Commonwealth of Puerto Rico
OFFICE OF THE COMMISIONER OF INSURANCE
P.O. Box 3593 Old San Juan Station
San Juan, Puerto Rico 00904

NO. 2080
DATE APRIL 6, 1976 2:00 PM
APPROVED JUAN A ALBORS

Secretary of State
BY: *Lourdes I Pierluisi*
Assistant Secretary of State

AMENDMENTS TO THE REGULATIONS OF THE INSURANCE CODE

SECTION 1. The insurance industry and the public at large are hereby notified of the approval of Rule 47 of the Regulations of the Puerto Rico Insurance Code, which is adopted by virtue of the provisions of Section 2.040 of Public Law No. 77, enacted on June 19, 1957, as amended, known as the Puerto Rico Insurance Code, which shall apply to unfair practices in the adjustment of claims, and which will read as follows:

RULE 47

UNFAIR PRACTICES IN THE ADJUSTMENT OF CLAIMS

AUTHORITY: Section 27.161

Section 27.161 of the Insurance Code prohibits authorized insurers to incur in unfair practices in the adjustment of claims. Sanctions may not necessarily be applied for an isolated act, however if any insurer carries out an act or practice prohibited by such section with such frequency that it may be deemed that it is a general business practice, such acts will constitute an unfair practice and fraud in the insurance business.

Section 1. This rule defines the minimum conditions that would constitute an unfair practice in the adjustment of claims, if such are violated frequently enough to be considered a general practice. This regulation does not preclude that other acts not specified herein be deemed a violation to Section 27.161 of the Code.

Section 2. Definitions

The terms used in this rule shall be defined as follows:

(a) Agent – means any person, company, association, or corporation that has been issued a license pursuant to the Insurance Code and that has been authorized to act as a representative of the insurer. With respect to group life, accident, and health insurance, a policyholder shall be deemed an agent of the insurer, within the authority granted by such insurer.

(b) Insured/Claimant – means any person, company, association, or corporation that, under the policy's terms, allegedly has the right to claim payment.

(c) Third-party claimant – means any person, company, association, or corporation that allegedly has cause for action against any person insured under a policy issued by an insurer.

(d) Investigation – means the procedure established by an insurer to determine if a claim is approved or denied.

(e) Notice of claim – means any notice, in writing or any other form, made by claimant to an insurer or its agent in which the relevant facts of the claim are addressed and the right to payment is maintained.

Section 3. Scope

This regulation shall apply to all authorized insurers in Puerto Rico.

(a) This regulation shall not apply to credit, title, worker's compensation, marine, and inland marine insurance.

(b) Paragraphs (a) and (b) of Section 7 of this Rule shall not apply to life, accident, and health insurance.

(c) Section 5 and 6, and paragraph (c) of Section 7

of this rule shall not apply to accident and health insurance in which claimant is not the policyholder, a certificate holder under a group policy, or a relative or a family member of the head of household who is the holder of such policy or certificate.

(d) Paragraph (b) of Section 4, as well as Section 5 shall not apply to insurance policies in which a claimant is represented by a public adjuster.

Section 4. Misrepresentation of Policy Terms

(a) No insurer may deny a claim based on a specific provision, condition, or exclusion of a policy unless said insurer clearly refers to such provision, condition, or exclusion in writing. Any other means of notification may be used provided it is duly noted in the claim file maintained by the insurer.

(b) Any communication related to the payment, settlement, or offer of settlement of benefits to an insured/claimant which does not include all of the amounts that shall be included in accordance with the claim filed by the insured/claimant, that is within the limits of the policy, and investigated by the insurer, may be deemed as a misrepresentation of the policy terms.

Section 5. Failure to Acknowledge Receipt

(a) Any insurer, after receiving a notice of claim, shall acknowledge receipt of such in writing within the next fifteen business days. The notice made to the insurer's agent shall be regarded as made to the insurer itself, provided the insurer authorized such agent to receive notice of claims. If the notice is made to an insurer's agent and such agent is not authorized to receive such notices, the agent has the obligation to notifying such to the claimant, as well as indicating the name and address of the person to whom the notification shall be sent within the next seven (7) days.

(b) Any communication received must be answered within fifteen days.

(c) With regards to a claim, any request made by the Office of the Commissioner must be answered within fifteen days.

Section 6. Reasonable Methods Used in the Investigation of Claims

An insurer shall establish a procedure that allows such insurer to initiate within fifteen business days the investigation of any claim that has been notified either by an insurer, a third-party claimant, or the authorized representative of such. Within fifteen days of receiving the notice of claim, the insurer shall mail a written notification to claimant in with each of the items, statements, and forms that the insurer reasonably deems will be required during such claim are specified. If based on the information the insurer has at hand, such insurer does not know which the requirements are, and then the notice must be made within a reasonable period of time.

Section 7. Methods Used to Arrive at a Quick and Fair Adjustment

(a) In any case in which there is no controversy with regard to coverage, it is the insurer's responsibility to offer claimant such amounts that are fair and reasonable within the limits of the policy, and that, in addition, in the investigation carried out by the insurer, the amounts claimed are shown to be fair and reasonable.

(a) In the case of an insured/claimant, when a policy provides for an adjustment and settlement of a loss of use of a motor vehicle based on the real market value or the replacement of the motor vehicle for another of the same class and of the same quality, at least, one of the following methods may be used:

(1) The insurer may choose to make a settlement in cash, which will be based on the real sale price of a vehicle of the same class and quality in the local market. Any divergence from such shall be supported by documentary evidence in which the motor vehicle's condition is

described in detail. Any reduction of such cost shall be described in detail in each item, indicating the amount involved.

(2) The insurer may decide to offer to replace the vehicle. Replacement of the vehicle is defined as a similar vehicle supplied and paid by the insurer at no additional cost to the insured, with the exception of the deductible amount. It is also provided that if the replacement vehicle has additional equipment that was not included in the vehicle that was declared a total loss, the claimant and the insurer may agree upon an additional cost for the corresponding additional equipment. In the event that the claimant chooses cash payment instead of a replacement, the insurer is required to issue a payment for the amount that would be paid for the replacement of the vehicle through other means, including taxes.

Before offering this settlement method, the insurer must have first offered to replace the vehicle of the insured/claimant, who in turn must have refused the offer. Both the offer and refusal must be included in the claim file maintained by the insurer.

(b) Within fifteen days of receiving the duly completed statement of loss, the insurer shall notify the insured/claimant or third-party claimant in writing of the approval or denial of the claim. If the insurer needs additional time to determine if the claim should be approved or denied, then the insurer must notify claimant of such within fifteen days of receiving the statement of loss.

If within 90 days from the date the insurer requests additional time for the investigation, the claim has not yet been adjusted, the insurer must notify the claimant or its representative in writing explaining the reasons additional time is needed to carry out the investigation. The claimant must be notified if the claim is fully or partially approved.

(c) Whenever there is no controversy over one or more aspects of the claim, the corresponding payment must be issued regardless if there is

controversy with other aspects of the claim, as long as such payment may be issued without prejudice to both parties.

(d) The insurer must pay the settlement amount agreed on a total or partial approval of a claim or an authorized repair within ten business days of receiving the acceptance of the settlement or as of the date the claim must comply with any condition established in such agreement, whichever occurs last.

(e) The following acts are deemed unfair acts or practices, as listed in Section 27.161 of the Code.

(1) Ceasing to provide claimants with claim forms, appropriate guidance, and assistance.

(2) Except as otherwise provided in the policy, not providing an insured with a service on the basis that another person or insurer may assume the payment responsibility.

(3) Making statements in writing or any other form informing claimant that claimant's rights shall be affected if claimant does not file evidence of vehicle loss, a description of the accident, a release, or the torts claim within a determined period of time.

(4) Making statements in writing or any other form requiring an insured to provide a written notification of loss within a specific period of time or, if such period of time is not complied with, the company would be released from its contractual obligation under the policy.

(5) Requiring that the insured/claimant sign a release agreement that could be interpreted as releasing the insurer from such contractual obligations that are not the object of the settlement.

(6) Requiring that the claimant accept a replacement vehicle.

(7) Requiring that the third-party claimant, as defined in Section 2 of this Rule, travel an unreasonable distance to inspect a replacement vehicle, to obtain a quotation for the repair, or that the vehicle be repaired in a particular place.

Section 2. This rule will be effective five days from publication of a notice of approval in a newspaper of general circulation, once a week for two consecutive weeks.

August 12, 1975

Signed
MANUEL JUARBE
Commissioner of Insurance