CHAPTER 72A

REGULATION OF TRADE PRACTICES

72A.20 METHODS, ACTS, AND PRACTICES WHICH ARE DEFINED AS UNFAIR OR DECEPTIVE.

[For text of subds 1 to 11, see M.S.2006]

Subd. 12. **Unfair service.** Causing or permitting with such frequency to indicate a general business practice any unfair, deceptive, or fraudulent act concerning any claim or complaint of an insured or claimant including, but not limited to, the following practices:

(1) misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;

(2) failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;

(3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;

(4) refusing to pay claims without conducting a reasonable investigation based upon all available information;

(5) failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;

(6) not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

(7) compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempting to settle a claim for less than the amount to which reasonable persons would have believed they were entitled by reference to written or printed advertising material accompanying or made part of an application;

(9) attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;

(10) making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made;

(11) making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;

(12) delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;

(13) failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage;

(14) failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement;

(15) requiring an insured to provide information or documentation that is or would be dated more than five years prior to or five years after the date of a fire loss, except for proof of ownership of the damaged property;

(16) stating or implying to an insured that filing a claim related to the I–35W bridge collapse for no–fault motor vehicle insurance benefits would or may result in cancellation or nonrenewal of the insured's policy or in a surcharge or other future increase in premium rates, when any such consequence of filing the claim would be prohibited by law;

(17) failing to promptly inform an insured who files a claim related to the I–35W bridge collapse and described in section 65B.133, subdivision 5a, of the provisions of that law, both orally and in writing.

[For text of subds 13 to 39, see M.S.2006]

History: *1Sp2007 c 2 art 2 s 3*

72A.497 ACCESS TO PERSONAL INFORMATION.

[For text of subds 1 and 2, see M.S.2006]

Subd. 3. **Health records.** (a) Health record information requested under subdivision 1 that has been supplied by a health care institution or a health professional must provide the identity of the health professional or health care institution that supplied the information. The health record information must be provided either directly to the individual or to a health professional designated by the person who is licensed to provide health care with respect to the condition to which the information relates, whichever the individual elects. If the information is provided to a designated health professional, the insurer, insurance agent, or insurance–support organization shall notify the person, at the time of the disclosure, that the information has been provided to the health professional.

(b) If a health professional or a health care institution has provided health information to an insurer, insurance–support organization, or insurance agent that the health professional or health care institution has determined and indicates in writing that the release of the health record information is detrimental to the physical or mental health of the person, or is likely to cause the individual to inflict self–harm or to harm another, the insurer, insurance agent, or insurance–support organization may provide that information directly to the individual only with the approval of the health professional with treatment responsibility for the condition to which the information relates. If approval is not obtained, the information must be provided to the health professional designated by the individual.

(c) Nothing in this section may reduce or affect a patient's rights under sections 144.291 to 144.298.

[For text of subds 4 to 6, see M.S.2006]

History: *2007 c 147 art 10 s 15*

72A.52 NOTICE REQUIREMENTS.

Subdivision 1. **Contents.** In addition to all other legal requirements a policy or contract of insurance described in section 72A.51 shall show the name and address of the insurer and the seller of the policy or contract and shall state, clearly and conspicuously in boldface type of a minimum size of ten points, a right to cancel notice which shall include the following:

(1) a minimum of ten days beginning on the date the policy is received by the owner;

(2) a minimum of 30 days beginning on the date the policy is received by the owner if the policy is a replacement policy;

(3) a requirement for the return of the policy to the company or an agent of the company;

(4) a statement that the policy is considered void from the beginning and the parties shall be in the same position as if no policy had been issued;

(5) a refund of all premiums paid, including any fees or charges, if the policy is returned; and

(6) a statement that notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed, and postage prepaid.

For variable annuity contracts issued pursuant to sections 61A.13 to 61A.21, this notice shall be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of the amount calculated in accordance with the provisions of section 72A.51, subdivision 3.

[For text of subd 2, see M.S.2006]

History: *2007 c 104 s 19*