Chapter 38

GEORGIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

§ 33-38-1. Purpose

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

The purpose of this chapter is to protect the persons specified in subsection (b) of Code Section 33-38-2, subject to certain limitations, against failure in the performance of contractual obligations, under life and health insurance policies and annuity contracts specified in subsection (a) of Code Section 33-38-2, 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 as limited by this chapter, (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.

History.—Code 1933, § 56-2201, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-2. Scope of provisions

Text of section effective until July 1, 2012

(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.

Text of section effective July 1, 2012

(a) This chapter shall provide coverage to the persons specified in subsection (b) of this Code section for direct, nongroup life, health, or annuity policies or contracts, for certificates under direct group policies and contracts, and for supplemental contracts to any of these, and for unallocated annuity contracts, in each case 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 annuities, annuities issued to or in connection with government lotteries, and any immediate or deferred annuity contracts.

(b)(1) Coverage under this chapter shall be provided only:

(A) 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 subparagraph (B) of this paragraph; and

(B) To persons who are owners of or certificate holders under such policies or contracts, other than unallocated annuity contracts and structured settlement annuities, to the persons who are the contract holders and who:

(i) Are residents; or

(ii) Are not residents, but the insurers which issued such policies or contracts are domiciled in this state; the states in which such persons reside have associations similar to the association created by this article; and such 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.

(2) For unallocated annuity contracts specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) of this subsection, provide coverage to:

(A) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(B) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(3) For structured settlement annuities specified in subsection (a) of this Code section, subparagraphs (A) and (B) of paragraph (1) of this subsection shall not apply, and this chapter shall, except as provided in paragraphs (4) and (5) 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)(I) The contract owner of the structured settlement annuity is a resident; or

(II) 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 chapter; 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.

(4) This chapter shall not provide coverage to:

(A) A person who is a payee or beneficiary of a contract owner who is a resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state; or

(B) A person covered under paragraph (2) of this subsection, if any coverage is provided by the association of another state to that person.

(5) This chapter 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 chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this subsection 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 chapter shall be construed in conjunction with other state laws to result in coverage by only one association.

(c) This chapter shall not provide coverage to:

(1) That portion or part of a policy or contract not guaranteed by an insurer, or under which the risk is borne by the policy or contract owner;

(2) A policy or contract of reinsurance or any policy or contract or part thereof assumed by the impaired or insolvent insurer under a contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

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

(B) On and after the date on which the member insurer becomes an impaired or insolvent insurer under this chapter, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available;

(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) A 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 other person under:

(A) A multiple employer welfare arrangement as defined in 29 U.S.C. Section 1002(40);

(B) A minimum premium group insurance plan;

(C) A stop-loss insurance policy; or

(D) An administrative services only contract;

(8) A portion of a policy or contract to the extent that it provides for:

(A) Dividends or experience rating credits;

(B) Voting rights; or

(C) Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(9) A 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;

(10) Any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(11) 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 or a government lottery;

(12) A portion of a policy or contract to the extent that the assessments required by Code Section 33-38-15 with respect to the policy or contract are preempted by federal or state law;

(13) 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;

(14) 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;

(15) 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 chapter, 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 paragraph, 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; or

(16) 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.

(d) The provisions of this Code section shall apply only to coverage the guaranty association provides in connection with any member insurer that

is placed under an order of liquidation with a finding of insolvency after the effective date of this Code section.

History.—Code 1933, § 56-2202, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1984, p. 1080, § 5; Ga. L. 1988, p. 1900, § 1; Ga. L. 1995, Act No. 501, § 5; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-3. Construction of provisions

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

This chapter shall be construed to effect the purpose set forth in Code Section 33-38-1.

History.—Code 1933, § 56-2218, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-4. Definitions

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

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) "Authorized assessment," or "authorized" when used in the context of assessments, means a resolution by the board of directors of the association 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.

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

(6) "Called assessment," or "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.

(7) "Contractual obligation" means any obligation under a covered policy, contract, or certificate under a group policy or contract, or portion thereof for which coverage is provided under Code Section 33-38-2.

(8) "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.

(9) "Covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Code Section 33-38-2.

(10) "Extra-contractual claims" shall include, for example, any claim not authorized by, or outside the scope of, the underlying policy or contract to include any claim based on bad faith, punitive or exemplary damages, treble damages, prejudgment or postjudgment interest, attorney's fees, or costs of litigation.

(11) "Impaired insurer" means a member insurer which is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction on or after July 1, 1981.

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

(13) "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 hospital or medical service corporation, whether profit or nonprofit;

(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;

(H) An organization that has a certificate or license limited to the issuance of charitable gift annuities under Code Sections 33-58-1 through 33-58-6; or

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

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

(15) "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" shall not include persons with a mere beneficial interest in a policy or contract.

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

(17) "Plan sponsor" means:

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

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

(C) In a case of a benefit plan established or maintained by two 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.

(18) "Premiums" means amounts or considerations, by whatever name called, received on covered policies or contracts, less returned premiums,

considerations and deposits thereon and less dividends and experience credits. The term "premiums" shall not include:

(A) Amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under this chapter except that assessable premium shall not be reduced on account of paragraph (3) of subsection (c) of Code Section 33-38-2, relating to interest limitations, and paragraph (12) of Code Section 33-38-7, relating to limitations with respect to one individual, one participant, and one contract owner;

(B) Premiums in excess of $5 million on an unallocated annuity contract; or

(C) With respect to multiple nongroup 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 million with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(19)(A) "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:

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

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

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

(iv) 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;

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

(vi) 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 50 percent 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.

(B) The principal place of business of a plan sponsor of a benefit plan described in subparagraph (C) of paragraph (17) of this Code section 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.

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

(21) "Resident" means any person who resides 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. Citizens of the United States who are either residents of foreign countries or residents of United States possessions, territories, or protectorates that do not have an association similar to the association created by this chapter shall be deemed residents of the state of domicile of the insurer that issued the policies or contracts.

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

(23) "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.

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

(25) "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.

History.—Code 1933, § 56-2203, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1988, p. 1900, § 2; Ga. L. 1995, Act No. 501, § 6; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-5. Establishment of association

(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.

Text of subsections (c) and (d) effective until July 1, 2012

(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.

Text of subsections (c) and (d) effective July 1, 2012

(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.

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

History.—Code 1933, § 56-2204, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 3; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-6. Board of directors

Text of section effective until July 1, 2012

(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.

Text of section effective July 1, 2012

(a) The board of directors of the association shall consist of not less than five nor more than nine member insurers serving terms as established in the plan of operation. The members of the board shall be selected by the Commissioner from a list provided to the Commissioner from the board. Vacancies on the board shall be 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 of members to the board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

(c) 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.

History.—Code 1933, § 56-2205, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-7. Powers and duties of association

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

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

(1) If a member 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 Commissioner, may, in its discretion:

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

(B) Provide such moneys, pledges, loans, 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;

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

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

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

(ii) Provide moneys, pledges, loans, notes, guarantees, or other means as are reasonably necessary to discharge the association's duties; or

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

(i) 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) With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or 45 days, but in no event less than 30 days, after the date on which the association becomes obligated with respect to the policies and contracts; and

(II) With respect to nongroup policies, contracts, and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than 30 days, from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds or annuitants, for nongroup policies and contracts, or group policy owners with respect to group policies and contracts, 30 days' notice of the termination, pursuant to division (i) of this subparagraph, of the benefits provided;

(iii) With respect to nongroup 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 division (iv) of this subparagraph, 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 provision of the policy or annuity or had a right only to make changes in premium by class;

(iv) In providing the substitute coverage required under division (iii) of this subparagraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy. 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. The association may reinsure any alternative or reissued policy;

(v)(I) Alternative policies adopted by the association shall be subject to the approval of the domiciliary insurance commissioner. 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 shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall 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;

(vi) 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 domiciliary insurance commissioner and the receivership court;

(vii) 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; and

(viii) When proceeding under this subparagraph with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with paragraph (3) of subsection (c) of Code Section 33-38-2;

(3) Nonpayment of premiums within 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 under this chapter with respect to the policy or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this chapter;

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order;

(5) The protection provided by this chapter 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;

(6) In carrying out its duties under paragraph (2) of this Code section, the association may:

(A) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption, or reinsurance agreement, if the association 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 association's duties under this chapter, or that the economic or financial conditions as they affect member insurers

are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest; and

(B) Subject to approval by a court in this state, 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;

(7) 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, pursuant to Code Sections 33-3-8 through 33-3-10, 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 paragraph. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to applicable state receivership law dealing with early access disbursements.

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

(9) Upon the Commissioner's 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;

(10) The association shall have standing to appear or intervene 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 chapter or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Such 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 another state with jurisdiction over an impaired or insolvent insurer for which 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;

(11)(A) Any person receiving benefits under this chapter 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 chapter, 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 causes of action 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 impaired or insolvent insurer.

(B) The subrogation rights of the association under this paragraph 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 chapter.

(C) In addition to subparagraphs (A) and (B) of this paragraph, 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.

(D) If subparagraphs (A) through (C) of this paragraph 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.

(E) 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 this paragraph, the person shall pay to the association the portion of the recovery attributable to the policies, or portion thereof, covered by the association;

(12) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

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

(B) With respect to one life, regardless of the number of policies or contracts:

(i) The amount of $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance;

(ii) In health insurance benefits, $300,000.00 for disability insurance; $300,000.00 for long-term care insurance; $300,000.00 for health insurance other than disability insurance as referenced above, long-term care insurance as referenced above, and basic hospital, medical, and surgical insurance or major medical insurance as referenced below, including any net cash surrender and net cash withdrawal values; and $500,000.00 for basic hospital, medical, and surgical insurance or major medical insurance; and

(iii) The amount of $300,000.00 in the present value of annuity benefits, but not more than $250,000.00 in net cash surrender and net cash withdrawal values for an annuity;

(C) With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, $300,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(D) However, in no event shall the association be obligated to cover more than:

(i) An aggregate of $300,000.00 in benefits with respect to any one life under subparagraph (B) of this paragraph except with respect to benefits

for basic hospital, medical, and surgical insurance and major medical insurance under division (ii) of this subparagraph, in which case the aggregate liability of the association shall not exceed $500,000.00 with respect to any one individual; 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 million in benefits, regardless of the number of policies and contracts held by the owner;

(E) With respect to either one contract owner provided coverage under subparagraph (b)(2)(B) of Code Section 33-38-2 or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts, $5 million in benefits, regardless of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than $5 million in benefits with respect to all these unallocated contracts; and

(F) The limitations set forth in this paragraph 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 chapter may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(13) In performing its obligations to provide coverage under Code Section 33-38-7, 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;

(14) In addition to the rights and powers elsewhere in this chapter, the association may:

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

(B) Sue or be sued, including the right to seek a declaratory judgment in any superior court of this state as to uncertainties with respect to the payment of benefits under this Code section. The association may also take any legal actions necessary or proper for recovery of any unpaid assessments under Code Section 33-38-15 and may settle claims or potential claims against it;

(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 issued to perform its obligations under this chapter;

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

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

(17) Take other necessary or appropriate action to discharge its duties and obligations under this chapter or to exercise its powers under this chapter;

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

(19) With respect to covered policies for which the association becomes obligated after an entry of an order of liquidation, the association may

elect to succeed to the rights of the insolvent insurer arising after the order of liquidation under any contract of reinsurance to which the insolvent insurer was a party, to the extent such contract provides coverage for losses occurring after the date of the order of liquidation. As a condition to making such election, the association must pay all unpaid premiums due under the contract for coverage relating to periods before and after the date on which the order of liquidation was entered;

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

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

(22) Exclusive venue in any action by or against the association is in the Superior Court of DeKalb County. The association may, at its option, waive such venue as to specific actions. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this chapter; and

(23) In carrying out its duties in connection with guaranteeing, assuming, or reinsuring policies or contracts under paragraph (1) or (2) of this Code section, 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:

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

(B) 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

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

(b) The provisions of this Code section shall apply only to coverage the guaranty association provides in connection with any member insurer that is placed under an order of liquidation with a finding of insolvency after the effective date of this Code section.

History.—Code 1933, § 56-2206, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 4; Ga. L. 1993, Act No. 353, § 3; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-8. Plan of operation

(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.

History.—Code 1933, § 56-2208, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-9. Delegation of powers and duties of association

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

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 (14) 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.

History.—Code 1933, § 56-2208, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1990, Act No. 714, § 33; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-10. Powers and duties of commissioner

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.

History.—Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-11. Records of meetings and negotiations

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

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. 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 (a) upon the termination of the impairment or insolvency of the insurer, or (b) 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.

History.—Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-12. Examination and regulation; financial report

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

The association shall be subject to examination and regulation by the Commissioner. Notwithstanding the foregoing, whether such examinations shall be conducted and the frequency of any such examination shall be at the sole discretion of 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.

History.—Code 1933, § 56-2212, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-13. Tax and fees exemption

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.

History.—Code 1933, § 56-2213, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-14. Immunity from liability

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

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 or her representatives, for any action or omission by them in the performance of their powers and duties under this chapter. This immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

History.—Code 1933, § 56-2214, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-15. Assessments of member insurers

Text of section effective until July 1, 2012

(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.

Text of section effective July 1, 2012

(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 authorized and called for the purpose of meeting administrative costs and legal 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 authorized and called 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 $300.00 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 authorized or called 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. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within 180 days after the assessment is authorized.

(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. 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.

(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.

(i)(1) 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.

(2) Within 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.

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

(4) 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.

(5) 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 Code section and member insurers shall promptly comply with a request.

History.—Code 1933, § 56-2207, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; Ga. L. 1988, p. 1900, § 5; Ga. L. 1990, Act No. 1330, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-16. Powers and duties of board of directors

(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.

Text of subsection (b) effective until July 1, 2012

(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.

Text of subsection (b) effective July 1, 2012

(b) The board of directors may, upon majority vote, 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.

History.—Code 1933, § 56-2210, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-17. Distributions

Text of section effective until July 1, 2012

(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.

Text of section effective July 1, 2012

(a) This chapter 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) 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 (11) of Code Section 33-38-7. The assets of the impaired or insolvent insurer attributable to covered policies shall be used by the association to continue the covered policies and pay the 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.

(c) As a creditor of the impaired or insolvent insurer as established in subsection (b) of this Code section and consistent with Code Section 33-37-33, 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 chapter. 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.

(d)(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 with interest thereon 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.

(3) No insurer that is subject to any delinquency proceedings, whether formal or informal, administrative or judicial, shall have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all

guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

(e)(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 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.

History.—Code 1933, § 56-2211, enacted by Ga. L. 1981, p. 1336, § 1; Ga. L. 1982, p. 3, § 33; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-18. Stay of proceedings

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

All proceedings in any court in this state in which the insolvent insurer is a party shall be stayed 180 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.

History.—Code 1933, § 56-2215, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-19. Notice

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

History.—Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-20. Appeals

Text of section effective until July 1, 2012

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.

Text of section effective July 1, 2012

Any action of the board of directors may be appealed to the Commissioner by any member insurer if such appeal is taken within 60 days of its receipt of notice 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 in accordance with the laws of this state that may apply to the actions or orders of the Commissioner.

History.—Code 1933, § 56-2209, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-21. Use of membership in advertising prohibited

(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

Text of subsection (b)(2) effective until July 1, 2012

(2) Suspension or revocation of his license or certificate of authority.

Text of subsection (b)(2) effective July 1, 2012

(2) Suspension or revocation of his or her license or certificate of authority.

History.—Code 1933, § 56-2216, enacted by Ga. L. 1981, p. 1336, § 1; 2012, HB 786, s 1, eff. 7-1-2012.

§ 33-38-22. Tax offsets

(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.

History.—Code 1981, § 33-38-22, enacted by Ga. L. 1988, p. 1900, § 6; Ga. L. 1989, Act No. 7, § 33; 2012, HB 786, s 1, eff. 7-1-2012.

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