverages afforded by the policy, and which result in claim payment, claim acceptance, compromise, or other disposition.

(5) Claimant. "Claimant" means any individual, corporation, association, partnership, or other legal entity asserting a claim against any individual, corporation, association, partnership, or other legal entity which is insured under an insurance policy or insurance contract of an insurer.

(6) Complaint. "Complaint" means a communication primarily expressing a grievance.

(7) Insurance policy. "Insurance policy" means any evidence of coverage issued by an insurer including all policies, contracts, certificates, riders, binders, and endorsements which provide or describe coverage. The term includes any contract issuing coverage under a self-insurance plan, group self-insurance plan, or joint self-insurance employee health plans.

(8) Insured. "Insured" means an individual, corporation, association, partnership, or other legal entity asserting a right to payment under their insurance policy or insurance contract arising out of the occurrence of the contingency or loss covered by the policy or contract. The term does not apply to a person who acquires rights under a mortgage.

(9) Insurer. "Insurer" includes any individual, corporation, association, partnership, reciprocal exchange, Lloyds, fraternal benefits society, self-insurer, surplus line insurer, self-insurance administrator, and nonprofit service plans under the jurisdiction of the department of commerce.

(10) Investigation. "Investigation" means a reasonable procedure adopted by an insurer to determine whether to accept or reject a claim.

(11) Notification of claim. "Notification of claim" means any communication to an insurer by a claimant or an insured which reasonably apprises the insurer of a claim brought under an insurance contract or policy issued by the insurer. Notification of claim to an agent of the insurer is notice to the insurer.

(12) Proof of loss. "Proof of loss" means the necessary documentation required from the insured to establish entitlement to payment under a policy.

(13) Self-insurance administrator. "Self-insurance administrator" means any vendor of risk management services or entities administering self-insurance plans, licensed pursuant to section 60A.23, subdivision 8.

(14) Self-insured or self-insurer. "Self-insured" or "self-insurer" means any entity authorized pursuant to section 65B.48, subdivision 3; chapter 62H; section 176.181, subdivision 2; Laws of Minnesota 1983, chapter 290, section 171; section 471.617; or section 471.981 and includes any entity which, for a fee, employs the services of vendors of risk management services in the administration of a self-insurance plan as defined by section 60A.23, subdivision 8, clause (2), subclauses (a) and (d).

(d) **STANDARDS FOR CLAIM FILING AND HANDLING.** The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3) unless provided otherwise by law or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. For claims made under a health policy the notification of claim must be in writing;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the department of commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive

under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

(8) failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

(9) demanding information which would not affect the settlement of the claim;

(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not habitable;

(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.

(e) **STANDARDS FOR FAIR SETTLEMENT OFFERS AND AGREE-**

MENTS. The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) making any partial or final payment, settlement, or offer of settlement, which does not include an explanation of what the payment, settlement, or offer of settlement is for;

(2) making an offer to an insured of partial or total settlement of one part of a claim contingent upon agreement to settle another part of the claim;

(3) refusing to pay one or more elements of a claim by an insured for which there is no good faith dispute;

(4) threatening cancellation, rescission, or nonrenewal of a policy as an inducement to settlement of a claim;

(5) failing to issue payment for any amount finally agreed upon in settlement of all or part of any claim within five business days from the receipt of the agreement by the insurer or from the date of the performance by the claimant of any conditions set by such agreement, whichever is later;

(6) failing to inform the insured of the policy provision or provisions under which payment is made;

(7) settling or attempting to settle a claim or part of a claim with an insured under actual cash value provisions for less than the value of the property immediately preceding the loss, including all applicable taxes and license fees. In no case may an insurer be required to pay an amount greater than the amount of insurance;

(8) except where limited by policy provisions, settling or offering to settle a claim or part of a claim with an insured under replacement value provisions for less than the sum necessary to replace the damaged item with one of like kind and quality, including all applicable taxes, license, and transfer fees;

(9) reducing or attempting to reduce for depreciation any settlement or any offer of settlement for items not adversely affected by age, use, or obsolescence;

(10) reducing or attempting to reduce for betterment any settlement or any offer of settlement unless the resale value of the item has increased over the preloss value by the repair of the damage.

(f) **STANDARDS FOR AUTOMOBILE INSURANCE CLAIMS HANDLING, SETTLEMENT OFFERS, AND AGREEMENTS.** In addition to the acts specified in paragraphs (d), (e), (g), (h), and (i), the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) if an automobile insurance policy provides for the adjustment and settlement of an automobile total loss on the basis of actual cash value or replacement

with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) comparable and available replacement automobile, with all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to the transfer or evidence of ownership of the automobile paid, at no cost to the insured other than the deductible amount as provided in the policy;

(b) a cash settlement based upon the actual cost of purchase of a comparable automobile, including all applicable taxes, license fees, at least pro rata for the unexpired term of the replaced automobile's license, and other fees incident to transfer of evidence of ownership, less the deductible amount as provided in the policy. The costs must be determined by:

(i) the cost of a comparable automobile, adjusted for mileage, condition, and options, in the local market area of the insured, if such an automobile is available in that area; or

(ii) one of two or more quotations obtained from two or more qualified sources located within the local market area when a comparable automobile is not available in the local market area. The insured shall be provided the information contained in all quotations prior to settlement; or

(iii) any settlement or offer of settlement which deviates from the procedure above must be documented and justified in detail. The basis for the settlement or offer of settlement must be explained to the insured;

(2) if an automobile insurance policy provides for the adjustment and settlement of an automobile partial loss on the basis of repair or replacement with like kind and quality and the insured is not an automobile dealer, failing to offer one of the following methods of settlement:

(a) to assume all costs, including reasonable towing costs, for the satisfactory repair of the motor vehicle. Satisfactory repair includes repair of both obvious and hidden damage as caused by the claim incident. This assumption of cost may be reduced by applicable policy provision; or

(b) to offer a cash settlement sufficient to pay for satisfactory repair of the vehicle. Satisfactory repair includes repair of obvious and hidden damage caused by the claim incident, and includes reasonable towing costs;

(3) regardless of whether the loss was total or partial, in the event that a damaged vehicle of an insured cannot be safely driven, failing to exercise the right to inspect automobile damage prior to repair within five business days following receipt of notification of claim. In other cases the inspection must be made in 15 days;

(4) regardless of whether the loss was total or partial, requiring unreasonable travel of a claimant or insured to inspect a replacement automobile, to obtain a

repair estimate, to allow an insurer to inspect a repair estimate, to allow an insurer to inspect repairs made pursuant to policy requirements, or to have the automobile repaired;

(5) regardless of whether the loss was total or partial, if loss of use coverage exists under the insurance policy, failing to notify an insured at the time of the insurer's acknowledgment of claim, or sooner if inquiry is made, of the fact of the coverage, including the policy terms and conditions affecting the coverage and the manner in which the insured can apply for this coverage;

(6) regardless of whether the loss was total or partial, failing to include the insured's deductible in the insurer's demands under its subrogation rights. Subrogation recovery must be shared at least on a proportionate basis with the insured, unless the deductible amount has been otherwise recovered by the insured. No deduction for expenses may be made from the deductible recovery unless an attorney is retained to collect the recovery, in which case deduction may be made only for a pro rata share of the cost of retaining the attorney;

(7) requiring as a condition of payment of a claim that repairs to any damaged vehicle must be made by a particular contractor or repair shop or that parts, other than window glass, must be replaced with parts other than original equipment parts;

(8) where liability is reasonably clear, failing to inform the claimant in an automobile property damage liability claim that the claimant may have a claim for loss of use of the vehicle;

(9) failing to make a good faith assignment of comparative negligence percentages in ascertaining the issue of liability;

(10) failing to pay any interest required by statute on overdue payment for an automobile personal injury protection claim;

(11) if an automobile insurance policy contains either or both of the time limitation provisions as permitted by section 65B.55, subdivisions 1 and 2, failing to notify the insured in writing of those limitations at least 60 days prior to the expiration of that time limitation;

(12) if an insurer chooses to have an insured examined as permitted by section 65B.56, subdivision 1, failing to notify the insured of all of the insured's rights and obligations under that statute, including the right to request, in writing, and to receive a copy of the report of the examination.

(g) **STANDARDS FOR RELEASES.** The following acts by an insurer, adjuster, or self-insured or self-insurance administrator constitute unfair settlement practices:

(1) requesting or requiring an insured or a claimant to sign a release that extends beyond the subject matter that gave rise to the claim payment;

(2) issuing a check or draft in payment of a claim that contains any language or provision that implies or states that acceptance of the check or draft constitutes a final settlement or release of any or all future obligations arising out of the loss.

(h) **STANDARDS FOR CLAIM DENIAL.** The following acts by an insurer, adjuster, or self-insured, or self-insurance administrator constitute unfair settlement practices:

(1) denying a claim or any element of a claim on the grounds of a specific policy provision, condition, or exclusion, without informing the insured of the policy provision, condition, or exclusion on which the denial is based;

(2) denying a claim without having made a reasonable investigation of the claim;

(3) denying a liability claim because the insured has requested that the claim be denied;

(4) denying a liability claim because the insured has failed or refused to report the claim, unless an independent evaluation of available information indicates there is no liability;

(5) denying a claim without including the following information:

(i) the basis for the denial;

(ii) the name, address, and telephone number of the insurer's claim service office or the claim representative of the insurer to whom the insured or claimant may take any questions or complaints about the denial; and

(iii) the claim number and the policy number of the insured;

(6) denying a claim because the insured or claimant failed to exhibit the damaged property unless:

(i) the insurer, within a reasonable time period, made a written demand upon the insured or claimant to exhibit the property; and

(ii) the demand was reasonable under the circumstances in which it was made.

(i) **STANDARDS FOR COMMUNICATIONS WITH THE DEPARTMENT.** In addition to the acts specified elsewhere in this section, the following acts by an insurer, adjuster, or a self-insured or self-insurance administrator constitute unfair settlement practices:

(1) failure to respond, within 15 working days after receipt of an inquiry from the commissioner, about a claim, to the commissioner;

(2) failure, upon request by the commissioner, to make specific claim files available to the commissioner;

(3) failure to include in the claim file all written communications and transactions emanating from, or received by, the insurer, as well as all notes and work papers relating to the claim. All written communications and notes referring to verbal communications must be dated by the insurer;

(4) failure to submit to the commissioner, when requested, any summary of complaint data reasonably required;

(5) failure to compile and maintain a file on all complaints. If the complaint deals with a loss, the file must contain adequate information so as to permit easy retrieval of the entire file. If the complaint alleges that the company, or agent of the company, or any agent producing business written by the company is engaged in any unfair, false, misleading, dishonest, fraudulent, untrustworthy, coercive, or financially irresponsible practice, or has violated any insurance law or rule, the file must indicate what investigation or action was taken by the company. The complaint file must be maintained for at least four years after the date of the complaint.

(j) **SCOPE.** This subdivision does not apply to workers' compensation insurance. Nothing in this subdivision abrogates any policy provisions.

Sec. 2. Minnesota Statutes 1986, section 72B.091, subdivision 2, is amended to read:

Subd. 2. The appraiser shall provide one legible copy of the appraisal to the vehicle owner and one legible copy of the appraisal to the repair shop designated by the owner if requested by the repair shop. The motor vehicle repair shop shall provide the vehicle owner and the insurance company or companies involved in the loss one legible copy of the appraisal. This appraisal shall include an itemized listing of those parts to be repaired and those parts to be replaced by new, used, rebuilt, reconditioned or replated parts. The appraisal shall contain the name of the insurance company ordering it, if any, the insurance company's address and telephone number, its file number, the appraiser's name, telephone number, and the proper identification of the vehicle being inspected. The appraisal shall indicate all significant old and unrelated damages and shall include an itemized listing of all damages, specifying those parts to be repaired and those parts to be replaced by new, used, rebuilt, reconditioned, or replated parts. The appraisal must disclose to the vehicle owner any parts to be used, other than window glass, which are not original equipment parts or which are not covered by the manufacturer's warranty on such parts.

Sec. 3. Minnesota Statutes 1986, section 325F.56, subdivision 8, is amended to read:

Subd. 8. "Written estimate" means a writing which includes:

(a) The name and address of the shop;

(b) A description of the problem to be repaired as described by the customer and any specific repair requested by the customer~~.~~;

(c) The charges for parts or materials listed with reasonable particularity and indicating whether the parts are new, used, rebuilt, ~~or~~ reconditioned, or replated if this information is known by the shop. If parts, other than window glass, used in the repair are new parts, the estimate must indicate whether or not those parts are original equipment parts;

(d) Labor charges;

(e) Tax;

(f) Any delivery charge;

(g) Any other charges; and

(h) The total estimated price.

Sec. 4. Minnesota Statutes 1986, section 325F.60, subdivision 1, is amended to read:

Subdivision 1. **DEFINITION; REQUIREMENTS.** Notwithstanding the provisions of section 325F.56, subdivision 2, for the purpose of this section "repair" means work of any value performed under a manufacturer's warranty, a service contract, or an insurance policy; or any repair work performed for a total value of more than $50, including the price of parts and materials, to restore a malfunctioning, defective, or worn motor vehicle, appliance, or dwelling place used primarily for personal, family, or household purposes and not primarily for business or agricultural purposes. "Repairs" do not include service calls or estimates. Upon completion of repairs, a shop shall provide the customer with a copy of a dated invoice for the repairs performed. If the customer receives a repaired motor vehicle or appliance without face to face contact with the shop, the shop shall mail the invoice to the customer within two business days after the shop has knowledge of removal of the item. The invoice shall contain the following information:

(a) The date of repair;

(b) The name and address of the shop;

(c) A description of all repairs performed;

(d) An itemization of the charges for parts, materials, labor, tax, delivery, and any other charges assessed against the customer;

(e) A notation specifying which parts, if any, are new, used, rebuilt, ~~or~~ reconditioned, or replated if that information is known by the shop. If parts, other than window glass, used in the repair are new parts, the invoice must indicate whether or not those parts are original equipment parts;

(f) A statement of any charge for a service call or for making an estimate;

(g) A statement of the odometer reading at the time a motor vehicle is presented for repairs; and

(h) A statement of the symptoms, as described by the customer, for which the repairs were sought.

Sec. 5. **EFFECTIVE DATE.**

Sections 1 to 4 are effective the day following final enactment.

Approved May 6, 1987

CHAPTER 65—S.F.No. 470

An act relating to the city of Duluth and the county of St. Louis; authorizing the filing of the plat of Spirit Valley.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **PLAT OF SPIRIT VALLEY.**

Notwithstanding any contrary provision of other law, ordinance, or charter, the St. Louis county recorder shall accept for filing, file, and record in that office the plat of Spirit Valley in the SW 1/4 of Section 7, Township 49 North, Range 14 West approved by the city of Duluth planning commission on October 9, 1984, without presentation of a certificate from the county treasurer that the taxes, including the current year's taxes, have been paid.

Notwithstanding any contrary provision of other law, ordinance, or charter, the St. Louis county auditor may amend the descriptions of any property contained within that plat of Spirit Valley which is subject to proceedings pursuant to Minnesota Statutes, chapters 279 to 282, to conform to the descriptions contained in the plat.

Sec. 2. **LOCAL APPROVAL.**

This act takes effect the day after compliance with Minnesota Statutes, section 645.021, subdivision 3, by the governing body of the city of Duluth and the governing body of the county of St. Louis.

Approved May 7, 1987

CHAPTER 66—S.F.No. 698

An act relating to education; authorizing northeast metropolitan intermediate school district No. 916 to issue certain bonds for the acquisition and betterment of a secondary vocational and special education facility.