HOUSE BILL NO. 145

INTRODUCED BY J. MCKENNEY

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE STATE INSURANCE CODE; ALLOWING INSURANCE COMPANIES TO USE BOOK-ENTRY SYSTEMS WITH RESPECT TO THEIR SECURITIES AND PROVIDING THE INSURANCE COMMISSIONER WITH RULEMAKING AUTHORITY; DEFINING "DISABILITY INCOME INSURANCE"; MODIFYING REQUIREMENTS AND PENALTIES FOR SURPLUS LINES PRODUCERS; REQUIRING THAT INSURERS PAY FEES AND COSTS ASSOCIATED WITH PREPARING AND FILING CERTAIN DOCUMENTS WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; PROVIDING THAT CERTAIN FEES AND PENALTIES BE DEPOSITED IN THE STATE SPECIAL REVENUE FUND TO THE CREDIT OF THE STATE AUDITOR RATHER THAN DEPOSITING THEM INTO THE GENERAL FUND; REVISING VARIOUS INCORPORATION REQUIREMENTS; CHANGING REPORTING REQUIREMENTS WITH RESPECT TO AN INDIVIDUAL OBTAINING 10 PERCENT OR MORE OF ANY CLASS OF EQUITY SECURITY IN A DOMESTIC STOCK INSURANCE COMPANY; REVISING THE DEFINITION OF "INSOLVENT INSURER"; CHANGING THE PENALTY FOR MISAPPROPRIATION OF INSURANCE PREMIUMS; MODIFYING INCONTESTABILITY PROVISIONS FOR DISABILITY BENEFITS AND CERTAIN DEATH BENEFITS; ALLOWING A GROUP INSURER TO CONTRACT WITH ANOTHER INSURER FOR CONVERSION POLICIES; MODIFYING COVERAGE FOR WELL-CHILD CARE; MODIFYING THE DEFINITION OF "THEFT" TO INCLUDE MISAPPROPRIATION OF INSURANCE PREMIUMS; AMENDING SECTIONS 33-1-408, 33-1-705, 33-1-1202, 33-2-115, 33-2-307, 33-2-326, 33-2-701, 33-2-708, 33-3-201, 33-3-441, 33-4-101, 33-4-202, 33-10-102, 33-10-207, 33-15-1107, 33-16-403, 33-17-503, 33-17-1101, 33-17-1102, 33-17-1204, 33-20-101, 33-20-103, 33-20-105, 33-20-114, 33-20-1202, 33-20-1203, 33-20-1204, 33-20-1205, 33-20-1206, 33-20-1207, 33-20-1209, 33-20-1210, 33-20-1213, 33-22-101, 33-22-107, 33-22-303, 33-22-512, 33-22-1512, 33-22-1513, 33-23-212, 33-23-214, 33-30-102, 33-30-107, 33-30-204, 33-31-111, 33-31-212, 33-33-201, 33-35-306, 45-6-301, AND 50-3-109, MCA; AND REPEALING SECTION 17-2-121, MCA."

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

NEW SECTION. **Section 1. Purpose.** The purpose of [sections 1 through 4] is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery

of securities certificates, subject to appropriate rules adopted by the commissioner.

NEW SECTION. **Section 2. Definitions.** As used in this chapter, the following definitions apply:

(1) "Clearing corporation" has the meaning provided in 30-8-112, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business in the foreign country, a clearing corporation may include a corporation that is organized or existing under the laws of any foreign country and is legally qualified under those laws to effect transactions in securities by computerized book entry.

(2) "Direct participant" means a bank, trust company, or other institution that maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(3) "Federal reserve book-entry system" means the computerized systems sponsored by the United States department of the treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and those agencies and instrumentalities, respectively, in federal reserve banks through banks that are members of the federal reserve system or that otherwise have access to the computerized systems.

(4) "Member bank" means a national bank, state bank, or trust company that is a member of the federal reserve system and through which an insurance company participates in the federal reserve book-entry system.

(5) "Security" has the meaning provided in 30-8-112.

NEW SECTION. **Section 3. Use of book-entry systems -- rules.** (1) (a) Other provisions of law may not be construed as prohibiting a domestic insurance company from depositing or arranging for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the federal reserve book-entry system.

(b) When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of the clearing corporation with any other securities deposited with the clearing corporation by any person, regardless of the ownership of the securities. Certificates representing securities of small denominations may be merged into one or more certificates of larger denominations.

(c) The records of any member bank through which an insurance company holds securities in the federal reserve book-entry system and the records of any custodian bank through which an insurance company holds

securities in a clearing corporation at all times must show that the securities are held for the insurance company and for which accounts of the insurance company.

(d) Ownership and other interests in securities subject to this subsection (1) may be transferred by bookkeeping entry on the books of a clearing corporation or in the federal reserve book-entry system without, in either case, physical delivery of certificates representing the securities.

(2) The commissioner may adopt rules that include but are not limited to rules governing the deposit by insurance companies of securities with clearing corporations and in the federal reserve book-entry system and rules pertaining to evidence that must be provided to the commissioner with respect to the recording of securities.

NEW SECTION. **Section 4. Deposit of securities by insurance companies.** (1) Securities qualified for deposit under [sections 1 through 4] may be deposited with a clearing corporation or held in the federal reserve book-entry system. Securities deposited with a clearing corporation or held in the federal reserve book-entry system may not be withdrawn by the insurance company without the approval of the commissioner.

(2) An insurance company holding securities in the manner provided for in this section shall provide to the commissioner evidence issued by its custodian or member bank through which the insurance company has deposited the securities in a clearing corporation or through which the securities are held in the federal reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian, other direct participant, or member bank and that the records of the custodian, other direct participant, or member bank reflect that the securities are held subject to the order of the commissioner.

NEW SECTION. **Section 5. Disability income insurance.** "Disability income insurance" means an individual or group policy of insurance that primarily provides payment to or for the benefit of the policyholder or certificate holder based, in whole or in part, upon lost wages or other earned income or business or financial losses as a result of an inability to work due to sickness, injury, or a combination of sickness and injury.

Section 6. Section 33-1-408, MCA, is amended to read:

"33-1-408. Conduct of examinations -- records -- correction of accounts -- appraisals. (1) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, ~~the~~ an examiner shall observe the guidelines and procedures set forth in the examiners' handbook adopted by the NAIC. The commissioner may also employ

other guidelines or procedures as the commissioner considers appropriate.

(2) Every company or person from whom information is sought and its officers, directors, employees, and agents shall provide to the examiners appointed under subsection (1) timely, convenient, and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, and any or all computer or other recordings relating to the property, assets, business, and affairs of the company being examined. The officers, directors, employees, and agents of the company or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees, or agents, to submit to examination or to comply with any reasonable written request of the examiners is grounds for suspension, refusal, or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. A proceeding for suspension, revocation, or refusal of any license or authority must be conducted pursuant to 33-1-318 and 33-1-701.

(3) The commissioner or any examiner has the power to issue subpoenas, administer oaths, and examine under oath any person concerning any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the commissioner may petition a court of competent jurisdiction and, upon proper showing, the court may enter an order compelling the witness to appear and testify or to produce documentary evidence. Failure to obey the court order is punishable as contempt of court.

(4) When making an examination under this part, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals and specialists as examiners. The cost of retaining the personnel must be borne by the company that is the subject of the examination.

(5) This part may not be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action pursuant to this title. Findings of fact and conclusions made pursuant to an examination are prima facie evidence in any legal or regulatory action.

(6) This part may not be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company workpapers or other documents, or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action that the commissioner may consider appropriate."

Section 7. Section 33-1-705, MCA, is amended to read:

"33-1-705. Rehearing. Upon written request of a party to a hearing filed with the commissioner within 30 days after any order made pursuant to ~~a~~ the hearing has been mailed or delivered to the persons entitled to

receive the ~~same~~ order, the commissioner may~~, in his discretion,~~ grant a rehearing or reargument of the matters involved in ~~such~~ the hearing. ~~Notice of such rehearing or reargument shall be given as provided in 33-1-703.~~"

Section 8. Section 33-1-1202, MCA, is amended to read:

"33-1-1202. Insurance fraud. A person commits the act of insurance fraud when the person:

(1) for the purpose of obtaining any money or benefit, presents or causes to be presented to any insurer, purported insurer, ~~broker~~ producer, or ~~agent~~ administrator, as defined in 33-17-102, any written or oral statement, including computer-generated documents, containing false, incomplete, or misleading information concerning any fact or thing material to, as part of, or in support of a claim for payment or other benefit pursuant to an insurance policy;

(2) assists, abets, solicits, or conspires with another to prepare or make any written or oral statement containing false, incomplete, or misleading information concerning any fact that is intended to be presented to any insurer or purported insurer or in connection with, material to, or in support of any claim for payment or other benefit pursuant to an insurance policy or contract;

(3) presents or causes to be presented to or by an insurer, purported insurer, ~~broker~~ producer, or ~~agent~~ administrator, as defined in 33-17-102, a materially false or altered application of insurance;

(4) accepts premium money knowing that coverage will not be provided;

(5) as a health care provider, submits a false or altered bill or report of physical condition to an insurer; or

(6) offers or accepts a direct or indirect inducement to file a false statement of claim with the intent of deceiving an insurer."

Section 9. Section 33-2-115, MCA, is amended to read:

"33-2-115. Application for certificate of authority. To apply for an original certificate of authority, an insurer shall file with the commissioner its application ~~therefor~~ accompanied by the applicable fees as specified in 33-2-708, showing its name, location of its home office or principal office in the United States, if an alien insurer, kinds of insurance to be transacted, date of organization or incorporation, form of organization, state or country of domicile, and ~~such~~ any additional information ~~as~~ that the commissioner may reasonably require~~,~~. ~~together with~~ The application must be accompanied by the following documents, as applicable:

(1) if a foreign insurer, a copy of its corporate charter or articles of incorporation, with all amendments ~~thereto~~, certified by the public officer with whom the originals are on file in the state or country of domicile;

(2) if a mutual insurer, a copy of its bylaws as amended, certified by its secretary or other officer having custody ~~thereof~~ of the bylaws;

(3) if a reciprocal insurer, copies of the power of attorney of its attorney-in-fact and of its subscribers' agreement, if any, certified by its attorney-in-fact;

(4) a copy of its financial statement as of the preceding December 31 ~~next preceding~~, sworn to by at least two executive officers of the insurer or certified by the public insurance supervisory official of the insurer's state of domicile or of entry into the United States;

(5) a copy of report of last examination, if any, made of the insurer, certified by the insurance supervisory official of its state of domicile or of entry into the United States;

(6) appointment of the commissioner pursuant to 33-1-601, as its attorney to receive service of legal process;

(7) if a foreign or alien insurer, a certificate of the public official having supervision of insurance in its state or country of domicile or state of entry into the United States, showing that it is authorized to transact the kinds of insurance proposed to be transacted in this state;

(8) if an alien insurer, a copy of the appointment and authority of its United States manager, certified by its officer having custody of its records;

(9) if a foreign insurer, certificate as to deposit if to be tendered pursuant to 33-2-111;

(10) if a domestic insurer, specimen copies of policies proposed to be offered in this state, together with premiums or premium rates applicable, or a declaration that ~~such~~ the rates as applicable will be those promulgated by designated rating organizations authorized to file ~~such~~ the rates in this state on behalf of the insurer."

Section 10. Section 33-2-307, MCA, is amended to read:

"33-2-307. Requirements for eligible surplus lines insurers. (1) A surplus lines insurance producer may not place insurance with an unauthorized insurer unless, at the time of placement, the unauthorized insurer:

(a) has established satisfactory evidence of good reputation and financial integrity; and

(b) is qualified under one of the following subsections:

(i) the insurer maintains capital and surplus or its equivalent under the laws of its state of domicile, which equals the greater of:

(A) the minimum capital and surplus requirements of 33-2-109 and 33-2-110; or

(B) ~~$10~~ $15 million. An insurer possessing less than ~~$10~~ $15 million capital and surplus may satisfy the

requirements of this subsection upon an affirmative finding of acceptability by the commissioner. The commissioner's finding must be based upon factors of the quality of management, capital, and surplus of a parent company; company underwriting profit and investment income trends; and company record and reputation within the industry. The commissioner may not make an affirmative finding of acceptability when the surplus lines insurer's capital and surplus is less than $7 million.

(ii) in the case of Lloyd's or another similar group including incorporated and unincorporated alien insurers, the insurer maintains a trust fund of not less than $50 million as security to the full amount of capital and surplus for all policyholders and creditors in the United States of each member of the group. The incorporated members of the group may not engage in any business other than underwriting as a member of the group and are subject to the same level of solvency regulation and control by the groups of domiciliary regulators as are the unincorporated members. The trust must comply with the terms and conditions established in subsection (1)(b)(iv) for alien insurers.

(iii) in the case of an insurance exchange created by the laws of individual states, the insurer maintains capital and surplus, or their substantial equivalent, of not less than $15 million in the aggregate. For an insurance exchange that maintains funds for the protection of each insurance exchange policyholder, each individual syndicate shall maintain minimum capital and surplus, or their substantial equivalent, of not less than $1.5 million. If the insurance exchange does not maintain funds for the protection of each insurance exchange policyholder, each individual syndicate shall meet the minimum capital and surplus requirements of subsection (1)(b)(i).

(iv) in the case of an alien insurer, the insurer maintains in the United States an irrevocable trust fund in either a national bank or a member of the federal reserve system, in an amount not less than $1.5 million, for the protection of all its policyholders in the United States and the trust fund consists of cash, securities, or letters of credit or of investments of substantially the same character and quality as those that are eligible investments for the capital and statutory reserves of insurers authorized to write like kinds of insurance in this state. The trust fund, which must be included in any calculation of capital and surplus or its equivalent, must have an expiration date that may not at any time be less than 5 years. In addition, the alien insurer must appear on the national association of insurance commissioners' Non-Admitted Insurers Quarterly Listing.

(c) has provided the commissioner a copy of its current annual statement, certified by the insurer not more than 6 months after the close of the period reported upon, or quarterly if considered necessary by the commissioner, and that is either:

(i) filed with and approved by the regulatory authority in the state of domicile of the unauthorized insurer; or

(ii) certified by an accounting or auditing firm licensed in the jurisdiction of the insurer's state of domicile.

(2) In the case of an insurance exchange, the statement required by subsection (1)(c) may be an aggregate combined statement of all underwriting syndicates operating during the period reported.

(3) In addition to meeting the requirements in subsection (1), an insurer is an eligible surplus lines insurer only if it appears on the most recent list of eligible surplus lines insurers published at least semiannually by the commissioner. This subsection does not require the commissioner to place or maintain the name of any unauthorized insurer on the list of eligible surplus lines insurers. An action may not lie against the commissioner or an employee of the commissioner for anything said in issuing the list of eligible surplus lines insurers referred to in this subsection.

(4) (a) The commissioner may declare an eligible surplus lines insurer ineligible if at any time the commissioner has reason to believe that it:

(i) is in unsound financial condition;

(ii) is no longer eligible under subsections (1) through (3);

(iii) has willfully violated the laws of this state; or

(iv) does not make reasonably prompt payment of just losses and claims in this state or elsewhere.

(b) The commissioner shall promptly mail notice of all declarations to each surplus lines insurance producer.

(5) As used in this section, the following definitions apply:

(a) "Capital", as used in the financial requirements of this section, means funds invested in for stocks or other evidences of ownership.

(b) "Surplus", as used in the financial requirements of this section, means funds over and above liabilities and capital of the insurer for the protection of policyholders."

Section 11. Section 33-2-326, MCA, is amended to read:

"33-2-326. Penalties. A surplus lines insurance producer who in this state represents or aids an unauthorized insurer in violation of this part is ~~guilty of a misdemeanor and shall be fined not more than $1,000 or be imprisoned in the county jail for a term no longer than 6 months, or both~~ subject to the penalties and procedures in 33-1-317 and 33-1-318."

Section 12. Section 33-2-701, MCA, is amended to read:

"33-2-701. Annual statement -- revocation or fine for failure to file -- penalty for perjury. (1) Each

authorized insurer shall annually on or before March 1 file with the commissioner a full and true statement of its financial condition, transactions, and affairs as of the preceding December 31. The statement must be in the general form and context as is required or not disapproved by the commissioner, as is in current use for similar reports to states in general with respect to the type of insurer and kinds of insurance to be reported upon, and as supplemented for additional information required by the commissioner. The statement must be completed in accordance with the annual statement instructions and the accounting practices and procedures manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the adequacy of the insurer's reserves. The statement must be verified by the oath of the insurer's president or vice president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation. The commissioner may waive the verification under oath.

(2) (a) Each domestic insurer shall file electronic versions of its annual and quarterly financial statements with the national association of insurance commissioners. The date for submission of the annual statement electronic filing is March 1. The dates for the submission of the quarterly statement electronic filings are as follows:

(i) the first quarter filing is due May 15;

(ii) the second quarter filing is due August 15; and

(iii) the third quarter filing is due November 15.

(b) The commissioner may exempt insurers that operate only in Montana from these filing requirements.

(c) The insurer shall pay all fees and costs associated with preparing the annual and other filings and submitting them to the national association of insurance commissioners.

(3) The statement of an alien insurer must relate only to its transactions and affairs in the United States unless the commissioner requires otherwise. If the commissioner requires a statement as to an alien insurer's affairs throughout the world, the insurer shall file the statement with the commissioner as soon as reasonably possible. The statement must be verified by the insurer's United States manager or other authorized officer.

(4) The commissioner may refuse to accept the fee for renewal of the insurer's certificate of authority, as provided in 33-2-117, or may suspend or revoke the certificate of authority of any insurer failing to file its annual statement when due or within an extension of time that the commissioner may grant.

(5) A director, officer, insurance producer, or employee of a company who subscribes to, makes, or concurs in making or publishing an annual statement or any other statement required by law knowing that the statement contains any material statement that is false ~~shall be punished by a fine of not more than $1,000~~ is subject to the penalty provisions of 33-1-317.

(6) The commissioner may impose a fine not to exceed $100 a day for each day after March 1 that an insurer fails to file the annual statement referred to in subsection (1). The fine may not exceed a maximum of $1,000."

Section 13. Section 33-2-708, MCA, is amended to read:

"33-2-708. Fees and licenses. (1) (a) Except as provided in 33-17-212(2), the commissioner shall collect a fee of $1,900 from each insurer applying for or annually renewing a certificate of authority to conduct the business of insurance in Montana.

(b) The commissioner shall collect certain additional fees as follows:

(i) nonresident insurance producer's license:

(A) application for original license, including issuance of license, if issued, ~~.....100.00~~ $100;

(B) annual renewal of license, ~~.....10.00~~ $10;

(ii) surplus lines insurance producer license:

(A) application for original license and for issuance of license, if issued, ~~.....50.00~~ $50;

(B) annual renewal of license, ~~.....50.00~~ $50;

(iii) 50 cents for each page for copies of documents on file in the commissioner's office.

(2) (a) The commissioner shall charge a fee of $75 for each course or program submitted for review as required by 33-17-1204 and 33-17-1205, but may not charge more than $1,500 to a sponsoring organization submitting courses or programs for review in any biennium.

(b) Insurers and associations composed of members of the insurance industry are exempt from the charge in subsection (2)(a).

(3) The commissioner shall promptly deposit with the state treasurer to the credit of the general fund all fines and penalties and those amounts received pursuant to 33-2-311, 33-2-705, ~~and~~ 33-28-201, and 50-3-109. All other fees collected by the commissioner pursuant to Title 33 and the rules adopted under Title 33 must be deposited in the state special revenue fund to the credit of the state auditor's office.

(4) All fees are considered fully earned when received. In the event of overpayment, only those amounts in excess of $10 will be refunded."

Section 14. Section 33-3-201, MCA, is amended to read:

"33-3-201. Incorporation. (1) This section applies to stock and mutual insurers ~~hereafter~~ incorporated in this state.

(2) Five or more individuals, none of whom are less than 18 years of age, may incorporate a stock insurer. Ten or more of ~~such~~ individuals, none of whom are less than 18 years of age, may incorporate a mutual insurer. At least a majority of the incorporators ~~shall~~ must be citizens of the United States. At least a majority of the incorporators ~~shall~~ must be residents of this state.

(3) The incorporators shall execute articles of incorporation in ~~quadruplicate~~ triplicate and acknowledge their execution ~~thereof~~ in the same manner as provided by law for the acknowledgment of deeds. The articles of incorporation ~~shall~~ must state the purpose for which the corporation is formed and ~~shall~~ must show:

(a) the name of the corporation. If a mutual corporation, the word "mutual" must be a part of the name. An alternative name or names may be specified for use in jurisdictions ~~wherein~~ where a conflict of name with that of another insurer or organization might otherwise prevent the corporation from being authorized to transact insurance ~~therein~~ in that jurisdiction.

(b) the duration of its existence, which may be perpetual;

(c) the kinds of insurance, as defined in this code, which the corporation is formed to transact;

(d) if a stock corporation, its authorized capital stock, the number of shares of common stock ~~into which divided~~, and the par value of each ~~such~~ share~~;~~. ~~which~~ The par value ~~shall~~ must be at least $1. Shares without par value or other than one class of voting common stock ~~shall~~ are not ~~be~~ authorized. The articles of incorporation may limit or deny present or future stockholders preemptive or preferential rights to acquire additional issues of the stock, ~~or~~ bonds, debentures, or other obligations convertible into stock, of the corporation, subject to the laws of Montana fixing the required representation and proportion of outstanding capital stock required to be represented and voted, for specified action, at any and all corporate meetings, elections, votes, or consent proceedings.

(e) if a stock corporation, the extent, if any, to which shares of its stock are subject to assessment;

(f) if a stock corporation, the number of shares subscribed, if any, by each incorporator;

(g) if a mutual corporation, the maximum contingent liability of its members, other than as to nonassessable policies, for payment of losses and expenses incurred. ~~Such~~ Any liability ~~shall~~ must be stated in the articles of incorporation but ~~shall~~ may not be less than one or more than six times the premium for the member's policy at the annual premium rate for a term of 1 year.

(h) the minimum, not less than 5, and the maximum, not more than 21, number of directors who ~~shall~~ constitute the board of directors and conduct the affairs of the corporation~~; also~~, and the names, addresses, and terms of the members of the initial board of directors. The term of office of initial directors ~~shall~~ may not be for ~~not~~ more than 1 year after the date of incorporation.

(i) the name of the county, and the city, town, or place within the county, in which its principal office or principal place of business is to be located in this state;

(j) ~~such~~ any other provisions, not inconsistent with law, ~~deemed~~ considered appropriate by the incorporators;

(k) the name and residence address of each incorporator and the citizenship of each incorporator who is not a citizen of the United States."

Section 15. Section 33-3-441, MCA, is amended to read:

"33-3-441. Equity securities of domestic stock insurance company -- statement of ownership. (1) When used in 33-3-441 through 33-3-447, the term "equity security" means:

(a) any stock or similar security;

(b) any security convertible, with or without consideration, into ~~such a~~ an equity security or carrying any warrant or right to subscribe to or purchase ~~such a~~ an equity security;

(c) any ~~such~~ warrant or right described in subsection (1)(b); or

(d) any other security ~~which~~ that the commissioner ~~shall deem~~ considers to be of a similar nature and ~~consider~~ considers necessary or appropriate, by ~~such~~ rules as ~~he~~ the commissioner may prescribe in the public interest or for the protection of investors, to treat as an equity security.

(2) ~~Every person who is directly or indirectly the beneficial owner of more than 10% of any class of any equity security of a domestic stock insurance company or who is a director or an officer of such company shall file with the commissioner, within 10 days after he becomes such beneficial owner, director, or officer, a statement, in such form as the commissioner may prescribe, of the amount of all equity securities of such company of which he is the beneficial owner, and within 10 days after the close of each calendar month thereafter.~~ A domestic stock insurance company shall report to the commissioner the name of any person who acquires 10% or more of any class of equity security of the company. The company shall report the name of the person within 30 days of the person's acquiring 10% or more of any class of equity security of the company. The company shall provide any other information about the person that the commissioner may require.

(3) ~~If there has been a change in such ownership during such month, such person shall file with the commissioner a statement, in such form as the commissioner may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.~~ If a person has not acquired at least a 10% interest of any class of equity security of a domestic stock insurance company during the last calendar year preceding the annual statement filing date, the company is only required

to report in the annual statement the names and percentages of those persons holding at least 10% interest in any class of equity security."

Section 16. Section 33-4-101, MCA, is amended to read:

"33-4-101. Scope of chapter -- provisions applicable. (1) The chapter applies to:

(a) all domestic mutual hail, fire, and other casualty insurers of farm property and stock and rural buildings formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1501 through 40-1517 of the Revised Codes of Montana, 1947;

(b) all domestic mutual rural insurers formed and immediately prior to January 1, 1961, lawfully transacting insurance under sections 40-1601 through 40-1625 of the Revised Codes of Montana, 1947;

(c) all insurers formed under this chapter.

(2) The insurance laws of this state do not apply to or govern, either directly or indirectly, domestic farm mutual insurers except as provided in this chapter.

(3) The following chapters and sections of this title apply to farm mutual insurers to the extent applicable and not inconsistent with the express provisions of this chapter and the reasonable implications of the express provisions of this chapter: chapter 1, parts 1 through 4, 7, 12, and 13; 33-2-112; 33-2-501; 33-2-502; 33-2-532 through 33-2-535; 33-2-708; 33-2-1212; chapter 2, parts 13 and 16; 33-2-1501; 33-2-1517(2); 33-3-218; 33-3-308; 33-3-309; 33-3-401; 33-3-402; 33-3-431; 33-3-436; and ~~chapter~~ chapters 18 and 19."

Section 17. Section 33-4-202, MCA, is amended to read:

"33-4-202. Declaration of intention to incorporate -- articles of incorporation -- fee. (1) The individuals proposing to form a farm mutual insurer as referred to in 33-4-201 shall file with the commissioner:

(a) a declaration of their intention to form the corporation signed by at least 100 incorporators if a proposed state mutual insurer or by at least 25 incorporators if a proposed county mutual insurer; and

(b) ~~four~~ three copies of proposed articles of incorporation executed by three or more of the incorporators. The signatures of the incorporators must be notarized.

(2) The articles of incorporation must state:

(a) the name of the corporation. If a state mutual insurer, the words "farm mutual" must be a part of the name; if a county mutual insurer, the name must contain the words "farm mutual" or "rural mutual" together with the name of the county in which its principal place of business is to be located. The name may not be so similar to one already used by a corporation in this state as to be misleading.

(b) if a county mutual insurer, the name of the county or counties in which the corporation is to transact insurance and the address where its principal business office will be located;

(c) if a state mutual insurer, the location of its principal business office, which must be located in this state;

(d) the objects and purposes for which the corporation is formed;

(e) whether the insurer intends to transact business on the cash premium plan or the assessment plan;

(f) the duration of the corporation's existence, which may be perpetual;

(g) the number of its directors, which may not be less than 5 or more than 11, and the names and addresses of the members of the initial board of directors appointed to manage the affairs of the corporation until the first annual meeting of the members at which time successors ~~are~~ must be elected and qualified;

(h) other provisions, not inconsistent with law, considered appropriate by the incorporators;

(i) the names, residences, and addresses of the incorporators and the value of their property to be insured in the county or counties where the operations of the corporation are to be transacted.

(3) At the time of filing of the articles of incorporation as provided in subsection (1), the incorporators shall pay to the commissioner a filing fee of $10. The commissioner shall deposit the fees with the state treasurer to the credit of the general fund."

Section 18. Section 33-10-102, MCA, is amended to read:

"33-10-102. Definitions. As used in this part, the following definitions apply:

(1) "Association" means the Montana insurance guaranty association created under 33-10-103.

(2) (a) "Covered claim" means an unpaid claim, including one for unearned premiums, that arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this part applies issued by an insurer, if the insurer becomes an insolvent insurer after July 1, 1971, and:

(i) the claimant or insured is a resident of this state at the time of the insured event; or

(ii) the property from which the claim arises is permanently located in this state.

(b) Covered claim does not include any amount:

(i) awarded as punitive or exemplary damages;

(ii) sought as a return of premium under a retrospective rating plan; or

(iii) due a reinsurer, insurer, insurance pool, or underwriting association as subrogation recoveries, reinsurance recoveries, contribution, or indemnification. A reinsurer, insurer, insurance pool, or underwriting association may not assert a claim for any amount against the insured of the insolvent insurer other than to the

extent that the claim exceeds the policy limits of the insolvent insurer's policy.

(3) "Insolvent insurer" means an insurer:

(a) authorized to transact insurance in this state either at the time the policy was issued or when the insured event occurred; and

(b) ~~determined to be insolvent by a court of competent jurisdiction~~ against whom an order of liquidation has been entered with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

(4) "Member insurer" means a person who:

(a) writes any kind of insurance to which this part applies under 33-10-101(3), including the exchange of reciprocal or interinsurance contracts; and

(b) is licensed to transact insurance in this state.

(5) (a) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this part applies, less return premiums on the policies and dividends paid or credited to policyholders of policies to which this part applies.

(b) Net direct written premiums does not include premiums on contracts between insurers or reinsurers.

(6) "Person" means any individual, corporation, partnership, association, or voluntary organization."

Section 19. Section 33-10-207, MCA, is amended to read:

"33-10-207. Immunity. There ~~shall be no~~ is not any liability on the part of and ~~no~~ a cause of action of any nature ~~shall arise~~ may not be brought against any member insurer or its ~~insurance producers~~ agents or employees, the association or its insurance producers or employees, members of the board of directors, or the commissioner or ~~his~~ the commissioner's representatives for any action taken by them in the performance of their powers and duties under this part."

Section 20. Section 33-15-1107, MCA, is amended to read:

"33-15-1107. Information about grounds for nonrenewal. (1) If the insurer or insurance producer receives a written request from an insured within ~~60~~ 90 business days from the date on which the insurer mailed a notice of cancellation or nonrenewal to the insured, the insurer or insurance producer shall, within 21 days of receiving the insured's written request, furnish the insured the information that the insurer or insurance producer used to make its decision. A notice is not effective unless it contains adequate information about the insured's right to make the request.

(2) This section does not apply if the ground for cancellation or nonrenewal is nonpayment of the

premium and the reason is stated in the notice."

Section 21. Section 33-16-403, MCA, is amended to read:

"33-16-403. Examination of application and investigation of applicant -- issuance of license -- fee. (1) The commissioner shall examine each application for a license to act as a rating or advisory organization pursuant to this part or a workers' compensation advisory organization pursuant to part 10 and the documents filed with the application and may make a further investigation of the applicant, its affairs, and its proposed plan of business as the commissioner considers appropriate.

(2) The commissioner shall issue the license applied for within 60 days of its filing if, from the examination and investigation, the commissioner is satisfied that:

(a) the business reputation of the applicant and its officers is good;

(b) the facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish; and

(c) the applicant and its proposed plan of operation conform to the requirements of this chapter.

(3) Otherwise, but only after a hearing upon notice, the commissioner shall, in writing, deny the application and notify the applicant of the decision and the reasons for the denial.

(4) The commissioner may grant an application in part only and issue a license to act as a rating, advisory, or workers' compensation advisory organization for one or more of the classes of insurance or subdivisions of the classes of insurance or class of risk, or a part or combination of a class of risk as are specified in the application, if the applicant qualifies for only a portion of the classes applied for.

(5) (a) Except as provided in subsection (5)(b), licenses issued pursuant to this section remain in effect until revoked as provided in this chapter. The fee for the license is $100 annually and must be deposited in the ~~general~~ state special revenue fund to the credit of the state auditor's office.

(b) Each workers' compensation advisory organization is required to renew its license annually."

Section 22. Section 33-17-503, MCA, is amended to read:

"33-17-503. Application -- fee -- expiration. (1) Before a consultant license is issued or renewed, the prospective licensee shall:

(a) properly file ~~in~~ with the office of the commissioner a written application on forms the commissioner prescribes; and

(b) pay a fee of $50, which the commissioner shall deposit with the state treasurer to be credited ~~to the~~

~~state's general~~ in the state special revenue fund to the credit of the state auditor's office.

(2) Each consultant license must be renewed each year by the consultant paying a continuation fee on or before May 31, and the license continues in force unless suspended, revoked, or otherwise terminated."

Section 23. Section 33-17-1101, MCA, is amended to read:

"33-17-1101. Place of business -- display of license -- records. (1) A resident insurance producer or consultant shall maintain a place or places of business in this state accessible to the public. A nonresident insurance producer or consultant may maintain a place or places of business in this state. An insurance producer's or consultant's place or places of business must be a place in which transactions are conducted under the ~~insurance producer's~~ license. The street address or addresses of the place or places of business must appear upon the license. This section does not prohibit the maintenance of a place of business in a licensee's place of residence.

(2) The license must be conspicuously displayed in a place of business at the street address shown on the license in a part of the place of business customarily open to the public.

(3) The insurance producer or consultant shall keep at a place of business complete records pertaining to transactions under the license for a period of at least 3 years after completion of the respective transactions, except that a title insurance producer, as defined in 33-25-105, shall retain records as provided in 33-25-214 and 33-25-216."

Section 24. Section 33-17-1102, MCA, is amended to read:

"33-17-1102. Reporting and accounting for premiums -- misappropriation. (1) All insurance premiums or return premiums received by an insurance producer must be held in a separate trust account. The insurance producer shall at all times act in a fiduciary capacity and shall, in the applicable regular course of business, account for and pay the insurance premiums or return premiums ~~he~~ the insurance producer receives to the insured, insurer, or insurance producer entitled to them. Except for a title insurance producer as defined in 33-25-105, an insurance producer may deposit and commingle in the same separate deposit all funds belonging to others so long as the amount of the deposit held for each respective person is reasonably ascertainable from the records and accounts of the licensee.

(2) Any insurance producer not lawfully entitled to the funds may not divert or appropriate the funds or any portion of the funds to ~~his~~ the insurance producer's own use.

(3) An insurance producer who ~~unlawfully~~ purposely or knowingly diverts or ~~appropriates~~ misappropriates

insurance premiums ~~or return premiums to his own use is, upon conviction, guilty of theft and is punishable as provided by law~~ commits theft pursuant to 45-6-301."

Section 25. Section 33-17-1204, MCA, is amended to read:

"33-17-1204. Review and approval of continuing education courses by commissioner -- advisory council. (1) The commissioner shall, after review by and at the recommendations of the advisory council established under subsection (2), approve only those continuing education courses, lectures, seminars, and instructional programs that the commissioner determines would improve the product knowledge, management, ethics, or marketing capability of the licensee. Course content, instructors, material, instructional format, and the sponsoring organization must be approved and periodically reviewed by the commissioner. The fee for approval of a course, lecture, seminar, or instructional program is listed in 33-2-708(2). The commissioner shall also determine the number of credit hours to be awarded for completion of an approved continuing education activity.

(2) The commissioner shall appoint an advisory council, pursuant to 2-15-122, consisting of at least one representative of the independent insurance agents of Montana, one representative of the ~~national~~ Montana association of insurance and financial ~~advisors-Montana~~ advisors, one representative of the professional insurance agents of Montana, one title insurance producer, two public members who are not directly employed by the insurance industry, one insurance producer or consultant not affiliated with any of the three listed organizations, and a nonvoting presiding officer from the department who will be appointed by the commissioner as a representative of the department. The members of the council shall serve a term of 2 years, except that the initial term of the representative from each organization is 3 years. The commissioner shall consult with the council in formulating rules and standards for the approval of continuing education activities and prior to approving specific education activities. The provisions of 2-15-122(9) and (10) do not apply to this council.

(3) In conducting periodic review of course content, instructors, material, instructional format, or a sponsoring organization, the commissioner may exercise any investigative power of the commissioner provided for in 33-1-311 or 33-1-315.

(4) If after review or investigation the commissioner determines an approved continuing education activity is not being operated in compliance with the standards established under this section, the commissioner may revoke approval, place the activity under probationary approval, or issue a cease and desist order under 33-1-318."

Section 26. Section 33-20-101, MCA, is amended to read:

"33-20-101. Scope. (1) Except as provided in subsection (2), parts 1 through 5 of this chapter apply only to contracts of life insurance and annuities, other than reinsurance, group life insurance, and group annuities.

(2) Sections 33-20-114, 33-20-131, and 33-20-150 also apply to group life insurance, and 33-20-114, 33-20-124, and 33-20-150 also apply to group annuities."

Section 27. Section 33-20-103, MCA, is amended to read:

"33-20-103. Standard provisions required -- exceptions. (1) ~~No~~ A policy of life insurance, other than group and pure endowments with or without return of premiums or of premiums and interest, ~~shall~~ may not be delivered or issued for delivery in this state unless it contains in substance all of the applicable provisions as required by 33-20-104 through 33-20-108, 33-20-110 through 33-20-116, and 33-20-131.

(2) This section ~~shall~~ does not apply to annuity contracts or to any provision of a life insurance policy, or contract supplemental ~~thereto~~ to an annuity contract or life insurance policy, relating to disability benefits or to additional benefits in the event of death by accident or accidental means. However, the provisions of 33-20-114 do apply to annuity contracts.

(3) Any ~~of such provisions~~ provision or portions ~~thereof~~ of a provision not applicable to single premium or term policies ~~shall~~ may not to that extent ~~not~~ be incorporated ~~therein~~ in single premium or term policies."

Section 28. Section 33-20-105, MCA, is amended to read:

"33-20-105. Incontestability. (1) There ~~shall~~ must be a provision that the policy, exclusive of provisions relating to disability benefits or to additional benefits in the event of death by accident or accidental means, ~~shall be~~ is incontestable, except for nonpayment of premiums, after it has been in force during the lifetime of the insured for a period of 2 years from its date of issue.

(2) A policy issued in connection with an exchange or a conversion is incontestable from the time of issue."

Section 29. Section 33-20-114, MCA, is amended to read:

"33-20-114. Payment of claims -- interest. (1) There ~~shall~~ must be a provision, which may be made by endorsement, that when a claim is made upon the death of the insured, settlement ~~shall~~ must be made upon receipt of proof of death and, at the insurer's option, surrender of the policy ~~and/or~~ or proof of the interest of the claimant, or both.

(2) There ~~shall~~ must be a provision, which may be made by endorsement, that settlement must be made

within 60 days of receipt of proof of death and that if settlement is made after the first 30 days, the settlement ~~shall~~ must include interest from the 30th day until settlement. Interest ~~shall~~ must be paid at the discount rate on 90-day commercial paper in effect at the federal reserve bank in the ninth federal reserve district at the time of proof of death or at the rate stated in the policy. The settlement period and interest provisions of this subsection apply to all claims upon deaths filed with an insurer ~~after October 1, 1985~~, regardless of whether those provisions are included in the policy."

Section 30. Section 33-20-1202, MCA, is amended to read:

"33-20-1202. Grace period. The group life insurance policy ~~shall~~ and certificate must contain a provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the death benefit coverage ~~shall~~ must continue in force, unless the policyholder ~~shall have~~ has given the insurer written notice of discontinuance in advance of the date of discontinuance and in accordance with the terms of the policy. The policy may provide that the policyholder ~~shall be~~ is liable to the insurer for the payment of a pro rata premium for the time the policy was in force during ~~such~~ the grace period."

Section 31. Section 33-20-1203, MCA, is amended to read:

"33-20-1203. Incontestability. The group life insurance policy ~~shall~~ and certificate must contain a provision that the validity of the policy ~~shall~~ may not be contested, except for nonpayment of premium, after it has been in force for 2 years from its date of issue and that ~~no~~ a statement made by any person insured under the policy relating to ~~his~~ the person's insurability ~~shall~~ may not be used in contesting the validity of the insurance with respect to which ~~such~~ the statement was made after ~~such~~ the insurance has been in force prior to the contest for a period of 2 years during ~~such~~ the person's lifetime or unless it is contained in a written instrument signed by ~~him~~ the person."

Section 32. Section 33-20-1204, MCA, is amended to read:

"33-20-1204. Application -- statements ~~deemed~~ considered representations. The group life insurance policy ~~shall~~ and certificate must contain a provision that a copy of the application, if any, of the policyholder ~~shall~~ must be attached to the policy when issued, that all statements made by the policyholder or by the persons insured ~~shall~~ must be ~~deemed~~ considered representations and not warranties, and that ~~no~~ a statement made by any person insured ~~shall~~ may not be used in any contest unless a copy of the instrument containing the statement is or has been furnished to ~~such~~ the person or to ~~his~~ the person's beneficiary."

Section 33. Section 33-20-1205, MCA, is amended to read:

"33-20-1205. Insurability. The group life insurance policy ~~shall~~ and certificate must contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish evidence of individual insurability satisfactory to the insurer as a condition to part or all of ~~his~~ the person's coverage."

Section 34. Section 33-20-1206, MCA, is amended to read:

"33-20-1206. Misstatement of age. The group life insurance policy ~~shall~~ and certificate must contain a provision specifying an equitable adjustment of premiums or of benefits or of both to be made in the event the age of a person insured has been misstated~~;~~. ~~such~~ The provision ~~to~~ must contain a clear statement of the method of adjustment to be used."

Section 35. Section 33-20-1207, MCA, is amended to read:

"33-20-1207. Payment of benefits. (1) The group life insurance policy ~~shall~~ and certificate must contain a provision that any ~~sum~~ benefits becoming due by reason of the death of the person insured ~~shall be~~ are payable to the beneficiary designated by the person insured, subject to the provisions of the policy. ~~in~~ In the event there is ~~no~~ not a designated beneficiary ~~as to all or any part of such sum living at the death of the person insured and subject to any right reserved by the insurer in the policy and set forth in the certificate to pay at its option a part of such sum not exceeding $500 to any person appearing to the insurer to be equitably entitled thereto by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured~~ with regard to all or some of the benefits, then those benefits must be considered a part of the intestate estate, pursuant to 72-2-111. In addition, the insurer may pay a benefit amount not exceeding $500 to any person appearing to the insurer to be equitably entitled to that amount by reason of having incurred funeral or other expenses incident to the last illness or death of the person insured.

(2) The provisions of 33-20-114(2) ~~shall~~ must be incorporated into the group life insurance policy and certificate and are applicable as set out in that subsection."

Section 36. Section 33-20-1209, MCA, is amended to read:

"33-20-1209. Conversion on termination of eligibility. (1) The group life insurance policy or certificate must contain a provision that if the insurance or any portion of it on a person covered under the policy ceases because of termination of employment or of membership in the class or classes eligible for coverage under the

policy, the person is entitled to have issued to the person by the insurer, without evidence of insurability, an individual policy of life insurance if the application for the individual policy is made and the first premium is paid to the insurer within 31 days after termination and provided that:

(a) the individual policy must, at the option of the person, be on any one of the forms, including but not limited to term insurance, if the group policy provides for term insurance, then customarily issued by the insurer at the age and for the amount applied for, and must offer benefits at least equal to those under the group coverage;

(b) the individual policy must, at the option of the insured, be in an amount not in excess of the amount of life insurance that ceases because of the termination, less the amount of any life insurance for which the person is insured under any other group policy within 31 days after the termination, provided that any amount of insurance that has matured on or before the date of the termination as an endowment payable to the person insured, whether in one sum or in installments or in the form of an annuity, may not, for the purposes of this provision, be included in the amount that is considered to cease because of the termination; and

(c) the premium on the individual policy is the insurer's then customary rate applicable to the form and amount of the individual policy, to the class of risk that the person belongs, and to the person's age attained on the effective date of the individual policy.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsection (1). The conversion carrier must be authorized to act as an insurer in this state and shall submit the conversion policies to the commissioner.

~~(2)~~(3) With the consent of the employer, a person covered under a group life insurance policy issued to an employer or to the trustees of a fund established by an employer under 33-20-1101 may continue the person's coverage under the group policy during the person's employment ~~notwithstanding~~ even if there has been a reduction of the person's regular work schedule to less than the minimum number of hours required for eligibility for membership. The premium charged for the continued coverage must be equal to that charged other members of the group. The person's coverage under the group will cease if the person subsequently becomes eligible for coverage under another group policy because of employment elsewhere."

Section 37. Section 33-20-1210, MCA, is amended to read:

"33-20-1210. Conversion on termination of policy or certificate. (1) The group life insurance policy or certificate must contain a provision that if the group policy or certificate terminates or is amended to terminate the insurance of any class of insured persons, every person insured under the group policy or certificate at the

date of the termination whose insurance terminates and who has been insured for at least 3 years prior to the termination date is entitled to have issued to the person by the insurer an individual policy of life insurance, subject to the same conditions and limitations that are provided by 33-20-1209, except that the group policy or certificate may provide that the amount of the individual policy may not exceed the smaller of:

~~(1)~~(a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy or certificate, less the amount of any life insurance for which the person is or becomes eligible under any group policy issued or reinstated by the same or another insurer within 31 days after the termination; or

~~(2)~~(b) $10,000.

(2) A group insurer may meet the requirements of this section by contracting with another insurer to issue conversion policies as described in subsection (1). The conversion carrier must be authorized to act as an insurer in this state and shall submit the conversion policies to the commissioner."

Section 38. Section 33-20-1213, MCA, is amended to read:

"33-20-1213. Policy and certificate provisions -- conformity with state statutes. Each policy and certificate regulated by this part must contain a provision or ~~the~~ its equivalent ~~thereto~~ as follows:

"Conformity with Montana statutes. The provisions of this policy or certificate conform to the minimum requirements of Montana law and control over any conflicting statutes of any state in which the insured resides on or after the effective date of this policy or certificate.""

Section 39. Section 33-22-101, MCA, is amended to read:

"33-22-101. Exceptions to scope. Parts 1 through 4 of this chapter, except 33-22-107, 33-22-110, 33-22-111, 33-22-114, 33-22-125, 33-22-129, 33-22-130 through 33-22-136, 33-22-140, 33-22-141, 33-22-142, 33-22-243, and 33-22-304, and part 19 of this chapter do not apply to or affect:

(1) any policy of liability or workers' compensation insurance with or without supplementary expense coverage;

(2) any group or blanket policy;

(3) life insurance, endowment, or annuity contracts or supplemental contracts that contain only those provisions relating to disability insurance ~~as~~ that:

(a) provide additional benefits in case of death or dismemberment or loss of sight by accident or accidental means; or

(b) operate to safeguard contracts against lapse or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract;

(4) reinsurance."

Section 40. Section 33-22-107, MCA, is amended to read:

"33-22-107. Premium increase restriction -- exception. (1) An insurer or a health service corporation that issues or renews a policy, certificate, or membership contract covering a resident of this state may not increase a premium in an individual's or an individual's group disability insurance policy more frequently than once during a 12-month period unless failure to increase the premium more frequently than once during the 12-month period would:

(a) place the insurer in violation of the laws of this state; or

(b) cause the financial impairment of the insurer to the extent that further transaction of insurance by the insurer injures or is hazardous to its policyholders or to the public.

(2) Subsection (1) does not apply to a premium increase necessitated by a state or federal law, court decision, or rule adopted by an agency of competent jurisdiction of the state or federal government."

Section 41. Section 33-22-303, MCA, is amended to read:

"33-22-303. Coverage for well-child care. (1) Each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided

at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, accident, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 42. Section 33-22-512, MCA, is amended to read:

"33-22-512. Coverage for well-child care. (1) Each group disability policy or certificate of insurance that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) Coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, accident, medicare supplement, or hospital indemnity policies or certificates.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a group disability policy or certificate of insurance issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 43. Section 33-22-1512, MCA, is amended to read:

"33-22-1512. Association plan and association portability plan premium. (1) The association shall establish the schedule of premiums to be charged eligible persons for membership in the association plan. The schedule of association plan premiums for eligible persons may not exceed 200% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The schedule of association portability plan premiums for federally defined eligible individuals may not at any time exceed 150% of the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state. The premium rates of the five insurers or health service corporations used to establish the premium rates for each type of coverage offered by the association must be determined by the commissioner from information provided annually at the request of the commissioner. The association shall use generally acceptable actuarial principles and structurally compatible rates.

(2) (a) The association, with the approval of the commissioner, may adopt a reduced premium rate schedule that is equitably proportional to the income level for eligible persons who have an income less than or equal to 150% of the federal poverty level. ~~The association may not adopt a reduced premium rate schedule unless it has secured federal or private funding specifically for that purpose and limits participation to the available funding.~~

(b) The association, with the approval of the commissioner, may adopt as many income categories as it finds necessary.

(c) Any person who qualifies for coverage under this section may apply to the association for a reduced premium. However, eligible persons with coverage in the traditional association plan must receive first priority for reduced premiums. By agreement of the association and the commissioner, reduced premiums may be made available to persons eligible for the portability plan.

(d) The association may grant as many reduced premiums as funding sources allow but may not

increase overall premium rates to subsidize the reduced premium rate schedule. The association may limit the number of people receiving reduced premiums when funds are not available and may establish a waiting list for reduced premiums, if necessary."

Section 44. Section 33-22-1513, MCA, is amended to read:

"33-22-1513. Operation of association plan and association portability plans. (1) Upon acceptance by the lead carrier under 33-22-1516, an eligible person may enroll in the association plan by payment of the association plan premium to the lead carrier.

(2) Upon application by a federally defined eligible individual to the lead carrier for an association portability plan, the association may not:

(a) decline to offer an association portability plan; or

(b) impose a preexisting condition exclusion with respect to an individual's association portability plan coverage if application for association portability plan coverage is made within 63 days following termination of the applicant's most recent prior creditable coverage.

(3) Not less than 88% of the association plan premiums paid to the lead carrier may be used to pay claims and not more than 12% may be used for payment of the lead carrier's direct and indirect expenses as specified in 33-22-1514.

(4) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan premiums.

(5) (a) Each participating member of the association shall share the losses because of claims expenses of the association plan and the association portability plan for plans issued or approved for issuance by the association and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs in the following manner:

(i) Each participating member of the association must be assessed by the association on an annual basis an amount not to exceed 1% of the association member's total disability insurance premium received from or on behalf of Montana residents as determined by the commissioner. Assessments made under this subsection (5)(a) or funds from any other source must be allocated to the association plan and the association portability plan in proportion to the needs of the two plans. If the needs of the association plan and the association portability plan exceed the funds generated by the 1% assessment, the association is then authorized to spend any funds

appropriated by the legislature for the support of the plans. Any appropriation to the association may be expended for the operation of the association plan or the association portability plan.

(ii) (A) Payment of an assessment is due within 30 days of receipt by a member of a written notice of the annual assessment. After 30 days, the association shall charge a member:

(I) a late payment penalty of 1.5% a month or fraction of a month on the unpaid assessment, not to exceed 18% of the assessment due;

(II) interest at the rate of 12% a year on the unpaid assessment, to be accrued at 1% a month or fraction of a month; or

(III) both of the charges in subsections (5)(a)(ii)(A)(I) and (5)(a)(ii)(A)(II).

(B) Failure by a contributing member to tender the association assessment within the 30-day period is grounds for termination of membership. A member terminated for failure to tender the association assessment is ineligible to write health care benefit policies or contracts in this state under 33-22-1503(2).

(iii) An associate member that ceases to do disability insurance business within the state remains liable for assessments through the calendar year in which the member ceased doing disability insurance business. The association may decline to levy an assessment against an association member if the assessment, as determined pursuant to this section, would not exceed $50.

(b) For purposes of this subsection (5), "total disability insurance premium" does not include premiums received from disability income insurance, credit disability insurance, disability waiver insurance, life insurance, medicare risk or other similar medicare health maintenance organization payments, or medicaid health maintenance organization payments.

(c) Any income in excess of the incurred or estimated claims expenses of the association plan and the association portability plan and the operating and administrative expenses of the association must be held at interest and used by the association to offset past and future losses because of claims expenses of the association plan and the association portability plan or be allocated to reduce association plan premiums.

(6) The proportion of the annual assessment allocated to the operation and expenses of the association plan, not to include any amount of late payment penalty or interest charged, may be offset by an association member against the premium tax payable by that association member pursuant to 33-2-705 for the year in which the annual assessment is levied. The commissioner shall report to the office of budget and program planning, as a part of the information required by 17-7-111, the total amount of premium tax offset claimed by association members during the preceding biennium. The proportion of the annual assessment allocated to the operation and expenses of the association portability plan and levied against an association member may not be offset against

the premium tax payable by that association member.

(7) The association may also accept funding from the federal government, private foundations, and other private funding sources."

Section 45. Section 33-23-212, MCA, is amended to read:

"33-23-212. Notice required for cancellation -- statement that insurer will specify reason upon request -- exception ~~-- penalty~~. (1) ~~Notwithstanding any other provision of this code, a~~ A cancellation by an insurer of a motor vehicle liability insurance policy ~~may~~ is not ~~be~~ effective prior to the mailing or delivery to the named insured, at the address shown in the policy, of a written notice of the cancellation stating the date on which, not less than 30 days after the date of ~~such~~ the mailing or delivery, the cancellation becomes effective. Other provisions of this code may not be construed as affecting the requirements provided in this subsection (1).

(2) A notice of cancellation of a policy to which 33-23-211 applies ~~may~~ is not ~~be~~ effective unless mailed or delivered by the insurer to the named insured at least 30 days prior to the effective date of cancellation~~;~~. ~~provided, however, that where~~ However, if cancellation is for nonpayment of premium, at least 10 days' notice of cancellation accompanied by the reason must be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation must state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than 21 days prior to the effective date of cancellation, the insurer shall specify the reason for the cancellation.

(3) Subsection (2) does not apply to nonrenewal.

~~(4) Any insurer willfully violating any provisions of subsection (2) of this section is guilty of a misdemeanor and is punishable by a fine not exceeding $500 for each violation thereof.~~"

Section 46. Section 33-23-214, MCA, is amended to read:

"33-23-214. Advance notice required for nonrenewal -- exceptions. (1) ~~No~~ An insurer may not fail to renew a motor vehicle liability policy unless it mails or delivers to the named insured, at the address shown in the policy, at least 30 days' advance notice of its intention not to renew. ~~Such~~ The notice must contain or be accompanied by a statement that upon written request made not later than ~~1 month~~ 90 days following the termination date of the policy of the named insured mailed or delivered to the insurer, the insurer will notify the insured in writing, within ~~15~~ 21 days of ~~his~~ the insured's request, of the reason or reasons for ~~such~~ nonrenewal.

(2) ~~Notwithstanding the~~ The failure of an insurer to comply with this section~~,~~ does not prevent the motor vehicle liability policy ~~must terminate~~ from terminating on the effective date of any other replacement or

succeeding motor vehicle liability policy procured by the insured with respect to any motor vehicle designated in both policies.

(3) This section does not apply ~~where~~ when the named insured has failed to discharge when due any of ~~his~~ the insured's obligations in connection with the payment of premiums for the policy or the policy's renewal ~~thereof~~ or any installment payments ~~therefor~~ for the policy, whether payable directly to the insurer or its insurance producer or indirectly under any premium finance plan or extension of credit.

(4) This section does not apply in any of the following cases:

(a) if the insurer has manifested its willingness to renew;

(b) in case of nonpayment of premium; provided that, ~~notwithstanding~~ regardless of the failure of an insurer to comply with this section, the policy must terminate on the effective date of any other insurance policy with respect to any motor vehicle designated in both policies;

(c) if the insured's insurance producer ~~or broker~~ has secured other coverage acceptable to the insured at least 20 days prior to the anniversary date of the policy or termination of the policy period.

(5) Renewal of a motor vehicle liability policy does not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of ~~such~~ the renewal.

(6) A notice of nonrenewal of a motor vehicle liability policy under this section, ~~which~~ when the policy has a term of less than 6 months, is effective only when based on one or more of the reasons listed in 33-23-211."

Section 47. Section 33-30-102, MCA, is amended to read:

"33-30-102. Application of this chapter -- construction of other related laws. (1) All health service corporations are subject to the provisions of this chapter. In addition to the provisions contained in this chapter, other chapters and provisions of this title apply to health service corporations as follows: 33-2-1212; 33-3-307; 33-3-308; 33-3-431; 33-3-701 through 33-3-704; 33-17-101; Title 33, chapter 2, part 19; Title 33, chapter 17, parts 2 and 10 through 12; and Title 33, chapters 1, 15, 18, 19, and 22, except 33-22-111.

(2) A law of this state other than the provisions of this chapter applicable to health service corporations must be construed in accordance with the fundamental nature of a health service corporation, and in the event of a conflict, the provisions of this chapter prevail."

Section 48. Section 33-30-107, MCA, is amended to read:

"33-30-107. Annual statement. (1) On or before March 1 of each year, each health service corporation shall file an annual statement for the preceding year on the national association of insurance commissioners'

health blank form with the commissioner of insurance. This annual statement must be completed in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual of the national association of insurance commissioners. The statement must be accompanied by an actuarial opinion attesting to the insurer's reserves.

(2) The health service corporation shall file a statement containing any other information concerning its financial affairs that may be reasonably requested by the commissioner.

(3) (a) Each health service corporation shall file electronic versions of its annual and quarterly financial statements with the national association of insurance commissioners. The date for submission of the annual statement electronic filing is March 1. The dates for submission of the quarterly statement electronic filing are as follows:

(i) the first quarter filing is due May 15;

(ii) the second quarter filing is due August 15; and

(iii) the third quarter filing is due November 15.

(b) The commissioner may exempt health service corporations operating only in Montana from these filing requirements.

(c) The health service corporation shall pay all fees and costs associated with preparing the annual statement and other filings and submitting them to the national association of insurance commissioners.

(4) The commissioner may, after notice and hearing, suspend or revoke a health service corporation's license or impose a fine not to exceed $100 a day and not to exceed $1,000 upon a health service corporation that fails to file an annual statement as required by this part."

Section 49. Section 33-30-204, MCA, is amended to read:

"33-30-204. Fees. (1) Every health service corporation subject to the provisions of this chapter shall pay the following fees to the commissioner for enforcement of the provisions of this chapter:

~~(a) filing any statement or report ..... $1~~

~~(b)~~(a) for a certified copy of any document or other paper filed in the office of the commissioner, per page, ~~..... $ .50~~ 50 cents;

~~(c) for a certificate with affixed seal ..... $10~~

~~(d)~~(b) filing of a membership contract, ~~.....~~$25;

~~(e)~~(c) filing of a membership contract package, ~~.....~~$100;

~~(f)~~(d) filing annual statement, ~~.....~~$25;

~~(g)~~(e) issuance of health service corporation license, ~~.....~~$300; and

~~(h)~~(f) annual continuation of health service corporation license, ~~.....~~$300.

(2) The commissioner shall promptly deposit with the state treasurer, to the credit of the ~~general~~ state special revenue fund of the state auditor's office, all fees and license fees received under this section."

Section 50. Section 33-31-111, MCA, is amended to read:

"33-31-111. Statutory construction and relationship to other laws. (1) Except as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health maintenance organization authorized to transact business under this chapter. This provision does not apply to an insurer or health service corporation licensed and regulated pursuant to the insurance or health service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this chapter.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its representatives is not a violation of any law relating to solicitation or advertising by health professionals.

(3) A health maintenance organization authorized under this chapter is not practicing medicine and is exempt from Title 37, chapter 3, relating to the practice of medicine.

(4) This chapter does not exempt a health maintenance organization from the applicable certificate of need requirements under Title 50, chapter 5, parts 1 and 3.

(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704. A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701 through 33-3-704.

(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;

(b) the provisions of Title 33, chapter 22, part 19;

(c) the requirements of 33-22-134 and 33-22-135;

(d) network adequacy and quality assurance requirements provided under chapter 36; or

(e) the requirements of Title 33, chapter 18, part 9.

(7) ~~Chapter~~ Title 33, chapter 1, parts 12 and 13, ~~of this title,~~ Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 19, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-244, 33-22-246, 33-22-247, 33-22-514, 33-22-521, 33-22-523, 33-22-524,

33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 51. Section 33-31-212, MCA, is amended to read:

"33-31-212. Fees. (1) Each health maintenance organization shall pay to the commissioner the following fees:

(a) for filing an application for a certificate of authority or amendment ~~thereto~~ to a certificate of authority, $300;

(b) for filing an amendment to the organization documents that requires approval, $25;

(c) for filing each annual statement, $25;

(d) for annual continuation of certificate of authority, $300.

(2) All fees, miscellaneous charges, fines, penalties, and those amounts received pursuant to 33-31-211(3) and 33-31-405 collected by the commissioner pursuant to this chapter and the rules adopted ~~thereunder~~ under this chapter must be deposited in the ~~general~~ state special revenue fund to the credit of the state auditor's office."

Section 52. Section 33-33-201, MCA, is amended to read:

"33-33-201. Standards for utilization review organizations. (1) A utilization review organization that conducts utilization reviews in this state for property and casualty insurers shall register with the commissioner prior to performing utilization reviews. The commissioner shall place a utilization review organization on the register when the utilization review organization provides information that establishes that the utilization review organization meets the standards set forth in this section. The commissioner shall remove from the register a utilization review organization that fails to meet the standards set forth in this section.

(2) Utilization review organizations may use only licensed or certified health care professionals to conduct utilization reviews.

(3) Utilization reviews must be conducted by health care professionals who are licensed or certified in the same specialty as the provider whose treatment is being received by the insured or claimant or by a health care professional who is qualified to render the treatment being reviewed.

(4) Utilization review organizations shall comply with all applicable state or federal medical privacy laws.

(5) Utilization review evaluations must use generally accepted standards for treatment of the illness, injury, or condition that is being reviewed.

(6) Utilization review opinions must be signed by the health care professional performing the review.

(7) A utilization review organization may not base its fees or charges on any recommendation for a reduction in payment under an insurance contract or on a percentage of claim savings."

Section 53. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions ~~of Title 33~~:

(a) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;

(b) Title 33, chapter 1, part 7;

(c) 33-3-308;

(d) Title 33, chapter 18, except 33-18-242;

(e) Title 33, chapter 19;

~~(e)~~(f) 33-22-131, 33-22-134, and 33-22-135; and

~~(f)~~(g) 33-22-525 and 33-22-526.

(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 54. Section 45-6-301, MCA, is amended to read:

"45-6-301. Theft. (1) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(2) A person commits the offense of theft when the person purposely or knowingly obtains by threat or deception control over property of the owner and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment

probably will deprive the owner of the property.

(3) A person commits the offense of theft when the person purposely or knowingly obtains control over stolen property knowing the property to have been stolen by another and:

(a) has the purpose of depriving the owner of the property;

(b) purposely or knowingly uses, conceals, or abandons the property in a manner that deprives the owner of the property; or

(c) uses, conceals, or abandons the property knowing that the use, concealment, or abandonment probably will deprive the owner of the property.

(4) A person commits the offense of theft when the person purposely or knowingly obtains or exerts unauthorized control over any part of any public assistance provided under Title 52 or 53 by a state or county agency, regardless of the original source of assistance, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) a fraudulent scheme or device.

(5) A person commits the offense of theft when the person purposely or knowingly obtains or exerts or helps another obtain or exert unauthorized control over any part of any benefits provided under Title 39, chapter 71 or 72, by means of:

(a) a knowingly false statement, representation, or impersonation; or

(b) deception or other fraudulent action.

(6) (a) A person commits the offense of theft when the person purposely or knowingly commits insurance fraud as provided in 33-1-1202 or 33-1-1302; or

(b) purposely or knowingly diverts or misappropriates insurance premiums as provided in 33-17-1102.

(7) A person commits the offense of theft of property by embezzlement when, with the purpose to deprive the owner of the property, the person:

(a) purposely or knowingly obtains or exerts unauthorized control over property of the person's employer or over property entrusted to the person; or

(b) purposely or knowingly obtains by deception control over property of the person's employer or over property entrusted to the person.

(8) (a) A person convicted of the offense of theft of property not exceeding $1,000 in value shall be fined an amount not to exceed $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a second offense shall be fined $1,000 or be imprisoned in the county jail for a term not to exceed 6 months, or both. A person convicted of a third or subsequent offense shall be fined $1,000 and be

imprisoned in the county jail for a term of not less than 30 days or more than 6 months.

(b) Except as provided in subsection (8)(c), a person convicted of the offense of theft of property exceeding $1,000 in value or theft of any commonly domesticated hoofed animal shall be fined an amount not to exceed $50,000 or be imprisoned in a state prison for a term not to exceed 10 years, or both.

(c) A person convicted of the offense of theft of property exceeding $10,000 in value by embezzlement shall be imprisoned in a state prison for a term of not less than 1 year or more than 10 years and may be fined an amount not to exceed $50,000. The court may, in its discretion, place the person on probation with the requirement that restitution be made under terms set by the court. If the terms are not met, the required prison term may be ordered.

(9) Amounts involved in thefts committed pursuant to a common scheme or the same transaction, whether from the same person or several persons, may be aggregated in determining the value of the property."

Section 55. Section 50-3-109, MCA, is amended to read:

"50-3-109. Tax on fire insurance premiums. (1) Each insurer authorized to effect insurance on risks enumerated in subsection (2) that is doing business in this state shall pay to the state auditor during the month of February or March in each year, in addition to the taxes on premiums required by law to be paid by it, taxes on the fire portion of the direct premiums on the enumerated risks received during the previous calendar year after deducting cancellations and return premiums. A tax of 2 1/2% must be deposited in the general fund as provided in ~~17-2-121~~ 33-2-708.

(2) The risks referred to in subsection (1) are:

(a) insurance of houses, buildings, and all other kinds of property against loss or damage by fire or other casualty;

(b) all kinds of insurance on goods, merchandise, or other property in the course of transportation, whether by land, water, or air;

(c) insurance against loss or damage to motor vehicles resulting from accident, collision, or marine and inland navigation and transportation perils;

(d) insurance of growing crops against loss or damage resulting from hail or the elements;

(e) insurance against loss or damage by water to any goods or premises arising from the breakage or leakage of sprinklers, pumps, or other apparatus;

(f) insurance against loss or legal liability for loss because of damage to property caused by the use of teams or vehicles, whether by accident or collision or by explosion of any engine, tank, boiler, pipe, or tire of any

vehicle; and

(g) insurance against theft of the whole or any part of a vehicle."

NEW SECTION. **Section 56. Repealer.** Section 17-2-121, MCA, is repealed.

NEW SECTION. **Section 57. Codification instruction.** (1) [Sections 1 through 4] are intended to be codified as an integral part of Title 33, chapter 3, and the provisions of Title 33, chapter 3, apply to [sections 1 through 4].

(2) [Section 5] is intended to be codified as an integral part of Title 33, chapter 1, part 2, and the provisions of Title 33, chapter 1, part 2, apply to [section 5].

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