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INSURANCE CODE - INS

DIVISION 1. GENERAL RULES GOVERNING INSURANCE [100 - 1879.8] (*Division 1 enacted by Stats. 1935, Ch. 145.*)

PART 2. THE BUSINESS OF INSURANCE [680 - 1879.8] (*Part 2 enacted by Stats. 1935, Ch. 145.*)

CHAPTER 1. General Regulations [680 - 1113] (*Chapter 1 enacted by Stats. 1935, Ch. 145.*)

ARTICLE 14.2. California Insurance Guarantee Association [1063 - 1063.19] (*Article 14.2 added by Stats. 1969, Ch. 1347.*)

1063. (a) Within 60 days after the original effective date of this article, all insurers, including reciprocal insurers, admitted to transact insurance in this state of any or all of the following classes only in accordance with the provisions of Chapter 1 (commencing with Section 100) of Part 1 of this division: fire (see Section 102), marine (see Section 103), plate glass (see Section 107), liability (see Section 108), workers' compensation (see Section 109), common carrier liability (see Section 110), boiler and machinery (see Section 111), burglary (see Section 112), sprinkler (see Section 114), team and vehicle (see Section 115), automobile (see Section 116), aircraft (see Section 118), and miscellaneous (see Section 120), shall establish the California Insurance Guarantee Association (the association); provided, however, this article shall not apply to the following classes or kinds of insurance: life and annuity (see Section 101), title (see Section 104), fidelity or surety including fidelity or surety bonds, or any other bonding obligations (see Section 105), disability or health (see Section 106), credit (see Section 113), mortgage guaranty, insolvency or legal (see Section 119), financial guaranty or other forms of insurance offering protection against investment risks (see Section 124), the ocean marine portion of any marine insurance or ocean marine coverage under any insurance policy including the following: the Jones Act (46 U.S.C. Sec. 688), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or any endorsement or policy affording protection and indemnity coverage, or reinsurance as defined in Section 620, or fraternal fire insurance written by associations organized and operating under Sections 9080 to 9103, inclusive. Any insurer admitted to transact only those classes or kinds of insurance excluded from this article shall not be a member insurer of the association. Each insurer admitted to transact a class of insurance included in this article, including the State Compensation Insurance Fund, as a condition of its authority to transact insurance in this state, shall participate in the association whether established voluntarily or by order of the commissioner after the elapse of 60 days following the original effective date of this article in accordance with rules to be established as provided in this article. It shall be the purpose of the association to provide for each member insurer insolvency insurance as defined in Section 119.5.

(b) The association shall be managed by a board of governors, composed of nine member insurers, each of which shall be appointed by the commissioner to serve initially for terms of one, two, or three years and thereafter for three-year terms so that three terms shall expire each year on December 31, and shall continue in office until his or her successor shall be appointed and qualified. At least five members of the board shall be domestic insurers. At least three of the members shall be stock insurers, and at least three shall be nonstock insurers. The nine members shall be representative, as nearly as possible, of the classes of insurance and of the kinds of insurers covered by this article. In case of a vacancy for any reason on the board, the commissioner shall appoint a member insurer to fill the unexpired term. In addition to the nine member insurers, the membership of the board shall also include one public member appointed by the President pro Tempore of the Senate, one public member appointed by the Speaker of the Assembly, one business member appointed by the commissioner, and one labor member appointed by the commissioner.

(c) The association shall adopt a plan of operations, and any amendments thereto, not inconsistent with the provisions of this article, necessary to assure the fair, reasonable, and equitable manner of administering the association, and to provide for other matters as are necessary or advisable to implement the provisions of this article. The plan of operations and any amendments thereto shall be subject to prior written approval by the commissioner. All members of the association shall adhere to the plan of operation.

(d) If for any reason the association fails to adopt a suitable plan of operation within 90 days following the original effective date of this article, or if at any time thereafter the association fails to adopt suitable amendments to the plan of operation, the commissioner shall after hearing adopt and promulgate reasonable rules as are necessary or advisable to effectuate the provisions of this chapter. These rules shall continue in force until modified by the commissioner after hearing or superseded by a plan of operation, adopted by the association and approved by the commissioner.

(e) In accordance with its plan of operation, the association may designate one or more of its members as a servicing facility, but a member may decline this designation. Each servicing facility shall be reimbursed by the association for all reasonable expenses it incurs and for all payments it makes on behalf of the association. Each servicing facility shall have authority to perform any functions of the association that the board of governors lawfully may delegate to it and to do so on behalf of and in the name of the association. The designation of servicing facilities shall be subject to the approval of the commissioner.

(f) The association shall have authority to borrow funds when necessary to effectuate the provisions of this article, and may provide in its plan of operations for any of the following:

(1) The issuance of notes, bonds, or debentures, or the establishment of a special purpose trust or other entity, solely for the purpose of facilitating a financing.

(2) The securing of that borrowing or those notes, bonds, or debentures by pledging or granting liens or mortgages, or by otherwise encumbering its real or personal property, including, but not limited to, premiums levied under Section 1063.5.

(g) The association, either in its own name or through servicing facilities, may be sued and may use the courts to assert or defend any rights the association may have by virtue of this article as reasonably necessary to fully effectuate the provisions thereof.

(h) The association shall have the right to intervene as a party in any proceeding instituted pursuant to Section 1016 wherein liquidation of a member insurer as defined in Section 1063.1 is sought.

(i) (1) The association shall have an annual audit of its financial condition conducted by an independent certified public accountant. The audit shall be conducted, to the extent possible, in accordance with generally accepted auditing standards (GAAS) and the report of the audit shall be submitted to the commissioner.

(2) The association shall annually audit at least one-third of the service companies retained by the association to adjust claims of insolvent insurers. The audits shall (A) assure that all covered claims are being investigated, adjusted, and paid in accordance with customary industry standards and practices and all applicable statutes, rules, and regulations, and (B) examine the management and supervisory systems overseeing the claims functions. The audits shall be conducted by the association or an independent auditor, provided that the three largest service companies, as measured by the number of claims processed for the association during the previous three fiscal years, shall be audited by an independent auditor at least once every three years. The association shall implement systems to retain independent auditing firms for the purpose of this paragraph, provided that no one firm is designated or utilized as an exclusive provider. Audits conducted pursuant to this paragraph shall be submitted annually to the commissioner for review.

(j) The commissioner shall examine the association to the same extent as, and in accordance with, the requirements of Article 4 (commencing with Section 729) of Chapter 1 of Part 2 of Division 1, which sets forth the examination requirements applicable to admitted insurers. A copy of the examination report shall be filed with the Chairpersons of the Senate and Assembly Committees on Insurance no later than December 31 of the year the report is completed.

(Amended by Stats. 2012, Ch. 786, Sec. 16. (AB 2303) Effective January 1, 2013.)

1063.1. As used in this article:

(a) "Member insurer" means an insurer required to be a member of the association in accordance with subdivision (a) of Section 1063, except and to the extent that the insurer is participating in an insolvency program adopted by the United States government.

(b) "Insolvent insurer" means an insurer that was a member insurer of the association, consistent with paragraph (11) of subdivision (c), either at the time the policy was issued or when the insured event occurred, and against which an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, or, in the case of the State Compensation Insurance Fund, if a finding of insolvency is made by a duly enacted legislative measure.

(c) (1) "Covered claims" means the obligations of an insolvent insurer, including the obligation for unearned premiums, that satisfy all of the following requirements:

(A) Imposed by law and within the coverage of an insurance policy of the insolvent insurer.

(B) Which were unpaid by the insolvent insurer.

(C) Which are presented as a claim to the liquidator in the state of domicile of the insolvent insurer or to the association on or before the last date fixed for the filing of claims in the domiciliary liquidating proceedings.

(D) Which were incurred before the date coverage under the policy terminated and before, on, or within 30 days after the date the liquidator was appointed.

(E) For which the assets of the insolvent insurer are insufficient to discharge in full.

(F) In the case of a policy of workers' compensation insurance, to provide workers' compensation benefits under the workers' compensation law of this state or under the workers' compensation law of any state if the injured worker is a resident of this state and not otherwise entitled to coverage from an organization similar to the association in any other state.

(G) In the case of other classes of insurance if the claimant or insured is a resident of this state at the time of the insured occurrence, or the property from which the claim arises is permanently located in this state.

(2) "Covered claims" also includes the obligations assumed by an assuming insurer from a ceding insurer when the assuming insurer subsequently becomes an insolvent insurer if, at the time of the insolvency of the assuming insurer, the ceding insurer is no longer admitted to transact business in this state. Both the assuming insurer and the ceding insurer shall have been member insurers at the time the assumption was made. "Covered claims" under this paragraph shall satisfy the requirements of subparagraphs (A) to (G), inclusive, of paragraph (1), except for the requirement that the claims be against policies of the insolvent insurer. The association has a right to recover a deposit, bond, or other assets that may have been required to be posted by the ceding company to the extent of covered claim payments and shall be subrogated to any rights the policyholders may have against the ceding insurer.

(3) "Covered claims" does not include obligations arising from the following:

(A) Life, annuity, health, or disability insurance.

(B) Mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks.

(C) Fidelity or surety insurance including fidelity or surety bonds, or any other bonding obligations.

(D) Credit insurance.

(E) Title insurance.

(F) Ocean marine insurance or ocean marine coverage under an insurance policy, including claims arising from the following: the Jones Act (46 U.S.C. Secs. 30104 and 30105), the Longshore and Harbor Workers' Compensation Act (33 U.S.C. Sec. 901 et seq.), or any other similar federal statutory enactment, or an endorsement or policy affording protection and indemnity coverage.

(G) A claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses, except a special excess workers' compensation policy issued pursuant to subdivision (c) of Section 3702.8 of the Labor Code that covers all or any part of workers' compensation liabilities of an employer that is issued, or was previously issued, a certificate of consent to self-insure pursuant to subdivision (b) of Section 3700 of the Labor Code.

(4) "Covered claims" does not include an obligation of the insolvent insurer arising out of a reinsurance contract, an obligation incurred after the expiration date of the insurance policy or after the insurance policy has been replaced by the insured, canceled at the insured's request, or canceled by the liquidator, or an obligation to a state or to the federal government. If the individual has a covered claim that includes medical services provided by a medical facility owned in whole or in part by a state or federal agency, the association may pay that claim directly to the facility, as long as the services provided otherwise qualify as a covered claim and the claim is owned by the medical facility asserting the claim.

(5) (A) "Covered claims" does not include an obligation to insurers, insurance pools, or underwriting associations, nor their claims for contribution, indemnity, or subrogation, equitable or otherwise, except as otherwise provided in this chapter.

(B) An insurer, insurance pool, or underwriting association may not maintain, in its own name or in the name of its insured, a claim or legal action against the insured of the insolvent insurer for contribution, indemnity, or by way of subrogation, except insofar as, and to the extent only, that the claim exceeds the policy limits of the insolvent insurer's policy. In those claims or legal actions, the insured of the insolvent insurer is entitled to a credit or setoff in the amount of the policy limits of the insolvent insurer's policy, or in the amount of the limits remaining, when those limits have been diminished by the payment of other claims.

(6) "Covered claims," except in cases involving a claim for workers' compensation benefits or for unearned premiums, does not include a claim in an amount of one hundred dollars (\$100) or less or the portion of a claim that is in excess of the applicable limits provided in the insurance policy issued by the insolvent insurer.

(7) (A) "Covered claims" does not include that portion of a claim, other than a claim for workers' compensation benefits, that is in excess of five hundred thousand dollars (\$500,000).

(B) For purposes of subparagraph (A), with respect to a policy of residential property insurance, each claim for a loss under a different coverage category shall be considered a separate covered claim.

(C) Notwithstanding subparagraph (A), a claim for damage to, or loss of, a dwelling structure under a policy of residential property insurance shall not exceed one million dollars (\$1,000,000) or the amount recoverable under the policy, whichever is less.

(8) "Covered claims" does not include an amount awarded as punitive or exemplary damages, or an amount awarded by the Workers' Compensation Appeals Board pursuant to Section 5814 or 5814.5 of the Labor Code because payment of compensation was unreasonably delayed or refused by the insolvent insurer.

(9) "Covered claims" does not include either of the following:

(A) A claim to the extent it is covered by any other insurance of a class covered by this article available to the claimant or insured.

(B) A claim by a person other than the original claimant under the insurance policy in the claimant's own name, the claimant's assignee as the person entitled thereto under a premium finance agreement as defined in Section 673 and entered into before insolvency, or the claimant's executor, administrator, guardian, or other personal representative or trustee in bankruptcy, and does not include a claim asserted by an assignee or one claiming by right of subrogation, except as otherwise provided in this chapter.

(10) "Covered claims" does not include an obligation arising out of the issuance of an insurance policy written by the separate division of the State Compensation Insurance Fund pursuant to Sections 11802 and 11803.

(11) "Covered claims" does not include an obligation of the insolvent insurer arising from a policy or contract of insurance issued or renewed before the insolvent insurer's admission to transact insurance in the State of California.

(12) "Covered claims" does not include surplus deposits of subscribers as defined in Section 1374.1.

(13) "Covered claims" shall also include an obligation arising under an insurance policy written to indemnify a permissibly self-insured employer pursuant to subdivision (b) or (c) of Section 3700 of the Labor Code for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention. However, for purposes of this article, those claims shall not be considered workers' compensation claims and therefore are subject to the per-claim limit in paragraph (7), and any payments and expenses related thereto shall be allocated to category (c) for claims other than workers' compensation, homeowners', and automobile, as provided in Section 1063.5.

These provisions shall apply to obligations arising under a policy as described herein issued to a permissibly self-insured employer or group of self-insured employers pursuant to Section 3700 of the Labor Code and notwithstanding any other provision of this code, those obligations shall be governed by this provision in the event that the Self-Insurers' Security Fund is ordered to assume the liabilities of a permissibly self-insured employer or group of self-insured employers pursuant to Section 3701.5 of the Labor Code. This paragraph applies only to insurance policies written to indemnify a permissibly self-insured employer or group of self-insured employers under subdivision (b) or (c) of Section 3700 of the Labor Code, for its liability to pay workers' compensation benefits in excess of a specific or aggregate retention, and this paragraph does not apply to special excess workers' compensation insurance policies unless issued pursuant to authority granted in subdivision (c) of Section 3702.8 of the Labor Code, and as provided for in subparagraph (G) of paragraph (3). In addition, this paragraph does not apply to a claims servicing agreement or insurance policy providing retroactive insurance of a known loss or losses as are excluded in subparagraph (G) of paragraph (3).

A permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall, to the extent required by the Labor Code, be responsible for paying, adjusting, and defending each claim arising under policies of insurance covered under this section, unless the benefits paid on a claim exceed the specific or aggregate retention, in which case:

(A) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy requires the insurer to defend and adjust the claim, the association shall be solely responsible for adjusting and defending the claim, and shall make all payments due under the claim, subject to the limitations and exclusions of this article with regard to covered claims. As to each claim subject to this paragraph, notwithstanding any other provisions of this code or the Labor Code, and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(B) If the benefits paid on the claim exceed the specific or aggregate retention, and the policy does not require the insurer to defend and adjust the claim, the permissibly self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, shall not have any further payment obligations with respect to the claim, but shall continue defending and adjusting the claim, and shall have the right, but not the obligation, in a proceeding to assert all applicable statutory limitations and exclusions as contained in this article with regard to the covered claim. CIGA shall have the right, but not the obligation, to intervene in a proceeding in which the self-insured employer, group of self-insured employers, or the Self-Insurers' Security Fund is defending a claim and shall be permitted to raise the appropriate statutory limitations and exclusions as contained in

this article with respect to covered claims. Regardless of whether the self-insured employer or group of self-insured employers, or the Self-Insurers' Security Fund, asserts the applicable statutory limitations and exclusions, or whether CIGA intervenes in a proceeding, CIGA shall be solely responsible for paying all benefits due on the claim, subject to the exclusions and limitations of this article with respect to covered claims. As to each claim subject to this paragraph, notwithstanding any other provision of this code or the Labor Code and regardless of whether the amount paid by CIGA is adequate to discharge a claim obligation, neither the self-insured employer, group of self-insured employers, nor the Self-Insurers' Security Fund, shall have an obligation to pay benefits over and above the specific or aggregate retention, except as provided in this subdivision.

(C) In the event that the benefits paid on the covered claim exceed the per-claim limit in paragraph (7), the responsibility for paying, adjusting, and defending the claim shall be returned to the permissibly self-insured employer or group of employers, or the Self-Insurers' Security Fund.

These provisions shall apply to all pending and future insolvencies. For purposes of this paragraph, a pending insolvency is one involving a company that is currently receiving benefits from the guarantee association.

(14) "Covered claims" also includes all obligations arising under a policy issued to cover cybersecurity, as long as the association's total liability for all those obligations does not exceed one million dollars (\$1,000,000) or the policy limits, whichever is less. Cybersecurity claims shall be covered by the account categorized pursuant to subparagraph (C) of paragraph (2) of subdivision (a) of Section 1063.5, unless the coverage is specifically attached to a policy that would otherwise be covered by an account categorized pursuant to subparagraph (A) or (B) of paragraph (2) of subdivision (a) of Section 1063.5.

(15) Notwithstanding any other provision in this section or Section 1063, if an insurance policy has been allocated to or assumed by a company that did not issue the policy pursuant to a state statute that provides for the division of an insurance company or the statutory assumption of designated policies by a new company, that statute provides a novation has been deemed to have occurred with respect to those policies, and that company is placed in liquidation, then to the extent a claim arising under that allocated or transferred policy would have been a covered claim had the original company been placed in liquidation before the statutory allocation or assumption, any claim arising under that same policy shall be a covered claim regardless of whether the company that allocated or assumed the policy was or was not a member at the time the policy was issued or when the insured event occurred.

(d) "Admitted to transact insurance in this state" means an insurer possessing a valid certificate of authority issued by the department.

(e) "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(f) "Control" 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 the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control is presumed to exist if a person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing, 10 percent or more of the voting securities of any other person. This presumption may be rebutted by showing that control does not in fact exist.

(g) "Claimant" means an insured making a first party claim or a person instituting a liability claim. However, no person who is an affiliate of the insolvent insurer may be a claimant.

(h) "Net direct written premiums" means the amount of direct written premiums in the annual financial statement on file with the commissioner, adjusted for any premiums written for any lines of insurance or types of coverages not covered by this article, plus premiums written in this state for coverage under a special excess workers' compensation policy.

(i) "Ocean marine insurance" includes marine insurance as defined in Section 103, except for inland marine insurance, as well as any other form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks, that are usually insured against by traditional marine insurance such as hull and machinery, marine builders' risks, and marine protection and indemnity. Those perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of a vessel, craft, or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness, or death for loss or damage to the property of the insured or another person.

(j) "Unearned premium" means that portion of a premium as calculated by the liquidator that had not been earned because of the cancellation of the insolvent insurer's policy and is that premium remaining for the unexpired term of the insolvent insurer's policy. "Unearned premium" does not include an amount sought as return of a premium under a policy providing retroactive insurance of a known loss or return of a premium under a retrospectively rated policy or a policy subject to a contingent surcharge or a policy in which the final determination of the premium cost is computed after expiration of the policy and is calculated on the basis of actual loss experienced during the policy period.

1063.2. (a) The association shall pay and discharge covered claims and, in connection therewith, pay for or furnish loss adjustment services and defenses of claimants when required by policy provisions. It may do so either directly by itself or through a servicing facility or through a contract for reinsurance and assumption of liabilities by one or more member insurers or through a contract with the liquidator, upon terms satisfactory to the association and to the liquidator, under which payments on covered claims would be made by the liquidator using funds provided by the association. Alternatively, the association may, with the express approval of the commissioner, reinsure with, or transfer liabilities to, a California admitted and authorized reinsurer or other reinsurer approved by the commissioner to limit or eliminate adverse development, to stabilize or limit the need for assessments, or to reduce its potential ultimate liability for covered claims, provided the association retains the ultimate responsibility to the policyholder or beneficiary for payment of claims covered by the reinsurance agreement. A reinsurance agreement or transfer of liabilities shall be paid for using the association's available funds from one of its accounts and shall not be charged to administrative expense or allocated to any liquidation estate. The payment and discharge of covered claims shall be undertaken by the association, either directly or through an authorized third-party administrator. Recoveries from a reinsurance agreement or transfer of liabilities shall solely be the property of the association, shall not inure to the benefit of any liquidation estate, and shall be paid to the association account from which the payment for the reinsurance or transfer of liabilities was made.

(b) (1) The association shall be a party in interest in all proceedings involving a covered claim, and shall have the same rights as the insolvent insurer would have had if not in liquidation, including, but not limited to, the right to all of the following:

(A) Appear, defend, and appeal a claim in a court of competent jurisdiction.

(B) Receive notice of, investigate, adjust, compromise, settle, and pay a covered claim.

(C) Investigate, handle, and deny a noncovered claim.

(2) The association shall have no cause of action against the insureds of the insolvent insurer for any sums it has paid out, except as provided by this article.

(3) Paragraph (2) does not limit the association's right to pursue unpaid reimbursements owed by an employer pursuant to a workers' compensation insurance policy with a deductible if the employer was obligated to reimburse the insurer for benefits payments and related expenses paid by the insurer or the association from a special deposit or from other association funds pursuant to the terms of the policy and related agreements.

(c) (1) If damages against uninsured motorists are recoverable by the claimant from his or her own insurer, the applicable limits of the uninsured motorist coverage shall be a credit against a covered claim payable under this article. A person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first-party claim for damage to property with a permanent location, he or she shall seek recovery first from the association of the permanent location of the property, and if it is a workers' compensation claim, he or she shall seek recovery first from the association of the residence of the claimant. A recovery under this article shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent. A member insurer may recover in subrogation from the association only one-half of any amount paid by that insurer under uninsured motorist coverage for bodily injury or wrongful death (and nothing for a payment for anything else), in those cases where the injured person insured by such an insurer has proceeded under his or her uninsured motorist coverage on the ground that the tortfeasor is uninsured as a result of the insolvency of his or her liability insurer (an insolvent insurer as defined in this article), provided that the member insurer shall waive all rights of subrogation against the tortfeasor. An amount paid a claimant in excess of the amount authorized by this section may be recovered by action, or other proceeding, brought by the association.

(2) A claimant having collision coverage on a loss that is covered by the insolvent company's liability policy shall first proceed against his or her collision carrier. That claimant or the collision carrier, if it is a member of the association, does not have the right to sue or continue a suit against the insured of the insolvent insurance company for that collision damage.

(d) The association shall have the right to recover from any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article the amount of any covered claim and allocated claims expense paid on behalf of that person pursuant to this article.

(e) A person having a claim or legal right of recovery under any governmental insurance or guaranty program that is also a covered claim, shall be required to first exhaust his or her right under the program. An amount payable on a covered claim shall be reduced by the amount of any recovery under the program.

(f) "Covered claims" for unearned premium by lenders under insurance premium finance agreements as defined in Section 673 shall be computed as of the earliest cancellation date of the policy pursuant to Section 673.

(g) "Covered claims" shall not include any judgments against or obligations or liabilities of the insolvent insurer or the commissioner, as liquidator, or otherwise resulting from alleged or proven torts, nor shall any default judgment or stipulated judgment against the insolvent insurer, or against the insured of the insolvent insurer, be binding against the association.

(h) "Covered claims" shall not include any loss adjustment expenses, including adjustment fees and expenses, attorney's fees and expenses, court costs, interest, and bond premiums, incurred before the appointment of a liquidator.

(Amended by Stats. 2018, Ch. 92, Sec. 154. (SB 1289) Effective January 1, 2019.)

1063.3. To aid in the detection and prevention of member insurer insolvencies:

(a) The board may, upon majority vote, make recommendations to the commissioner on matters pertaining to regulation for solvency.

(b) The board may prepare a report on the history and causes of any member insurer insolvency in which the association was obligated to pay covered claims, based on the information available to the association, and submit that report along with any recommendations resulting therefrom to the commissioner.

(c) The board may request the Self-Insurers' Security Fund to prepare, and the Self-Insurers' Security Fund may provide to the board, a report identifying the aggregate amount of liability, including the estimated exposure for every insurance carrier admitted to transact workers' compensation insurance in this state, under all specific excess workers' compensation policies in existence for a given period in this state as reported by the private self-insured employers to the Director of Industrial Relations in the annual reports submitted pursuant to Section 3702.2 of the Labor Code.

(Amended by Stats. 2005, Ch. 395, Sec. 2. Effective January 1, 2006.)

1063.4. (a) Insureds entitled to the protection of this article shall cooperate with the association in accordance with their policies in the same manner as they would have been required to cooperate with their insurer if it were not in liquidation and shall be deemed to have assigned to the association any right to make claim against the liquidator for a refund of unearned premium for the period of coverage provided by the association beginning on the date of the order of liquidation to the date of expiration or cancellation.

(b) Any insured or claimant entitled to the benefits of this article who elects to proceed under this article shall be deemed to have assigned to the association his or her rights against the estate of the insolvent insurer.

(Amended by Stats. 1994, Ch. 6, Sec. 6. Effective February 10, 1994.)

1063.5. (a) (1) To the extent necessary to secure funds for the association for payment of the administrative expenses of the association, covered claims of insolvent insurers, and for payment of reasonable costs of adjusting the claims, the association shall collect premium payments from its member insurers sufficient to discharge its obligations.

(2) The association shall allocate its claim payments and costs, incurred or estimated to be incurred, to one or more of the following categories:

(A) Workers' compensation claims.

(B) Homeowners' claims and automobile claims, including all of the following:

(i) Automobile material damage.

(ii) Automobile liability (both personal injury and death and property damage).

(iii) Medical payments.

(iv) Uninsured motorist claims.

(C) Claims other than workers' compensation, homeowners', and automobile, as defined above.

(3) Separate premium payments shall be required for each category.

(4) The premium payments for each category shall be used to pay the claims and costs allocated to that category.

(b) (1) The rate of premium charged shall be a uniform percentage of net direct written premium in the preceding calendar year applicable to that category.

(2) The rate of premium charges to each member insurer in the appropriate categories shall be based on the net direct written premium of each member insurer as shown in the latest year's annual financial statement on file with the commissioner.

(3) In cases of a dispute as to the amount of the net direct written premium between the association and one of its member insurers, the written decision of the commissioner shall be final.

(c) Within 90 days after the filing of an annual statement, each member insurer shall file a report to the association indicating the amount of premiums not subject to the association's premium charge and the amount of special excess workers' compensation premiums for the preceding calendar year. The report is not required in any year in which a premium charge is not made by the association.

(d) In charging premiums to member insurers, the association shall adjust, if necessary, the net direct written premiums shown on a member insurer's annual statement by excluding any premiums written for any lines of insurance or types of coverage not covered by this article under paragraph (3) of subdivision (c) of Section 1063.1.

(e) (1) The premium charged to any member insurer for any of the three categories or a category established by the association shall not be more than 2 percent of the net direct written premium unless there are bonds outstanding that were issued pursuant to Article 14.26 (commencing with Section 1063.70).

(2) If bonds issued pursuant to Article 14.26 (commencing with Section 1063.70) are outstanding, the premium charged to a member insurer for the category for which the bond proceeds are being used to pay claims and expenses shall not be more than 1 percent of the net direct written premium for that category.

(f) (1) The association may exempt or defer, in whole or in part, the premium charge of any member insurer, if the premium charge would cause the member insurer's financial statement to reflect an amount of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment, no dividends shall be paid to shareholders or policyholders by the company whose premium charge was deferred.

(2) Deferred premium charges shall be paid when the payment will not reduce capital or surplus below required minimums.

(g) After all covered claims of insolvent insurers and expenses of administration have been paid, any unused premiums and any reimbursements or claims dividends from liquidators remaining in any category shall be retained by the association and applied to reduce future premium charges in the appropriate category.

(h) The commissioner may suspend or revoke the certificate of authority to transact business in this state of a member insurer that fails to pay a premium when due and after demand has been made.

(i) Interest at a rate equal to the current federal reserve discount rate plus $2\frac{1}{2}$ percent per annum shall be added to the premium of any member insurer that fails to submit the premium requested by the association within 30 days after the mailing request. However, in no event shall the interest rate exceed the legal maximum.

(j) This section shall apply only to premium charges paid on or after January 1, 2017.

(Amended by Stats. 2022, Ch. 408, Sec. 3. (AB 2154) Effective January 1, 2023.)

1063.6. All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in the state shall, subject to waiver by the association in specific cases involving covered claims and subject to waiver by the commissioner as to matters that are not covered claims, be stayed for 60 days from the date that an order of liquidation or an order of receivership with a finding of insolvency has been entered by a superior court in this state or by a court in the state of domicile of the insurer, and an additional time thereafter as may be determined necessary by the court to permit proper defense or conduct of all pending causes of action by the association or the commissioner, as applicable. The stay as to matters to which the insolvent insurer is a party shall be superseded by and when an injunction or stay order is entered by the court in this state having jurisdiction of the liquidation or the ancillary liquidation.

The liquidator, receiver, or statutory successor of an insolvent member insurer shall permit reasonable access by the association to the insolvent insurer's records as is necessary for the association to carry out its duties with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the association with copies of these records upon the reasonable request of the association and at the expense of the association.

(Amended by Stats. 1999, Ch. 83, Sec. 119. Effective January 1, 2000.)

1063.7. When a liquidator, domiciliary or ancillary, is appointed in this state for any member insurer, the liquidator shall promptly give notice of his or her appointment and a brief description of the contents of this article and of the nature and functions of the association by prepaid first-class mail, to: (a) all persons known or reasonably expected to have or be interested in claims against the insurer, at the last known address within this state; (b) all insureds of the insurer, at the last known address within this state, accompanied by a notice of the date of termination of insurance; and (c) the board of governors of the association. That notice may, but need not be, combined with the notice provided for in Section 1021. When notice is being provided by an ancillary liquidator, notice is only required to the extent information is available to provide the notice. The ancillary liquidator may also rely on the notice provided by the domiciliary liquidator to satisfy the notice requirements of this section. The liquidator may also require that producers

of record of the insurer give prompt written notice of the same information, by first-class mail, to their insureds at the last known address within this state. The liquidator shall also promptly publish the notice pursuant to the requirements of Section 1022 and by publication elsewhere in this state as the court shall direct.

(Amended by Stats. 2017, Ch. 417, Sec. 9. (AB 1696) Effective January 1, 2018.)

1063.8. Notwithstanding any other provision of law, the association shall be exempt from all license fees, income, franchise, privilege, property, or occupation taxes levied or assessed by this state, any municipality, county, or other political subdivision of this state. The rules of the commissioner promulgated pursuant to this article may exempt the association from: filing an annual statement, maintaining minimum required capital, paying any fees or reimbursements, or meeting any other requirement or doing any other thing required by this code or other laws relating to insurance.

(Amended by Stats. 1970, Ch. 1205.)

1063.9. (a) The operation of the association shall at all times be subject to the regulation of the commissioner. The commissioner, or any deputy or examiner, or any person whom the commissioner shall appoint, shall have the power of visitation and examination into the affairs of the association and free access to all books, papers, and documents that relate to the business of the association, may summon and qualify witnesses under oath, and may examine officers, agents or employees, or any other person having knowledge of the affairs, transactions, or conditions of the association.

(b) Any member insurer aggrieved by any action or decision of the association may appeal to the commissioner within 30 days after the action or decision of the association and after exhaustion of administrative remedies may seek court relief as provided in Section 12940.

(Amended by Stats. 1970, Ch. 1205.)

1063.10. All orders or decisions of the commissioner made pursuant to Chapter 1347, Statutes of 1969 (of which this article is a part) and the provisions thereof as amended from time to time, shall be subject to judicial review as provided in Section 12940.

(Amended by Stats. 1970, Ch. 1205.)

1063.11. The commissioner may, upon notice and opportunity for all interested parties to be heard, issue such rules, regulations and orders as may be necessary to carry out the provisions of this article. Such rules and regulations shall be adopted, amended or repealed in accordance with Chapter 4.5 (commencing with Section 11371) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 1969, Ch. 1347.)

1063.12. (a) The association, its member insurers, and its officers, directors, agents or employees of the association, or its member insurers, shall under no circumstances be liable for any sum in excess of the amount of covered claims of the insolvent insurer, as defined under subdivision (c) of Section 1063.1 of this article and the costs of administration and the costs of loss adjustment, investigation and defenses relating to claims thereunder.

(b) Any person or member made a party to any action, suit or proceeding because such person or member served on the board of governors or on a committee or was an officer or employee of the association shall be held harmless and be indemnified by the association against all liability and costs (including the amounts of judgments, settlements, fines or penalties) and expenses incurred in connection with such action, suit or proceeding; provided, however, such indemnification shall not be provided on any matter in which the person or member shall be finally adjudged in any such action, suit or proceeding to have committed a breach of duty involving gross negligence, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office.

(c) The costs and expenses of such indemnification shall be prorated and paid for by the members in the same manner as provided in the plan of operations for the proration of premiums.

(d) The provisions of this section shall not be construed as creating any right in any third person, and shall be applicable only as between the association and its member insurers and its officers, directors, agents, or employees of the association or its member insurers.

(Amended by Stats. 1979, Ch. 384.)

1063.13. No member insurer of the association shall engage in the unlawful trade practice defined and condemned in subdivision (g) of Section 790.03.

(Added by Stats. 1970, Ch. 1205.)

1063.14. (a) (1) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain provisions whereby each member insurer is required to recoup, in the year following the premium charge, a sum calculated to recoup the premium charge

paid by the member insurer under this article by way of a surcharge on premiums charged for insurance policies to which this article applies.

(2) Amounts recouped shall not be considered premiums for any other purpose, including the computation of gross premium tax or agents' commission.

(b) The plan of operation adopted pursuant to subdivision (c) of Section 1063 shall contain a provision requiring a member insurer to recoup the premium charge amount, as determined by the association, through a surcharge on premiums charged for insurance policies to which this article applies, even if a premium charge was not yet paid to the association because the member insurer had no direct written premium for insurance policies to which this article applies for the prior year. All surcharges collected in this manner shall be remitted to the association within 60 days of the end of the calendar year in which the surcharge is collected.

(c) (1) The amount of any surcharge shall be separately stated on either a billing or policy declaration sent to an insured. The association shall determine the rate of the surcharge and the collection period for each category, and these shall be mandatory for all member insurers of the association who write business in those categories.

(2) Each member insurer shall file a report in accordance with the provisions of the plan of operation indicating the amount of surcharges it has collected.

(A) Member insurers who collect surcharges in excess of premium charges paid in the preceding year pursuant to Section 1063.5 shall remit the excess to the association as an additional premium within 30 days after the association has determined the amount of the excess recoupment and given notice to the member insurer of that amount. The excess shall be applied to reduce future premium charges in the appropriate category.

(B) Member insurers who report surcharge collections that are less than what they paid in the preceding year's premium charge shall receive reimbursement from the association for the shortfall in surcharge collection.

(C) Member insurers may amend their reports indicating the amount of surcharges collected for the prior five years if they discover there was an error in the original reports filed with the association.

(d) The plan of operation may permit a member insurer to omit collection of the surcharge from any of its insureds only if the expense of collecting the surcharge would exceed the amount of the surcharge, provided, however, that a member insurer is not entitled to reimbursement from the association pursuant to subparagraph (B) of paragraph (2) of subdivision (b) of any amount omitted from collection pursuant to this subdivision.

(e) This section applies only to premium charges paid on or after January 1, 2017.

(Amended by Stats. 2022, Ch. 408, Sec. 4. (AB 2154) Effective January 1, 2023.)

1063.145. The statement of the amount of surcharge required to be provided under subdivision (b) of Section 1063.14 shall include a description of, and purpose for, the California Insurance Guarantee Association, as follows:

"Companies writing property and casualty insurance business in California are required to participate in the California Insurance Guarantee Association. If a company becomes insolvent the California Insurance Guarantee Association settles unpaid claims and assesses each insurance company for its fair share.

California law requires all companies to surcharge policies to recover these assessments. If your policy is surcharged, 'CA Surcharge' with an amount will be displayed on your premium notice."

(Amended by Stats. 2006, Ch. 538, Sec. 453. Effective January 1, 2007.)

1063.15. In any workers' compensation matter the association shall have the same period of time within which to act or to exercise a right as is accorded to the insurer by the Labor Code, and those time periods shall be tolled against the association until 45 days after the appointment of a domiciliary or receiver.

(Added by Stats. 1991, Ch. 537, Sec. 2.)

1063.17. (a) All meetings of the board of governors of the association and its investment and audit committees shall be open and public, and all persons shall be permitted to attend any meeting of the association except as otherwise provided in subdivision (g). This shall apply to meetings conducted in person and via teleconference. Attendance at telephonically conducted meetings by members of the public shall be made available by the publication by the association in its meeting notices as set forth below of a call-in number and passcode that members of the public may use to participate in the meeting.

(b) As used in this section, "meeting" includes any congregation of a majority of the members of the board of governors or the investment and audit committee, as applicable, at the same time to hear, discuss, or deliberate upon any item that is within the responsibility of the association as set forth in this article or in the association's plan of operations. Notwithstanding the foregoing, a meeting shall not include any of the following:

(1) Individual contacts or conversations between a member of the board of governors and any other person, including, but not limited to, any employee or official of the association, that do not violate subdivision (c).

(2) The attendance of a majority of the members of the board of governors or a committee at an industry conference or other gathering organized by a person or organization other than the association, provided that a majority of the members do not discuss among themselves any item that is within the responsibility of the association as set forth in this article or in the association's plan of operations.

(3) The attendance of a majority of the members, the board of governors, or a committee at a purely social or ceremonial occasion, provided that a majority of the members do not discuss among themselves any item that is within the responsibility of the association as set forth in this article or in the association's plan of operations.

(c) (1) A majority of the members of the board of governors shall not, outside a meeting authorized by this article, use a series of communications of any kind, directly or through intermediaries, to discuss, deliberate, or take action on any item of business that is within the responsibility of the association as set forth in this article or in the association's plan of operations.

(2) Paragraph (1) shall not be construed as preventing any employee or officer of the association from engaging in separate conversations or communications outside of a meeting authorized by this article with members of the board of governors in order to answer questions or provide information regarding matters within the responsibility of the association, if that person does not communicate to members of the board of governors the comments or position of any other member or members of the board.

(d) All meetings of the association authorized under this article shall comply with the protections and prohibitions contained in Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132), and the federal rules and regulations adopted in implementation of that act.

(e) The association shall provide notice of its meetings that are open and public pursuant to subdivision (a). This notice and an agenda of items to be discussed shall be provided at least 10 days in advance of the meeting via the association's Internet Web site, and the notice shall be published in a newspaper of general circulation in the State of California. In addition, members of the public may request notice by regular mail or by e-mail by making a written request to the association for notice of meetings that are open and public pursuant to subdivision (a). Notice may be waived, or the 10-day period modified with respect to any particular meeting by the board of governors of the association upon request submitted to the commissioner stating the need for a modified notice and exigent circumstances requiring waiver of the notice requirement at least 24 hours in advance of the meeting time set. The approval of the commissioner shall be deemed granted if a written denial of the request for waiver or modification of the notice period is not received at least four hours prior to the commencement of the meeting to be conducted under the modified notice. Notice of a meeting that does not meet the 10-day notice requirement under this subdivision shall be posted on the association's Internet Web site and provided by e-mail to members of the public who have made a written request for e-mail notice to the association of meetings that are open and public pursuant to subdivision (a). A summary agenda shall be included in each such notice, but members of the board of governors may bring additional items of business to any such meeting.

(f) At any meeting where notice is required pursuant to this section, the association shall reserve time for public comment on the issues addressed at the meeting.

(g) Nothing in this section shall be construed to prohibit the board of governors of the association or its investment and audit committees from holding a closed meeting or a closed session of an open and public meeting to discuss any of the following subjects:

(1) Bond issuances or other matters relating to borrowings of the association.

(2) Matters regarding the detection and prevention of insolvency of members of the association as contemplated by this article.

(3) Nonpublic information received from liquidators, receivers, and regulators regarding members of the association.

(4) Nonpublic information received from the California Liquidation Office.

(5) Proprietary information regarding third-party administrators, vendors that provide products and services in connection with claims administration, or investments made by the association. Proprietary information also includes information which the association and its corresponding out-of-state associations only have access to pursuant to binding contractual confidentiality provisions.

(6) Nonpublic financial information regarding members of the association, including information in support of requests for assessment deferrals.

(7) Statutory interpretations and other advice received from legal counsel to the association, whether in connection with litigation or otherwise.

(8) Appointment, employment, evaluation of performance, or dismissal of any employee or vendor that provides products and services in connection with claims administration of the association.

(9) Deliberations concerning the purchase, sale, exchange, or lease of real or personal property, including investment property.

(10) Matters posing a threat of criminal or terrorist activity against the association, its personnel, or its property.

(11) Covered claims and purported covered claims against the association.

(12) Disputes and purported disputes with or involving members of the association.

(13) Any other matters as permitted by the commissioner under the association's approved plan, provided such matters may be heard in a closed meeting or a closed session consistent with Section 11126 of the Government Code.

(h) With respect to any closed meeting or session held as permitted by subdivision (g), the association shall do both of the following:

(1) Disclose, prior to the closed meeting or the closed session, the general nature of the item or items to be discussed in the closed session. The disclosure may take the form of a reference to the item or items as they are listed by number or letter on the agenda. In the closed session, the board of governors may consider only those matters covered in its disclosure. After any closed session, the board of governors shall reconvene in open session prior to adjournment and shall make any reports, provide any documentation, or make any other disclosures that may be required consistent with this article. The announcements required to be made in open session pursuant to this subdivision may be made at the location announced in the agenda for the closed session, as long as the public is allowed to be present at that location for the purpose of hearing the announcement.

(2) Provide periodic reports to the commissioner identifying the matters covered in each such closed meeting or session and the provision of subdivision (g) pursuant to which the subject was discussed.

(i) Nothing in this section shall require or authorize the disclosure of names or other information that would constitute an invasion of privacy or otherwise unnecessarily divulge the particular facts concerning the closed session or the disclosure of which is prohibited by state or federal law.

(j) The commissioner or his or her designated representative shall be permitted to attend all meetings of the board of governors and its investment and audit committees, specifically including closed meetings and sessions. Any information discussed in closed meetings or sessions shall be treated by the commissioner and his or her designated representatives as confidential pursuant to the provisions of Section 12919.

(Added by Stats. 2008, Ch. 407, Sec. 1. Effective January 1, 2009.)

1063.18. (a) Nothing in this article requires a final determination of a claim in an insolvent insurer's liquidation proceeding before a covered claim may be submitted to the California Insurance Guarantee Association (CIGA). Nothing in this article requires a claim to first be determined and approved by the liquidator before CIGA pays and discharges a covered claim. If a claim is presented to the association and all requirements under paragraph (1) of subdivision (c) of Section 1063.1 for processing a covered claim are satisfied, the association shall proceed to process the claim for payment under this article.

(b) If the association provides a written denial of a nonworkers' compensation claim, the person asserting the claim against the association shall have one year to bring an action challenging the denial, including an action for declaratory relief. If the written denial is based on a failure to exhaust other insurance available to pay the claim, a claim shall be reasserted against the association within six months after all other insurance has been exhausted.

(Added by Stats. 2015, Ch. 85, Sec. 1. (AB 822) Effective January 1, 2016.)

1063.19. (a) The association may administer the Prescribed Fire Claims Fund established by Section 4500 of the Public Resources Code, subject to prior written approval by the commissioner. The association shall seek the commissioner's approval by amending the association's plan of operations in accordance with Section 1063.

(b) Upon approval by the commissioner and if contracted to administer the Prescribed Fire Claims Fund by the Department of Forestry and Fire Protection on the department's behalf, the association is authorized to administer or assist in administering the Prescribed Fire Claims Fund consistent with Section 4500 of the Public Resources Code. The association shall not settle or adjust any claims to the fund while seeking to subrogate against the fund.

(c) The state, the association, the association's member insurers, and officers, directors, agents, and employees of the association or its member insurers shall not be liable for claims for losses described in Section 4500 of the Public Resources Code in excess of the amount in the Prescribed Fire Claims Fund or for the costs of administration, loss adjustment, investigation, and defenses relating to those claims in excess of the amount in the fund.

(d) This section shall remain in effect only until January 1, 2028, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2028, deletes or extends that date.

(Added by Stats. 2022, Ch. 606, Sec. 1. (SB 926) Effective September 27, 2022. Repealed as of January 1, 2028, by its own provisions.)