DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE BUREAU

ESSENTIAL INSURANCE

(By authority conferred on the director of the department of insurance and financial services by sections 210, 2102, 2113, 2127, and 2130 of the insurance code of 1956, 1956 PA 218, MCL 500.210, 500.2102, 500.2113, 500.2127, and 500.2130 and Executive Reorganization Order No. 2013-1, MCL 550.991)

R 500.1501 Definitions.

Rule 1. (1) As used in these rules:

(a) “Classification” means a grouping of individuals or risks on the basis of 1 or more characteristics for purposes of measuring and rating differences in anticipated losses or expenses, or both. A classification does not include a grouping of individuals or risks solely for statistical data gathering purposes.

(b) “Code” means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(c) “Complaint” means a written statement by a person to an insurer, a producer, or the director claiming that an insurer or producer has improperly denied him or her automobile insurance or home insurance or has charged an incorrect premium for automobile insurance or home insurance.

(d) “Denial” or “denied” means both declination and termination.

(e) “Incorrect premium” means a premium charged for automobile insurance or home insurance that is not consistent with a rate or rating plan or classification approved by the department.

(f) “Loss portion” means the portion of a rate that is attributable to provisions for incurred losses and allocated loss adjustment expenses.

(g) “Loss ratio” means any of the following ratios for a specified time period, as appropriate for the context of evaluation:

(i) The ratio of actual incurred losses to total earned premiums at collected rate levels.

(ii) The ratio of actual incurred losses to total earned premiums at current rate levels.

(iii) The ratio of reasonably anticipated incurred losses to total estimated earned premiums at proposed rate levels.

(h) “Rating cell” means a group of individuals or risks for which a single rate is determined when 2 or more rating classifications are combined to define a population of individuals or risks for rating purposes.

(i) “Relativity” means either the ratio of rates for any 2 rating classifications or the absolute difference in rates for any 2 rating classifications, whichever is applicable for a particular rating system.

(j) “Uncertainty of loss” means a measure of the nature and the extent of the variability of actual losses for a group of individuals or risks from the mean anticipated loss for the group and includes other similar measures of risk.

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(k) “Underwriting” means the offer or refusal to insure, the offer or refusal to continue to insure, or the limitation of the amount of coverage available to, an individual, risk, or class of individuals or risks.

(2) A term defined in the code has the same meaning when used in these rules.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1502 Other insurance coverages to be considered to be automobile insurance.

Rule 2. In addition to the insurance coverages described in section 2102(2)(a), (b), and (c) of the code, MCL 500.2102, all of the following insurance coverages are considered to be automobile insurance under section 2102(2)(d) of the code, MCL 500.2102:

(a) Insurance coverage commonly known as “uninsured motorist insurance,” for both bodily injury and property damage claims.

(b) Insurance coverage for the liability existing under section 3135(3)(e) of the code, MCL 500.3135.

(c) Insurance coverage commonly known as “underinsured motorist insurance.”

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1503 Excessive rates.

Rule 3. For the purposes of section 2109(1)(a) of the code, MCL 500.2109, both of the following apply in determining whether a rate for automobile insurance or home insurance is excessive:

(a) A rate is unreasonably high for the insurance coverage provided if it is unreasonably high in relation to anticipated losses or expenses, or both, or to the uncertainty of loss for the insurance coverage provided.

(b) A determination regarding the existence of a reasonable degree of competition must give due consideration to, at a minimum, all of the following:

(i) The relevant market for the coverage or the type of insurance to which the rate applies.

(ii) The number of insurers and the number of self-insurers actively engaged in underwriting or providing the coverage or type of insurance in the relevant market.

(iii) The distribution of rates and market shares for those insurers in the relevant market. Market shares may be measured either by premiums or exposures.

(iv) Past and prospective trends in the availability of coverage and coverage options for insurance of that type in the relevant market.

(v) Profits attributable to insurance of that type in relation to the profitability of other types of insurance, to the uncertainty of loss for that and other types of insurance, and to the amount of capital and surplus funds available to support premium underwritings for that and other types of insurance.

(vi) The ability and potential for insurers to enter and exit the relevant market and for financial capital and surplus funds to be allocated to, and to be removed from, the relevant market.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1504 Inadequate rates.

Rule 4. For purposes of section 2109(1)(b) of the code, MCL 500.2109, all of the following apply in determining whether a rate for automobile insurance or home insurance is inadequate:

(a) A rate is unreasonably low for the insurance coverage provided if it is unreasonably low in relation to anticipated losses or expenses, or both, or to the uncertainty of loss for the insurance coverage provided.

(b) Applicants who are in good faith entitled to procure the insurance through ordinary methods are the persons who are eligible persons, as defined in section 2103(1) or (2) of the code, MCL 500.2103, with respect to that insurance.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1505 Unfairly discriminatory rates.

Rule 5. (1) For purposes of section 2109(1)(c) of the code, MCL 500.2109, a rate for a coverage is unfairly discriminatory in relation to another rate for the same coverage if the differential between the rates is not reasonably justified by differences in losses, expenses, or both, or by differences in the uncertainty of loss, for the individuals or risks to which the rates apply. A reasonable justification must be supported by a reasonable classification system; by sound actuarial principles when applicable; and by actual and credible loss and expense statistics or, in the case of new coverages and classifications, by reasonably anticipated loss and expense experience.

(2) A rate is not unfairly discriminatory because it reflects differences in expenses for individuals or risks with similar anticipated losses, or because it reflects differences in losses for individuals or risks with similar expenses.

(3) A reasonable classification system is a system designed to group individuals or risks with similar characteristics into rating classifications that are likely to identify significant differences in mean anticipated losses or expenses, or both, between the groups, as determined by sound actuarial principles and by actual and credible loss and expense statistics or, in the case of new coverages or classifications, by reasonably anticipated loss and expense experience.

(4) Sound actuarial principles must include, but are not limited to, all of the following principles:

(a) That data used in developing classifications and rates are derived from the experience of a population or sample of risks that is sufficiently similar to the anticipated insured population so that the statistics obtained can reasonably be expected to produce representative and reliable estimates of the anticipated loss and expense experience for the insured population and are calculated in a manner that is suitable to their intended use.

(b) That a reasonable predictive relationship can be demonstrated to exist between a characteristic used in defining a rating classification and anticipated losses, anticipated expenses, or the uncertainty of loss for the risks to which the classification applies.

(c) That if rates for individual rating cells are calculated by means of arithmetic combinations of relativities for the classifications defining those rating cells, the relativities are combined in a manner that equitably reflects the anticipated loss and expense experience for those rating cells.

(d) That sampling techniques used in developing classifications and in estimating loss and expense experience are suitable to their intended application.

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(e) That with regard to private passenger automobile insurance and private residential property insurance, rates for an insurance coverage provided are established in a manner that can reasonably be anticipated to produce loss ratios that are substantially uniform among the classifications, kinds, or types of individuals or risks to which the rates apply. Evaluation of loss ratios must make appropriate adjustments for differences in deductibles and limits of liability among insureds, for expense provisions that are not allocated to premiums on a percentage-of-premium basis, and for differences in contingency factors among classifications and must give due consideration to the credibility of experience for groupings of individuals or risks, to trends in past and prospective loss experience, and to historical patterns between projected and realized loss ratios. For purposes of this subdivision, "substantially uniform" means the absence of significant variations among loss ratios. This subdivision does not prohibit the use of appropriate pure premium relativities to estimate or evaluate rate relativities.

(5) Data of an insurer or rating organization used in calculating actual and credible loss statistics must be of sufficient volume, or combined in an appropriate manner with suitable data of sufficient volume, so that the statistics calculated are reasonably credible and can reasonably be anticipated to produce reliable estimates of anticipated loss and expense experience.

(6) Data for reasonably anticipated experience used in calculating rates for new coverages and in establishing new classifications must, to the extent possible, be based on actual experience for similar coverages and for groups of risks similar to the proposed classification and be of sufficient volume so that statistics produced can reasonably be anticipated to produce reliable estimates of loss and expense experience.

(7) Relevant external information, including general economic data and other indicators, may be given due consideration in evaluating or projecting loss and expense experience.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1506 Expense provisions.

Rule 6. (1) The expense portion of a rate must, with regard to each category of expense, be examined and evaluated independent of the loss portion of the rate. Expenses must not be presumed to change by the same percentage as losses are anticipated to change.

(2) Predictions of future expense costs must give due consideration to trends and changes in historical expense levels, in actual or reasonably allocated expenses incurred, and in external expense indices and indicators.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1507 Expense allocation.

Rule 7. (1) Expense provisions for each category of expenses must be reasonably allocated among classifications in a manner that equitably reflects variations, if any, in the manner in which those expenses are anticipated to be incurred with respect to the groups of individuals or risks defined by those classifications. Expenses, other than allocated loss adjustment expenses, must not be presumed to be incurred proportionally to classification relativities based on anticipated loss.

(2) Expense provisions for premium taxes, if any, must reflect the applicable premium tax rate.

(3) Expense provisions for each other category of expenses must be reasonably allocated among classifications based on losses, coverages, exposures, or other basis that equitably measures the variations, if any, in the manner in which those expenses are anticipated to be incurred with respect to the classifications. Expense allocation methods may include percentage-of-premium, uniform-per-coverage, uniform-per-exposure, or other basis, as appropriate and justified.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1508 Complaint-resolution process; notice of rights; private informal managerial-level conference.

Rule 8. (1) At the time of a denial of automobile insurance or home insurance, the insurer or producer making the denial shall provide the person subject to the denial written notice of his or her right to submit a complaint and to have a private informal managerial-level conference if he or she has reason to believe that the denial is improper.

(2) If a person has reason to believe that he or she has been charged in incorrect premium and informs the insurer or producer of that belief, the insurer or producer shall promptly provide the person written notice of his or her right to submit a complaint and to have a private informal managerial-level conference.

(3) The written notices required under subrule (1) and (2) of this rule must be in language understandable to a person of ordinary intelligence and must include, but need not be limited to, an explanation of all of the following:

(a) The person's right to submit a complaint and the procedure the person shall follow if he or she wishes to submit a complaint.

(b) The person's right to be provided information pertinent to the denial or premium charge upon request, subject to payment of a reasonable copying charge. An insurer's reasonable copying charge under this subdivision must not exceed the rate charged for copying by the department in accordance with the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246. The director shall inform insurers of that maximum allowable copying charge on an annual basis.

(c) The person's right to a private informal managerial-level conference addressing the complaint with the insurer, the procedure the person shall follow if he or she wishes to request a private informal managerial-level conference, and the process applicable to a private informal managerial-level conference. All of the following apply to that process:

(i) If a private informal managerial-level conference is requested, the conference and proposed resolution must be provided by the insurer within 30 days after the date of the person's request.

(ii) The private informal managerial-level conference may be held by telephone, video teleconference or other substantially similar electronic means, or in-person, as long as the following requirements are met:

(A) If the conference is held by telephone or video teleconference or other substantially similar electronic means, the insurer shall state at the beginning of the conference that it is a private informal managerial-level conference and identify all persons by name and title who are listening to, or otherwise participating in, the conference. In addition, the insurer shall either provide a toll-free telephone service or other service at no cost to the person making the complaint, or pay all charges associated with the conference. As applicable, the written notice

Courtesy of Michigan Administrative Rules

must indicate the telephone number that must be called and state that the telephone number may be called collect if a toll-free number is not provided or explain in sufficient detail other instructions for participating in a conference held by video teleconference or other substantially similar electronic means.

(B) If the conference is held in-person, the conference must be held within a reasonably accessible distance from the Michigan residence of the person or persons named on the policy as insured or the location of the risk and be held at a time reasonably convenient to the person making the complaint or the person's designated representative.

(iii) The private informal managerial-level conference must include the participation of the person making the complaint, or the person's designated representative, and a supervisory or higher level representative of the insurer who is authorized to decide the dispute on behalf of the insurer.

(d) The person's right to submit a complaint to the director and for a review and determination if the private informal managerial-level conference fails to resolve the dispute. The written notice must explain this right as described in R 500.1510.

(e) The person's right to appoint another person as his or her designee to act on his or her behalf throughout the complaint-resolution process set forth in this rule and R 500.1509 to R 500.1514.

(4) A compliant, request for information pertinent to the denial or premium charge, and request for a private informal managerial-level conference submitted pursuant to subrule (3) of this rule must be made not later than 30 days after the date of the written notice required under subrule (1) or (2) of this rule unless an exception is made by the insurer to extend that 30-day period. An exception extending the 30-day period under this subrule must be in writing and provided to the person making the complaint or request for information or private informal managerial-level conference.

(5) An insurer or producer shall send the written notices required under subrules (1) and (2) of this rule, or if applicable, a written extension of the 30-day period under subrule (4) of this rule, by mail, unless the insurer or producer and the person entitled to the notice or extension have previously agreed to another means of communication and that agreement includes within its scope the notice or extension contemplated under this rule and is consistent with applicable law.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1509 Complaint-resolution process; information provided following private informal managerial-level conference.

Rule 9. (1) Upon the conclusion of a private informal managerial-level conference, the insurer shall provide the person making the complaint the following information in writing and in language understandable to a person of ordinary intelligence:

(a) The action taken by the insurer to resolve the dispute.

(b) The facts and documentation supporting the action.

(c) The specific section or sections of the law supporting the action.

(d) A statement explaining the person's right to submit a complaint to the director and for a review and determination within 120 days after the date that the information under this rule is mailed or provided if the person disagrees with the proposed resolution included in the information. The statement must also provide instructions regarding how to submit a complaint

to the director and request a review and determination, provide the department's toll-free number and mailing address, and clearly indicate the date that the information under this rule is mailed or provided.

(e) A statement describing the status of the automobile or home insurance coverage or coverages involved.

(2) The insurer shall mail the information under subrule (1) of this rule to the person making the complaint, unless the insurer and the person have previously agreed to another means of communication and that agreement includes within its scope providing the information contemplated under this rule and is consistent with applicable law.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1510 Complaint-resolution process; right to director's review and determination; review of written materials; meeting.

Rule 10. (1) If a person has reason to believe an insurer or producer has improperly denied him or her automobile insurance or home insurance or has charged an incorrect premium for that insurance and a private informal managerial-level conference fails to resolve the dispute because the person disagrees with the insurer's proposed resolution following the conference or the insurer did not provide a private informal managerial-level conference and proposed resolution within 30 days after the date of the person's request, the person has a right to submit a complaint to the director and for a review and determination to resolve the dispute.

(2) The person making the complaint shall submit the complaint and request for the director's review and determination in a form and manner approved by the director within 120 days after the date the insurer mails or provides the information required under R 500.1509 or within 120 days after the expiration of the 30-day period that the insurer has to provide a proposed resolution to the person making the complaint if no proposed resolution is provided during that 30-day period.

(3) The person making the complaint is entitled to a review of the dispute by the director either through a review of written materials or, upon the person's written request, through a meeting, subject to subrule (4) of this rule. A request for a meeting must be made at the same time the person submits the complaint and request for the director's review and determination.

(4) A meeting requested pursuant to subrule (3) of this rule, may, as permitted by the director, be held by telephone, video teleconference or other substantially similar electronic means, or if requested by the person making the complaint, in-person. A request for an in-person meeting must be made at the same time the person submits the complaint and request for the director's review and determination. Any meeting under this subrule must include the director or his or her designee, the person making the complaint or his or her designated representative, and a supervisory or higher level representative of the insurer authorized to act on behalf of the insurer. If an in-person meeting is held, the insurer's authorized representative may participate through telephone or video teleconference or other substantially similar electronic means. The director shall conduct any meeting under this subrule in a manner that allows the person making the complaint and insurer to present relevant facts, records, dates, times, and names to substantiate their respective positions regarding the dispute.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

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R 500.1511 Complaint-resolution process; notice of director's review of dispute.

Rule 11. The director shall do all of the following within 10 business days after the director receives a complaint and request for the director's review and determination, as applicable:

(a) For a review and determination conducted through a meeting pursuant to R 500.1510(4), set a time for the meeting and notify the person making the complaint and the insurer of the time, manner, and place of the meeting.

(b) For all review and determinations, notify the insurer of the time period within which any reply must be submitted to the director and of the disputed issue or issues under consideration. A copy of that notification must be provided to the person making the complaint.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1512 Complaint-resolution process; basis for director's determination; failure to supply materials or information.

Rule 12. (1) If a review and determination is conducted through written materials, the director shall base his or her determination upon written materials submitted by the person making the complaint and the insurer.

(2) If a review and determination is conducted through a meeting pursuant to R 500.1510(4), the director shall base his or her determination upon written materials submitted by the person making the complaint and the insurer, any statements made at the meeting, or a combination of both.

(3) If the person making the complaint or the insurer fails to supply any materials or information in a timely manner, the director shall base his or her determination upon materials and information available to the director at the time of the determination.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1513 Complaint-resolution process; director's decision; contested case.

Rule 13. (1) If a review and determination is conducted through written materials, the director shall issue a written decision of his or her determination of the disputed issue or issues within 15 business days after the insurer submits a reply to the complaint during the time period established by the director under R 500.1511 or, if a reply is not submitted to the director during that time period, within 15 business days after that time period has expired.

(2) If a review and determination is conducted through a meeting pursuant to R 500.1510(4), the director shall issue a written decision of his or her determination of the disputed issue or issues within 15 business days after the meeting is concluded.

(3) The director shall indicate in the written decision that if either the insurer or the person making the complaint disagrees with the determination, the director, if requested to do so, shall proceed to hear the matter as a contested case under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328.

(4) The director shall provide copies of the written decision to the insurer and the person making the complaint.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

Courtesy of Michigan Administrative Rules

R 500.1514 Complaint-resolution process; remedies based on director's review and determination.

Rule 14. (1) Subject to subrule (2) of this rule, if the director concludes that the person making the complaint was improperly denied automobile insurance or home insurance, the director shall order an appropriate remedy.

(2) If the director concludes that the automobile insurance or home insurance of the person making the complaint was improperly terminated, the person may select any of the following remedies:

(a) The termination is deemed invalid and coverage is reinstated effective as of the date of the termination upon payment of the applicable premium.

(b) The termination is deemed invalid and coverage is reinstated effective as of the date of the director's decision issued under R 500.1513 upon payment of the applicable premium, subject to the following conditions if the person has secured coverage from an insurer other than the insurer that improperly terminated the insurance:

(i) Upon notice from the person, the coverage must be canceled and the insurer providing the coverage shall provide the person a refund of premium pursuant to the insurer's filed rating rules.

(ii) The insurer that improperly terminated the insurance shall pay the person any additional premium expenditures incurred by the person as a result of seeking additional coverage in excess of the pro rata premium the person would have paid for the coverage from the improperly terminating insurer for the same period of time.

(c) If the person has secured coverage from an insurer other than the insurer that improperly terminated the insurance, the person may continue that coverage, and the termination is deemed invalid but coverage is not reinstated.

(3) If the director concludes that the person making the complaint was charged an incorrect premium, the director shall order an appropriate remedy.

(4) If the director orders an appropriate remedy under this rule, the insurer shall, within 10 business days after the director's order, comply with the director's order, provide the required remedy to the person making the complaint, if any, and provide documentation to the director showing how the specific remedy was determined, calculated, or assessed when providing it to the person.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1515 Collection and reporting of data by insurers.

Rule 15. For purposes of section 2127 of the code, MCL 500.2127, all of the following apply:

(a) Every insurer subject to chapter 21 of the code, MCL 500.2101 to 500.2131, underwriting automobile insurance or home insurance, or both, in this state shall report data concerning the insurance in accordance with statistical plans and reporting forms approved by the director. The reporting plans and forms must provide for the collection of only the information the director finds necessary to monitor and evaluate the automobile and home insurance markets in this state, as provided in section 2127 of the code, MCL 500.2127.

Courtesy of Michigan Administrative Rules

(b) Statistical plans approved by order of the director for licensed statistical gathering agencies are accepted to provide adequate historical premium, exposure, loss, and expense information for automobile and home insurance.

(c) Supporting data for automobile and home insurance rate filings submitted in accordance with the forms with instructions issued by the director are assumed to comply substantially with information needs for evaluating overall rate level needs, 1 of the elements in monitoring and evaluating markets per section 2127 of the code, MCL 500.2127.

(d) The director shall accept annual statement data on 1 element in the process of monitoring competition.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1516 Exchange of claim information.

Rule 16. Every insurer subject to chapter 21 of the code, MCL 500.2101 to 500.2131, shall exchange claim information for automobile insurance and home insurance as provided in these rules to the extent the information is available from the responding company's data base. The information must not be requested for selected policyholders on the basis of age, sex, or other factor that is discriminatory in nature.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1517 Exchange of automobile insurance claim information.

Rule 17. (1) Every insurer subject to chapter 21 of the code, MCL 500.2101 to 500.2131, underwriting automobile insurance shall respond, on a form similar to figure 1 under R 500.1521, within 30 calendar days, to a request by another insurer for information concerning the claim history of a specified person.

(2) The reporting insurer shall report automobile insurance claim information as follows:

(a) The name and address of the insured.

(b) The policy number of such insured.

(c) The name of the driver of the insured vehicle, if known.

(d) The period of time insured, if available, but in all cases, the expiration date.

(e) Whether the claim is open or closed at the time of the report.

(f) Date or dates of loss.

(g) Amount of loss paid under each coverage.

(3) The requesting insurer shall specify in its request for claim information the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1518 Exchange of home insurance claim information.

Rule 18. (1) Every insurer subject to chapter 21 of the code, MCL 500.2101 to 500.2131, underwriting home insurance shall respond, on a form similar to figure 1 under R 500.1521,

Courtesy of Michigan Administrative Rules

within 30 calendar days, to a request by another insurer for information concerning the claim history of a specified person. The claim information requested or reported must be information as described in section 2111(7)(f) of the code, MCL 500.2111.

(2) The reporting insurer shall report home insurance information as follows:

(a) Name and address of the insured.

(b) Policy number of such insured.

(c) Location of insured premises.

(d) Date of loss or losses.

(e) Amount paid.

(f) Coverage involved.

(g) Whether or not a fire loss was investigated by civil authorities.

(3) The requesting insurer shall specify in its request the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1519 Exchange of claim information; reporting period.

Rule 19. An insurer is responsible for reporting, upon request, automobile insurance and home insurance claim information only for current policies or those that expired 90 days immediately preceding the date of receipt of a request for claim information. The claim information reported must cover the 3 years last preceding the expiration date, including claim information originally reported by another carrier.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1520 Fee for providing claim data prohibited.

Rule 20. A fee must not be charged by an insurer for providing the claim information required by these rules for the first 12 calendar months immediately following October 30, 1981.

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1521 Figure 1.

Rule 21. Figure 1 reads as follows:

Date Submitted: ______________________

Named Insured _____________________

Address ______________________________

Responding Company

Policy Number ________________________ Period Insured: From ______ to ______

We recently received an application for auto property (circle one) insurance from the above individual. As provided for in Section 2130 of the Insurance Code of 1956, 1956 PA 218, MCL

500.2130, please supply the claim experience for the past 3 years as available. If additional space is needed, please complete on the back of this form.

FOR AUTOMOBILE CLAIMS

Claim Status (Check One)				Amount of Loss Paid			Name of Driver of Insured
Open	Closed	Loss Date	BI	PIP	PD	Coll	Vehicle if Available
1.______	________	_________	_____	_____	_____	_____	_______________
2.______	________	_________	_____	_____	_____	_____	_______________
3.______	________	_________	_____	_____	_____	_____	_______________

FOR HOME INSURANCE CLAIMS

Location of Premises Insured	Loss Date	Amount Paid	Coverage Involved	If Investigated Made by Civil Authority Please Identify
1.__________________	_________	_________	_________	______________________
2.__________________	_________	_________	_________	______________________
3.__________________	_________	_________	_________	______________________

Enclosed is a self addressed stamped envelope. Thank you.
Form Completed by

____
Name of Company

____
Address

____
Date Completed

History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

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