

MARYLAND CLAIM SETTLEMENT LAWS AND REGULATIONS

LAWS: SUBTITLE 3. UNFAIR CLAIM SETTLEMENT PRACTICES

§ 27-301. Intent and effect of subtitle.

(a) Intent of subtitle.- The intent of this subtitle is to provide an additional administrative remedy to a claimant for a violation of this subtitle or a regulation that relates to this subtitle.

(b) Effect of subtitle.-

(1) This subtitle provides administrative remedies only.

(2) This subtitle does not provide or prohibit a private right or cause of action to, or on behalf of, a claimant or other person in any state.

(3) This subtitle does not impair the right of a person to seek redress in law or equity for conduct that otherwise is actionable.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]

§ 27-302. Scope of subtitle.

(a) Policies covered.- This subtitle applies to each individual or group policy, contract, or certificate of an insurer or nonprofit health service plan that:

(1) is delivered or issued in the State;

(2) is issued to a group that has a main office in the State; or

(3) covers individuals who reside or work in the State.

(b) Exclusions.- This subtitle does not apply to:

(1) reinsurance;

(2) workers' compensation insurance; or

(3) surety insurance.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]

§ 27-303. Unfair claim settlement practices - In general.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(3) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(4) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which payment is being made;

(5) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(6) fail to provide promptly on request a reasonable explanation of the basis for a denial of a claim;

(7) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(8) fail to comply with the provisions of Title 15, Subtitle 10A of this article; or

(9) fail to act in good faith, as defined under § 27-1001 of this title, in settling a first-party claim under a policy of property and casualty insurance.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; ch. 755; 2007, ch. 150.]

§ 27-304. Same - General business practice.

It is an unfair claim settlement practice and a violation of this subtitle for an insurer or nonprofit health service plan, when committed with the frequency to indicate a general business practice, to:

(1) misrepresent pertinent facts or policy provisions that relate to the claim or coverage at issue;

(2) fail to acknowledge and act with reasonable promptness on communications about claims that arise under policies;

(3) fail to adopt and implement reasonable standards for the prompt investigation of claims that arise under policies;

(4) refuse to pay a claim without conducting a reasonable investigation based on all available information;

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

(6) fail to make a prompt, fair, and equitable good faith attempt, to settle claims for which liability has become reasonably clear;

(7) compel insureds to institute litigation to recover amounts due under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds;

(8) attempt to settle a claim for less than the amount to which a reasonable person would expect to be entitled after studying written or printed advertising material accompanying, or made part of, an application;

(9) attempt to settle a claim based on an application that is altered without notice to, or the knowledge or consent of, the insured;

(10) fail to include with each claim paid to an insured or beneficiary a statement of the coverage under which the payment is being made;

(11) make known to insureds or claimants a policy of appealing from arbitration awards in order to compel insureds or claimants to accept a settlement or compromise less than the amount awarded in arbitration;

(12) delay an investigation or payment of a claim by requiring a claimant or a claimant's licensed health care provider to submit a preliminary claim report and subsequently to submit formal proof of loss forms that contain substantially the same information;

(13) fail to settle a claim promptly whenever liability is reasonably clear under one part of a policy, in order to influence settlements under other parts of the policy;

(14) fail to provide promptly a reasonable explanation of the basis for denial of a claim or the offer of a compromise settlement;

(15) refuse to pay a claim for an arbitrary or capricious reason based on all available information;

(16) fail to meet the requirements of Title 15, Subtitle 10B of this article for preauthorization for a health care service;

(17) fail to comply with the provisions of Title 15, Subtitle 10A of this article; or

(18) fail to act in good faith, as defined under § 27-1001 of this title, in settling a first-party claim under a policy of property and casualty insurance.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 111, § 2; ch. 112, § 2; ch. 755; 1999, ch. 71; 2007, ch. 150.]

§ 27-304.1. Regulations.

The Commissioner shall adopt regulations that establish standards and procedures for:

(1) the settlement of claims involving the total loss of a private passenger motor vehicle; and

(2) the determination of the private passenger motor vehicle's total loss value.

[2003, ch. 439.]

§ 27-305. Penalties.

(a) For violation of § 27-303.- The Commissioner may impose a penalty:

(1) not exceeding \$2,500 for each violation of § 27-303 of this subtitle or a regulation adopted under § 27-303 of this subtitle; and

(2) not exceeding \$125,000 for each violation of § 27-303(9) of this subtitle or a regulation adopted under § 27-303(9) of this subtitle.

(b) For violation of § 27-304.- The penalty for a violation of § 27-304 of this subtitle is as provided in §§ 1-301, 4-113, 4-114, and 27-103 of this article.

(c) Restitution.-

(1) On finding a violation of this subtitle, the Commissioner may require an insurer or nonprofit health service plan to make restitution to each claimant who has suffered actual economic damage because of the violation.

(2) Subject to paragraph (3) of this subsection, restitution may not exceed the amount of actual economic damage sustained, subject to the limits of any applicable policy.

(3) For a violation of § 27-303(9) of this subtitle, the Commissioner may require restitution to an insured for the following:

- (i) actual damages, which actual damages may not exceed the limits of any applicable policy;
- (ii) expenses and litigation costs incurred by the insured in pursuing an administrative complaint under § 27-303(9) of this subtitle, including reasonable attorney's fees; and
- (iii) interest on all actual damages, expenses, and litigation costs incurred by the insured computed:
 - 1. at the rate allowed under § 11-107(a) of the Courts Article; and
 - 2. from the date on which the insured's claim would have been paid if the insurer acted in good faith.
- (4) The amount of attorney's fees recovered from an insurer under paragraph (3) of this subsection may not exceed one-third of the actual damages recovered.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2; 1998, ch. 755; 1999, ch. 71; 2007, ch. 150.]

§ 27-306. Appeals.

An appeal from an order issued by the Commissioner under this subtitle shall be taken in accordance with § 2-215 of this article.

[An. Code 1957, art. 48A, § 230A; 1997, ch. 35, § 2.]

MARYLAND REGULATIONS ON CLAIM SETTLEMENTS

COMAR 31.15.07

.01 Scope.

This chapter is applicable to all property and casualty and title insurers, but does not include reinsurance, workers' compensation, or surety.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Application" means an initial application for the issuance of an insurance policy.

(2) "Claim" means a demand for payment or an inquiry regarding the possibility of payment for a loss incurred under one or more coverages provided by the policy.

(3) "Claimant" means either a first-party claimant or a third-party claimant and may include, in a particular case, the claimant's designated legal representative or a member of the claimant's immediate family designated by the claimant.

(4) "First-party claimant" means any person asserting a right to payment under an insurance policy pursuant to which the person is insured, which right arises out of the occurrence of a contingency or loss covered by the policy.

(5) "Investigation" means all activities of an insurer directly or indirectly related to the determination of the insurer's liabilities under coverages afforded by an insurance policy.

(6) "Licensed producer" means a person issued a license in accordance with the provisions of Insurance Article, Title 10, Subtitle 1, Annotated Code of Maryland.

(7) "Notification of a claim" means notification by a claimant, in writing or by other means acceptable under the terms of the insurance policy, which reasonably apprises the insurer of the facts pertinent to the claim and which is made:

(a) Directly to the insurer in the case of a title insurance policy;

(b) Directly to the Maryland Automobile Insurance Fund in the case of a policy issued by the Fund; or

(c) To an insurer or its producer who has an appointment from that insurer as defined in Insurance Article, §1-101(g), Annotated Code of Maryland, in all other cases.

(8) "Policy" means an individual or group policy, contract, or certificate issued by an insurer.

(9) "Producer" means any person authorized to represent an insurer with respect to a claim, or a licensed producer.

(10) "Proof of loss" means the submission to an insurer of all factual information necessary for an insurer to determine the nature of the loss, the applicable coverage, and the amount due under that applicable coverage.

(11) "Third-party claimant" means any person asserting a claim against a person insured under an insurance policy.

(12) "Unreasonable delay" means, except with respect to claims for personal injury protection benefits made pursuant to Insurance Article, §19-505, Annotated Code of Maryland, the failure to make payment to claimants of amounts properly due them within 15 working days after receipt of a properly completed claim form or other proof of loss unless a longer period of time is provided for in the insurance contract or unless otherwise provided for by law, when there is no significant dispute as to coverage, liability, and amount of damages.

.03 Unfair Claim Settlement Practices.

A. A prohibited unfair claim settlement practice occurs if an insurer commits one or more of the following acts:

(1) Misrepresents pertinent facts or policy provisions relating to the claim at issue. For the purposes of this regulation, misrepresentation includes, but is not limited to, the following acts:

- (a) Providing incomplete or misleading disclosure of pertinent facts or policy provisions relating to the claim at issue;
 - (b) Concealing from a first-party claimant benefits, coverages, or other provisions of a policy when these benefits, coverages, or other provisions are pertinent to the claim at issue;
 - (c) Failing, upon written request, to disclose to a first-party claimant all benefits, coverages, or other provisions of an insurance policy under which a claim is presented;
 - (d) Except when there is a time limit specified in the policy or provided by law, making oral or written statements to any claimant that:
 - (i) There is a requirement that the claimant give written notice of loss or proof of loss within a specified time, and
 - (ii) The company is relieved of its obligations under the policy if the time limit is not complied with;
 - (e) Making oral or written statements to any claimant that there is a requirement that the claimant sign a release that extends beyond the subject matter that gave rise to the claim payment; or
 - (f) Issuing a check or draft in partial settlement of a loss or claim under a specific coverage or coverages, which check or draft contains language releasing the insurer or its insured from their total liability.
- (2) Attempts to settle a claim on the basis of an application which has been altered without notice to, or the knowledge or consent of, the insured. An insurer may not be found to have violated this regulation unless the:
- (a) Insurer knew or had reason to know of the alteration; and
 - (b) Alteration is material to settlement of the claim at issue.
- (3) Refuses to pay a claim for an arbitrary or capricious reason based on all available information.
- (4) Fails to include, in any claim paid to an insured or beneficiary, a statement or other identification setting forth the specific policy coverage under which the payment is made.
- (5) Fails to make a good faith attempt to settle a claim promptly under one portion of a policy, whenever liability is reasonably clear, in order to influence settlements under other portions of the policy.
- (6) Fails to promptly provide a reasonable explanation of the basis for denial of a claim when requested to do so.
- (7) Fails to act in good faith in settling a first party claim under a policy of property and casualty insurance.

B. A prohibited unfair claim settlement practice occurs if an insurer commits one or more of the following acts with such frequency as to indicate a general business practice:

- (1) Misrepresents pertinent facts or policy provisions relating to the coverages at issue. For the purposes of this regulation, misrepresentation includes, but is not limited to, the following acts:
- (a) Providing incomplete or misleading disclosure of pertinent facts or policy provisions related to the coverages at issue;
 - (b) Concealing from a first-party claimant benefits, coverages, or other provisions of a policy when these benefits, coverages, or other provisions are pertinent to the claim at issue;

(c) Failing, upon written request, to disclose to a first-party claimant all benefits, coverages, or other provisions of an insurance policy under which a claim is presented;

(d) Except when there is a time limit specified in the policy or provided by law, making oral or written statements to any claimant that:

(i) There is a requirement that the claimant give written notice of loss or proof of loss within a specified time, and

(ii) The company is relieved of its obligations under the policy if the time limit is not complied with;

(e) Making oral or written statements by any claimant that there is a requirement that the claimant sign a release that extends beyond the subject matter that gave rise to the claim payment; or

(f) Issuing a check or draft in partial settlement of a loss or claim under a specific coverage or coverages, which check or draft contains language releasing the insurer or its insured from total liability.

(2) Fails to include, in claims paid to insureds or beneficiaries, statements or other identification setting forth the specific policy coverage under which the payments are made.

(3) Fails to promptly provide to any claimants reasonable explanations of the basis for denial of claims or the offer of compromise settlements.

(4) Fails to adopt and implement reasonable standards for the prompt investigation of claims arising under policies.

(5) Refuses to pay claims without conducting reasonable investigations based on all available information.

(6) Fails to make good faith attempts to settle claims promptly, fairly, or equitably once liability has become reasonably clear.

(7) Compels insureds to institute litigation to recover amounts due them under policies by offering substantially less than the amounts ultimately recovered in actions brought by the insureds.

(8) Attempts to settle claims on the basis of applications which have been altered without notice to, or the knowledge or consent of, insureds. An insurer may not be found to have violated this regulation unless the:

(a) Insurer knew or had reason to know of the alterations; and

(b) Alterations are material to settlement of the claims at issue.

(9) Fails to make good faith attempts to settle claims promptly under one portion of a policy, whenever liability is reasonably clear, in order to influence settlements under other portions of the policy.

(10) Fails, upon receipt of notification of claims, to acknowledge receipt of the notification within 15 working days, unless payment is made within that period of time.

(11) Fails, upon receipt of inquiries from the Maryland Insurance Administration regarding claims, to furnish the Maryland Insurance Administration with adequate responses to the inquiries within 15 working days or within the time period specified by the Maryland Insurance Administration in correspondence to the insurer, whichever is greater.

(12) Fails to affirm or deny coverage of claims within 15 working days after receiving properly completed claim forms or other proofs of loss, unless the provisions of Regulation .04B of this chapter apply or unless there is a time limit specified in the policy.

(13) Refuses to fully satisfy claims for arbitrary or capricious reasons.

(14) Refuses or unreasonably delays payment to claimants of amounts due them when coverage, liability, and amount of damages are reasonably clear.

(15) Fails to provide appropriate replies to claimants or their representatives within 15 working days of receiving written communications from claimants or their representatives which suggest that a response is expected.

(16) Fails to act in good faith in settling a first party claim under a policy of property and casualty insurance.

C. The provision of any claim forms required by the insurer, instructions, and reasonable assistance, in order that first-party claimants can comply with policy conditions and the insurer's reasonable requirements for filing claims, shall satisfy the requirement that insurers acknowledge receipt of notification of claims within 15 working days.

.04 Standards for Prompt Investigation of Claims.

A. Insurers shall, for at least 3 years, make available for inspection by the Maryland Insurance Administration records of denials of claims and supporting documentation.

B. If an insurer has not completed its investigation of a first party claim within 45 days of notification, the insurer shall promptly notify the first-party claimant, in writing, of the actual reason that additional time is necessary to complete the investigation. Notice shall be sent to the first-party claimant after each additional 45-day period until the insurer either affirms or denies coverage and damages.

C. In any case in which a first-party claimant is neither an attorney nor represented by an attorney, the insurer shall, upon receipt of a written claim, inform that claimant in writing that there may be an applicable statute of limitations which may bar that claimant's rights in the future.

D. An insurer that denies a claim on the grounds of a specific policy provision, condition, or exclusion shall advise the claimant as to the provision, condition, or exclusion on which the denial is based.

E. When there is a reasonable basis, supported by specific information available for review by the Commissioner, that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved of the requirement contained in B and C of this regulation that the insurer state the reason that more time is required.

F. If a claim is denied for reasons other than those described in §D or E of this regulation, an appropriate notation shall be made in the claim file of the insurer.

.05 Time for Filing Claim for Personal Injury Protection Benefits.

Upon receipt of written notice from an insured of the occurrence of an accident, each insurer providing benefits required under Insurance Article, §19-505, Annotated Code of Maryland, shall notify the insured of the latest date on which an original claim for benefits may be

presented to the insurer, as provided in Insurance Article, §19-508(a), Annotated Code of Maryland.

.07 Computation of Time.

If an insurer requires additional information in order to properly consider a claim, the number of days which elapse between the date the insurer requests additional information and the date the insurer receives a response to the request may not be counted whenever these regulations require action by an insurer within a stated period of time.

.08 Claims Registers.

A. Each insurer shall maintain claims registers separately for:

- (1) Private passenger automobile insurance;
- (2) All other liability insurance;
- (3) Homeowner's insurance;
- (4) All other property insurance; and
- (5) Title insurance.

B. Claims registers may be maintained manually or on computer-generated tapes from which hard copy can be supplied.

C. Claims registers shall list chronologically, by date of report, each claim received, if a Maryland-domiciled insurer, and each claim received from a Maryland resident, if a foreign insurer doing business in Maryland, showing the:

- (1) Date of loss;
- (2) Policy or contract number;
- (3) Name of the insured; and
- (4) General nature of the claim.

D. Claims registers shall be available for inspection by the Insurance Commissioner or by persons designated by the Commissioner for a period of at least 3 years following the date of the filing of the claim.

E. Insurers shall have 6 months from the effective date of this chapter to establish the claims registers required by this regulation.

.09 General Business Practices.

A. The methodology of §B of this regulation shall be used to determine whether an insurer has engaged in unfair claim settlement practices with such frequency as to constitute a general

business practice within the meaning of Insurance Article, §27-304, Annotated Code of Maryland.

B. It shall be considered prima facie evidence of a general business practice of committing unfair claim settlement practices if, in any 12-month period, it is found that the number of unfair claim settlement practices with respect to claims handling by foreign insurers of claims of Maryland residents, or by domestic insurers of all claims of the insurer, equals or exceeds the following, if the total number of claims during any 12-month period is:

(1) Less than 10,000, three claims with the same unfair claim settlement practice out of a random sampling of 50 claims; or

(2) Ten thousand or more, six claims with the same unfair claim settlement practice out of a random sampling of 100 claims.

C. An insurer may overcome the presumption that a general business practice violation has occurred by presenting evidence to the Commissioner relating to the harm to claimants caused by the violation, the nature of the violation, the insurer's intent, and other relevant factors.

.10 Penalties.

Penalties for violations of these regulations shall be assessed in accordance with Insurance Article, §§4-113, 27-301, 27-305, and 27-306, Annotated Code of Maryland.

Administrative History

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Regulation .02B amended effective January 14, 2010 (37:1 Md. R. 17)

Regulation .03A, B amended effective January 26, 2009 (36:2 Md. R. 103)

Regulation .10 amended effective January 14, 2010 (37:1 Md. R. 17)

OTHER MARYLAND LAWS ON HOMEOWNER'S INSURANCE

§19–201.

(a) In this subtitle the following words have the meanings indicated.

(b) “Additional optional coverage” means a coverage or service that covers the structures, contents, property, or activities on property that is available for purchase in connection with a standard homeowner’s insurance policy.

(c) “Insurer” means an insurer that issues or delivers a policy of homeowner’s insurance in the State.

§ 19-202. Coverage for water damage.

(a) In general.- An insurer that issues, sells, or delivers a homeowner's insurance policy shall at time of application and renewal offer in writing to provide coverage for loss that:

- (1) is caused by or results from water that backs up through sewers or drains; and
- (2) is not caused by the negligence of the insured.

(b) Telephone renewals.- If an application or renewal is made by telephone, the insurer is deemed to be in compliance with subsection (a) of this section if, within 7 calendar days after the date of application or renewal, the insurer sends by certificate of mailing the offer to the applicant or insured.

(c) Internet renewals.- If an application or renewal is made using the Internet, the insurer is deemed to be in compliance with subsection (a) of this section if the insurer provides the offer to the applicant or insured prior to submission of the application or renewal.

[An. Code 1957, art. 48A, § 4781/2; 1996, ch. 11; 2006, ch. 388, § 1; 2008, ch. 72.]

§ 19-203. Liability coverage for family day care providers.

An insurer that issues or delivers a policy or contract of homeowner's liability insurance in the State shall offer to provide to a policyholder, who is registered as a family day care provider under Title 5, Subtitle 5, Part V of the Family Law Article, coverage of at least \$300,000 for liability that results from bodily injury, property damage, or personal injury arising out of an insured's activities as a family day care provider.

[An. Code 1957, art. 48A, § 481D; 1996, ch. 11; 2006, ch. 388, § 1.]

§ 19-204. Provisions for payment of medical expenses.

A policy or contract of homeowner's liability insurance that contains a representation that the insurer will pay all reasonable medical expenses incurred for bodily injury caused by an accident to an individual covered by the policy or contract may not be issued unless the policy or contract also provides that the insurer will pay all medical expenses incurred within 3 years after the date of the accident.

[An. Code 1957, art. 48A, § 4811/2; 1996, ch. 11; 2006, ch. 388, § 1.]

§19-205.

(a) (1) An insurer shall provide a policyholder with an annual statement that summarizes the coverages and exclusions under the policy issued by the insurer.

(2) The insurer's statement shall be clear and specific.

(3) The insurer's statement shall state whether the coverages under the policy provide for replacement cost, actual cash value, or other method of loss payment for covered structures and contents.

(4) The insurer's statement shall include a disclosure that states:

(i) the policyholder should read the policy for complete information on coverages and exclusions;

(ii) the policyholder should refer to the declarations page for a listing of coverages purchased;

(iii) the policyholder should communicate with the insurance producer or the insurer for any additional information regarding the scope of coverages in the policy;

(iv) the statement does not include additional optional coverage purchased by the policyholder, if any;

(v) the statement is not part of the policy or contract of insurance and does not create a private right of action;

(vi) all rights, duties, and obligations are controlled by the policy and contract of insurance; and

(vii) the standard homeowner's insurance policy does not cover losses from flood.

(b) The statement under subsection (a) of this section:

(1) is not part of the policy or contract of insurance; and

(2) does not create a private right of action.

(c) The Commissioner may adopt regulations to implement the provisions of this section.

§19–206.

(a) (1) An insurer that sells or negotiates homeowner's insurance in the State shall provide an applicant, at the time a policy of homeowner's insurance is initially purchased, with a written notice that states that a standard homeowner's insurance policy does not cover losses from flood.

(2) If an application is made by telephone, the insurer is deemed to be in compliance with this section if, within 7 calendar days after the date of application, the insurer sends by certificate of mailing the notice to the applicant or insured.

(3) If an application is made using the Internet, the insurer is deemed to be in compliance with this section if the insurer provides the notice to the applicant prior to the submission of the application.

(b) The notice shall:

(1) state that flood insurance may be available through the National Flood Insurance Program or other sources;

(2) provide the applicant with the contact information for the National Flood Insurance Program;

(3) advise the applicant to confirm the need for flood insurance with the National Flood Insurance Program or the applicant's mortgage lender;

(4) advise the applicant to contact the National Flood Insurance Program, the applicant's insurer, or the applicant's insurance producer for information about flood insurance;

(5) advise the applicant that flood insurance may be available for covered structures and their contents;

(6) advise the applicant that a claim under a flood insurance policy may be adjusted and paid on a different basis than a claim under a homeowner's insurance policy; and

(7) advise the applicant that a separate application must be completed to purchase flood insurance.

(c) A notice required to be sent by certificate of mailing under this section may be sent with the statement required under § 19–207 of this article.

(d) A notice provided under this section does not create a private right of action.

§19–207.

(a) (1) An insurer that sells or negotiates homeowner's insurance in the State shall provide an applicant, at the time of application for homeowner's insurance, with a written statement that lists all additional optional coverage available from the insurer to the applicant.

(2) If an application is made by telephone, the insurer is deemed to be in

compliance with this section if, within 7 calendar days after the date of application, the insurer sends by certificate of mailing the statement to the applicant or insured.

(3) If an application is made using the Internet, the insurer is deemed to be in compliance with this section if the insurer provides the statement to the applicant prior to submission of the application.

(b) The statement shall:

(1) be on a separate form;

(2) be titled, in at least 12 point type, "Additional Optional Coverage Not Included in the Standard Homeowner's Insurance Policy";

(3) contain the following disclosure in at least 10 point type:

"Your standard homeowner's insurance policy does not cover all risks. You may need to obtain additional insurance to cover loss or damage to your home, property, and the contents of your home or to cover risks related to business or personal activities on your property.

This statement provides a list of the types of additional insurance coverage that are available. Contact your insurance company, insurance producer, or insurance agent to discuss these additional coverages.";

(4) contain a list of additional optional coverage.

(c) A statement required to be sent by certificate of mailing under this section may be sent with the notice required under § 19-206 of this article.

(d) A statement provided under this section does not create a private right of action.

§ 19-208. Coverage for additional living expenses.

(a) In general.- A policy of homeowner's, fire, farmowner's, or dwelling insurance that provides coverage for additional living expenses incurred by an insured as a result of a covered loss may not be issued, sold, or delivered in the State if the policy contains language that limits coverage for additional living expenses to a period of time that is less than 12 months.

(b) Unenforceable provisions.- A clause in a policy of homeowner's, fire, farmowner's, or dwelling insurance that purports to limit coverage for additional living expenses incurred by an insured as a result of a covered loss to a period of time that is less than 12 months is void and unenforceable.

(c) Optional additional requirements by Commissioner.- Notwithstanding subsection (a) of this section, the Commissioner may require an insurer to provide coverage for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance for up to 24 months if the Commissioner finds that covered property remains uninhabitable due to delays in repair or replacement caused:

(1) by the insurer; or

(2) by factors beyond the control of the insured.

(d) Construction.- Nothing in this section shall be construed to:

(1) prohibit or prevent the enforcement of a monetary limit of liability for additional living expenses under a policy of homeowner's, fire, farmowner's, or dwelling insurance;

(2) prohibit an insurer from denying coverage for additional living expenses if the carrier determines that at the time the additional living expenses were incurred the covered property was not unfit to live in; or

(3) prohibit an insurer from denying coverage for additional living expenses on the grounds that the covered property was unfit to live in at the time that the additional living expenses were incurred because of delays in repair or replacement caused by the insured.

[2008, ch. 95.]

§19-210.

(a) An insurer shall offer at least one actuarially justified premium discount on a policy of homeowner's insurance to a policyholder who submits proof of improvements made to the insured premises as a means of mitigating loss from a hurricane or other storm.

(b) Means of mitigating loss include:

(1) the installation of one or more of the following:

(i) hurricane shutters;

(ii) secondary water barrier;

(iii) reinforced roof coverings;

(iv) braced gable ends;

(v) reinforced roof to wall connections;

(vi) tie downs; and

(vii) reinforced opening protections;

(2) repair or replacement of:

(i) exterior doors, including garage doors;

(ii) hurricane resistant trusses, studs, and other structural components; and

(iii) repair or replacement of manufactured home piers, anchors, and tie down straps; and

(3) any mitigation effort that materially mitigates loss from a hurricane or other storm otherwise covered under the policy.

(c) Improvements made to the insured premises under this section shall be inspected by a contractor licensed by the Department of Labor, Licensing, and Regulation.

(d) (1) An insurer shall be allowed to inspect the improvements that are the

basis of a premium discount under this section.

(2) (i) Verification of improvements that are the basis of a premium discount under this section rests with the insurer.

(ii) An insurer may accept an inspection certificate issued by a governmental agency as verification of improvements that are the basis of a premium discount under this section.

(e) A premium discount offered under this section shall:

(1) comply with the provisions of Title 11 of this article; and

(2) only be offered for improvements identified by the Commissioner as qualified mitigation actions made to the insured premises that may materially mitigate loss from a hurricane or other storm otherwise covered under the policy.

(f) (1) An insurer that offers a premium discount under this section shall provide a policyholder with an annual statement regarding the availability of the discount and the method of applying for the discount.

(2) The notice required under paragraph (1) of this subsection may be sent with the statement required under § 19–205 of this subtitle.

(g) The Commissioner may adopt regulations to implement the provisions of this section.