

CALIFORNIA INSURANCE CODE

790.3 (h) Unfair claims settlement practices.

Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

- (1) Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue.
- (2) Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies.
- (3) Failing to adopt and implement reasonable standards for the prompt investigation and processing of claims arising under insurance policies.
- (4) Failing to affirm or deny coverage of claims within a reasonable time after proof of loss requirements have been completed and submitted by the insured.
- (5) Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.
- (6) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds, when the insureds have made claims for amounts reasonably similar to the amounts ultimately recovered.
- (7) Attempting to settle a claim by an insured for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application.
- (8) Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured, his or her representative, agent, or broker.
- (9) Failing, after payment of a claim, to inform insureds or beneficiaries, upon request by them, of the coverage

under which payment has been made.

- (10) Making known to insureds or claimants a practice of the insurer of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.
- (11) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either, to submit a preliminary claim report, and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.
- (12) Failing to settle claims promptly, where liability has become apparent, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.
- (13) Failing to provide promptly a reasonable explanation of the basis relied on in the insurance policy, in relation to the facts or applicable law, for the denial of a claim or for the offer of a compromise settlement.
- (14) Directly advising a claimant not to obtain the services of an attorney.
- (15) Misleading a claimant as to the applicable statute of limitations.
- (16) Delaying the payment or provision of hospital, medical, or surgical benefits for services provided with respect to acquired immune deficiency syndrome or AIDS-related complex for more than 60 days after the insurer has received a claim for those benefits, where the delay in claim payment is for the purpose of investigating whether the condition preexisted the coverage. However, this 60-day period shall not include any time during which the insurer is awaiting a response for relevant medical information from a health care provider.