Chapter 42. Wyoming Life and Health Insurance Guaranty Association

§ 26-42-101. Short title

This chapter is known as the "Wyoming Life and Health Insurance Guaranty Association Act."

§ 26-42-102. Definitions

As used in this act:

(a) "Account" means any of the three (3) accounts created by W.S. 26-42-104(a).

(b) "Association" means the Wyoming life and health insurance guaranty association created by W.S. 26-42-104.

(c) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the Board of Directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(d) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(e) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means any obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under W.S. 26-42-103.

(h) "Covered policy" means any policy or contract or portion of a policy or contract for which coverage is provided by W.S. 26-42-103.

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

(j) "Impaired insurer" means a member insurer which is not an insolvent insurer andis placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(k) "Insolvent insurer" means a member insurer which after the effective date of this act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(l) "Member insurer" means any insurer which is licensed or holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided by W.S. 26-42-103 and includes any insurer whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A fraternal benefit society;

(ii) A mandatory state pooling plan;

(iii) A stipulated premium insurance company;

(iv) A local mutual burial association;

(v) A mutual assessment company or any entity that operates on an assessment basis;

(vi) An insurance exchange; or

(vii) Any entity similar to any of the above.

(m) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(n) "Owner" of a policy or contract and "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the insurer. The terms owner, contract owner and policy owner do not include persons with a mere beneficial interest in a policy or contract

(o) "Person" means an individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(p) "Plan sponsor" means:

(i) The employer in the case of a benefit plan established or maintained by a single employer;

(ii) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(iii) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(q) "Premiums" means amounts received on covered policies or contracts less premiums, considerations and deposits returned thereon, and less dividends and experience credits thereon, but does not include any amounts received for any policies or contracts or for the portions of any policies or contracts for which coverage is not provided by W.S. 26-42-103(b) except that assessable premium shall not be reduced due to W.S. 26-42-103(c)(iii) relating to interest limitations and W.S. 26-42-103(d)(ii) relating to limitations with respect to any one individual, one participant and one contract owner. "Premiums" shall not include:

(i) Premiums on an unallocated annuity contract; or

(ii) With respect to multiple non-group policies of life insurance owned by one owner, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of $5,000,000 with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(r) (i) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the

entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(A) The state in which the primary executive and administrative headquarters of the entity is located;

(B) The state in which the principal office of the chief executive officer of the entity is located;

(C) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(D) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(E) The state from which the management of the overall operations of the entity is directed; and

(F) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

(ii) The principal place of business of a plan sponsor of a benefit plan shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(s) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the insurer.

(t) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this act, shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

(u) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(v) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(w) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or life, health or annuity contract.

(x) "This act" means W.S. 26-42-101 through 26-42-118.

(y) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

➡ § 26-42-103. Coverage and limitations

(a) This act shall provide coverage for the policies and contracts specified in subsection (b) of this section and provide coverage:

(i) To persons who are owners or certificate holders under the policies or contracts (other than structured settlement annuities) and in each case who:

(A) Are residents; or

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

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

(II) The states in which the persons reside have associations similar to the association created by this act;

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

(ii) To persons who are the beneficiaries, assignees or payees of the persons described in paragraph (a)(i) of this section regardless of where they reside except for nonresident certificate holders under group policies or contracts.

(iii) For structured settlement annuities specified in subsection b; paragraphs (i) and (ii) of this subsection shall not apply, and this act shall (except as provided in paragraphs (iv) and (v) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

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

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

(I) (1) The contract owner of the structured settlement annuity is a resident; or

(2) The contract owner of the structured settlement annuity is not a resident; but

- The insurer that issued the structured settlement annuity is domiciled in this state; and
- The state in which the contract owner resides has an association similar to the association created by this act; and

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

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

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

(b) This act shall provide coverage to persons specified in subsection (a) of this section for direct, nongroup life, health, annuity and supplemental policies or contracts and for certificates under direct group policies and contracts issued by member insurers except as limited by this act. Annuity contracts and certificates under group annuity contracts include allocated funding agreements, structured settlement annuities and any immediate or deferred annuity contracts.

(c) This act shall not provide coverage for:

(i) Any portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policyholder or contract holder.

(ii) Any policy or contract of reinsurance unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

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

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

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this act, exceeds the rate of interest determined by subtracting three (3) percentage points from the most recent and available Moody's Corporate Bond Yield Average.

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

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

(B) A minimum premium group insurance plan;

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

(D) An administrative services only contract.

(v) Any portion of a policy or contract to the extent it provides dividends or experience rating credits, voting

rights or provides payment of any fees or allowances to any person, including the policyholder or contract holder, in connection with the service to or administration of the policy or contract.

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

(vii) A portion of a policy or contract to the extent that the assessments required by W.S. 26-42-107 with respect to the policy or contract are preempted or otherwise not permitted by federal or state law.

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

(A) Claims based on marketing materials;

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

(C) Misrepresentations of or regarding policy benefits;

(D) Extra-contractual claims or;

(E) A claim for penalties or consequential or incidental damages.

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

(x) An unallocated annuity contract.

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

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

(xiii) Any annuity contract or group annuity certificate which is not issued to and not owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under the contract or certificate

(xiv) Any annuity contract or group annuity certificate which is issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees for the purpose of providing retirement benefits.

(d) The benefits for which the association may be liable shall in no event exceed the lesser of:

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

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

(I) $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance;

(II) In health insurance benefits:

(1) $100,000 for coverages not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values;

(2) $300,000 for disability insurance and $300,000 for long-term care;

(3) $300,000 for basic hospital medical and surgical insurance or major medical insurance;

(III) $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

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

(C) However, in no event shall the association be obligated to cover more than (i) an aggregate of $500,000 in benefits with respect to any one life under paragraph (d)(ii)(A) of this section, or (ii) with respect to one owner of multiple non-group policies of life insurance, whether the policy owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

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

(e) In performing its obligations to provide coverage under W.S. 26-42-106, the association shall not be required to guarantee, assume, reinsure or perform, or cause to be guaranteed, assumed, reinsured or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

(f) The liability of the association is strictly limited by the express terms of the covered policies and contracts and by the provisions of this act and is not affected by the contents of any brochures, illustrations, advertisements or oral statements by agents, brokers or others used or made in connection with their sale. The association is not liable for any extracontractual, exemplary or punitive damages, attorney's fees or interest other than as provided for by the terms of such policies or contracts, as limited by this act.

➡ § 26-42-104. Creation of the association

(a) The nonprofit legal entity known as the Wyoming life and health insurance guaranty association is continued. All member insurers are members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under the plan of operation established and approved under W.S. 26-42-108 and shall exercise its powers through a board of directors provided by W.S. 26-42-105. For purposes of administration and assessment the association shall maintain the three (3) following accounts:

(i) The life insurance account;

(ii) The health insurance account; and

(iii) The annuity account.

(b) The association is under the supervision of the commissioner and is subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

➡ § 26-42-105. Board of directors

(a) The board of directors of the association consists of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation provided by W.S. 26-42-108. The members of the board are selected by member insurers subject to the approval of the commissioner. Vacancies on the board are filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the commissioner.

(b) In approving selections or in appointing members to the board, the commissioner shall consider, among other factors, whether all member insurers are fairly represented.

(c) Members of the board shall be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors. Members of the board shall not otherwise be compensated by the association for their services.

➡ § 26-42-106. Powers and duties of the association

(a) If a member insurer is an impaired insurer, the association may in its discretion and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, that are approved by the commissioner:

(i) Guarantee, assume or reinsure or cause to be guaranteed, assumed or reinsured any or all of the policies or contracts of the impaired insurer;

(ii) Provide monies, pledges, loans, notes, guarantees, or other means proper to effectuate this subsection and assure payment of the contractual obligations of the impaired insurer pending action taken as authorized by this subsection..

(b) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(i) (A) (I) Guaranty, assume or reinsure or cause to be guaranteed, assumed or reinsured, the policies or contracts of the insolvent insurer; or

(II) Assure payment of the contractual obligations of the insolvent insurer; and

(B) Provide monies, pledges, loans, notes, guarantees or other means as reasonably necessary to discharge the duties; or

(ii) Provide benefits and coverages in accordance with the following provisions:

(A) With respect to life and health insurance policies and annuities, assure payment of benefits for premiums identical to the premiums and benefits (except for terms of conversion and renewability) that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

:

(I) For group policies and contracts, not later than the earlier of the next renewal date under the policies or contracts or forty-five (45) days and not less than thirty (30) days after the date on which the association is obligated under the policies and contracts;

(II) For non-group policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or one (1) year and not less than thirty (30) days from the date on which the association is obligated under the policies and contracts.

(B) Make diligent efforts to provide all known insureds or annuitants (for non-group policies and contracts), or group policy owners with respect to group policies and contracts, thirty (30) days notice of the termination (pursuant to paragraph (A) of this subsection) of the benefits provided;

(C) For non-group life and health insurance policies and annuities covered by the association, make available to each known insured or annuitant, or owner if other than the insured or annuitant, and with respect to an individual formerly insured or formerly an annuitant under a group policy who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of paragraph (D) of this subsection, if the insureds or annuitants had a right under law or the terminated policy or annuity to convert coverage to individual coverage or to continue an individual policy or annuity in force until a specified age or for a specified time, during which the insurer had no right unilaterally to make changes in any provisions of the policy or annuity or had a right only to make changes in premium by class;

(D) (I) In providing the substitute coverage required under paragraph (C) of this subsection, the association may offer either to reissue the terminated coverage or to issue an alternative policy.

(II) Alternative or reissued policies shall be offered without requiring evidence of insurability and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy.

(III) The association may reinsure any alternative or reissued policy;

(E) (I) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner and the receivership court. The association may adopt alternative policies of various types for future issuance without regard to any particular impairment or insolvency.

(II) Alternative policies shall contain at least the minimum statutory provisions required in this state and provide benefits that are not unreasonable in relation to the premium charged. The association shall set the premiums in accordance with a table of rates which it adopts and which reflect the amount of insurance to be provided and the age and class of risk of each insured but do not reflect any changes in the health of the insured after the original policy was last underwritten;

(III) Any alternative policy issued by the association shall provide coverage of a type similar to that of

the policy issued by the impaired or insolvent insurer, as determined by the association.

(F) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy, the premium shall be set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to approval of the commissioner or a court of competent jurisdiction;

(G) The association's obligations with respect to coverage under any policy of the impaired or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, the insured or the association.

(H) When proceeding under paragraph (b)(ii) with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with W.S. 26-42-103(c)(iii).

(c) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy or coverage incurred pursuant to this act, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this act.

(d) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer belongs to and is payable at the direction of the association, and the association is liable for unearned premiums due to policy or contract owners arising after the entry of the order.

(e) The protection provided by this act shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(f) In carrying out its duties under subsections (b) of this section the association may, subject to approval by a court of competent jurisdiction:

(i) Impose permanent policy or contract liens in connection with any guarantee, assumption or reinsurance agreement, if the association finds that the amounts which may be assessed under this act are less than the amounts needed to assure full and prompt performance of the association's duties under this act or that the economic or financial conditions as they affect member insurers are sufficiently adverse that it is within the public interest to render the imposition of the permanent policy or contract liens;

(ii) Impose temporary moratoriums or liens on payments of cash values and policy loans or any other right to withdraw funds held in conjunction with policies or contracts in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(g) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of an insurer domiciled in this state or in a reciprocal state shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy owners claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy owners' claims in this state related

to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of state assets pursuant to applicable state receivership law dealing with early access disbursements .

(h) If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in subsection (b) of this section, the commissioner shall have the powers and duties of the association under this act with respect to the insolvent insurer.

(i) The association may render assistance and advice to the commissioner upon his request concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of any impaired or insolvent insurer.

(j) The association shall have standing to appear before any court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this act or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including but not limited to, proposals for reinsuring, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in any state with jurisdiction over an impaired or insolvent insurer if the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(k) (i) A person receiving benefits under this act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this act, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative coverages. The association may require an assignment to it of such rights and cause of action by any payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this act upon the person.

(ii) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this act.

(iii) In addition to paragraphs (i) and (ii) above, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary or payee of a policy or contract with respect to the policy or contracts (including without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this act, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore, excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130).

(iv) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies (or portion thereof) covered by the association.

(v) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies (or portion thereof) covered by the association.

(l) The association may:

(i) Enter into contracts as necessary or proper to carry out the provisions and purposes of this act.

(ii) Sue or be sued including taking any legal actions necessary or proper to recover any unpaid assessments under W.S. 26-42-107 and to settle claims or potential claims against it.

(iii) Borrow money to effect the purposes of this act. Any notes or other evidence of indebtedness of the association not in default are legal investments for domestic insurers and may be carried as admitted assets.

(iv) Employ or retain persons as necessary to handle the financial transactions of the association and to perform other functions as necessary or proper under this act.

(v) Take legal action as necessary or appropriate to avoid or recover payment of improper claims.

(vi) Exercise, for the purposes of this act and to the extent approved by the commissioner, the powers of a domestic life or health insurer. The association shall not issue insurance policies or annuity contracts other than those issued to perform its obligations under this act.

(vii) Organize itself as a corporation or in other legal form permitted by the laws of the state.

(viii) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this act with respect to the person, and the person shall promptly comply with the request.

(ix) Take other necessary or appropriate action to discharge its duties and obligations under this act or to exercise its powers under this act.

(m) The association may join an organization of one (1) or more other state associations of similar purposes to further the purposes and administer the powers and duties of the association.

(n) With respect to covered policies for which the association becomes obligated after an entry of an order or liquidation or rehabilitation, the association may elect to succeed to the rights of the insolvent insurer arising after the date of the order of liquidation or rehabilitation under any contract of reinsurance to which the insolvent insurer was a party, to the extent that the contract provides coverage for losses occurring after the date of the order of liquidation or rehabilitation. As a condition to making this election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date of the order of liquidation or rehabilitation.

(o) The board of directors of the association shall have discretion and may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of this act in an economical and efficient manner.

(p) Where the association has arranged or offered to provide the benefits of this act to a covered person under a plan or arrangement that fulfills the association's obligations under this act, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(q) The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this act.

(r) In carrying out its duties in connection with guaranteeing, assuming or reinsuring policies or contracts under subsections a or b, the association may, subject to approval of the receivership court, issue substitute coverage for a

policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(i) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;

(ii) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract, and;

(iii) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

➡ § 26-42-107. Assessments

(a) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers separately for each account and at a time and for amounts as the board finds necessary. Assessments are due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at the rate set by 28 U.S.C. § 1961 on and after the due date.

(b) There shall be two (2) assessments as follows:

(i) Class A assessments shall be authorized and called to pay administrative and legal costs and other expenses and examinations conducted under the authority of W.S. 26-42-110(e). Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer;

(ii) Class B assessments shall be authorized and called as necessary to carry out the powers and duties of the association under W.S. 26-42-106 with regard to an impaired or an insolvent insurer.

(c) The amount of any Class A assessment shall be determined at the discretion of the board of directors and such assessments shall be authorized and called on a non-pro rata basis. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as fair and reasonable under the circumstances.

(d) (i) Class B assessments against member insurers for each account shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the insurer became impaired) bears to the premiums received on business in this state for the calendar years by all assessed member insurers.

(ii) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be made until necessary to implement the purposes of this act. Classification of assessments under subsection (b) of this section and computation of assessments under subsections (c) and (d) of this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized as-

sessment not yet called within one hundred eighty (180) days after the assessment is authorized..

(e) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(f) (i) (A) Subject to the provisions of subparagraph (B) of this paragraph, the total of all assessments authorized by the association with respect to a member insurer for each account shall not in any one (1) calendar year exceed two percent (2%) of the insurer's average premiums received in this state on the policies and contracts covered by the account during the three (3) calendar years preceding the year in which the insurer became an impaired or insolvent insurer.

(B) If two (2) or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (A) of this paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(C) If the maximum assessment including the other assets of the association in an account does not provide in any one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this act.

(ii) The board may provide in the plan of operation provided by W.S. 26-42-108 a method of allocating funds among claims, whether relating to one (1) or more impaired or insolvent insurers when the maximum assessment will be insufficient to cover anticipated claims.

(g) Any member insurer may, in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this act, consider the amount reasonably necessary to meet its assessment obligations under this act.

(h) The board may refund to member insurers the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains and income from investments. The board shall use an equitable method to make the refunds and the refunds shall be in proportion to the contribution of each insurer to the account. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses.

(i) (i) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(ii) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(iii) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(iv) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(v) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member company. Interest on a refund due a protesting member shall be paid at the rate actually earned by the association

(j) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

(k) The association shall issue to each insurer paying an assessment under this act, other than a Class A assessment, a certificate of contribution in a form prescribed by the commissioner for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the insurer in its financial statement as an asset in a form and for an amount, if any, and a period of time as approved by the commissioner.

➡ § 26-42-108. Plan of operation

(a) The association shall maintain a plan of operation to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments to the plan of operation shall be submitted to the commissioner and are effective upon the commissioner's written approval or after thirty (30) days if he has not disapproved them.

(b) If the association fails to submit a suitable plan of operation or suitable amendments to the plan, the commissioner shall after notice and hearing adopt and promulgate reasonable rules as necessary or advisable to implement the provisions of this act. The rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(c) All member insurers shall comply with the plan of operation.

(d) The plan of operation shall, in addition to requirements enumerated in other provisions of this act:

(i) Establish procedures for handling the assets of the association;

(ii) Establish the amount and method of reimbursing members of the board of directors under W.S. 26-42-105;

(iii) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(iv) Establish procedures for records to be kept of all financial transactions of the association, the association's agents and the board of directors;

(v) Establish the procedures for making selections for the board of directors and submitting them to the commissioner;

(vi) Establish any additional procedures for assessments under W.S. 26-42-107;

(vii) Contain additional provisions necessary or proper for the execution of the powers and duties of the associa-

tion.

(e) The plan of operation may provide that any or all powers and duties of the association, except those under W.S. 26-42-106(l)(iii) and 26-42-107, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of the association or its equivalent in two (2) or more states. The corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner and may be made only to a corporation, association or organization which extends protection similar to that provided by this act.

§ 26-42-109. Duties and powers of the commissioner

(a) In addition to the duties and powers enumerated in other provisions of this act, the commissioner shall:

(i) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate state for each member insurer;

(ii) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to eliminate the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties under this act;

(iii) In any liquidation or rehabilitation proceeding involving a domestic insurer, be appointed as the liquidator or rehabilitator.

(b) The commissioner may suspend or revoke after notice and hearing the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than one hundred dollars ($100.00) per month.

(c) Any action of the board of directors or the association may be appealed to the commissioner by any member insurer if an appeal is taken within sixty (60) days of the final action being appealed. Any final action or order of the commissioner is subject to judicial review in a court of competent jurisdiction.

(d) The liquidator, rehabilitator or conservator of any impaired or insolvent insurer may notify all interested persons of the effect of this act.

➡ **§ 26-42-110. Prevention of insolvencies**

(a) To aid in the detection and prevention of insurer insolvencies or impairments, the commissioner shall:

(i) Notify the commissioners of all the other states, territories of the United States and the District of Columbia by mail within thirty (30) days of any of the following actions taken against a member insurer:

(A) Revocation of license;

(B) Suspension of license; or

(C) Issuance of any formal order requiring the company to:

(I) Restrict its premium writing;

(II) Obtain additional contributions to surplus;

(III) Withdraw from the state;

(IV) Reinsure all or any part of its business; or

(V) Increase capital, surplus or any other account for the security of policyholders or creditors.

(ii) Report to the board of directors when he has taken any actions provided by paragraph (i) of this subsection or has received a report from any other commissioner indicating that any action provided by paragraph (i) of this subsection has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner;

(iii) Report to the board of directors when he has reasonable cause to believe from any completed or pending examination of any member company that the company may be an impaired or insolvent insurer;

(iv) Furnish to the board of directors the national association of insurance commissioners insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners, and the board may use this information in carrying out its duties and responsibilities under this section. The report and its information shall be kept confidential by the board of directors until the commissioner or other lawful authority makes it a public record.

(b) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting his duties and responsibilities regarding the financial condition of member insurers and companies seeking admission to transact insurance business in this state.

(c) The board of directors may by majority vote make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any company seeking to do any insurance business in this state. The reports and recommendations are confidential and shall not be considered public documents.

(d) It is the duty of the board of directors by majority vote to notify the commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.

(e) The board of directors may by majority vote request that the commissioner order an examination of any member insurer which the board in good faith believes may be an impaired or insolvent insurer. Within thirty (30) days of the receipt of a request, the commissioner shall begin an examination. The examination may be conducted as a national association of insurance commissioners examination or may be conducted by persons designated by the commissioner. The cost of the examination shall be paid by the association and the examination report shall be treated the same as other examination reports. In no event shall the examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (a) of this section. The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner but it shall not be open to public inspection prior to the release of the examination report to the public.

(f) The board of directors may by majority vote make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(g) The board of directors shall at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims prepare a report to the commissioner containing information it has in its possession bearing on the history and causes of the insolvency. The board shall cooperate with the boards of directors of guaranty associa-

tions in other states in preparing a report on the history and causes of insolvency of a particular insurer and may adopt by reference any report prepared by other associations.

➡ § 26-42-111. Credits for assessments paid; tax offsets

(a) A member insurer may offset against its premium tax liability to this state an assessment described in W.S. 26-42-107(k) to the extent of ten percent (10%) of the amount of the assessment for each of the ten (10) calendar years following the year in which the assessment was paid. If a member insurer ceases doing business, all uncredited assessments may be credited against its premium tax liability for the year it ceases doing business.

(b) Any sums which are acquired by refund pursuant to W.S. 26-42-107(h) from the association by member insurers and which have been offset against premium taxes as provided in subsection (a) of this section, shall be paid by the insurers to this state as required by the commissioner. The association shall notify the commissioner that the refunds have been made.

➡ § 26-42-112. Assessment liability; records; assets; proceedings against impaired or insolvent insurer

(a) This act shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(b) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under W.S. 26-42-106. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except (i) upon the termination of the impairment or insolvency of the insurer, or (ii) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under W.S. 26-42-113.

(c) For the purpose of carrying out its obligations under this act, the association is deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as assignee or subrogee pursuant to W.S. 26-42-106(k). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this act. As used in this subsection, “assets attributable to covered policies” means that proportion of the assets which the reserves that should have been established for such policies bear to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.

(d) As a creditor of the impaired or insolvent insurer as established in subsection c of this section, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this act. If the liquidator has not, within 120 days of a final determination of insolvency of an insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(e) (i) Prior to the termination of any liquidation, rehabilitation or conservation proceeding the court may consider the contributions of the respective parties including the association, the shareholders and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.

(ii) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims and interest on the claims of the association for funds expended in carrying out its

powers and duties under W.S. 26-42-106 with respect to the insurer have been fully recovered by the association.

(f) (i) If an order for liquidation or rehabilitation of an insurer domiciled in this state is entered, the receiver appointed under the order shall have a right to recover on behalf of the insurer from any affiliate that controlled it, the amount of distributions other than stock dividends paid by the insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of subsections (ii), (iii) and (iv) of this section.

(ii) No such distribution is recoverable if the insurer shows that when paid the distribution was lawful and reasonable and that the insurer did not know and could not reasonably have known the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(iii) Any person who was an affiliate that controlled the insurer at the time the distributions were paid is liable up to the amount of distributions he received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared is liable up to the amount of distributions he would have received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions they are jointly and severally liable.

(iv) The maximum amount recoverable under subsections (i) through (iii) of this section is the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(v) If any person liable under subsection (iii) of this section is insolvent, all its affiliates that controlled it at the time the distribution was paid are jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

➡ § 26-42-113. Examination of the association; annual report

The association is subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner each year not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year.

➡ § 26-42-114. Tax exemptions

The association is exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real property.

➡ § 26-42-115. Stay of proceedings; reopening default judgments

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

➡ § 26-42-116. Prohibited advertisement of association chapter in insurance sales; notice to policyholders

(a) No person including an insurer, agent or affiliate of an insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public in any newspaper, magazine or other publication, in the form of a notice, circular, pamphlet, letter or poster, over any radio station or television station, or in any other way, any advertisement, announcement or written or oral

statement which uses the existence of the association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance covered by this act. This subsection shall not apply to the association or any other entity which does not sell or solicit insurance.

(b) Within one hundred eighty (180) days of the effective date of this act, the association shall prepare a summary document describing the general purposes and current limitations of the act and complying with subsection (c) of this section and submit it to the commissioner for approval. Sixty (60) days after receiving approval, no insurer may deliver a policy or contract described in W.S. 26-42-103(b) to a policyholder or contract holder unless the document provided in subsections (b) and (c) of this section is delivered to the policyholder or contract holder prior to or at the time of delivery of the policy or contract except if subsection (d) of this section applies. The document shall be available upon request by a policyholder. The distribution, delivery or contents or interpretation of the document shall not mean that either the policy or the contract or the policyholder or contract holder would be covered in the event of impairment or insolvency of a member insurer. The description document shall be revised by the association as required by this act. Failure to receive the document does not give the policyholder, contract holder, certificate holder or insured any greater rights than those stated in this act.

(c) The document prepared under subsection (b) of this section shall contain a clear and conspicuous disclaimer on its face. The commissioner shall promulgate a rule establishing the form and content of the disclaimer. The disclaimer shall:

(i) State the name and address of the life and health insurance guaranty association and insurance department;

(ii) Prominently warn the policyholder or contract holder that the association may not cover the policy or if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;

(iii) State that the insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance;

(iv) Emphasize that the policyholder or contract holder should not rely on coverage under the association when selecting an insurer;

(v) Provide other information as directed by the commissioner.

(d) Insurers and agents shall deliver the document and disclaimer described under subsections (b) and (c) of this section when a customer is solicited if a “free look” period is not provided in the policy.

➞ § 26-42-117. Immunity

Except as provided by W.S. 26-42-106(l)(ii), 26-42-109(b) and 26-42-112, there shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this act. Immunity shall extend to the participation in any organization of one (1) or more other state associations of similar purposes and to any such organization and its agents or employees.

➞ § 26-42-118. Prospective application

The re-enactment of this act in 2011 shall not apply to any member insurer that, before the effective date of the re-enactment, has been placed under an order of liquidation with a finding of insolvency.