33-38-1.

The purpose of this chapter is to protect policy owners, insureds, beneficiaries, annuitants, payees, and assignees of life insurance policies, health insurance policies, annuity contracts, and supplemental contracts, subject to certain limitations, against failure in the performance of contractual obligations due to the impairment or insolvency of the insurer issuing such policies or contracts. To provide this protection, (1) an association of insurers is created to enable the guaranty of payment of benefits and continuation of coverages, (2) members of the association are subject to assessment to provide funds to carry out the purpose of this chapter, and (3) the association is authorized to assist the Commissioner, in the prescribed manner, in the detection and prevention of insurer impairments or insolvencies.

33-38-2.

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for direct, nongroup life, health, annuity, and supplemental policies or contracts, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement agreements, lottery contracts, and any immediate or deferred annuity contracts.

(b) Coverage under this chapter shall be provided only:

(1) To persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees, or payees of the persons covered under paragraph (2) of this subsection; and

(2) To persons who are owners of or certificate holders under such policies or contracts or, in the case of unallocated annuity contracts, to the persons who are the contract holders and who:

(A) Are residents; or

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

(i) The insurers which issued such policies or contracts are domiciled in this state;

(ii) Such insurers never held a license or certificate of authority in the states in which such persons reside;

(iii) Such states have associations similar to the association created by this article; and

(iv) Such persons are not eligible for coverage by such associations.

(c) This chapter shall not apply to:

(1) That portion or part of a variable life insurance or variable annuity contract not guaranteed by an insurer;

(2) That portion or part of any policy or contract under which the risk is borne by the policyholder;

(3) Any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, other than reinsurance for which assumption certificates

have been issued;
(4) Any policy, contract, certificate, or subscriber agreement issued by a nonprofit hospital service corporation referred to in Chapter 19 of this title, a health care plan referred to in Chapter 20 of this title, a nonprofit medical service corporation referred to in Chapter 18 of this title, a prepaid legal services plan, as defined in Code Section 33-35-2, and a health maintenance organization, as defined in Code Section 33-21-1;
(5) Any policy, contract, or certificate issued by a fraternal benefit society, as defined in Code Section 33-15-1;
(6) Accident and sickness insurance as defined in Code Section 33-7-2 when written by a property and casualty insurer as part of an automobile insurance contract;
(7) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation; or
(8) Any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or association of natural persons benefit plan.

33-38-3.
This chapter shall be liberally construed to effect the purpose set forth in Code Section 33-38-1, which Code section shall constitute an aid and guide to interpretation.

33-38-4.
As used in this chapter, the term:
(1) 'Account' means any of the two accounts created under Code Section 33-38-5.
(2) 'Affiliate' means any person that directly, or indirectly through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.
(3) 'Association' means the Georgia Life and Health Insurance Guaranty Association created under Code Section 33-38-5.
(4) 'Contractual obligation' means any obligation under covered policies or contracts. Notwithstanding any other provision of this chapter, 'contractual obligation' shall not include a claim filed after the final date set by the court for the filing of claims against the liquidator or other such court appointed authority.
(5) 'Control' or 'controlled' means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise.
(6) 'Covered policy' means any policy or contract within the scope of this chapter under Code Section 33-38-2.
(7) 'Health insurance' means accident and sickness insurance, as that class of insurance is defined in Code Section 33-7-2.
(8) 'Impaired insurer' means a member insurer deemed by the Commissioner on or after July 1, 1981, to be potentially unable to fulfill its contractual obligations but not an insolvent insurer.

(9) 'Insolvent insurer' means a member insurer against which a final order of liquidation containing a finding of insolvency has been entered by a court of competent jurisdiction on or after July 1, 1981.

(10) 'Member insurer' means any insurer which is licensed or which holds a certificate of authority to transact in this state any kind of insurance for which coverage is provided under Code Section 33-38-2 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:

(A) A nonprofit hospital or medical service corporation;

(B) A health care corporation;

(C) A health maintenance organization;

(D) A fraternal benefit society;

(E) A mandatory state pooling plan;

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

(G) An insurance exchange; or

(H) Any entity similar to those described in subparagraphs (A) through (G) of this paragraph.

(11) 'Person' means any individual, corporation, partnership, association, or voluntary organization.

(12) 'Premiums' means direct gross insurance premiums and annuity considerations received on covered policies, less return premiums and considerations thereon and dividends paid or credited to policyholders on such direct business. The term 'premiums' does not include premiums and considerations on contracts between insurers and reinsurers. The term 'premiums' does not include any premiums in excess of $5 million on any unallocated annuity contract.

(13) 'Resident' means any person who is domiciled in this state at the time a member insurer is determined to be an impaired or insolvent insurer and to whom contractual obligations are owed. 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.

33-38-5.

(a) There is created a nonprofit, unincorporated association to be known as the Georgia Life and Health Insurance Guaranty Association. All member insurers shall be and remain 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 Code Section 33-38-8 and shall exercise its powers through a board of directors established under Code Section 33-38-6.

(b) The association shall come under the immediate supervision of the Commissioner and shall be subject to the applicable provisions of the insurance laws of this state.

(c) For purposes of administration and assessment, the association shall maintain two accounts: (1) the health insurance account; and (2) the life insurance and annuity account. The life insurance and annuity account shall contain three subaccounts: (A) the life insurance account; (B) the annuity account; and (C) the unallocated annuity account which

shall include contracts qualified under Section 403(b) of the United States Internal Revenue Code.

(d) For purposes of assessment, supplementary contracts shall be covered under the account in which the basic policy is covered.

33-38-6.

(a) The board of directors of the association shall consist of seven members and shall at all times contain at least one member from a domestic insurer. The members, who shall not be considered employees of the Insurance Department, shall be appointed as follows:

(1) The Commissioner shall compile a list of the two stock insurers most likely to incur the largest assessment, per insurer, for each of the accounts under Code Section 33-38-5; he shall compile a list of the two nonstock insurers most likely to incur the largest assessment, per insurer, for each of the accounts under Code Section 33-38-5; and he shall compile a list of the two domestic insurers, either stock or nonstock, most likely to incur the largest assessment, for each of the accounts listed under Code Section 33-38-5. The Commissioner shall solicit from these 18 insurers the names of 18 individuals as nominees for members to the board of directors. The Commissioner shall thereupon separately certify in writing the nominations from stock and nonstock insurers and separately for each account;

(2) From the nominations so certified for each such account, the Commissioner shall appoint one stock member and one nonstock member to the board of directors until six directors have been appointed. Then the Commissioner shall appoint from the remaining nominations the chairman of the board who shall also be its chief executive; and

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

(b) Any member may be removed from office by the Commissioner when, in his judgment, the public interest may so require.

(c) Each member so appointed shall serve for a term of three years and until his successor has been appointed and qualified.

(d) If there occurs, for any reason, a vacancy in the board of directors, the Commissioner shall appoint a member to fill the unexpired term of office from the nominations as heretofore described.

(e) Members of the board may be reimbursed from the assets of the association for reasonable expenses incurred by them in their capacity as members of the board of directors, but members of the board shall not otherwise be compensated by the association for their services.

33-38-7.

In addition to the powers and duties enumerated elsewhere in this chapter, the association shall have the following powers and duties:

(1) Whenever a domestic insurer is an impaired insurer, the association, subject to any conditions, other than those conditions which impair the contractual obligations of the impaired insurer, imposed by the association and approved by the impaired insurer and

the Commissioner, may:

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

(B) Provide such moneys, pledges, notes, guarantees, or other means as are proper to effectuate subparagraph (A) of this paragraph and assure payment of the contractual obligations of the impaired insurer pending action under subparagraph (A) of this paragraph; and

(C) Loan money to the impaired insurer;

(2) Whenever a domestic insurer is an insolvent insurer, the association shall, subject to the approval of the Commissioner:

(A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of the insolvent insurer;

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

(C) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties;

(3) Whenever a foreign or alien insurer is an insolvent insurer, the association shall, subject to the approval of the Commissioner:

(A) Guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the covered policies of residents;

(B) Assure payment of the contractual obligations of the insolvent insurer to residents; and

(C) Provide such moneys, pledges, notes, guarantees, or other means as are reasonably necessary to discharge such duties.

This paragraph shall not apply where the Commissioner has determined that the foreign or alien insurer´s domiciliary jurisdiction or state of entry provides protection by statute substantially similar to that provided by this chapter for residents of this state;

(4)(A) In carrying out its duties under paragraphs (2) and (3) of this Code section, the association may impose permanent policy liens or contract liens in connection with any guarantee, assumption, or reinsurance agreement if the court:

(i) Finds that the amounts which can be assessed under this chapter are less than the amounts needed to assure full and prompt performance of the insolvent insurer´s contractual obligations or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of policy or contract liens to be in the public interest; and

(ii) Approves the specific policy liens or contract liens to be used.

(B) Before being obligated under paragraphs (2) and (3) of this Code section, the association may request that there be imposed temporary moratoriums or liens on payments of cash values and policy loans in addition to any contractual provisions for deferral of such cash value payments or policy loans. Such temporary moratoriums and liens may be imposed if they are approved by a court of competent jurisdiction;

(5) If the association fails to act within a reasonable period of time, as provided in paragraphs (2) and (3) of this Code section, the Commissioner shall have the powers and duties of the association under this chapter with respect to insolvent insurers;

(6) Upon his request, the association may render assistance and advice to the Commissioner concerning rehabilitation, payment of claims, continuance of coverage, or the performance of other contractual obligations of any impaired or insolvent insurer;
(7) The association shall have standing to appear before any court in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this chapter. Such standing shall extend to all matters germane to the powers and duties of the association, including but not limited to proposals for reinsuring or guaranteeing the covered policies of the impaired or insolvent insurer and the determination of the covered policies and contractual obligations;

(8)(A) Any person receiving benefits under this chapter shall be deemed to have assigned the rights under the covered policy to the association to the extent of the benefits received because of this chapter, whether the benefits are payments of contractual obligations or continuation of coverage. The association may require an assignment to it of such rights by any payee, policy or contract owner, beneficiary, insured, or annuitant as a condition precedent to the receipt of any rights or benefits conferred by this chapter upon such person. The association shall be subrogated to these rights against the assets of any insolvent insurer.

(B) The subrogation rights of the association under this paragraph shall have the same priority against the assets of the insolvent insurer as that possessed by the person entitled to receive benefits under this chapter;

(9) The contractual obligations of the insolvent insurer for which the association becomes or may become liable shall be as great as, but no greater than, the contractual obligations of the insolvent insurer would have been in the absence of an insolvency, unless such obligations are reduced as permitted by paragraph (4) of this Code section. With respect to any one contract holder covered by an unallocated annuity contract, the association shall be liable for not more than $5 million in benefits irrespective of the number of such contracts held by that contract holder. With respect to any other covered policy, the aggregate liability of the association on any one life shall not exceed $100,000.00 with respect to the payment of cash values or $300,000.00 for all benefits including cash values; provided, however, that with respect to claims under policies written to provide benefits as required under Chapter 9 of Title 34, relating to workers´ compensation, such claims shall be in the full amount as provided by such chapter; and
(10) The association may:

(A) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this chapter;

(B) Bring or defend actions, including taking any legal actions necessary or proper for recovery of any unpaid assessments under Code Section 33-38-15;

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

(D) Employ or retain such persons as are necessary to handle the financial transactions of the association and to perform such other functions as become necessary or proper under this chapter;

(E) Negotiate and contract with any liquidator, rehabilitator, conservator, or ancillary receiver to carry out the powers and duties of the association;

(F) Take such legal action as may be necessary to avoid payment of improper claims; and

(G) Exercise, for the purposes of this chapter and to the extent approved by the Commissioner, the powers of a domestic life or health insurer; but in no case may the association issue insurance policies or annuity contracts other than those necessary to perform the contractual obligations of the impaired or insolvent insurer.

33-38-8.

(a) The association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner. If the association fails to submit a suitable plan of operation within 180 days following July 1, 1981, or, if at any time thereafter the association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the association and approved in writing by the Commissioner.

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

(c) The plan of operation shall, in addition to requirements enumerated elsewhere in this chapter:

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

(2) Establish the amount and method of reimbursing members of the board of directors under Code Section 33-38-6;

(3) Establish regular places and times for meetings of the board of directors;

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

(5) Establish any additional procedures for assessments under Code Section 33-38-15; and

(6) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

33-38-9.

The plan of operation described in Code Section 33-38-8 may provide that any or all powers and duties of the association, except those under subparagraph (C) of paragraph (10) of Code Section 33-38-7 and Code Section 33-38-15, shall be delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association or its equivalent in two or more states. Such a 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 Code section 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 not substantially less favorable and effective than that provided for by this chapter.

33-38-10.

In addition to the duties and powers enumerated elsewhere in this chapter:

(1) The Commissioner shall:

(A) Upon request of the board of directors, provide the association with a statement of the premiums in the appropriate states for each member insurer; and

(B) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good 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 comply promptly with such demand shall not excuse the association from the performance of its powers and duties under this chapter; and

(2) 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.

33-38-11.

Records shall be kept of all negotiations and meetings in which the association or its representatives are involved to discuss the activities of the association in carrying out its powers and duties under Code Section 33-38-7. Records of such negotiations or meetings shall be made public only upon the termination of a liquidation, rehabilitation, or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the impairment or insolvency of the insurer, or upon the order of a court of competent jurisdiction. Nothing in this Code section shall limit the duty of the association to render a report of its activities under Code Section 33-38-12.

33-38-12.

The association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit to the Commissioner not later than May 1 of each year a financial report and a report of its activities for the preceding calendar year on forms approved by the Commissioner.

33-38-13.

The association shall be exempt from all taxation in this state based upon income or gross receipts and shall likewise be exempt from all state and local occupation license and business fees and occupation license and business taxes.

33-38-14.

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 taken by them in the performance of their powers and duties under this chapter.

33-38-15.

(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 the health account and for each subaccount of the life insurance and annuity account at such time and for such amounts as the board finds necessary. Assessment shall be due not less than 30 days after prior written notice to the member insurers.

(b) There shall be two classes of assessments, as follows:

(1) Class A assessments shall be made for the purpose of meeting administrative costs and other general expenses not related to a particular impaired or insolvent insurer, and examinations conducted under the authority of subsection (c) of Code Section 33-38-16; and

(2) Class B assessments shall be made to the extent necessary to carry out the powers and duties of the association under Code Section 33-38-7 with regard to an impaired or insolvent insurer.

(c)(1) The amount of any Class A assessment shall be determined by the board of directors and may be made on a pro rata or non-pro rata basis. If a Class A assessment is made on a pro rata basis, the board may provide that it be credited against future Class B assessments. An assessment for costs and expenses other than for examinations which is made on a non-pro rata basis shall not exceed $150.00 per company in any one calendar year. The amount of any Class B assessment shall be allocated for assessment purposes among the accounts or subaccounts in subsection (c) of Code Section 33-38-5 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 being fair and reasonable under the circumstances.

(2) Class B assessments against member insurers for each account or subaccount 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 or subaccount for the three most recent calendar years for which information is available preceding the year in which the insurer became impaired or insolvent, as the case may be, bears to such premiums received on business in this state for such calendar years by all assessed member insurers.

(3) 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 chapter. Classification of assessments under subsection (b) of this Code section and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible.

(d) The association may abate or defer in whole or in part the assessment of a member insurer if, in the opinion of the board of directors, 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 such 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 Code section.

(e)(1) The total of all assessments upon a member insurer for each account shall not in any one calendar year exceed 2 percent of such insurer´s premiums received in this state on the policies covered by the account during the calendar year preceding the assessment. If the maximum assessment in any account, together with the other assets of the association, does not provide in any one year in such 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 chapter.

(2) The total of all assessments upon a member insurer for each subaccount of the life insurance and annuity account shall not in any one calendar year exceed 2 percent of such insurer´s premiums received in this state on the policies covered by the subaccount during the calendar year preceding the assessment. If the maximum assessment for any subaccount of the life insurance and annuity account in any one year does not provide an amount sufficient to carry out the responsibilities of the association, then the board shall assess the other subaccounts of the life insurance and annuity account for the necessary additional amount up to the maximum assessment level provided in paragraph (1) of this subsection.

(f) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each insurer to that account or subaccount, the amount by which the assets of the account or subaccount exceed the amount the board finds is necessary to carry out the obligations of the association during the coming year with regard to that account or subaccount, including assets accruing from net realized gains and income from investments. A reasonable amount may be retained in any account or subaccount to provide funds for the continuing expenses of the association and for future losses if the board determines that refunds are impractical.

(g) It shall be proper for any member insurer in determining its premium rates and policy owner dividends as to any kind of insurance within the scope of this chapter to consider the amount reasonably necessary to meet its assessment obligations under this chapter.

(h) The association shall issue to each insurer paying an assessment under this chapter, 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 such form, for such an amount and for such period of time, not to exceed five years from the date of assessment, as the Commissioner may approve.

33-38-16.

(a) The board of directors may, upon 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 to the solvency of any company seeking to do

an insurance business in this state. Such reports and recommendations shall not be considered public documents.
(b) It shall be the duty of the board of directors, upon majority vote, to notify the Commissioner of any information indicating any member insurer may be an impaired or insolvent insurer.
(c) The board of directors may, upon 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 30 days of the receipt of such request, the Commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners´ examination or may be conducted by such persons as the Commissioner designates. The cost of such examination shall be paid by the association and the examination report shall be treated the same as other examination reports. In no event shall such 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 Code 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.
(d) The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.
(e) 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 such information as it may have in its possession bearing on the history and causes of such insolvency. The board shall cooperate with the board of directors of guaranty associations 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 such other associations.

33-38-17.
(a) For the purpose of carrying out its obligations under this chapter, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of the assets attributable to covered policies, reduced by any amounts to which the association is entitled as subrogee pursuant to paragraph (8) of Code Section 33-38-7. All assets of the impaired or insolvent insurer attributable to covered policies shall be used by the association to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this chapter. For purposes of this subsection, that portion of the total assets of an impaired or insolvent insurer that is attributable to covered policies shall be determined by using the same proportion as the reserves that should have been established for such policies bears to the reserves that should have been established for all policies of insurance written by the impaired or insolvent insurer.
(b)(1) Prior to the termination of any liquidation, rehabilitation, or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, 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 such insolvent insurer. In such a determination, consideration shall be given to the welfare of the policyholders of the continuing or successor insurer.
(2) No distribution to stockholders of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association for funds expended in carrying out its powers and duties under Code Section 33-38-7, with respect to such insurer, has been fully recovered by the association.
(c)(1) If an order for liquidation or rehabilitation of an insurer domiciled in this state has been entered, the receiver appointed under such order shall have a right on behalf of the insurer to recover from any affiliate the amount of distributions, other than stock dividends paid by the insurer on its capital stock, made at any time during the five years preceding the petition for liquidation or rehabilitation, subject to the limitations of this subsection and subsections (a) and (b) of this Code section.
(2) No such distribution shall be recoverable if the insurer shows that the distribution was lawful and reasonable when paid and that the insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.
(3) Any person who was an affiliate that controlled the insurer at the time the distributions were paid shall be liable to the extent of the distributions received. Any person who was an affiliate that controlled the insurer at the time the distributions were declared shall be liable to the extent of the distributions that would have been received if such distributions had been paid immediately. Whenever two persons are liable with respect to the same distribution, they shall be jointly and severally liable.
(4) The maximum amount recoverable under this subsection shall be the amount needed, in excess of all other available assets of the insolvent insurer, to pay the contractual obligations of the insolvent insurer.
(5) Whenever any person liable under paragraph (3) of this subsection is insolvent, all affiliates that controlled it at the time the distribution was paid shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

33-38-18.
All proceedings in any court in this state in which the insolvent insurer is a party shall be stayed 60 days from the date of a final order of liquidation, rehabilitation, or conservation to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment entered under any decision, order, verdict, or finding based on default, the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such action on the merits.

33-38-19.
The liquidator, rehabilitator, or conservator of any impaired insurer may notify all interested persons of the effect of this chapter.

33-38-20.
Any action of the board of directors may be appealed to the Commissioner by any member insurer if such appeal is taken within 30 days of the action being appealed. Any final action or order of the Commissioner shall be subject to judicial review in a court of competent jurisdiction.

33-38-21.
(a) No person, including an insurer or 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 statement which uses the existence of the association for the purposes of sales, solicitation, or inducement to purchase any form of insurance covered by this chapter. This Code section shall not apply to the association or any other entity which does not sell or solicit insurance.
(b) Any person who violates subsection (a) of this Code section may, after notice and hearing and upon order of the Commissioner, be subject to one or more of the following:
(1) A monetary penalty of not more than $1,000.00 for each act or violation, but not to exceed an aggregate penalty of $10,000.00; or
(2) Suspension or revocation of his license or certificate of authority.

33-38-22.
(a) A member insurer may offset against its premium tax liability to this state an assessment described in Code Section 33-38-15 to the extent of 20 percent of the amount of such assessment for each of the five calendar years following the year in which such assessment was paid. In the event a member insurer should cease 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 subsection (f) of Code Section 33-38-15, from the association by member insurers and which have theretofore been offset against premium taxes as provided in subsection (a) of this Code section shall be paid by such insurers to this state in such manner as the Commissioner may require. The association shall notify the Commissioner that such refunds have been made.