(Third Corrected Copy)

CHAPTER 89

AN ACT concerning automobile insurance and revising parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.17:30A-2.1 Findings, declarations relative to automobile insurance and consolidation of operations.

1. With respect to sections 2 through 34 of this act, the Legislature finds and declares that:

a. The Unsatisfied Claim and Judgment Fund, created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.) currently serves a dual purpose: its original intent to pay the claims of victims of hit and run or uninsured motor vehicle accidents in certain circumstances, and a subsequent objective to reimburse private passenger automobile insurers when medical expense benefits payments exceed $75,000 per person per accident.

b. When the Unsatisfied Claim and Judgment Fund was charged with reimbursing an insurer for medical expense benefits in excess of $75,000 per person per accident, the amount of medical expense benefits provided on a per person, per accident basis was unlimited. However, insurers are required at present to provide medical expense benefits only up to $250,000 per person per accident. Prospective elimination of the reimbursement function of the Unsatisfied Claim and Judgment Fund for medical expense benefits in excess of $75,000 per person for an injury suffered in an accident covered by a policy issued or renewed on or after January 1, 2004 is deemed appropriate. Insurers would continue to be reimbursed for medical benefits in excess of $75,000 per person per accident for injuries suffered in accidents covered by policies issued or renewed prior to January 1, 2004.

c. Since all motor vehicle liability policies issued in this State, except basic automobile insurance policies, include coverage for the payment of all or part of the sums which a person insured thereunder shall be legally entitled to recover as compensatory damages from owners or operators of uninsured motor vehicles (other than hit and run motor vehicles), the number of third party claims made against the Unsatisfied Claim and Judgment Fund is not substantial. It would be more efficient to have these claims administered by the New Jersey Property-Liability Insurance Guaranty Association, established pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.).

d. The New Jersey Automobile Full Insurance Underwriting Association, created pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.) and the Market Transition Facility, created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11) have both ceased issuing private passenger automobile insurance policies and are currently in run off, operating only to process the remaining claims against them. Currently, the funding for the claims payment and other operational activities of the New Jersey Automobile Full Insurance Underwriting Association and the Market Transition Facility is primarily provided by the New Jersey Automobile Insurance Guaranty Fund, created pursuant to section 23 of P.L.1990, c.8 (C.17:33B-5). However, existing statutes do not state how the consolidation or runoff operations of these entities will be handled. Administrative and operational efficiencies would result from consolidating these entities and transferring the claims handling and other administrative duties of these entities to the New Jersey Property-Liability Insurance Guaranty Association.

e. Based upon recent financial and actuarial analysis, it is anticipated that the value of all residual New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility assets, including the balances in the New Jersey Automobile Insurance Guaranty Fund, to be transferred to the New Jersey Property-Liability Insurance Guaranty Association will be adequate to allow the association to discharge all remaining obligations of the New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility which are now to be administered by the association. Since no asset shortfall is projected, no additional assessment or other revenue generating powers are being conferred upon the association at this time with respect to such remaining obligations.

f. It is in the public interest to authorize the transfer and consolidation of compatible operations of the Unsatisfied Claim and Judgment Fund, the New Jersey Automobile Full Insurance Underwriting Association, and the Market Transition Facility to the New Jersey Property-Liability Insurance Guaranty Association.

g. Following transfer to the New Jersey Property-Liability Insurance Guaranty Association by the Unsatisfied Claim and Judgment Fund of all its management, administrative and claim

functions, the Unsatisfied Claim and Judgment Fund shall continue to exist as a separate legal entity subject to the provisions of P.L.2003, c.89 (C.17:30A-2.1 et al.).

h. The New Jersey Property-Liability Insurance Guaranty Association will run off the remaining policyholder claim obligations of the New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility. The New Jersey Property-Liability Insurance Guaranty Association will also run off the obligations of the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1) and take over all governance, administrative and financial functions of the Unsatisfied Claim and Judgment Fund, including the claim payment function.

i. As part of the consolidation being accomplished by P.L.2003, c.89 (C.17:30A-2.1 et al.), the New Jersey Property-Liability Insurance Guaranty Association is formally designated as a servicing facility for several statutory entities for which it currently provides administrative services and also for the Unsatisfied Claim and Judgment Fund which, pursuant to P.L.2003, c.89 (C.17:30A-2.1 et al.), is transferring specified functions to the New Jersey Property-Liability Insurance Guaranty Association. The association is also authorized to serve, either by designation or by contract, as a servicing facility for other entities which may be recommended by the association's board of directors and approved by the commissioner.

j. This act is not intended to abrogate in any way the settlement agreement entered into by the State and member insurers of the Market Transition Facility in June, 1994.

2. Section 2 of P.L.1974, c.17 (C.17:30A-2) is amended to read as follows:

C.17:30A-2 Payment of covered claims.

2. a. The purpose of this act is to provide a mechanism for the payment of covered claims under certain insurance policies, to avoid excessive delay in payment, to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, to provide an association to assess the cost of such protection among insurers, and to provide a mechanism to run off, manage, administer and pay claims asserted against the Unsatisfied Claim and Judgment Fund, created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.), the New Jersey Automobile Full Insurance Underwriting Association, created pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.), and the Market Transition Facility, created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11).

b. This act shall apply to all kinds of direct insurance, except life insurance, accident and health insurance, workers' compensation insurance, title insurance, annuities, surety bonds, credit insurance, mortgage guaranty insurance, municipal bond coverage, fidelity insurance, investment return assurance, ocean marine insurance and pet health insurance.

3. Section 6 of P.L.1974, c.17 (C.17:30A-6) is amended to read as follows:

C.17:30A-6 New Jersey Property-Liability Insurance Guaranty Association.

6. There is created a private, nonprofit, unincorporated, legal entity to be known as the New Jersey Property-Liability Insurance Guaranty Association. All insurers defined as member insurers in subsection 5 f. shall be and remain members of the association as a condition of their authority to transact insurance in this State. The association shall perform its functions under a plan of operation established and approved under section 9 and shall exercise its powers through a board of directors established under section 7.

The association is also authorized and shall have all of the powers necessary and appropriate for the management and administration of the affairs of the New Jersey Surplus Lines Insurance Guaranty Fund, in accordance with the provisions of the "New Jersey Surplus Lines Insurance Guaranty Fund Act," P.L.1984, c.101 (C.17:22-6.70 et seq.).

The association is also authorized and shall have all of the powers necessary and appropriate for the management and administration of the affairs of, and the payment of valid claims asserted against: the Unsatisfied Claim and Judgment Fund, created pursuant to the provisions of P.L.1952, c.174 (C.39:6-61 et seq.); the New Jersey Automobile Full Insurance Underwriting Association, created pursuant to the provisions of P.L.1983, c.65 (C.17:30E-1 et seq.); and the

Market Transition Facility created pursuant to the provisions of section 88 of P.L.1990, c.8 (C.17:33B-11).

4. Section 8 of P.L.1974, c.17 (C.17:30A-8) is amended to read as follows:

C.17:30A-8 Association's obligations, powers and duties.

8. a. The association shall:

(1) Be obligated to the extent of the covered claims against an insolvent insurer incurred, in the case of private passenger automobile insurance, prior to or after the determination of insolvency, but before the policy expiration date or the date upon which the insured replaces the policy or causes its cancellation, or in the case of insurance other than private passenger automobile insurance, covered claims against such insolvent insurer incurred prior to or 90 days after the determination of insolvency, or before the policy expiration date if less than 90 days after said determination, or before the insured replaces the policy or causes its cancellation, if he does so within 90 days of the determination, but such obligation shall include only that amount of each covered claim which is less than $300,000.00 and subject to any applicable deductible contained in the policy, except that the $300,000.00 limitation shall not apply to a covered claim arising out of insurance coverage mandated by section 4 of P.L.1972, c.70 (C.39:6A-4). In the case of benefits payable under subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4), the association shall be liable for payment of benefits in an amount not to exceed the amount set forth in section 4 of P.L.1972, c.70 (C.39:6A-4). In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the limits of liability stated in the policy of the insolvent insurer from which the claim arises;

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) Assess member insurers in amounts necessary to pay:

(a) The obligations of the association under paragraphs (1) and (11) of this subsection;

(b) The expenses of handling covered claims;

(c) The cost of examinations under section 13; and

(d) Other expenses authorized by this act, excluding expenses incurred by the association pursuant to paragraphs (9) and (10) of this subsection.

The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment.

Each member insurer shall be notified of the assessment not later than 30 days before it is due. No member insurer of the association may be assessed pursuant to this paragraph (3) in any year in an amount greater than 2% of that member insurer's net direct written premiums for the calendar year preceding the assessment with regard to the association's obligation to pay covered claims and related expenses arising under coverages issued by insolvent insurers pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.).

The association may, subject to the approval of the commissioner, exempt, abate or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts 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. In the event an assessment against a member insurer is exempted, abated, or deferred, in whole or in part, because of the limitations set forth in this section, the amount by which such assessment is exempted, abated, or deferred shall be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. If the maximum assessment, together with the other assets of the association, does not provide in any one year an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as it is permitted by this act. Each member insurer serving as a servicing facility may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by such member insurer;

(4) Investigate claims brought against the association and adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested;

(5) Notify such persons as the commissioner directs under paragraph (1) of subsection b. of section 10 of P.L.1974, c.17 (C.17:30A-10);

(6) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer. The association is designated as a servicing facility for the administration of claim obligations of: (a) the New Jersey Surplus Lines Insurance Guaranty Fund; (b) the New Jersey Medical Malpractice Reinsurance Association; and (c) the Unsatisfied Claim and Judgment Fund. The association may also be designated or may contract as a servicing facility for any other entity which may be recommended by the association's board of directors and approved by the commissioner;

(7) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this act;

(8) Make loans to the New Jersey Surplus Lines Insurance Guaranty Fund and the Unsatisfied Claim and Judgment Fund is such amounts and on such terms as the board of directors may determine are necessary or appropriate to effectuate the purposes of P.L.2003, c.89 (C.17:30A-2.1 et al.) in accordance with the plan of operation; provided, however, no such loan transaction shall be authorized to the extent the federal tax exemption of the association would be withdrawn or the association would otherwise incur any federal tax or penalty as a result of such transaction;

(9) Assess member insurers in amounts necessary to make loans pursuant to paragraph (10) of this subsection. The estimated assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year preceding the assessment bears to the net direct written premiums of all member insurers for the calendar year preceding the assessment with actual assessments adjusted in the succeeding year based on the proportion that the assessed member insurer's net direct written premiums in the year of assessment bears to the net direct written premiums of all member insurers for that year.

(a) For the purposes of this paragraph, "net direct written premiums" shall not include medical malpractice liability insurance premiums paid to member insurers to which an additional charge has been applied for deposit in the New Jersey Medical Malpractice Reinsurance Recovery Fund as provided in the "Medical Malpractice Liability Insurance Act," P.L.1975, c.301 (C.17:30D-1 et seq.) and the regulations promulgated pursuant thereto.

(b) In the event that the commissioner certifies that loans in amounts less than $160 million per calendar year as provided in paragraph (10) of this subsection will satisfy the current and anticipated financial obligations of the Market Transition Facility, without reference to the amount of funds remaining from the sale of the Market Transition Facility Senior Lien Revenue Bonds, a member insurer, and all of its affiliates as defined in subsection a. of section 1 of P.L.1970, c.22 (C.17:27A-1), shall be subject to a reduced assessment pursuant to this paragraph if the member insurer and all such affiliates: (I) did not issue or renew a policy of private passenger automobile insurance in this State on or after January 1, 1973; (ii) were not assessed as members of the Market Transition Facility as established by section 88 of P.L.1990, c.8 (C.17:33B-11); and (iii) had not relinquished voluntarily any expectation they may have had for the repayment of loans made pursuant to paragraph (10) of this subsection, as provided by paragraph (2) of subsection b. of section 6 of P.L.1983, c.65 (C.17:29A-35), pursuant to any court order or settlement agreement approved by any court of competent jurisdiction, on or before the effective date of this 1995 amendatory act. The reduced assessment of such members shall be equal to their proportionate share of the difference between the amount certified by the commissioner and the total of the assessment of all other insurers subject to such assessment. If the amount of such difference is zero or less, the reduced assessment shall be zero;

(10) Make loans in the amount of $160 million per calendar year, beginning in calendar year

1990, or upon certification by the commissioner, as provided by paragraph (b) of subsection (9) of this section, that lesser amounts will satisfy the current and anticipated financial obligations of the Market Transition Facility, such lesser amounts as may be collected pursuant to paragraph (9) of this subsection, to the New Jersey Automobile Insurance Guaranty Fund created pursuant to section 23 of P.L.1990, c.8 (C.17:33B-5), except that no loan shall be made pursuant to this paragraph after December 31, 1997. In no event shall member insurers subject to assessments have their financial obligation increased due to reductions granted pursuant to paragraph (9) of this subsection;

(11) Reimburse an insurer for medical expense benefits in excess of $75,000 per person per accident as provided in section 2 of P.L.1977, c.310 (C.39:6-73.1) for injuries covered under an automobile insurance policy issued prior to January 1, 2004;

(12) Undertake all of the management, administrative, and claims activities of the Unsatisfied Claim and Judgment Fund, created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.), the New Jersey Automobile Full Insurance Underwriting Association, created pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.), and the Market Transition Facility, created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11).

b. The association may:

(1) Employ or retain such persons as are necessary to handle claims and perform such other duties of the association;

(2) Borrow and separately account for funds from any source, including, but not limited to, the New Jersey Surplus Lines Insurance Guaranty Fund and the Unsatisfied Claim and Judgment Fund, in such amounts and on such terms, as the board of directors may determine are necessary or appropriate to effectuate the purpose of this act in accordance with the plan of operation; provided, however, no such borrowing transaction shall be authorized to the extent the federal tax exemption of the association would be withdrawn or the association would otherwise incur any federal tax or penalty as a result of such transaction;

(3) Sue or be sued;

(4) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this act;

(5) Perform such other acts as are necessary or proper to effectuate the purpose of this act;

(6) Refund to the member insurers in proportion of the contribution of each member insurer that amount by which the assets exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities, as estimated by the board of directors for the coming year.

5. Section 9 of P.L.1974, c.17 (C.17:30A-9) is amended to read as follows:

C.17:30A-9 Plan of operation.

9. a. (1) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner;

(2) If the association fails to submit a plan of operation acceptable to the commissioner within 90 days following the effective date of this act, or if at any time thereafter the association fails to submit an acceptable amendment to the plan, the commissioner shall, after notice and hearing adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this act. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

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

c. The plan of operation shall:

(1) Establish the procedures whereby all the powers and duties of the association under section 8 of this act will be performed;

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

(3) Establish the amount and method of reimbursing members of the board of directors under section 7 of this act;

(4) Establish procedures by which claims may be filed with the association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent and a list of such claims shall be periodically submitted to the association by the receiver or liquidator;

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

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

(7) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within 30 days after the action or decision;

(8) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner;

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

(10) Establish procedures for the transition and consolidation of compatible functions of the Unsatisfied Claim and Judgment Fund, the New Jersey Automobile Full Insurance Underwriting Association and the Market Transition Facility in order to eliminate redundant operational activities and promote greater efficiencies in claims handling and other operations;

(11) Establish procedures as necessary or proper to finance the operation of and account for receipts and disbursements as well as other financial transactions involving the Unsatisfied Claim and Judgment Fund, the New Jersey Automobile Full Insurance Underwriting Association and the Market Transition Facility;

(12) Create such advisory boards as necessary or proper to assist in the administration and management of the operations of the Unsatisfied Claim and Judgment Fund.

d. The plan of operation may provide that any or all powers and duties of the association except those under sections 8a.(3) and 8b.(2), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent. Such a corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of the functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this act.

C.17:30A-6.1 Transfer of functions, powers, duties to PLIGA.

6. a. Notwithstanding the provisions of any other law to the contrary, all of the functions, powers and duties of the New Jersey Automobile Full Insurance Underwriting Association, created pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.), and the Market Transition Facility, created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11), shall be transferred to the New Jersey Property-Liability Insurance Guaranty Association, established pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.).

b. Notwithstanding the provisions of any other law to the contrary, the commissioner shall provide for the liquidation of the policyholder liabilities and an orderly transfer and transition of the operations, functions, powers and duties, including all the remaining assets and policyholder liabilities of the New Jersey Automobile Full Insurance Underwriting Association, created pursuant to P.L.1983, c.65 (C.17:30E-1 et seq.), and the Market Transition Facility, created pursuant to section 88 of P.L.1990, c.8 (C.17:33B-11), to the New Jersey Property-Liability Insurance Guaranty Association.

c. Notwithstanding the provisions of any other law to the contrary, all balances in the New Jersey Automobile Insurance Guaranty Fund created pursuant to section 23 of P.L.1990, c.8 (C.17:33B-5) are hereby transferred to the New Jersey Property-Liability Insurance Guaranty Association.

d. Notwithstanding any other law to the contrary, the commissioner may in his discretion provide for the liquidation of the liabilities and an orderly transition of the operations, functions,

powers and duties of the Unsatisfied Claim and Judgment Fund, created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.) regarding its obligations pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1) to the New Jersey Property-Liability Insurance Guaranty Association.

e. Notwithstanding any other law to the contrary, the commissioner may in his discretion by order determine when the status as separate legal entities of the New Jersey Automobile Full Insurance Underwriting Association and the Market Transition Facility may be terminated.

C.39:6-64c Unsatisfied Claim and Judgment Fund abolished, transfer to PLIGA.

7. The Unsatisfied Claim and Judgment Fund Board in the Department of Banking and Insurance, established pursuant to P.L.1952, c.174 (C.39:6-61 et seq.), is hereby abolished and all its functions, powers and duties, along with the Unsatisfied Claim and Judgment Fund, including all its assets, liabilities and balances, are transferred from the Department of Banking and Insurance to the New Jersey Property-Liability Insurance Guaranty Association, established pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.). Wherever in any law, rule or regulation, reference is made to the Unsatisfied Claim and Judgment Fund Board, the same shall mean and refer to the New Jersey Property-Liability Insurance Guaranty Association.

8. Section 2 of P.L.1954, c.174 (C.39:6-62) is amended to read as follows:

C.39:6-62 Definitions relative to New Jersey Property-Liability Insurance Guaranty Association.

2. Definitions. As used in this act:

"Association" means the New Jersey Property-Liability Insurance Guaranty Association created pursuant to P.L.1974, c.17 (C.17:30A-1 et seq.).

"Commissioner" means the Commissioner of Banking and Insurance.

"Unsatisfied Claim and Judgment Fund" or "Fund" means the fund derived from the sources specified in this act.

"Qualified person" means a resident of this State or the owner of a motor vehicle registered in this State or a resident of another state, territory, or federal district of the United States or province of Canada or of a foreign country, in which recourse is afforded, to residents of this State, of substantially similar character to that provided for by this act; provided, however, that no person shall be a qualified person where such person is an insured under a policy provision providing coverage for damages sustained by the insured as a result of the operation of an uninsured motor vehicle in a form authorized to be included in automobile liability policies of insurance delivered or issued for delivery in this State, pursuant to the provisions of, or any supplement to, chapter 28 of Title 17 of the Revised Statutes or in a form substantially similar thereto.

"Uninsured motor vehicle" means a motor vehicle as to which there is not in force a liability policy meeting the requirements of section 3 or 26 of the "Motor Vehicle Security-Responsibility Law," P.L.1952, c.173 (C.39:6-25 or C.39:6-48), and which is not owned by a holder of a certificate of self-insurance under said law, but shall not include a motor vehicle with a policy in force which is insured pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1).

"Person" includes natural persons, firms, copartnerships, associations and corporations.

"Insurer" means any insurer authorized in this State to write the kinds of insurance specified in paragraphs d. and e. of R.S.17:17-1.

"Net direct written premiums" means direct gross premiums written on policies, insuring against legal liability for bodily injury or death and for damage to property arising out of the ownership, operation or maintenance of motor vehicles, which are principally garaged in this State, less return premiums thereon and dividends paid to policyholders on such direct business.

9. Section 3 of P.L.1952, c.174 (C.39:6-63) is amended to read as follows:

C.39:6-63 Creation, maintenance of fund.

3. For the purpose of creating and maintaining the fund:

(a) (Deleted by amendment, P.L.1968, c.323, s.3.)

(b) (Deleted by amendment, P.L.1968, c.323, s.3.)

(c) (Deleted by amendment, P.L.1968, c.323, s.3.)

(d) Commencing on or before December 30, 2003, and on or before December 30 in each year thereafter, the association shall calculate the probable amount which will be needed to carry out its responsibilities under section 35 of P.L.2003, c.89 (C.39:6-86.7), section 9 of P.L.1952, c.174 (C.39:6-69) and section 7 of P.L.1972, c.198 (C.39:6-86.1) during the ensuing year. In that calculation, the association shall take into consideration the amount presently reserved for pending claims, anticipated payments from the fund during that year and during the two years after that year, anticipated amounts to be reserved for claims pending during that year, and the desirability of maintaining a surplus over and above those anticipated payments and present and anticipated reserves, which surplus shall not exceed the amount actually paid from the fund during the 12 full calendar months immediately preceding the date of calculation. The probable amount needed to carry out the provisions of this section shall be assessed against insurers for that year's contribution to the fund.

(e) Whenever any of the provisions concerning the method and sources of assessments on insurers, the maximum amounts payable from the fund, eligibility or qualifications of claimants, or amounts to be deducted from payments made from the fund are amended by law, the association may, if the association deems it necessary, rescind any assessment on insurers. The association shall then, within 30 days of the adoption of such amendment, recalculate the probable amount which will be needed to carry out the provisions of P.L.2003, c.89 (C.17:30A-2.1 et al.) during the ensuing fiscal year, in accordance with the provisions of subsection (d) of this section. If, in the judgment of the association, the estimated balance of the fund at the beginning of the next year will be sufficient to meet those needs, the association shall determine the contributions of insurers, if any, in accordance with the provisions of subsection (d) of this section.

10. Section 18 of P.L.1955, c.1 (C.39:6-64.1) is amended to read as follows:

C.39:6-64.1 Plan of operation.

18. a. The association may from time to time, adopt and amend a plan of operation, subject to the approval of the commissioner, necessary or desirable in connection with its functions, duties and responsibilities in administering this act.

The plan of operation shall provide that the Unsatisfied Claim and Judgment Fund may (1) borrow and separately account for moneys from any source, including, but not limited to, the New Jersey Property-Liability Insurance Guaranty Association and the New Jersey Surplus Lines Insurance Guaranty Fund, in such amounts and on such terms as the board of directors may determine, are necessary or appropriate and (2) make loans, in such amounts and on such terms as the board of directors may determine are necessary or appropriate, to the New Jersey Property-Liability Insurance Guaranty Association and the New Jersey Surplus Lines Insurance Guaranty Fund.

b. There shall be no liability on the part of and no cause of action of any nature shall arise against the association, its agents, employees, or the commissioner or his designees for any action taken by them in the performance of their powers and duties under P.L.2003, c.89 (C.17:30A-2.1 et al.).

11. Section 5 of P.L.1952, c.174 (C.39:6-65) is amended to read as follows:

C.39:6-65 Notice of intention to make claim.

5. Any qualified person, or the personal representative of such person, who suffers damages resulting from bodily injury or death or damage to property arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, and whose damages may be satisfied in whole or in part from the fund, shall, except in cases in which the claim is asserted by actions brought under section 18 of this act pursuant to section 19 of this act, within 180 days after the accident, as a condition precedent to the right thereafter to apply for payment from the fund, give notice to the association, the form and contents of which shall be prescribed by the association, of his intention to make a claim thereon for such damages if otherwise

uncollectible; provided, any such qualified person may, in lieu of giving said notice within said time, make proof to the court on the hearing of the application for the payment of a judgment (a) that he was physically incapable of giving said notice within said period and that he gave said notice within 180 days after he became physically capable to do so or in the event he did not become so capable, that a notice was given on his behalf within a reasonable period, or (b) that he gave notice to the association within 15 days of receiving notice that an insurer had disclaimed on a policy of insurance so as to remove or withdraw liability insurance coverage for his claim against a person or persons who allegedly caused him to suffer damages. A copy of the complaint shall be furnished to the association if an action has theretofore been brought for the enforcement of such claim. Such person shall also notify the association of any action thereafter instituted for the enforcement of such claim within 15 days after the institution thereof and such notice shall be accompanied by a copy of the complaint.

The New Jersey Motor Vehicle Commission is hereby authorized and empowered, the provisions of any other law relating to the confidential nature of any reports or information furnished to or filed with the division notwithstanding, to furnish to the association upon its request, for such use, utilization and purposes as the association may deem reasonably appropriate to administer this act and discharge its functions hereunder, any reports or information filed by any person or persons claiming benefits under the provisions of this act, that the director has with regard to any accident, and any operator or owner of a motor vehicle involved in any accident, and as to any automobile or motor vehicle liability insurance or bond carried by an operator or owner of any motor vehicle.

12. Section 7 of P.L.1952, c.174 (C.39:6-67) is amended to read as follows:

C.39:6-67 Defense of actions against motorists.

7. The association may through counsel enter an appearance on behalf of the defendant, file a defense, appear at the trial or take such other steps as it may deem appropriate on the behalf and in the name of the defendant, and may thereupon, on the behalf and in the name of the defendant, conduct his defense, take recourse to any appropriate method of review on behalf of, and in the name of, the defendant, and all such acts shall be deemed to be the acts of such defendant; provided, however, that nothing contained herein shall deprive the defendant of the right to also employ his own counsel and defend the action. All expense incurred by the association in connection with any review prosecuted or defended by it from a judgment rendered in such action, including its attorneys' fees in connection therewith, shall be borne by the fund.

13. Section 8 of P.L.1952, c.174 (C.39:6-68) is amended to read as follows:

C.39:6-68 Cooperation of defendant.

8. In any case in which the association has assumed under this act, the defense of any action, the defendant shall co-operate with the association in the defense of such action. In the event of his failure to do so, the association may apply to the court for an order directing such co-operation.

14. Section 9 of P.L.1952, c.174 (C.39:6-69) is amended to read as follows:

C.39:6-69 Unpaid judgments.

9. When any qualified person recovers a valid judgment in any court of competent jurisdiction in this State against any other person, who was the operator or owner of a motor vehicle, for injury to, death of, any person or persons, or a similar valid judgment in such court against such a defendant for an amount in excess of $500.00, exclusive of interest and costs, for damage to property, except property of others in charge of such operator or owner or such operator's or owner's employees, arising out of the ownership, maintenance or use of the motor vehicle in this State on or after April 1, 1955, and any amount remains unpaid thereon in the case of a judgment for bodily injury or death, or any amount in excess of $500.00 remains unpaid

thereon in case of a judgment for damage to property, such judgment creditor may, upon the termination of all proceedings, including reviews and appeals in connection with such judgment, file a verified claim in the court in which the judgment was entered, and upon 10 days' written notice to the association may apply to the court for an order directing payment out of the fund, of the amount unpaid upon such judgment for bodily injury or death, which does not exceed, or upon such judgment for damage to property, which exceeds the sum of $500.00 and does not exceed--

(a) The maximum amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident, and

(b) The maximum amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to, or death of, more than one person, in any one accident, and

(c) The maximum amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident.

15. Section 10 of P.L.1952, c.174 (C.39:6-70) is amended to read as follows:

C.39:6-70 Hearing on application for payment of judgment.

10. Hearing on application for payment of judgment. The court shall proceed upon such application, in a summary manner, and, upon the hearing thereof, the applicant shall be required to show:

(a) He is not a person covered with respect to such injury or death by any workers' compensation law, or the personal representative of such a person,

(b) He is not a spouse, parent or child of the judgment debtor, or the personal representative of such spouse, parent or child,

(c) He was not at the time of the accident a person (1) operating or riding in a motor vehicle which he had stolen or participated in stealing or (2) operating or riding in a motor vehicle without the permission of the owner, and is not the personal representative of such a person,

(d) He was not at the time of the accident, the owner or registrant of an uninsured motor vehicle, or was not operating a motor vehicle in violation of an order of suspension or revocation,

(e) He has complied with all of the requirements of section 5,

(f) The judgment debtor at the time of the accident was not insured under a policy of automobile liability insurance under the terms of which the insurer is liable to pay in whole or in part the amount of the judgment,

(g) He has obtained a judgment as set out in section 9 of this act, stating the amount thereof and the amount owing thereon at the date of the application,

(h) He has caused to be issued a writ of execution upon said judgment and the sheriff or officer executing the same has made a return showing that no personal or real property of the judgment debtor, liable to be levied upon in satisfaction of the judgment, could be found or that the amount realized on the sale of them or of such of them as were found, under said execution, was insufficient to satisfy the judgment, stating the amount so realized and the balance remaining due on the judgment after application thereon of the amount realized,

(i) He has caused the judgment debtor to make discovery under oath, pursuant to law, concerning his personal property and as to whether such judgment debtor was at the time of the accident insured under any policy or policies of insurance described in subsection (f) of this section,

(j) He has made all reasonable searches and inquiries to ascertain whether the judgment debtor is possessed of personal or real property or other assets, liable to be sold or applied in satisfaction of the judgment,

(k) By such search he has discovered no personal or real property or other assets, liable to be sold or applied or that he has discovered certain of them, describing them, owned by the judgment debtor and liable to be so sold and applied and that he has taken all necessary action and proceedings for the realization thereof and that the amount thereby realized was insufficient to satisfy the judgment, stating the amount so realized and the balance remaining due

on the judgment after application of the amount realized,

(l) The application is not made by or on behalf of any insurer by reason of the existence of a policy of insurance, whereby the insurer is liable to pay, in whole or in part, the amount of the judgment and that no part of the amount to be paid out of the fund is sought in lieu of making a claim or receiving a payment which is payable by reason of the existence of such a policy of insurance and that no part of the amount so sought will be paid to an insurer to reimburse or otherwise indemnify the insurer in respect of any amount paid or payable by the insurer by reason of the existence of such a policy of insurance,

(m) Whether or not he has recovered a judgment in an action against any other person against whom he has a cause of action in respect of his damages for bodily injury or death or damage to property arising out of the accident and what amounts, if any, he has received by way of payments upon the judgment, or by way of settlement of such cause of action, in whole or in part, from or on behalf of such other person,

(n) In order to recover for noneconomic loss, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2) for accidents to which the benefits of sections 7 and 10 of P.L.1972, c.198 (C.39:6-86.1 and C.39:6-86.4) apply, the injured person shall have sustained an injury described in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8).

Whenever the applicant satisfies the court that it is not possible to comply with one or more of the requirements enumerated in subsections (h) and (i) of this section and that the applicant has taken all reasonable steps to collect the amount of the judgment or the unsatisfied part thereof and has been unable to collect the same, the court may dispense with the necessity for complying with such requirements.

The association may appear and be heard on application and show cause why the order should not be made.

16. Section 11 of P.L.1952, c.174 (C.39:6-71) is amended to read as follows:

C.39:6-71 Order for payment of judgment.

11. The court shall make an order directed to the association requiring the association to make payment from the fund of such sum, if any, as it shall find to be payable upon said claim, pursuant to the provisions of and in accordance with the limitations contained in this act, if the court is satisfied, upon the hearing:

(a) Of the truth of all matters required to be shown by the applicant by section 10,

(b) That the applicant has fully pursued and exhausted all remedies available to him for recovering damages against all persons mentioned in subparagraph (m) of section 10 by

(1) Commencing action against all such persons against whom the applicant might reasonably be considered as having a cause of action in respect of such damages and prosecuting every such action in good faith to judgment and

(2) Taking all reasonable steps available to him to collect on every judgment so obtained and by applying the proceeds of any judgment or recovery so obtained towards satisfaction of the amount due upon the judgment for payment of which the claim is made.

Any amount which the plaintiff has received or can collect by way of payments upon the judgment or by way of settlement of the cause of action, in whole or in part, from or on behalf of any person other than the judgment debtor, described in subparagraph (m) of section 10, shall be deducted from the amount due upon the judgment for payment of which claim is made.

17. Section 12 of P.L.1952, c.174 (C.39:6-72) is amended to read as follows:

C.39:6-72 Contents of petition; settlement of claim.

12. (a) In any action against an operator or owner of a motor vehicle for injury to or death of any person or for damage to property arising out of the ownership, maintenance or use of said vehicle in this State on or after April 1, 1955, pending in any court of competent jurisdiction in this State, the plaintiff may upon notice to the association file a verified petition with the court alleging:

(1) the matters set forth in subparagraphs (a), (b), (c), (d), (e) and (f) of section 10;

(2) that the petition is not presented on behalf of an insurer under circumstances set forth in subparagraph (1) of section 10;

(3) that he has entered into an agreement with the defendant to settle all claims set forth in the complaint in said action and the amount proposed to be paid to him pursuant thereto;

(4) that the said proposed settlement has been entered into with and by the consent of the Superior Court and approved by the association;

(5) that the defendant has executed and delivered to the association a verified statement of his financial condition;

(6) that a judgment against the defendant would be uncollectible;

(7) that the defendant has undertaken in writing to repay to the association the sum that he would be required to pay under such settlement, and has executed a confession of judgment in connection therewith.

If the court be satisfied of the truth of the allegations in said petition and of the fairness of such proposed settlement, it may enter an order approving the same and directing the association, upon receipt of the undertaking and confession of judgment mentioned in subparagraph (7) of this section, to make payment to the plaintiff of the amount agreed to be accepted.

(b) The association may settle any claim, without court approval, if satisfied:

(1) that the claimant is not a person of the character described in subparagraphs (a), (b), (c), (d), (e) and (f) of section 10;

(2) that the settlement is not made on behalf of an insurer under circumstances set forth in subparagraph (e) of section 10; and

(3) that a judgment against the owner or operator of the motor vehicle involved in the accident would be uncollectible, and that such owner or operator has consented to such settlement, executed and delivered to the association a verified statement of his financial condition and undertaken in writing to repay to the association the sum to be paid under the settlement, and executed a confession of judgment in connection therewith.

18. Section 13 of P.L.1952, c.174 (C.39:6-73) is amended to read as follows:

C.39:6-73 $500 exclusion.

13. Except with respect to medical expense benefits paid pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1), no order shall be made for the payment and the association shall make no payment, out of the fund, of

(a) Any claim for damage to property for less than $500.00,

(b) The first $500.00 of any judgment for damage to property or of the unsatisfied portion thereof, or

(c) The unsatisfied portion of any judgment which, after deducting $500.00 therefrom if the judgment is for damage to property, exceeds

(1) the maximum or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person in any one accident, and

(2) the maximum amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to, or death of, more than one person, in any one accident, and

(3) the maximum amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident; provided, that such maximum amounts shall be reduced by any amount received or recovered as specified in subsection (m) of section 10.

(d) Any claim for damage to property which includes any sum greater than the difference between said maximum amounts and the sum of $500.00, and any amount paid out of the fund in excess of the amount so authorized may be recovered by the association in an action brought to it against the person receiving the same.

19. Section 2 of P.L.1977, c.310 (C.39:6-73.1) is amended to read as follows:

C.39:6-73.1 Assumption of excess payment by fund; exceptions.

2. In the event medical expense benefits paid by an insurer, in accordance with subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) or section 4 of P.L.1998, c.21 (C.39:6A-3.1), are in excess of $75,000.00 on account of personal injury to any one person in any one accident covered under a policy issued prior to January 1, 2004, the Unsatisfied Claim and Judgment Fund shall assume the following: a. the entire excess for a medical expense benefits claim covered under a policy issued before January 1, 1991; and b. such excess up to $250,000 for a medical expense benefits claim covered under a policy issued on or after January 1, 1991 and the Unsatisfied Claim and Judgment Fund shall reimburse the insurer therefor in accordance with rules and regulations promulgated by the commissioner; provided, however, that this provision is not intended to broaden the coverage available to accidents involving uninsured or hit-and-run automobiles, to provide extraterritorial coverage, or to pay excess medical expenses.

The Unsatisfied Claim and Judgment Fund shall cease to reimburse an insurer for medical expense benefits under this section for injuries covered under a policy issued on or after January 1, 2004.

20. Section 14 of P.L.1952, c.174 (C.39:6-74) is amended to read as follows:

C.39:6-74 Default and consent judgments.

14. No claim shall be allowed and ordered to be paid out of the fund if the court shall find, upon the hearing for the allowance of the claim, that it is founded upon a judgment which was entered by default unless (1) the claimant shall have complied with the requirements of section 5, and (2) prior to the entry of such judgment the association shall have been given notice of intention to enter the judgment and file a claim thereon against the fund and shall have been afforded an opportunity to take such action as it shall deem advisable.

If the court, upon a hearing for the allowance of any claim against the fund, finds that it was a claim which was not assigned by the association for defense, or that the action upon such claim was not fully and fairly defended, or that the judgment thereon was entered upon the consent or with the agreement of the defendant, the court shall allow such claim but shall order it to be paid only in such sum as the court shall determine to be justly due and payable out of the fund, on the basis of the actual amount of damages for which the defendant was liable to the plaintiff under the cause of action, upon which the judgment was rendered and reduced by any amount received from any person mentioned in subparagraph (m) of section 10, notwithstanding that the judgment is for a greater amount.

21. Section 17 of P.L.1952, c.174 (C.39:6-77) is amended to read as follows:

C.39:6-77 Assignment of judgments to association.

17. Assignment of judgments to association. The association shall not pay any sum from the fund, in compliance with an order made for that purpose, in any case in which the claim is founded upon a judgment, except a judgment obtained against the association under this act, until the applicant assigns the judgment to the association and, thereupon, the association shall be deemed to have all the rights of the judgment creditor under the judgment and shall enforce and collect the same for the full amount thereof with interest and costs and if more money is collected upon any such judgment than the amount paid out of the fund, the association shall pay the balance, after reimbursing the fund, to the judgment creditor. Upon assignment of a judgment to the association the association may enter into agreement with the defendant for reimbursement of the fund by lump sum or installment payments, including waiver of interest and subordination of the lien of the judgment where the same is determined to be advantageous in obtaining reimbursement of payments made by the fund. Any such agreement may be annexed to an application for a court order made pursuant to section 27(b).

22. Section 18 of P.L.1952, c.174 (C.39:6-78) is amended to read as follows:

C.39:6-78 Identity of vehicle, operator, owner unascertainable.

18. When the death of, or personal injury to, any person arises out of ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, but the identity of the motor vehicle and of the operator and owner thereof cannot be ascertained or it is established that the motor vehicle was, at the time said accident occurred, in the possession of some person other than the owner without the owner's consent and that the identity of such person cannot be ascertained, any qualified person who would have a cause of action against the operator or owner or both in respect to such death or personal injury may bring an action therefor against the association in any court of competent jurisdiction, but no judgment against the association shall be entered in such an action unless the court is satisfied, upon the hearing of the action, that--

(a) The claimant has complied with the requirements of section 5,

(b) The claimant is not a person covered with respect to such injury or death by any workers' compensation law, or the personal representative of such a person,

(c) The claimant was not at the time of the accident the owner or registrant of an uninsured motor vehicle, or was not operating a motor vehicle in violation of an order of suspension or revocation,

(d) The claimant has a cause of action against the operator or owner of such motor vehicle or against the operator who was operating the motor vehicle without the consent of the owner of the motor vehicle,

(e) All reasonable efforts have been made to ascertain the identity of the motor vehicle and of the owner and operator thereof and either that the identity of the motor vehicle and the owner and operator thereof cannot be established, or that the identity of the operator, who was operating the motor vehicle without the owner's consent, cannot be established,

(f) The action is not brought by or on behalf of an insurer under circumstances set forth in paragraph (1) of section 10.

23. Section 19 of P.L.1952, c.174 (C.39:6-79) is amended to read as follows:

C.39:6-79 Action within 180 days of entry of judgment.

19. When in an action in respect to the death of, or personal injury to, any person, arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, judgment is rendered for the defendant on the sole ground that such death or personal injury was occasioned by a motor vehicle--

(a) The identity of which, and of the owner and operator of which, has not been established, or

(b) Which was in the possession of some person other than the owner or his agent without the consent of the owner and the identity of the operator has not been established, such cause shall be stated in the judgment and the plaintiff in such action may within 180 days from the date of the entry of such judgment bring an action upon said cause of action against the association in the manner provided in section 18.

24. Section 20 of P.L.1952, c.174 (C.39:6-80) is amended to read as follows:

C.39:6-80 Impleading association in "hit-and-run" cases.

20. Impleading association in "hit-and-run" cases. When an action has been commenced in respect of the death or injury of any person arising out of the ownership, maintenance or use of a motor vehicle in this State on or after April 1, 1955, the plaintiff shall be entitled to make the association a party thereto if the provisions of section 18 or 19 shall apply in any such case, and the plaintiff has made the application and the court has entered the order provided for in section 18.

25. Section 21 of P.L.1952, c.174 (C.39:6-81) is amended to read as follows:

C.39:6-81 Defense of such actions by association.

21. Defense of such actions by association. In any action brought under sections 18 and 19 of this act, the association may appear. The association shall for all purposes of the action be deemed to be the defendant. The association shall have available to it any and all defenses which would have been available to said operator or owner or both if the action had been brought against them or either of them and process upon them or either of them had been duly served within this State, but the association shall be entitled to defend in all cases without asserting any specific facts.

26. Section 22 of P.L.1952, c.174 (C.39:6-82) is amended to read as follows:

C.39:6-82 Settlement of actions against the association.

22. Settlement of actions against the association. In any action brought against the association pursuant to an order by the court entered in accordance with the provisions of section 18, the plaintiff may file a verified petition alleging that he has entered into an agreement with the association to settle all claims set forth in the complaint in said action and the amount proposed to be paid to him pursuant thereto. If the court be satisfied of the fairness of such proposed settlement, it may enter an order approving such settlement and enter a judgment against the association for the amount so agreed to be paid thereunder.

27. Section 23 of P.L.1952, c.174 (C.39:6-83) is amended to read as follows:

C.39:6-83 Credits against judgment.

23. Credits against judgment. A judgment against the association shall be reduced by any amounts which such plaintiff has received from any person mentioned in subparagraph (m) of section 10.

28. Section 24 of P.L.1952, c.174 (C.39:6-84) is amended to read as follows:

C.39:6-84 Limitation on amount of judgment.

24. When a judgment is obtained against the association, in an action brought under this act, upon the determination of all proceedings including appeals and reviews, the court shall make an order directed to the association directing it to pay out of the fund to the plaintiff in the action the amount thereof which does not exceed $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person and, subject to such limits for the death of, or injury to, any one person, does not exceed $30,000.00, exclusive of interest and costs, on account of the injury to, or death of, more than one person, in any one accident, provided that such maximum amount shall be reduced by any amount received or recovered by the plaintiff as specified in subparagraph (m) of section 10.

29. Section 25 of P.L.1952, c.174 (C.39:6-85) is amended to read as follows:

C.39:6-85 Subrogation.

25. Subrogation. When judgment has been obtained against the association in an action brought under this act, the association shall, upon payment from the fund of the amount of the judgment to the extent provided in this act, be subrogated to the cause of action of the judgment creditor against the operator and owner of the motor vehicle by which the accident was occasioned and shall bring an action against either or both of such persons for the amount of the damage sustained by the judgment creditor when and in the event that the identity of either or both of such persons shall be established, and shall recover the same out of any funds which would be payable in respect to the death or injury under any policy of insurance, which was in force at the time of the accident and in event that more is recovered and collected in any such action than the amount paid out of the fund by reason of the judgment, the association shall pay the balance, after reimbursing the fund, to the judgment creditor.

30. Section 7 of P.L.1972, c.198 (C.39:6-86.1) is amended to read as follows:

C.39:6-86.1 UCJF benefits.

7. When any person qualified to receive payments under the provisions of the "Unsatisfied Claim and Judgment Fund Law" suffers bodily injury or death as a pedestrian, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), caused by a motor vehicle, including an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), and a motorcycle, or by an object propelled therefrom, or arising out of an accident while occupying, entering into, alighting from, or using an automobile, registered or principally garaged in this State for which personal injury protection benefits under the "New Jersey Automobile Reparation Reform Act," P.L.1972, c.70 (C.39:6A-1 et seq.), or section 19 of P.L.1983, c.362 (C.17:28-1.3), would be payable to such person if personal injury protection coverage were in force and the damages resulting from such accident or death are not satisfied due to the personal injury protection coverage not being in effect with respect to such accident, or when a pedestrian suffers bodily injury as provided by section 35 of P.L.2003, c.89 (C.39:6-86.7) then in such event the Unsatisfied Claim and Judgment Fund shall provide, under the following conditions, the following benefits:

a. Medical expenses benefits. Payment of all medical expense benefits in accordance with a benefits plan, subject to the approval of the commissioner, for reasonable, necessary and appropriate treatment and provision of services in an amount not exceeding $250,000 per person per accident. In the event of death, payment shall be made to the estate of the decedent. The benefits plan shall set forth the benefits provided by the Unsatisfied Claim and Judgment Fund, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the Unsatisfied Claim and Judgment Fund may provide.

Medical expense benefit payments shall be subject to a deductible of $250.00 on account of injury in any one accident and a copayment of 20% of any benefits payable between $250.00 and $5,000.00.

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100.00. Such sums shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200.00, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12.00 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380.00, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000.00, on account of the death to any one person in any one accident shall be payable to decedent's estate.

Provided, however, that no benefits shall be paid under this section unless the person applying for benefits has demonstrated that he is not disqualified by reason of the provisions of subsection (a), (c), (d) or (l) of section 10 of P.L.1952, c.174 (C.39:6-70), or any other provision of law.

31. Section 12 of P.L.1972, c.198 (C.39:6-86.6) is amended to read as follows:

C.39:6-86.6 Recovery from uninsured motorist.

12. The association shall be entitled to recover on behalf of the Unsatisfied Claim and Judgment Fund for all payments made by it pursuant to sections 7 and 10 of this act, regardless of fault, from any person who owned or operated the automobile involved in the accident and whose failure to have the required insurance coverage in effect at the time of the accident resulted in the payment of personal injury protection benefits. If the identity of the owner and operator is not ascertained until after personal injury protection benefits have been paid then the association shall be entitled to recover for such payments, regardless of fault, from the operator if he was driving without the owner's permission or from the operator and the owner if he was driving with the owner's permission or, in either case, from the insurer if there is an insurance policy providing personal injury protection benefits that was in effect at the time of the accident with respect to such automobile.

The association is authorized to bring an action, which shall be a summary proceeding, in the Superior Court to reduce the right provided by this section to judgment.

32. Section 27 of P.L.1952, c.174 (C.39:6-87) is amended to read as follows:

C.39:6-87 Registration, etc. not restored until fund is reimbursed.

27. Registration, etc. not restored until fund is reimbursed. Where the license or privileges of any person, or the registration of a motor vehicle registered in his name, has been suspended or cancelled under the Motor Vehicle Security-Responsibility Law of this State, and the association has paid from the fund any amount in settlement of a claim or towards satisfaction of a judgment against that person, or for the payment of personal injury protection benefits as provided in section 7 and section 10 of this act, the cancellation or suspension shall not be removed, nor the license, privileges, or registration restored, nor shall any new license or privilege be issued or granted to, or registration be permitted to be made by, that person until he has

(a) Repaid in full to the association the amount so paid by him together with interest thereon at 8% per annum from the date of such payment; and

(b) Satisfied all requirements of said Motor Vehicle Security-Responsibility Law in respect of giving proof of ability to respond in damages for future accidents, provided, that the court in which such judgment was rendered may, upon 10 days' notice to the association, make an order permitting payment of the amount of such person's indebtedness to the fund, to be made in installments, or in the event the fund makes personal injury protection benefit payments, such person and the fund by agreement may provide for repayment to the fund to be made in installments, and in such case, such person's driver's license, or his driving privileges, or registration certificate, if the same have been suspended or revoked, or have expired, may be restored or renewed and shall remain in effect unless and until such person defaults in making any installment payment specified in such order. In the event of any such default, the New Jersey Motor Vehicle Commission shall upon notice of such default suspend such person's driver's license, or driving privileges or registration certificate until the amount of his indebtedness to the fund has been paid in full.

33. Section 28 of P.L.1952, c.174 (C.39:6-88) is amended to read as follows:

C.39:6-88 Fund to be held in trust.

28. Fund to be held in trust. All sums received by the association pursuant to any of the provisions of this act shall become part of the fund, and shall be held by the association in trust for the carrying out of the purposes of this act and for the payment of the cost of administering this act.

34. Section 30 of P.L.1952, c.174 (C.39:6-90) is amended to read as follows:

C.39:6-90 Penalty for false statements.

30. Any person and any agent or servant of such person, who knowingly files with the fund or the association or either of them, any notice, statement or other document required under this act, which is false or untrue or contains any material misstatement of fact shall be subject to a

penalty as provided in section 5 of P.L.1983, c.320 (C.17:33A-5) and damages as provided in section 7 of P.L.1983, c.320 (C.17:33A-7).

C.39:6-86.7 Provision of personal injury protection benefits, certain pedestrians.

35. The Unsatisfied Claim and Judgment Fund created pursuant to P.L.1952, c.174 (C.39:6-61 et seq.) shall provide personal injury protection benefits pursuant to section 7 of P.L.1972, c.198 (C.39:6-86.1) to a pedestrian sustaining bodily injury in this State caused by an automobile, other than to a named insured or a member of the named insured's family residing in his household, if that pedestrian is entitled to personal injury protection coverage under an automobile insurance policy.

36. Section 4 of P.L.1998, c.21 (C.39:6A-3.1) is amended to read as follows:

C.39:6A-3.1 Election of basic automobile insurance policy; coverage provided.

4. As an alternative to the mandatory coverages provided in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), any owner or registered owner of an automobile registered or principally garaged in this State may elect a basic automobile insurance policy providing the following coverage:

a. Personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household, who sustained bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. "Personal injury protection coverage" issued pursuant to this section means and includes payment of medical expense benefits, as provided in the policy and approved by the commissioner, for the reasonable and necessary treatment of bodily injury in an amount not to exceed $15,000 per person per accident; except that, medical expense benefits shall be paid in an amount not to exceed $250,000: (1) for all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement or (2) for medically necessary treatment of other permanent or significant injuries rendered at a trauma center or acute care hospital immediately following the accident and until the patient is stable, no longer requires critical care and can be safely discharged or transferred to another facility in the judgment of the attending physician. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of personal injury to any one person in any one accident covered by a policy issued or renewed prior to January 1, 2004, such excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). Benefits provided under basic coverage shall be in accordance with a benefit plan provided in the policy and approved by the commissioner. The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard

treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for herein, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of this amendatory and supplementary act. The commissioner shall not advertise for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

Medical expense benefits payable under this subsection shall not be assignable, except to a provider of service benefits, in accordance with policy terms approved by the commissioner, nor shall they be subject to levy, execution, attachment or other process for satisfaction of debts. Medical expense benefits payable in accordance with this subsection may be subject to a deductible and copayments as provided for in the policy, if any. No insurer or provider providing service benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

Notwithstanding the provisions of P.L.2003, c.18, physical therapy treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of their respective practices.

b. Liability insurance coverage insuring against loss resulting from liability imposed by law for property damage sustained by any person arising out of the ownership, maintenance, operation or use of an automobile in an amount or limit of $5,000, exclusive of interest and costs, for damage to property in any one accident.

c. In addition to the aforesaid coverages required to be provided in a basic automobile insurance policy, optional liability insurance coverage insuring against loss resulting from liability imposed by law for bodily injury or death in an amount or limit of $10,000, exclusive of interests and costs, on account of injury to, or death of, one or more persons in any one accident.

If a named insured has elected the basic automobile insurance policy option and an immediate family member or members or relatives resident in his household have one or more policies with the coverages provided for in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), the provisions of section 12 of P.L.1983, c.362 (C.39:6A-4.2) shall apply.

Every named insured and any other person to whom the basic automobile insurance policy, with or without the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of this section, applies shall be subject to the tort option provided in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8).

No licensed insurance carrier shall refuse to renew the coverage stipulated by this section of an eligible person as defined in section 25 of P.L.1990, c.8 (C.17:33B-13) except in accordance with the provisions of section 26 of P.L.1988, c.119 (C.17:29C-7.1) or with the consent of the Commissioner of Banking and Insurance.

37. Section 4 of P.L.1972, c.70 (C.39:6A-4) is amended to read as follows:

C.39:6A-4 Personal injury protection coverage, regardless of fault.

4. Personal injury protection coverage, regardless of fault.

Except as provided by section 45 of P.L.2003, c.89 (C.39:6A-3.3) and section 4 of P.L.1998, c.21 (C.39:6A-3.1), every standard automobile liability insurance policy issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) shall contain personal injury protection benefits for the payment of benefits without regard to negligence, liability or fault of any kind, to the named insured and members of his family residing in his household who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with permission of the named insured.

"Personal injury protection coverage" means and includes:

a. Payment of medical expense benefits in accordance with a benefit plan provided in the policy and approved by the commissioner, for reasonable, necessary, and appropriate treatment and provision of services to persons sustaining bodily injury, in an amount not to exceed $250,000 per person per accident. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of bodily injury to any one person in any one accident, that excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1). The policy form, which shall be subject to the approval of the commissioner, shall set forth the benefits provided under the policy, including eligible medical treatments, diagnostic tests and services as well as such other benefits as the policy may provide. The commissioner shall set forth by regulation a statement of the basic benefits which shall be included in the policy. Medical treatments, diagnostic tests, and services provided by the policy shall be rendered in accordance with commonly accepted protocols and professional standards and practices which are commonly accepted as being beneficial for the treatment of the covered injury. Protocols and professional standards and practices and lists of valid diagnostic tests which are deemed to be commonly accepted pursuant to this section shall be those recognized by national standard setting organizations, national or state professional organizations of the same discipline as the treating provider, or those designated or approved by the commissioner in consultation with the professional licensing boards in the Division of Consumer Affairs in the Department of Law and Public Safety. The commissioner, in consultation with the Commissioner of the Department of Health and Senior Services and the applicable licensing boards, may reject the use of protocols, standards and practices or lists of diagnostic tests set by any organization deemed not to have standing or general recognition by the provider community or the applicable licensing boards. Protocols shall be deemed to establish guidelines as to standard appropriate treatment and diagnostic tests for injuries sustained in automobile accidents, but the establishment of standard treatment protocols or protocols for the administration of diagnostic tests shall not be interpreted in such a manner as to preclude variance from the standard when warranted by reason of medical necessity. The policy form may provide for the precertification of certain procedures, treatments, diagnostic tests, or other services or for the purchase of durable medical goods, as approved by the commissioner, provided that the requirement for precertification shall not be unreasonable, and no precertification requirement shall apply within ten days of the insured event. The policy may provide that certain benefits provided by the policy which are in excess of the basic benefits required by the commissioner to be included in the policy may be subject to reasonable copayments in addition to the copayments provided for pursuant to subsection e. of this section, provided that the copayments shall not be unreasonable and shall be established in such a manner as not to serve to encourage underutilization of benefits subject to the copayments, nor encourage overutilization of benefits. The policy form shall clearly set forth any limitations on benefits or exclusions, which may include, but need not be limited to, benefits which are otherwise compensable under workers' compensation, or benefits for treatments deemed to be experimental or investigational, or benefits deducted pursuant to section 6 of P.L.1972, c.70 (C.39:6A-6). The commissioner may enlist the services of a benefit consultant in establishing the basic benefits level provided in this subsection, which shall be set forth by regulation no later than 120 days following the enactment date of P.L.1998, c.21 (C.39:6A-1.1 et al.). The commissioner shall not advertise for bids for the consultant as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9).

Notwithstanding the provisions of P.L.2003, c.18, physical therapy treatment shall not be reimbursable as medical expense benefits pursuant to this subsection unless rendered by a licensed physical therapist pursuant to a referral from a licensed physician, dentist, podiatrist or chiropractor within the scope of their respective practices.

b. Income continuation benefits. The payment of the loss of income of an income producer as a result of bodily injury disability, subject to a maximum weekly payment of $100. Such sum shall be payable during the life of the injured person and shall be subject to an amount or limit of $5,200, on account of injury to any one person in any one accident, except that in no case shall income continuation benefits exceed the net income normally earned during the period in which the benefits are payable.

c. Essential services benefits. Payment of essential services benefits to an injured person shall be made in reimbursement of necessary and reasonable expenses incurred for such substitute essential services ordinarily performed by the injured person for himself, his family and members of the family residing in the household, subject to an amount or limit of $12 per day. Such benefits shall be payable during the life of the injured person and shall be subject to an amount or limit of $4,380, on account of injury to any one person in any one accident.

d. Death benefits. In the event of the death of an income producer as a result of injuries sustained in an accident entitling such person to benefits under this section, the maximum amount of benefits which could have been paid to the income producer, but for his death, under subsection b. of this section shall be paid to the surviving spouse, or in the event there is no surviving spouse, then to the surviving children, and in the event there are no surviving spouse or surviving children, then to the estate of the income producer.

In the event of the death of one performing essential services as a result of injuries sustained in an accident entitling such person to benefits under subsection c. of this section, the maximum amount of benefits which could have been paid to such person, under subsection c., shall be paid to the person incurring the expense of providing such essential services.

e. Funeral expenses benefits. All reasonable funeral, burial and cremation expenses, subject to a maximum benefit of $1,000, on account of the death of any one person in any one accident shall be payable to the decedent's estate.

Benefits payable under this section shall:

(1) Be subject to any option elected by the policyholder pursuant to section 13 of P.L.1983, c.362 (C.39:6A-4.3);

(2) Not be assignable, except to a provider of service benefits under this section in accordance with policy terms approved by the commissioner, nor subject to levy, execution, attachment or other process for satisfaction of debts.

Medical expense benefit payments shall be subject to any deductible and any copayment which may be established as provided in the policy. Upon the request of the commissioner or any party to a claim for benefits or payment for services rendered, a provider shall present adequate proof that any deductible or copayment related to that claim has not been waived or discharged by the provider.

No insurer or health provider providing benefits to an insured shall have a right of subrogation for the amount of benefits paid pursuant to any deductible or copayment under this section.

38. Section 27 of P.L.1990, c.8 (C.17:33B-15) is amended to read as follows:

C.17:33B-15 Provision of automobile insurance coverage by insurers.

27. a. On or after April 1, 1992, every insurer, either by one or more separate rating plans filed in accordance with the provisions of section 6 of P.L.1988, c.156 (C.17:29A-45) prior to March 1, 1998, or section 14 of P.L.1997, c.151 (C.17:29A-46.1) on or after March 1, 1998, or through one or more affiliated insurers, shall provide automobile insurance coverage for eligible persons. This subsection shall become inoperative on January 1, 2009.

b. No insurer shall refuse to insure, refuse to renew, or limit coverage available for automobile insurance to an eligible person who meets its underwriting rules as filed with and approved by the commissioner in accordance with the provisions of section 7 of P.L.1988, c.156 (C.17:29A-46) prior to March 1, 1998 or section 15 of P.L.1997, c.151 (C.17:29A-46.2) on or after March 1, 1998. This subsection shall become inoperative on January 1, 2009.

c. Notwithstanding the provisions of subsections a. and b. of this section to the contrary, any qualified insurer engaged in writing automobile insurance in an automobile insurance urban enterprise zone pursuant to section 22 of P.L.1997, c.151 (C.17:33C-4) may limit the number of exposures written through its UEZ agent or agents, or in the case of a qualified insurer doing business on a direct writing basis, the qualified insurer may limit the number of exposures written in an automobile insurance urban enterprise zone consistent with its marketing plans and goals as provided in subsection a. of section 21 of P.L.1997, c.151 (C.17:33C-3). Nothing in this subsection shall be construed to relieve a qualified insurer from its obligation under subsections a. and b. of this section to write all eligible persons residing within an automobile insurance urban enterprise zone through its non-UEZ agent points of access.

d. (1) Notwithstanding the provisions of subsections a. and b. of this section to the contrary, an insurer may file underwriting rules by which it may refuse to issue or limit coverage available for automobile insurance in any rating territory to an eligible person if the insurer has increased its aggregate number of private passenger automobile non-fleet exposures in the rating territory during the previous year: by 5% during the one-year period beginning January 1, 2004; by 4% during the one-year period beginning January 1, 2005; by 3% during the one-year period beginning January 1, 2006; by 2% during the one-year period beginning January 1, 2007; and by 1% during the one year period beginning January 1, 2008, provided further that an insurer may file with the commissioner for a lower percentage growth standard than that listed in this subsection and the commissioner shall approve such a filing if he finds that the insurer does not have the financial and business resources to accommodate growth statewide at a higher percentage than that proposed in the filing.

(2) Underwriting rules filed pursuant to this subsection shall provide that the rules are activated only upon the filing with the commissioner of a proper certification. The certification shall be by an officer of the insurer attesting to the aggregate number of private passenger automobile non-fleet exposures in each rating territory on June 30 and December 31 of the preceding year and clearly identify any rating territory in which the insurer has met the percentage growth standard established by this subsection. Such underwriting rules shall be operational in the identified territory on the first day of the second calendar month after the end of the calendar six-month period in which the percentage growth standard has been met. Such underwriting rules shall be operational in an identified territory for a period of six months, unless prior to their expiration, an officer of the insurer files a certification with the commissioner attesting that the percentage growth standard in an identified territory continues to be met.

(3) Notwithstanding any provision of this section to the contrary, the commissioner may make operative the provisions of subsections a. and b. of this section only by order finding one of the following circumstances:

(a) The commissioner determines, after a hearing, that a competitive market does not exist among insurers authorized to write private passenger automobile insurance in this State, which determination shall only be made pursuant to subsection f. of this section, provided, however, that there shall be a rebuttable presumption that a competitive market exists among insurers authorized to write private passenger automobile insurance in this State if the plan established pursuant to P.L.1970, c.215 (C.17:29D-1) is insuring less than 10% of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State.

(b) The commissioner certifies that the plan established pursuant to P.L.1970, c.215 (C.17:29D-1) is insuring 10% or more of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State.

(4) Any order issued by the commissioner that makes operative the provisions of subsections a. and b. of this section may limit the form of policies to which the order applies and shall establish a maximum increase in an insurer's aggregate number of private passenger automobile non-fleet exposures to which the order applies, which increase shall not exceed the maximum limit set forth in paragraph (1) of this subsection d.

(5) An eligible person denied or refused renewal of automobile insurance in a rating territory by an insurer granted relief pursuant to this subsection shall be advised by the insurer that coverage may be available from another insurer or that coverage is available from the plan established pursuant to P.L.1970, c.215 (C.17:29D-1). The commissioner shall establish by

regulation the form and content of the notice to be provided to such an eligible person.

(6) The provisions of this subsection d. shall not reduce an insurer's obligation to renew policies pursuant to section 26 of P.L.1988, c.119 (C.17:29C-7.1).

e. The commissioner may suspend, revoke or otherwise terminate the certificate of authority to transact automobile insurance business in this State of any insurer who violates the provisions of this section.

f. (1) A determination that a competitive market for private passenger automobile insurance does not exist may be made by the commissioner, after notice and hearing, based on two or more of the factors set forth in paragraph (2) of this subsection. A hearing under this subsection shall be held consistent with the rulemaking provisions of the "Administrative Procedure Act," P.L.1968, c.410 (C.52.14B-1 et seq.), except that an order by the commissioner pursuant to this subsection shall include specific finding of fact and be supported by clear and convincing evidence. Any ruling that finds that competition does not exist within the market for automobile insurance shall include specific findings regarding: (a) the actions the State and the commissioner have taken to return the market to a competitive market; and (b) an explanation regarding why those actions have failed to return the market to a competitive market. A ruling pursuant to this subsection shall expire one year after issued unless rescinded earlier by the commissioner or unless the commissioner renews the ruling after a hearing and a finding as to continued lack of a reasonable degree of competition.

(2) The following factors shall be considered by the commissioner for purposes of determining if a reasonable degree of competition does not exist in a particular line of private passenger automobile insurance:

(a) The number of insurers or groups of affiliated insurers actively engaged in providing coverage in the market, taking into account the specialization traditionally associated with the line of insurance;

(b) Measures of market concentration and changes of market concentration over time, including, but not limited to, the Herfindahl-Hirschman Index (HHI) and the United States Department of Justice merger guidelines for an unconcentrated market;

(c) Ease of entry and exit and the existence of financial or economic barriers that could prevent new insurers from entering the market;

(d) The extent to which any insurer or group of affiliated insurers controls all or a dominant portion of the market and has actively sought to prevent competition;

(e) Whether the total number of insurers writing the line of insurance in this State is sufficient to provide multiple options;

(f) The availability of insurance coverage to consumers in the voluntary market; and

(g) The opportunities available to consumers in the market to acquire pricing and other consumer information.

(3) The commissioner shall monitor, and take all reasonable actions to maintain, the degree and continued existence of competition in this State on an on-going basis. In doing so, the commissioner may utilize existing relevant information, analytical systems and other sources, or rely on any combination thereof. Monitoring activities may be conducted internally within the department, in cooperation with other state insurance departments, through outside contractors and in any other manner determined appropriate by the commissioner.

39. Section 1 of P.L.1970, c.215 (C.17:29D-1) is amended to read as follows:

C.17:29D-1 Rules, regulations for insurance plans; administration; requirements for automobile plan.

1. The Commissioner of Banking and Insurance may adopt, issue and promulgate rules and regulations establishing a plan for the providing and apportionment of insurance coverage for applicants therefor who are in good faith entitled to, but are unable to procure the same, through ordinary methods. Every insurer admitted to transact and transacting any line, or lines, of insurance in the State of New Jersey shall participate in such plan and provide insurance coverage to the extent required in such rules and regulations.

The governing board of any plan established pursuant to the commissioner's rules and regulations shall continue to exercise such administrative authority, subject to the commissioner's oversight and as provided in any rules and regulations promulgated pursuant to this section, as

is necessary to ensure the plan's efficient operation, including, but not limited to, the authority to investigate complaints and hear appeals from applicants, insureds, producers, servicing carriers or participants about any matter pertaining to the plan's proper administration, as well as the authority to appoint subcommittees to hear such appeals. Any determination of an appeal by a plan's governing board shall be subject to review by the commissioner on the record below, and shall not be considered a contested case under the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The commissioner's determination shall be a final order and shall be subject to review by the Superior Court.

Any plan established pursuant to this section to provide insurance for automobiles, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), shall provide:

a. For a rating system which shall produce rates for each coverage which are adequate for the safeness and soundness of the plan, and are not excessive nor unfairly discriminatory with regard to risks in the plan involving essentially the same hazards and expense elements, which rates may be changed from time to time by a filing with the commissioner in a manner and form approved by the commissioner;

b. For rates charged to plan insureds which shall be sufficient to meet the plan's expenses and the plan's losses on an incurred basis, including the establishment and maintenance of actuarially sound loss reserves to cover all future costs associated with the exposure;

c. For a limited assignment distribution system permitting insurers to enter into agreements with other mutually agreeable insurers or other qualified entities to transfer their applicants and insureds under such plan to such insurers or other entities, including applicants and insureds who may be covered by special automobile insurance polices issued pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3);

d. That it shall not provide insurance coverage for more than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State. The plan shall provide for the cessation of the acceptance of applications or the issuance of new policies to eligible persons at any time it reaches 10 percent of marketshare, as certified by the commissioner, until such time that the commissioner certifies that the plan is insuring less than 10 percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State;

e. Except for risks written in automobile insurance urban enterprise zones pursuant to subsection i., or risks written pursuant to subsection j. of this section, that it shall not provide coverage to an eligible person as defined pursuant to section 25 of P.L.1990, c.8 (C.17:33B-13);

f. (Deleted by amendment, P.L.1997, c.151.)

g. That the plan shall not be subsidized by any source external to the plan;

h. That a qualified insurer who writes automobile insurance risks in those automobile insurance urban enterprise zones designated by the commissioner pursuant to section 20 of P.L.1997, c.151 (C.17:33C-2) shall receive assigned risk credits for voluntary risks written in those designated automobile insurance urban enterprise zones as a direct writer or through a UEZ agent or agents or through any agent with whom the insurer has an in-force contract as of the effective date of P.L.1997, c.151 (C.17:33B-64 et al.). The commissioner shall establish by regulation the manner in which any qualified automobile insurer may utilize the provisions of this subsection. In no event shall that credit apply to reduce an insurer's obligations under subsection i. of this section;

i. (1) For a voluntary rating tier to accommodate eligible persons, as defined in section 25 of P.L.1990, c.8 (C.17:33B-13), residing in automobile insurance urban enterprise zones, designated by the commissioner pursuant to section 20 of P.L.1997, c.151 (C.17:33C-2), to provide increased availability and encourage the voluntary writing of eligible persons residing in those zones;

(2) The rates utilized in this voluntary rating tier shall be the voluntary market rates in use by the insurer to whom the risk is assigned in that territory;

(3) The voluntary rating tier shall not provide insurance coverage for more than five percent of the aggregate number of private passenger automobile non-fleet exposures being written in the total private passenger automobile insurance market in this State, and the number of exposures written in the voluntary rating tier shall be included for computing the maximum number of exposures permitted to be written in the plan;

(4) The plan shall distribute risks submitted by qualified producers to insurers authorized to write automobile insurance in this State pursuant to a fair and nondiscriminatory formula established by the commissioner. The formula shall provide that insurers which have, and maintain, an aggregate voluntary automobile insurance marketshare in automobile insurance urban enterprise zones, which is reasonably equal to the insurer's voluntary Statewide marketshare excluding risks written in automobile insurance urban enterprise zones, shall be exempt from these distributions;

(5) Qualified producers may submit eligible person risks from automobile insurance urban enterprise zones to the plan for coverage in the voluntary rating tier. As used in this subsection i.: a "qualified producer" means a UEZ agent, as defined in section 19 of P.L.1997, c.151 (C.17:33C-1), who has met any limit on exposures that may be written in accordance with the UEZ agent's agreement with the appointing insurer pursuant to section 22 of P.L.1997, c.151 (C.17:33C-4); and a producer who: is duly licensed with property/casualty authority for the three years immediately preceding the effective date of P.L.1997, c.151 (C.17:33B-64 et al.); has no affiliation with a voluntary market insurer for the placement of automobile insurance; had an affiliation with a voluntary market insurer for the placement of automobile insurance that was terminated by the insurer in the last three years; demonstrates to the plan his competency, efficiency and effectiveness in the solicitation, negotiation and effectuation of automobile insurance as evidenced by any history of disciplinary actions or complaints against the producer, and other relevant factors; conducts his business in an office in an automobile insurance urban enterprise zone; and meets such other requirements as may be established by the commissioner by regulation. For purposes of this subsection i., 'insurer" means an insurer or group of affiliated insurers admitted or authorized to transact the business of automobile insurance in this State;

(6) This subsection shall expire on the first day of the 97th month after the first policy using the voluntary rating tier required by this subsection was issued to a risk, as certified by the commissioner;

j. For a voluntary rating tier to accommodate eligible persons, as defined in section 25 of P.L.1990, c.8 (C.17:33B-13), denied or refused renewal of automobile insurance in a rating territory by an insurer granted relief pursuant to subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15);

k. That an insurer granted relief pursuant to subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15) shall receive assigned risk credits for voluntary risks written in excess of the percentage growth standard established by that subsection d. The commissioner shall establish by regulation the manner in which such an insurer may utilize the provisions of this subsection. In no event shall that credit apply to reduce an insurer’s obligations under subsection i. of this section; and

l. That an insurer granted relief pursuant to subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15) shall also receive assigned risk credits for the voluntary first renewal of an eligible person written pursuant to subsection j. of this section.

Prior to the adoption or amendment of such rules and regulations, the commissioner shall consult with such members of the insurance industry as he deems appropriate. Such consultation shall be in addition to any otherwise required public hearing or notice with regard to the adoption or amendment of rules and regulations.

The governing body administering the plan shall report annually to the Legislature and the Governor on the activities of the plan. The report shall contain an actuarial analysis regarding the adequacy of the rates for each coverage for the safeness and soundness of the plan.

40. Section 15 of P.L.1997, c.151 (C.17:29A-46.2) is amended to read as follows:

C.17:29A-46.2 Underwriting rules; factors.

15. a. Insurers shall put in writing all underwriting rules applicable to each rate level utilized pursuant to section 14 of P.L.1997, c.151 (C.17:29A-46.1). An insurer may take into account factors, including, but not limited to, driving record characteristics appropriate for underwriting and classification in formulating its underwriting rules; provided that no underwriting rule based on motor vehicle violations shall be formulated in such a manner as to assign any named insured to a rating tier other than the standard rating tier applicable to the insured's territory solely on the basis of accumulating four motor vehicle points or less. No underwriting rule shall operate

in such a manner as to assign a risk to a rating plan on the basis of the territory in which the insured resides or any other factor which the commissioner finds is a surrogate for territory. An insurer which knowingly fails to transact automobile insurance consistently with its underwriting rules shall be subject to a fine of not less than $1,000 for each violation.

b. All underwriting rules applicable to each rate level as provided for in section 14 of P.L.1997, c.151 (C.17:29A-46.1) shall be filed with the commissioner and shall be subject to his prior approval. All underwriting rules shall be subject to public inspection. Except as provided in subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15), insurers shall apply their underwriting rules uniformly and without exception throughout the State, so that every applicant or insured conforming with the underwriting rules will be insured or renewed, and so that every applicant not conforming with the underwriting rules will be refused insurance.

c. An insurer with more than one rating plan for private passenger automobile insurance policies providing identical coverages shall not adopt underwriting rules which would permit a person to be insured for private passenger automobile insurance under more than one of the rating plans.

d. An insurer that revises its underwriting rules with respect to the assignment of insureds to rating tiers based on the number of accumulated motor vehicle points, as provided by subsection a. of this section, as amended by P.L.2003, c.89, shall certify to the commissioner that the revised rule will produce rates that are revenue neutral based upon the insurer's current coverages and book of business.

41. Section 14 of P.L.1944, c.27 (C.17:29A-14) is amended to read as follows:

C.17:29A-14 Filing of rate changes; hearing.

14. a. With regard to all property and casualty lines, a filer may, from time to time, alter, supplement, or amend its rates, rating systems, or any part thereof, by filing with the commissioner copies of such alterations, supplements, or amendments, together with a statement of the reason or reasons for such alteration, supplement, or amendment, in a manner and with such information as may be required by the commissioner. If such alteration, supplement, or amendment shall have the effect of increasing or decreasing rates, the commissioner shall determine whether the rates as altered thereby are reasonable, adequate, and not unfairly discriminatory. If the commissioner shall determine that the rates as so altered are not unreasonably high, or inadequate, or unfairly discriminatory, he shall make an order approving them. If he shall find that the rates as altered are unreasonable, inadequate, or unfairly discriminatory, he shall issue an order disapproving such alteration, supplement or amendment.

b. (Deleted by amendment, P.L.1984, c.1.)

c. If an insurer or rating organization files a proposed alteration, supplement or amendment to its private passenger automobile insurance rating system, or any part thereof, the commissioner shall transmit the filing to the appropriate office in the Division of Insurance, which office shall issue a preliminary determination within 90 days of receipt of a rate filing, except that the commissioner may, for good cause, extend the time for a preliminary determination by not more than 30 days. The preliminary determination shall set forth the basis for accepting, rejecting or modifying the rates as filed. A copy of the preliminary determination shall be provided to the filer and other interested parties. Unless the filer or other interested party requests a hearing, the commissioner may adopt the preliminary determination as final within 30 days of the preliminary determination. If a hearing is requested, it shall proceed on an expedited basis in accordance with the provisions of this section. If a preliminary determination is not made within the time provided, a filing shall be transmitted to the Office of Administrative Law for a hearing and the commissioner shall adopt the determination of the administrative law judge as a final decision on the filing.

For filings other than private passenger automobile, if an insurer or rating organization files a proposed alteration, supplement or amendment to its rating system, or any part thereof, which would result in a change in rates, the commissioner may, or upon the request of the filer or the appropriate office in the Division of Insurance shall, certify the matter for a hearing. The hearing shall, at the commissioner's discretion, be conducted by himself, by a person appointed by the commissioner pursuant to section 26 of P.L.1944, c.27 (C.17:29A-26), or by the Office of Administrative Law, created by P.L.1978, c.67 (C.52:14F-1 et seq.), as a contested case. The

following requirements shall apply to the hearing:

(1) The hearing shall commence within 30 days of the date of the request or decision that a hearing is to be held. The hearing shall be held on consecutive working days, except that the commissioner may, for good cause, waive the consecutive working day requirement. If the hearing is conducted by an administrative law judge, the administrative law judge shall submit his findings and recommendations to the commissioner within 30 days of the close of the hearing. The commissioner may, for good cause, extend the time within which the administrative law judge shall submit his findings and recommendations by not more than 30 days. A decision shall be rendered by the commissioner not later than 60 days, or, if he has granted a 30-day extension, not later than 90 days, from the close of the hearing. A filing shall be deemed to be approved unless rejected or modified by the commissioner within the time period provided herein.

(2) The commissioner, or the Director of the Office of Administrative Law, as appropriate, shall notify all interested parties, including the appropriate office in the Division of Insurance on behalf of insurance consumers, of the date set for commencement of the hearing, on the date of the filing of the request for a hearing, or within 10 days of the decision that a hearing is to be held.

(3) The insurer or rating organization making a filing on which a hearing is held shall bear the costs of the hearing.

(4) The commissioner may promulgate rules and regulations (a) to establish standards for the submission of proposed filings, amendments, additions, deletions and alterations to the rating system of filers, which may include forms to be submitted by each filer; and (b) making such other provisions as he deems necessary for effective implementation of this act.

d. (Deleted by amendment, P.L.1984, c.1.)

e. (Deleted by amendment, P.L.2003, c.89.)

42. Section 34 of P.L.1997, c.151 (C.17:29A-46.6) is amended to read as follows:

C.17:29A-46.6 Proposed alteration to rating system, expedited.

34. a. Notwithstanding section 14 of P.L.1944, c.27 (C.17:29A-14), an insurer, affiliated group of insurers or rating organization may elect to file a proposed alteration to its rating system pursuant to the expedited process set forth in this section when the filer requests either an increase of no more than 7% or any decrease in its Statewide average base rate for private passenger automobile insurance.

b. A filer electing to use this expedited process shall file with the commissioner that reasonable information and calculations necessary to support the rate change which the commissioner prescribes by regulation. The prescribed filing requirements shall recognize the intent of this section to provide an expedited process that will not produce rates that are excessive, inadequate for the safety and soundness of the insurer, or unfairly discriminatory between risks in the State involving substantially the same hazards and expense elements.

c. If the commissioner determines that the filing includes all the information and calculations required to support the rate change, the commissioner shall approve the filing.

d. A decision on a filing requesting an increase of up to 3% shall be rendered not later than 30 days after receipt of the filing, unless the commissioner grants an extension, in which case a decision shall be rendered not later than 45 days after receipt of the filing. A decision on a filing requesting an increase of more than 3%, but not more than 7%, shall be rendered not less than 45 days after receipt of the filing, unless the commissioner grants an extension, in which case a decision shall be rendered not later than 60 days after receipt of the filing. A filing shall be complete and received when the filing is accompanied by a certification by a qualified actuary which states that the material, data and documentation, which is part of the filing, includes the documents set forth in regulations, supports the requested rate change and is consistent with generally accepted ratemaking principles of the actuarial profession. A filing shall be deemed to be approved unless rejected or modified by the commissioner within the time provided.

e. The commissioner shall not approve any rate change pursuant to this expedited process that results in an overall increase of more than 7% or an increase in any single coverage of more than 10%.

f. An insurer shall not file more than one request for an increase in rates pursuant to this section in any 12-month period, provided that this limitation shall not apply to a filing for an

overall reduction in rates or prohibit a filing to recover an overall reduction in rates, or to a filing reflecting a statutory change in coverage.

g. An insurer not using this expedited process in a 12-month period may elect to file a proposed alteration to its rating system that will result in a rate change of not more than double the increase permitted pursuant to subsection e. of this section if the filing complies with subsections b. and c. of this section and is made not more than once within a twenty-four month period.

C.17:29A-52 Automobile Insurance Consumer Bill of Rights.

43. a. Every insurer writing private passenger automobile insurance in this State shall provide each insured at least annually and each applicant upon receipt of initial application with an Automobile Insurance Consumer Bill of Rights. The Automobile Insurance Consumer Bill of Rights shall contain information that the Commissioner of Banking and Insurance establishes by regulation as necessary, relevant or appropriate to improve the understanding of the rights and responsibilities of consumers and insurers regarding automobile insurance.

b. To further assist consumers in evaluating an automobile insurer, the commissioner shall develop and disseminate an Automobile Insurance Report Card. Those insurers with more than 50,000 insured private passenger automobiles writing private passenger automobile insurance in this State shall maintain and submit annually to the commissioner customer satisfaction data. The commissioner shall establish by regulation the methodology and criteria to be used in collecting the customer satisfaction data, including, but not limited to, the use of a survey. This data, including consumer complaint ratios and other relevant consumer information designated by the commissioner, shall be included in the Automobile Insurance Report Card. The Automobile Insurance Report Card shall be available on the official website of the Department of Banking and Insurance, and shall be updated annually.

c. Every insurer writing private passenger automobile insurance in this State shall also provide each new applicant seeking automobile insurance and each insured upon request, with three premium scenarios demonstrating the effect of different coverage choices. The commissioner shall establish by regulation the types of coverage examples for which insurers shall provide premium scenarios and the time in which such scenarios shall be provided.

d. If the commissioner finds, after notice and hearing, that an insurer has a pattern and practice of failing to provide any of the information required by this section, the commissioner may, after notice and hearing, order the payment of a penalty not to exceed $1,000 for each offense. Each instance of a failure to provide information to an insured, an applicant or the commissioner, as the case may be, shall be a separate offense and subject to assessment of a separate penalty. Penalties assessed pursuant to this section shall be collected by the commissioner pursuant to the "Penalty Enforcement Law of 1999," P.L.1999, c.274 (C.2A:58-10 et seq.).

C.17:29A-53 Insurance rate increases, notices published on website.

44. a. The Department of Banking and Insurance shall publish on its official website, to the extent practicable, as the case may be: (1) notice of all filings for consumer insurance rate increases; (2) all requests for hearing dates for such increases; and (3) the date or dates a hearing is to be held. Publication on the website shall take place within three business days of the applicable notice of filing, request for hearing, and date or dates of hearings.

b. If an insurer or rating organization files for a consumer insurance overall rate increase, the insurer or rating organization shall, in conjunction with such filing, notify the public of the proposed rate change; except, however, the filer is not required to notify the public of the proposed rate change if the rate increase pertains to: (1) an expedited prior approval rate filing made pursuant to either section 34 of P.L.1997, c.151 (C.17:29A-46.6) or section 3 of P.L.2001, c.409 (C.17:36-5.35); (2) rating system changes made pursuant to sections 14 through 18 and section 34 of P.L.1997, c.151 (C.17:29A-46.1 et seq.), or (3) a rate filing made pursuant to any statutory change in coverage provided under a policy of private passenger automobile insurance.

c. (1) For insurers, that notice shall be communicated through regular or electronic mail to the named policy holders who use the products and services subject to the overall rate increase, within 10 business days after the applicable filing and shall conform to a form prescribed by the Department of Banking and Insurance pursuant to regulations.

(2) For rating organizations, the notice shall be communicated in a form and manner prescribed by the commissioner by regulation.

d. For purposes of this section, "consumer insurance rate increases" means prior approval rate increases for: personal lines property casualty coverages; or Medicare supplemental coverages.

C.39:6A-3.3 Establishment of special automobile insurance policy.

45. a. In order to assist certain low income individuals in this State and encourage their greater compliance in satisfying the mandatory private passenger automobile insurance requirements, the Legislature intends to establish a special automobile insurance policy. The special automobile insurance policy shall be offered only to individuals who qualify for and are actively covered by designated government subsidized programs in the State. For the purpose of this section, "eligible low income individual" means an individual who meets the income criteria established by the commissioner by regulation. In setting the low income criteria, the commissioner shall limit availability to those persons eligible and enrolled in the federal Medicaid program.

b. As an additional option to the mandatory coverage provided in sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4) or the alternative covered provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1), an owner or registered owner of an automobile registered or principally garaged in this State, who is an eligible low income individual, may elect a special automobile insurance policy providing the following coverage:

(1) Emergency personal injury protection coverage, for the payment of benefits without regard to negligence, liability or fault of any kind, only to the named insured and dependent members of his family, as defined by the federal Medicaid program, residing in his household, who sustain bodily injury as a result of an accident while occupying, entering into, alighting from or using an automobile, or as a pedestrian, caused by an automobile or by an object propelled by or from an automobile, and to other persons sustaining bodily injury while occupying, entering into, alighting from or using the automobile of the named insured, with the permission of the named insured. "Emergency personal injury protection coverage" issued pursuant to this section means and includes only payment of treatment for emergency care in an amount not to exceed $250,000 per person per accident. "Emergency care" means all medically necessary treatment of a traumatic injury or a medical condition manifesting itself by acute symptoms of sufficient severity such that absence of immediate attention could reasonably be expected to result in: death; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. Such emergency care shall include all medically necessary care immediately following an automobile accident, including, but not limited to, immediate pre-hospitalization care, transportation to a hospital or trauma center, emergency room care, surgery, critical and acute care. Emergency care extends during the period of initial hospitalization until the patient is discharged from acute care by the attending physician. Emergency care shall be presumed when medical care is initiated at a hospital within 120 hours of the accident. "Emergency personal injury protection coverage" shall also include all medically necessary treatment of permanent or significant brain injury, spinal cord injury or disfigurement after the patient is discharged from acute care. In the event benefits paid by an insurer pursuant to this subsection are in excess of $75,000 on account of bodily injury to any one person in any one accident covered by a policy issued or renewed prior to January 1, 2004, that excess shall be paid by the insurer and shall be reimbursable to the insurer from the Unsatisfied Claim and Judgment Fund pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1);

(2) Death benefit in the amount of $10,000;

(3) The tort option provided in subsection a. of section 8 of P.L.1972, c.70 (C.39:6A-8) shall apply to every named insured and any other person to whom the special automobile insurance policy applies.

c. A special automobile insurance policy shall not provide liability, collision, comprehensive, uninsured or underinsured motorist coverage.

d. The policy form for special automobile insurance policies shall be subject to the approval of the Commissioner of Banking and Insurance and shall clearly and conspicuously set forth the limitations on benefits provided under the policy.

e. The commissioner shall approve the rating system to be used for a special automobile

insurance policy, which shall be administered by the plan created pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1), to provide a uniform Statewide rate to be utilized by all insurers providing coverage through a special automobile insurance policy. The rate established by the commissioner shall be sufficient to reimburse the insurer for the cost of writing the policy and an amount set by the commissioner to be forwarded to the Unsatisfied Claim and Judgment Fund to offset claims paid by the Unsatisfied Claim and Judgment Fund. The commissioner may adjust the rate annually.

f. Special automobile insurance policies shall be assigned to insurers pursuant to the apportionment methodology of the plan created pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1). The number of policies assigned pursuant to this subsection shall not be included in the determination of a competitive market pursuant to subsection d. of section 27 of P.L.1990, c.8 (C.17:33B-15).

46. Section 5 of P.L.1998, c.21 (C.39:6A-3.2) is amended to read as follows:

C.39:6A-3.2 Issuance, renewal of automobile insurance policies, required coverage.

5. a. All automobile insurance policies issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) shall be issued or renewed including at least the coverages required pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4), unless the named insured elects a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or, after the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.), a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). Election of a basic automobile insurance policy or a special automobile insurance policy shall be in writing and signed by the named insured on the coverage selection form required by section 17 of P.L.1983, c.362 (C.39:6A-23). The coverage selection form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that: (1) election of a basic automobile insurance policy will result in less coverage than the $250,000 medical expense benefits coverage mandated prior to the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.); or (2) election of a special automobile insurance policy will result in coverage only for emergency care. Furthermore, the coverage election form shall contain a statement, clearly readable and in 12-point bold type, in a form approved by the commissioner, that election of a special automobile insurance policy, or a basic automobile insurance policy without the optional $10,000 liability coverage provided for in section 4 of P.L.1998, c.21 (C.39:6A-3.1) may subject the named insured to a claim or judgment for noneconomic loss which is not covered by the basic or special automobile insurance policy, and which may place his assets at risk, and in the event the named insured is sued, the insurer shall not provide legal counsel.

b. The insurance coverages provided for in section 4 of P.L.1998, c.21 (C.39:6A-3.1) shall be offered by every insurer which writes insurance coverages pursuant to sections 3 and 4 of P.L.1972, c.70 (C.39:6A-3 and 39:6A-4) for a period of five years after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.). The commissioner shall require every company writing such insurance coverage to report to him annually during that five-year period as to the number of policies written pursuant to this subsection in the previous year, the number of policies with the coverage offered pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) which have been converted to policies with the coverage offered pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) and any other information the commissioner may require such as, but not limited to, the age of the policyholders and the territories in which the policyholders reside. The commissioner shall then report to the Governor and the Legislature regarding the acceptance of the basic automobile insurance policy by the automobile insurance consumers of this State annually for the first four years the basic policy is sold. On or before January 1, 2003, the commissioner shall make a final, cumulative report which shall include recommendations as to the continuation of the basic policy to the Governor and the Legislature.

c. The insurance coverages provided for in section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be offered or provided pursuant to subsection f. of that section for a period of five years after the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.). On or before January 1, 2008, the commissioner shall make a final report which shall include recommendations as to the continuation of the special policy to the Governor and the Legislature.

47. Section 14 of P.L.1985, c.520 (C.39:6A-4.5) is amended to read as follows:

C.39:6A-4.5 Loss of right to sue for failure to insure, for DWI, for intentional acts.

14. a. Any person who, at the time of an automobile accident resulting in injuries to that person, is required but fails to maintain medical expense benefits coverage mandated by section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident while operating an uninsured automobile.

b. Any person who is convicted of, or pleads guilty to, operating a motor vehicle in violation of R.S.39:4-50, section 2 of P.L.1981, c.512 (C.39:4-50.4a), or a similar statute from any other jurisdiction, in connection with an accident, shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of the accident.

c. Any person acting with specific intent of causing injury to himself or others in the operation or use of an automobile shall have no cause of action for recovery of economic or noneconomic loss sustained as a result of an accident arising from such conduct.

48. Section 5 of P.L.1972, c.70 (C.39:6A-5) is amended to read as follows:

C.39:6A-5 Payment of personal injury protection coverage benefits.

5. Payment of personal injury protection coverage benefits.

a. An insurer may require written notice to be given as soon as practicable after an accident involving an automobile with respect to which the policy affords personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to section 4 of P.L.1972, c.70 (C.34:6A-4), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). In the case of claims for medical expense benefits under any of those policies, written notice shall be provided to the insurer by the treating health care provider no later than 21 days following the commencement of treatment. Notification required under this section shall be made in accordance with regulations adopted by the Commissioner of Banking and Insurance and on a form prescribed by the Commissioner of Banking and Insurance. Within a reasonable time after receiving notification required pursuant to this act, the insurer shall confirm to the treating health care provider that its policy affords the claimant personal injury protection coverage benefits as required by section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3).

b. For the purposes of this section, notification shall be deemed to be met if a treating health care provider submits a bill or invoice to the insurer for reimbursement of services within 21 days of the commencement of treatment.

c. In the event that notification is not made by the treating health care provider within 21 days following the commencement of treatment, the insurer shall reserve the right to deny, in accordance with regulations established by the Commissioner of Banking and Insurance, payment of the claim and the treating health care provider shall be prohibited from seeking any payment directly from the insured. In establishing the standards for denial of payment, the Commissioner of Banking and Insurance shall consider the length of delay in notification, the severity of the treating health care provider's failure to comply with the notification provisions of this act based upon the potential adverse impact to the public and whether or not the provider has engaged in a pattern of noncompliance with the notification provisions of this act. In establishing the regulations necessary to effectuate the purposes of this subsection, the Commissioner of Banking and Insurance shall define specific instances where the sanctions permitted pursuant to this subsection shall not apply. Such instances may include, but not be limited to, a treating medical provider's failure to provide notification to the insurer as required by this act due to the insured's medical condition during the time period within which notification is required.

d. A health care provider who fails to notify the insurer within 21 days and whose claim for payment has been denied by the insurer pursuant to the standards established by the Commissioner of Banking and Insurance may, in the discretion of a judge of the Superior Court,

be permitted to refile such claim provided that the insurer has not been substantially prejudiced thereby. Application to the court for permission to refile a claim shall be made within 14 days of notification of denial of payment and shall be made upon motion based upon affidavits showing sufficient reasons for the failure to notify the insurer within the period of time prescribed by this act.

e. (Deleted by amendment, P.L.1998, c.21.)

f. In instances when multiple treating health care providers render services in connection with emergency care, the Commissioner of Banking and Insurance shall designate, through regulation, a process whereby notification by one treating health care provider to the insurer shall be deemed to meet the notification requirements of all the treating health care providers who render services in connection with emergency care.

g. Personal injury protection coverage benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4) and medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or emergency care medical expense benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be overdue if not paid within 60 days after the insurer is furnished written notice of the fact of a covered loss and of the amount of same. If such written notice is not furnished to the insurer as to the entire claim, any partial amount supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer. Any part or all of the remainder of the claim that is subsequently supported by written notice is overdue if not paid within 60 days after such written notice is furnished to the insurer; provided, however, that any payment shall not be deemed overdue where, within 60 days of receipt of notice of the claim, the insurer notifies the claimant or his representative in writing of the denial of the claim or the need for additional time, not to exceed 45 days, to investigate the claim, and states the reasons therefor. The written notice stating the need for additional time to investigate the claim shall set forth the number of the insurance policy against which the claim is made, the claim number, the address of the office handling the claim and a telephone number, which is toll free or can be called collect, or is within the claimant's area code. Written notice to the organization administering dispute resolution pursuant to sections 24 and 25 of P.L.1998, c.21 (C.39:6A-5.1 and C.39:6A-5.2) shall satisfy the notice request for additional time to investigate a claim pursuant to this subsection. For the purpose of determining interest charges in the event the injured party prevails in a subsequent proceeding where an insurer has elected a 45-day extension pursuant to this subsection, payment shall be considered overdue at the expiration of the 45-day period or, if the injured person was required to provide additional information to the insurer, within 10 business days following receipt by the insurer of all the information requested by it, whichever is later.

For the purpose of calculating the extent to which any benefits are overdue, payment shall be treated as being made on the date a draft or other valid instrument which is equivalent to payment was placed in the United States mail in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

h. All overdue payments shall bear interest at the percentage of interest prescribed in the Rules Governing the Courts of the State of New Jersey for judgments, awards and orders for the payment of money.

i. All automobile insurers and the Unsatisfied Claim and Judgment Fund shall provide any claimant with the option of submitting a dispute under this section to dispute resolution pursuant to sections 24 and 25 of P.L.1998, c.21 (C.39:6A-5.1 and C.39:6A-5.2).

49. Section 24 of P.L.1998, c.21 (C.39:6A-5.1) is amended to read as follows:

C.39:6A-5.1 Dispute resolution provided regarding recovery of personal injury protection benefits.

24. a. Any dispute regarding the recovery of medical expense benefits or other benefits provided under personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) arising out of the operation, ownership, maintenance or use of an automobile may be submitted to dispute resolution on the initiative of any party to the dispute, as hereinafter provided.

b. The Commissioner of Banking and Insurance shall designate an organization, and for that

purpose may, at his discretion, advertise for proposals, for the purpose of administering dispute resolution proceedings regarding medical expense benefits and other benefits provided under personal injury protection pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits coverage pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or emergency care medical expense benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3). The commissioner shall promulgate rules and regulations with respect to the conduct of the dispute resolution proceedings. The organization administering dispute resolution shall utilize qualified professionals who serve on a full-time basis and who meet standards of competency established by the commissioner. The commissioner shall establish standards of performance for the organization to ensure the independence and fairness of the review process, including, but not limited to, standards relative to the professional qualifications of the professionals presiding over the dispute resolution process, and standards to ensure that no conflict of interest exists which would prevent the professional from performing his duties in an impartial manner. The standards of performance shall include a requirement that the organization establish an advisory council composed of parties who are users of the dispute resolution mechanism established herein. The commissioner may contract with a consulting firm for the formulation of the standards of performance of the organization and establishment of qualifications for the persons who are to conduct the dispute resolution proceedings. The commissioner shall not advertise for bids for the consulting firm, as provided in sections 3 and 4 of P.L.1954, c.48 (C.52:34-8 and 52:34-9). Compensation to the dispute resolution professionals shall be established by the commissioner and adjusted from time to time as appropriate, with the approval of the commissioner. In no case shall compensation be paid on a contingency basis. The organization shall establish a dispute resolution plan, which shall include procedures and rules governing the dispute resolution process and provisions for monitoring the dispute resolution process to ensure adherence to the standards of performance established by the commissioner. The plan, and any amendments thereto, shall be subject to the approval of the commissioner.

c. Dispute resolution proceedings under this section 24 and section 25 of this amendatory and supplementary act shall include disputes arising regarding medical expense benefits provided under subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), benefits provided pursuant to subsection b., c., d. or e. of section 4 of P.L.1972, c.70 (C.39:6A-4), subsection b., c., d. or e. of section 7 of P.L.1972, c.198 (C.39:6-86.1), and disputes as to additional first party coverage benefits required to be offered pursuant to section 10 of P.L.1972, c.70 (C.39:6A-10). Disputes involving medical expense benefits may include, but not necessarily be limited to, matters concerning: (1) interpretation of the insurance contract; (2) whether the treatment or health care service which is the subject of the dispute resolution proceeding is in accordance with the provisions of section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) or the terms of the policy; (3) the eligibility of the treatment or service for compensation; (4) the eligibility of the provider performing the treatment or service to be compensated under the terms of the policy or under regulations promulgated by the commissioner, including whether the person is licensed or certified to perform such treatment; (5) whether the disputed medical treatment was actually performed; (6) whether diagnostic tests performed in connection with the treatment are those recognized by the commissioner; (7) the necessity or appropriateness of consultations by other health care providers; (8) disputes involving application of and adherence to fee schedules promulgated by the commissioner; and (9) whether the treatment performed is reasonable, necessary, and compatible with the protocols provided for pursuant to P.L.1998, c.21 (C.39:6A-1.1 et al.). The dispute resolution professionals may review the entire claims file of the insurer, subject to any confidentiality requirement established pursuant to State or federal law. All decisions of the dispute resolution professional shall be in writing, in a form prescribed by the commissioner, shall state the issues in dispute, the findings and conclusions on which the decision is based, and shall be signed by the dispute resolution professional. All decisions of a dispute resolution professional shall be binding. The dispute resolution organization shall provide for the retention of all documents used in dispute resolution proceedings under this section and section 25 of this amendatory and supplementary act, including the written decision, for a period of at least five years, in a form approved by the commissioner, or for such additional time as may be established by the commissioner. The written decisions of the dispute resolution

professional shall be forwarded to the commissioner, who shall establish a record of the proceedings conducted under the dispute resolution procedure, which shall be accessible to the public and may be used as guidance in subsequent dispute resolution proceedings.

d. With respect to disputes as to the diagnosis, the medical necessity of the treatment or diagnostic test administered to the injured person, whether the injury is causally related to the insured event or is the product of a preexisting condition, or disputes as to the appropriateness of the protocols utilized by the provider, the dispute resolution professional shall, either at his option or at the request of any party to the dispute, refer the matter to a medical review organization for a determination. The determination of the medical review organization on the dispute referred shall be presumed to be correct by the dispute resolution professional, which presumption may be rebutted by a preponderance of the evidence. Should the dispute resolution professional find that the decision of the medical review organization is not correct, the reasons supporting that finding shall be set forth in the dispute resolution professional's written decision.

e. Any person submitting a matter to the dispute resolution process established herein may submit for review all or a portion of a disputed treatment or treatments or a dispute regarding a diagnostic test or tests or a dispute regarding the providing of services or durable medical goods. Any portion of a treatment or diagnostic test or service which is not under review shall be reimbursed in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5). If the dispute resolution proceeding results in a determination that all or part of a treatment or treatments, diagnostic test or tests or service performed, or durable medical goods provided are medically necessary and appropriate, reimbursement shall be made with interest payable in accordance with the provisions of section 5 of P.L.1972, c.70 (C.39:6A-5).

50. Section 6 of P.L.1972, c.70 (C.39:6A-6) is amended to read as follows:

C.39:6A-6 Collateral source.

6. Collateral Source. The benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) and the benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) shall be payable as loss accrues, upon written notice of such loss and without regard to collateral sources, except that benefits, collectible under workers' compensation insurance, employees' temporary disability benefit statutes, Medicare provided under federal law, and benefits, in fact collected, that are provided under federal law to active and retired military personnel shall be deducted from the benefits collectible under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) and the benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3).

If an insurer has paid those benefits and the insured is entitled to, but has failed to apply for, workers' compensation benefits or employees' temporary disability benefits, the insurer may immediately apply to the provider of workers' compensation benefits or of employees' temporary disability benefits for a reimbursement of any benefits pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) it has paid.

51. Section 7 of P.L.1972, c.70 (C.39:6A-7) is amended to read as follows:

C.39:6A-7 Exclusion from certain insurance benefits.

7. Exclusions. a. Insurers may exclude a person from benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits provided in section 4 of P.L.1998, c.21 (C.39:6A-3.1) and benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) if that person's conduct contributed to his personal injuries or death occurred in any of the following ways:

(1) while committing a high misdemeanor or felony or seeking to avoid lawful apprehension or arrest by a police officer; or

(2) while acting with specific intent of causing injury or damage to himself or others.

b. An insurer may also exclude from the benefits provided in sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), the medical expense benefits provided in section 4 of P.L.1998,

c.21 (C.39:6A-3.1) and benefits provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) any person having incurred injuries or death, who, at the time of the accident:

(1) was the owner or registrant of an automobile registered or principally garaged in this State that was being operated without personal injury protection coverage;

(2) was occupying or operating an automobile without the permission of the owner or other named insured;

(3) was a person other than the named insured or a member of the named insured's family residing in his household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a named insured or member of the named insured's family residing in his household under the terms of another policy; or

(4) was a member of the named insured's family residing in the named insured's household, if that person is entitled to coverage under section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), or both, section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) as a named insured under the terms of another policy.

52. Section 8 of P.L.1972, c.70 (C.39:6A-8) is amended to read as follows:

C.39:6A-8 Tort exemption, limitation on the right to noneconomic loss.

8. Tort exemption; limitation on the right to noneconomic loss.

One of the following two tort options shall be elected, in accordance with section 14.1 of P.L.1983, c.362 (C.39:6A-8.1), by any named insured required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4):

a. Limitation on lawsuit option. Every owner, registrant, operator or occupant of an automobile to which section 4 of P.L.1972, c.70 (C.39:6A-4), personal injury protection coverage, section 4 of P.L.1998, c.21 (C.39:6A-3.1), medical expense benefits coverage, or section 45 of P.L.2003, c.89 (C.39:6A-3.3) regardless of fault, applies, and every person or organization legally responsible for his acts or omissions, is hereby exempted from tort liability for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), or is a person who has a right to receive benefits under section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State, unless that person has sustained a bodily injury which results in death; dismemberment; significant disfigurement or significant scarring; displaced fractures; loss of a fetus; or a permanent injury within a reasonable degree of medical probability, other than scarring or disfigurement. An injury shall be considered permanent when the body part or organ, or both, has not healed to function normally and will not heal to function normally with further medical treatment. For the purposes of this subsection, "physician" means a physician as defined in section 5 of P.L.1939, c.115 (C.45:9-5.1).

In order to satisfy the tort option provisions of this subsection, the plaintiff shall, within 60 days following the date of the answer to the complaint by the defendant, provide the defendant with a certification from the licensed treating physician or a board-certified licensed physician to whom the plaintiff was referred by the treating physician. The certification shall state, under penalty of perjury, that the plaintiff has sustained an injury described above. The certification shall be based on and refer to objective clinical evidence, which may include medical testing, except that any such testing shall be performed in accordance with medical protocols pursuant to subsection a. of section 4 of P.L.1972, c.70 (C.39:6A-4) and the use of valid diagnostic tests administered in accordance with section 12 of P.L.1998, c.21 (C.39:6A-4.7). Such testing may not be experimental in nature or dependent entirely upon subjective patient response. The court may grant no more than one additional period not to exceed 60 days to file the certification pursuant to this subsection upon a finding of good cause.

A person is guilty of a crime of the fourth degree if that person purposefully or knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any

certification filed pursuant to this subsection. Notwithstanding the provisions of subsection e. of N.J.S.2C:44-1, the court shall deal with a person who has been convicted of a violation of this subsection by imposing a sentence of imprisonment unless, having regard to the character and condition of the person, the court is of the opinion that imprisonment would be a serious injustice which overrides the need to deter such conduct by others. If the court imposes a noncustodial or probationary sentence, such sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution. Nothing in this subsection a. shall preclude an indictment and conviction for any other offense defined by the laws of this State. In addition, any professional license held by the person shall be forfeited according to the procedures established by section 4 of P.L.1997, c.353 (C.2C:51-5); or

b. No limitation on lawsuit option. As an alternative to the basic tort option specified in subsection a. of this section, every owner, registrant, operator, or occupant of an automobile to which section 4 of P.L.1972, c.70 (C.39:6A-4), personal injury protection coverage, section 4 of P.L.1998, c.21 (C.39:6A-3.1), medical expense benefits coverage, or section 45 of P.L.2003, c.89 (C.39:6A-3.3), regardless of fault, applies, and every person or organization legally responsible for his acts or omissions, shall be liable for noneconomic loss to a person who is subject to this subsection and who is either a person who is required to maintain the coverage mandated by P.L.1972, c.70 (C.39:6A-1 et seq.) or is a person who has a right to receive benefits under section 4 of that act (C.39:6A-4), as a result of bodily injury, arising out of the ownership, operation, maintenance or use of such automobile in this State.

The tort option provisions of subsection b. of this section shall also apply to the right to recover for noneconomic loss of any person eligible for benefits pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), section 4 of P.L.1998, c.21 (C.39:6A-3.1) or section 45 of P.L.2003, c.89 (C.39:6A-3.3) but who is not required to maintain personal injury protection coverage pursuant to section 4 of P.L.1972, c.70 (C.39:6A-4), medical expense benefits coverage pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) and is not an immediate family member, as defined in section 14.1 of P.L.1983, c.362 (C.39:6A-8.1), under a standard automobile insurance policy or basic automobile insurance policy.

The tort option provisions of subsection a. of this section shall also apply to any person subject to section 14 of P.L.1985, c.520 (C.39:6A-4.5) and to every named insured and any other person to whom the benefits of the special automobile insurance policy provided in section 45 of P.L.2003, c.89 (C.39:6A-3.3) or the medical expense benefits of the basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) apply whether or not the person has elected the optional $10,000 liability coverage insuring against loss resulting from liability imposed by law for bodily injury or death provided for in subsection c. of section 4 of P.L.1998, c.21 (C.39:6A-3.1).

The tort option provisions of subsections a. and b. of this section as provided in this 1998 amendatory and supplementary act shall apply to automobile insurance policies issued or renewed on or after the effective date of P.L.1998, c.21 (C.39:6A-1.1 et al.) and as otherwise provided by law.

53. Section 20 of P.L.1983, c.362 (C.39:6A-9.1) is amended to read as follows:

C.39:6A-9.1 Recovery from tortfeasor.

20. An insurer, health maintenance organization or governmental agency paying benefits pursuant to subsection a., b. or d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3), personal injury protection benefits in accordance with section 4 or section 10 of P.L.1972, c.70 (C.39:6A-4 or 39:6A-10), medical expense benefits pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), as a result of an accident occurring within this State, shall, within two years of the filing of the claim, have the right to recover the amount of payments from any tortfeasor who was not, at the time of the accident, required to maintain personal injury protection or medical expense benefits coverage, other than for pedestrians, under the laws of this State, including personal injury protection coverage required to be provided in accordance with section 18 of P.L.1985, c.520 (C.17:28-1.4), or although required did not maintain personal injury protection or medical expense benefits coverage at the time of the accident. In the case of an accident occurring in this

State involving an insured tortfeasor, the determination as to whether an insurer, health maintenance organization or governmental agency is legally entitled to recover the amount of payments and the amount of recovery, including the costs of processing benefit claims and enforcing rights granted under this section, shall be made against the insurer of the tortfeasor, and shall be by agreement of the involved parties or, upon failing to agree, by arbitration.

54. Section 11 of P.L.1972, c.70 (C.39:6A-11) is amended to read as follows:

C.39:6A-11 Contribution among insurers.

11. Contribution among insurers. If two or more insurers are liable to pay benefits under sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10) under a standard automobile insurance policy for the same bodily injury, or death, of any one person, the maximum amount payable shall be as specified in those sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), section 4 of P.L.1998, c.21 (C.39:6A-3.1) and section 45 of P.L.2003, c.89 (C.39:6A-3.3), respectively, if additional first party coverage applies and any insurer paying the benefits shall be entitled to recover from each of the other insurers, only by inter-company arbitration or inter-company agreement, an equitable pro-rata share of the benefits paid.

55. Section 12 of P.L.1972, c.70 (C.39:6A-12) is amended to read as follows:

C.39:6A-12 Inadmissibility of evidence of losses collectible under personal injury protection coverage.

12. Inadmissibility of evidence of losses collectible under personal injury protection coverage. Except as may be required in an action brought pursuant to section 20 of P.L.1983, c.362 (C.39:6A-9.1), evidence of the amounts collectible or paid under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), amounts collectible or paid for medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) and amounts collectible or paid for benefits under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), to an injured person, including the amounts of any deductibles, copayments or exclusions, including exclusions pursuant to subsection d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3), otherwise compensated is inadmissible in a civil action for recovery of damages for bodily injury by such injured person.

The court shall instruct the jury that, in arriving at a verdict as to the amount of the damages for noneconomic loss to be recovered by the injured person, the jury shall not speculate as to the amount of the medical expense benefits paid or payable by an automobile insurer under personal injury protection coverage payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) to the injured person, nor shall they speculate as to the amount of benefits paid or payable by a health insurer, health maintenance organization or governmental agency under subsection d. of section 13 of P.L.1983, c.362 (C.39:6A-4.3).

Nothing in this section shall be construed to limit the right of recovery, against the tortfeasor, of uncompensated economic loss sustained by the injured party.

56. Section 13 of P.L.1972, c.70 (C.39:6A-13) is amended to read as follows:

C.39:6A-13. Discovery of facts as to personal injury protection coverage.

13. Discovery of facts as to personal injury protection coverage. The following apply to personal injury protection coverage benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) and benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3):

a. Every employer shall, if a request is made by an insurer or the Unsatisfied Claim and Judgment Fund providing personal injury protection benefits under a standard automobile insurance policy or medical expense benefits payable under a basic automobile insurance policy

against whom a claim has been made, furnish forthwith, in a form approved by the Commissioner of Banking and Insurance, a signed statement of the lost earnings since the date of the bodily injury and for a reasonable period before the injury, of the person upon whose injury the claim is based.

b. Every physician, hospital, or other health care provider providing, before and after the bodily injury upon which a claim for personal injury protection benefits or medical expense benefits is based, any products, services or accommodations in relation to such bodily injury or any other injury, or in relation to a condition claimed to be connected with such bodily injury or any other injury, shall, if requested to do so by the insurer or the Unsatisfied Claim and Judgment Fund against whom the claim has been made, furnish forthwith a written report of the history, condition, treatment, dates and costs of such treatment of the injured person, and produce forthwith and permit the inspection and copying of his or its records regarding such history, condition, treatment dates and costs of treatment. The person requesting such records shall pay all reasonable costs connected therewith.

c. The injured person shall be furnished upon demand a copy of all information obtained by the insurer or the Unsatisfied Claim and Judgment Fund under the provisions of this section, and shall pay a reasonable charge, if required by the insurer and the Unsatisfied Claim and Judgment Fund.

d. Whenever the mental or physical condition of an injured person covered by personal injury protection under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy is material to any claim that has been or may be made for such past or future personal injury protection benefits or medical expense benefits, such person shall, upon request of an insurer or the Unsatisfied Claim and Judgment Fund submit to mental or physical examination conducted by a health care provider licensed in this State in the same profession or specialty as the health care provider whose services are subject to review under this section and who is located within a reasonable proximity to the injured person's residence. The injured person shall provide or make available to the provider any pertinent medical records or medical history that the provider deems necessary to the examination. The costs of any examinations requested by an insurer or the Unsatisfied Claim and Judgment Fund shall be borne entirely by whomever makes such request. Such examination shall be conducted within the municipality of residence of the injured person. If there is no qualified health care provider to conduct the examination within the municipality of residence of the injured person, then such examination shall be conducted in an area of the closest proximity to the injured person's residence. Insurers providing personal injury protection coverage under a standard automobile insurance policy or medical expense benefits under a basic automobile insurance policy are authorized to include reasonable provisions requiring those claiming personal injury protection coverage benefits or medical expense benefits to submit to mental or physical examination as requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section. Failure to submit to a mental or physical examination requested by an insurer or the Unsatisfied Claim and Judgment Fund pursuant to the provisions of this section shall subject the injured person to certain limitations in coverage as specified in regulations promulgated by the commissioner.

e. If requested by the person examined, a party causing an examination to be made, shall deliver to him a copy of every written report concerning the examination rendered by an examining health care provider, at least one of which reports must set out his findings and conclusions in detail. After such request and delivery, the party causing the examination to be made is entitled upon request to receive from the person examined every written report available to him, or his representative, concerning any examination, previously or thereafter made of the same mental or physical condition.

f. The injured person, upon reasonable request by the insurer or the Unsatisfied Claim and Judgment Fund, shall sign all forms, authorizations or releases for information, approved by the Commissioner of Banking and Insurance, which may be necessary to the discovery of the above facts, in order to reasonably prove the injured person's losses.

g. In the event of any dispute regarding an insurer's or the Unsatisfied Claim and Judgment Fund's or an injured person's right as to the discovery of facts about the injured person's earnings or about his history, condition, treatment, dates and costs of such treatment, or the submission of such injured person to a mental or physical examination subject to the provisions of this

section, the insurer, Unsatisfied Claim and Judgment Fund or the injured person may petition a court of competent jurisdiction for an order resolving the dispute and protecting the rights of all parties. The order may be entered on motion for good cause shown giving notice to all persons having an interest therein. Such court may protect against annoyance, embarrassment or oppression and may as justice requires, enter an order compelling or refusing discovery, or specifying conditions of such discovery; the court may further order the payment of costs and expenses of the proceeding, as justice requires.

57. Section 11 of P.L.1972, c.203 (C.39:6A-13.1) is amended to read as follows:

C.39:6A-13.1 Two-year limitation on action for payment of benefits.

11. a. Every action for the payment of benefits payable under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits payable under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), except an action by a decedent's estate, shall be commenced not later than two years after the injured person or survivor suffers a loss or incurs an expense and either knows or in the exercise of reasonable diligence should know that the loss or expense was caused by the accident, or not later than four years after the accident whichever is earlier, provided, however, that if benefits have been paid before then an action for further benefits may be commenced not later than two years after the last payment of benefits.

b. Every action by a decedent's estate for the payment of benefits provided under a standard automobile insurance policy pursuant to sections 4 and 10 of P.L.1972, c.70 (C.39:6A-4 and 39:6A-10), medical expense benefits provided under a basic automobile insurance policy pursuant to section 4 of P.L.1998, c.21 (C.39:6A-3.1) or benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3), shall be commenced not later than two years after death or four years after the accident from which death results, whichever is earlier, provided, however, that if benefits had been paid to the decedent prior to his death then an action may be commenced not later than two years after his death or four years after the last payment of benefits, whichever is earlier, provided, further, that if the decedent's estate has received benefits before then an action for further benefits shall be commenced not later than two years from the last payment of benefits.

58. Section 15 of P.L.1972, c.70 (C.39:6A-15) is amended to read as follows:

C.39:6A-15 Penalties for false and fraudulent representation.

15. In any claim or action arising for benefits payable under a standard automobile insurance policy under section 4 of P.L.1972, c.70 (C.39:6A-4), any claim or action arising for medical expense benefits payable under a basic automobile insurance policy under section 4 of P.L.1998, c.21 (C.39:6A-3.1) or any claim or action arising for benefits payable under a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3) wherein any person obtains or attempts to obtain from any other person, insurance company or Unsatisfied Claim and Judgment Fund any money or other thing of value by (1) falsely or fraudulently representing that such person is entitled to such benefits; (2) falsely and fraudulently making statements or presenting documentation in order to obtain or attempt to obtain such benefits; or (3) cooperates, conspires or otherwise acts in concert with any person seeking to falsely or fraudulently obtain, or attempt to obtain, such benefits may upon conviction be fined not more than $5,000.00, or imprisoned for not more than three years or both, or in the event the sum so obtained or attempted to be obtained is not more than $500.00, may upon conviction, be fined not more than $500.00, or imprisoned for not more than six months or both, as a disorderly person.

In addition to any penalties imposed by law, any person who is either found by a court of competent jurisdiction to have violated any provision of P.L.1983 c.320 (C.17:33A-1 et seq.) pertaining to automobile insurance or been convicted of any violation of Title 2C of the New Jersey Statutes arising out of automobile insurance fraud shall not operate a motor vehicle over the highways of this State for a period of one year from the date of judgment or conviction.

59. Section 2 of P.L.1968, c.385 (C.17:28-1.1) is amended to read as follows:

C.17:28-1.1 Required coverage; exceptions.

2. a. Except for a basic automobile insurance policy, no motor vehicle liability policy or renewal of such policy of insurance, including a standard liability policy for an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), insuring against loss resulting from liability imposed by law for bodily injury or death, sustained by any person arising out of the ownership, maintenance or use of a motor vehicle, shall be issued in this State with respect to any motor vehicle registered or principally garaged in this State unless it includes coverage in limits for bodily injury or death as follows:

(1) an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident, and

(2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of more than one person, in any one accident, under provisions approved by the Commissioner of Banking and Insurance, for payment of all or part of the sums which the insured or his legal representative shall be legally entitled to recover as damages from the operator or owner of an uninsured motor vehicle, or hit and run motor vehicle, as defined in section 18 of P.L.1952, c.174 (C.39:6-78), because of bodily injury, sickness or disease, including death resulting therefrom, sustained by the insured, caused by accident and arising out of the ownership, maintenance, operation or use of such uninsured or hit and run motor vehicle anywhere within the United States or Canada; except that uninsured motorist coverage shall provide that in order to recover for non-economic loss, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), for accidents to which the benefits of section 4 (C.39:6A-4) of that act apply, the tort option elected pursuant to section 8 (C.39:6A-8) of that act shall apply to that injured person.

All motor vehicle liability policies, except basic automobile insurance policies, shall also include coverage for the payment of all or part of the sums which persons insured thereunder shall be legally entitled to recover as damages from owners or operators of uninsured motor vehicles, other than hit and run motor vehicles, because of injury to or destruction to the personal property of such insured, with a limit in the aggregate for all insureds involved in any one accident of $5,000.00, and subject, for each insured, to an exclusion of the first $500.00 of such damages.

b. Uninsured and underinsured motorist coverage shall be provided as an option by an insurer to the named insured electing a standard automobile insurance policy up to at least the following limits: $250,000.00 each person and $500,000.00 each accident for bodily injury; $100,000.00 each accident for property damage or $500,000.00 single limit, subject to an exclusion of the first $500.00 of such damage to property for each accident, except that the limits for uninsured and underinsured motorist coverage shall not exceed the insured's motor vehicle liability policy limits for bodily injury and property damage, respectively.

Rates for uninsured and underinsured motorist coverage for the same limits shall, for each filer, be uniform on a Statewide basis without regard to classification or territory.

c. Uninsured and underinsured motorist coverage provided for in this section shall not be increased by stacking the limits of coverage of multiple motor vehicles covered under the same policy of insurance nor shall these coverages be increased by stacking the limits of coverage of multiple policies available to the insured. If the insured had uninsured motorist coverage available under more than one policy, any recovery shall not exceed the higher of the applicable limits of the respective coverages and the recovery shall be prorated between the applicable coverages as the limits of each coverage bear to the total of the limits.

d. Uninsured and underinsured motorist coverage shall be subject to the policy terms, conditions and exclusions approved by the Commissioner of Banking and Insurance, including, but not limited to, unauthorized settlements, nonduplication of coverage, subrogation and arbitration.

e. For the purpose of this section, (1) "underinsured motorist coverage" means insurance for damages because of bodily injury and property damage resulting from an accident arising out of the ownership, maintenance, operation or use of an underinsured motor vehicle. Underinsured motorist coverage shall not apply to an uninsured motor vehicle. A motor vehicle is underinsured when the sum of the limits of liability under all bodily injury and property damage

liability bonds and insurance policies available to a person against whom recovery is sought for bodily injury or property damage is, at the time of the accident, less than the applicable limits for underinsured motorist coverage afforded under the motor vehicle insurance policy held by the person seeking that recovery. A motor vehicle shall not be considered an underinsured motor vehicle under this section unless the limits of all bodily injury liability insurance or bonds applicable at the time of the accident have been exhausted by payment of settlements or judgments. The limits of underinsured motorist coverage available to an injured person shall be reduced by the amount he has recovered under all bodily injury liability insurance or bonds;

(2) "uninsured motor vehicle" means:

(a) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is no bodily injury liability insurance or bond applicable at the time of the accident;

(b) a motor vehicle with respect to the ownership, operation, maintenance, or use of which there is bodily injury liability insurance in existence but the liability insurer denies coverage or is unable to make payment with respect to the legal liability of its insured because the insurer has become insolvent or bankrupt, or the Commissioner of Banking and Insurance has undertaken control of the insurer for the purpose of liquidation;

(c) a hit and run motor vehicle as described in section 18 of P.L.1952, c.174 (C.39:6-78); or

(d) an automobile covered by a special automobile insurance policy pursuant to section 45 of P.L.2003, c.89 (C.39:6A-3.3).

"Uninsured motor vehicle" shall not include an automobile covered by a basic automobile insurance policy; an underinsured motor vehicle; a motor vehicle owned by or furnished for the regular use of the named insured or any resident of the same household; a self-insurer within the meaning of any financial responsibility or similar law of the state in which the motor vehicle is registered or principally garaged; a motor vehicle which is owned by the United States or Canada, or a state, political subdivision or agency of those governments or any of the foregoing; a land motor vehicle or trailer operated on rails or crawler treads; a motor vehicle used as a residence or stationary structure and not as a vehicle; or equipment or vehicles designed for use principally off public roads, except while actually upon public roads.

60. Section 1 of P.L.1972, c.197 (C.39:6B-1) is amended to read as follows:

C.39:6B-1 Maintenance of motor vehicle liability insurance coverage.

1. a. Every owner or registered owner of a motor vehicle registered or principally garaged in this State shall maintain motor vehicle liability insurance coverage, under provisions approved by the Commissioner of Banking and Insurance, insuring against loss resulting from liability imposed by law for bodily injury, death and property damage sustained by any person arising out of the ownership, maintenance, operation or use of a motor vehicle wherein such coverage shall be at least in: (1) an amount or limit of $15,000.00, exclusive of interest and costs, on account of injury to, or death of, one person, in any one accident; and (2) an amount or limit, subject to such limit for any one person so injured or killed, of $30,000.00, exclusive of interest and costs, on account of injury to or death of, more than one person, in any one accident; and (3) an amount or limit of $5,000.00, exclusive of interest and costs, for damage to property in any one accident.

b. Notwithstanding the provisions of subsection a. of this section, an owner or registered owner of an automobile, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), registered or primarily garaged in the State may satisfy the requirements of subsection a. of this section by maintaining a basic automobile insurance policy containing coverages provided pursuant to subsections a. and b. of section 4 of P.L.1998, c.21 (C.39:6A-3.1).

c. Notwithstanding the provisions of subsection a. of this section, an owner or registered owner of an automobile, as defined in section 2 of P.L.1972, c.70 (C.39:6A-2), registered or primarily garaged in the State may satisfy the requirements of subsection a. of this section by maintaining a special automobile insurance policy containing coverages provided pursuant to subsection b. of section 45 of P.L.2003, c.89 (C.39:6A-3.3).

61. Section 2 of P.L.1968, c.158 (C.17:29C-7) is amended to read as follows:

C.17:29C-7 Notice of cancellation; reasons.

2. (A) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) Nonpayment of premium or nonpayment of a residual market equalization charge imposed pursuant to the provisions of section 20 of P.L.1983, c.65 (C.17:30E-8); or

(b) The driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period; or

(c) Knowingly providing materially false or misleading information in connection with any application for insurance, renewal of insurance or claim for benefits under an insurance policy; or

(d) The insurer determines, within 60 days of issuance of the policy, that the named insurer does not meet the approved underwriting rules of the insured then in effect.

(B) (Deleted by amendment, P.L.2003, c.89.)

(C) (Deleted by amendment, P.L.2003, c.89.)

(D) This section shall not apply to nonrenewal.

(E) Nothing in this section shall be interpreted to limit the ability of an insurer to void a policy ab initio as otherwise provided by law.

(F) The commissioner shall adopt rules and regulations necessary or appropriate to effectuate the purposes of this section.

62. Section 4 of P.L.1968, c.158 (C.17:29C-9) is amended to read as follows:

C.17:29C-9 Intention not to renew, notice required.

4. No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy, at least 60 days' advance notice of its intention not to renew, except that the commissioner may extend the advance notice period up to an additional 30 days by regulation. This section shall not apply:

(a) If the insurer has manifested its willingness to renew; nor

(b) In case of nonpayment of premium;

provided that, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

63. Section 25 of P.L.1990, c.8 (C.17:33B-13) is amended to read as follows:

C.17:33B-13 Definitions.

25. As used in sections 25 through 33 of this 1990 amendatory and supplementary act:

"Automobile" means an automobile as defined in section 2 of P.L.1972, c.70 (C.39:6A-2).

"Automobile insurance" means insurance for an automobile including coverage for bodily injury liability and property damage liability, comprehensive and collision coverages, uninsured and underinsured motorist coverage, personal injury protection coverage, additional personal injury protection coverage and any other automobile insurance required by law.

"Commissioner" means the Commissioner of Banking and Insurance.

"Declination" means:

a. Refusal by an insurance agent to submit an application on behalf of an applicant to any of the insurers represented by the agent;

b. Refusal by an insurer to issue an automobile insurance policy to an eligible person upon receipt of an application for automobile insurance;

c. The offer of automobile insurance coverage with less favorable terms or conditions than those requested by an eligible person; or

d. The refusal by an insurer or agent to provide, upon the request of an eligible person, an application form or other means of making an application or request for automobile insurance coverage.

"Automobile insurance eligibility points" means points calculated under the schedule promulgated by the commissioner pursuant to section 26 of this act.

"Eligible person" means a person who is an owner or registrant of an automobile registered in this State or who holds a valid New Jersey driver's license to operate an automobile, but does not include any person:

a. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy has been convicted pursuant to R.S.39:4-50 or section 2 of P.L.1981, c.512 (C.39:4-50.4a), or for an offense of a substantially similar nature committed in another jurisdiction; has been convicted of a crime of the first, second or third degree resulting from the use of a motor vehicle; or has been convicted of theft of a motor vehicle;

b. Whose driver's license to operate an automobile is under suspension or revocation;

c. Who has been convicted, within the five-year period immediately preceding application for or renewal of a policy of automobile insurance, of fraud or intent to defraud involving an insurance claim or an application for insurance; or who has been successfully denied, within the immediately preceding five years, payment by an insurer of a claim in excess of $1,000 under an automobile insurance policy, if there was evidence of fraud or intent to defraud involving the automobile insurance claim or application;

d. Whose policy of automobile insurance has been canceled because of nonpayment of premium or financed premium within the immediately preceding two-year period, unless the premium due on a policy for which application has been made is paid in full before issuance or renewal of the policy;

e. Who fails to obtain or maintain membership or qualification for membership in a club, group, or organization, if membership is a uniform requirement of the insurer as a condition of providing insurance, and if the dues or charges, if any, or other conditions for membership or qualifications for membership are applied uniformly throughout this State, are not expressed as a percentage of the insurance premium, and do not vary with respect to the rating classification of the member or potential member except for the purpose of offering a membership fee to family units. Membership fees, if applicable, may vary in accordance with the amount or type of coverage if the purchase of additional coverage, either as to type or amount, is not a condition for reduction of dues or fees;

f. Whose driving record for the three-year period immediately preceding application for or renewal of a policy of automobile insurance has an accumulation of automobile insurance eligibility points as determined under the schedule promulgated by the commissioner pursuant to section 26 of this act;

g. Who possesses such other risk factors as determined to be relevant by rule or regulation of the commissioner; or

h. Who, during the three-year period immediately preceding application for, or renewal of, an automobile insurance policy, has knowingly provided materially false or misleading information in connection with an application for insurance, renewal of insurance or claim for benefits under an insurance policy.

"Insurance agent" or "agent" means an insurance agent as defined by subsection f. of section 2 of P.L.1987, c.293 (C.17:22A-2) and shall also include an insurance broker as defined by subsection g. of section 2 of P.L.1987, c.293 (C.17:22A-2) who has a brokerage relationship with an insurer.

"Insurer" means any insurer authorized or admitted to write automobile insurance in this State, but does not include the New Jersey Automobile Full Insurance Underwriting Association created pursuant to sections 13 through 34 of P.L.1983, c.65 (C.17:30E-1 et seq.) or any residual market mechanism implemented pursuant to section 1 of P.L.1970, c.215 (C.17:29D-1).

64. Section 26 of P.L.1990, c.8 (C.17:33B-14) is amended to read as follows:

C.17:33B-14 Schedule of automobile insurance eligibility points.

26. The commissioner shall, within 90 days of the effective date of this act, promulgate a schedule of automobile insurance eligibility points by rule or regulation adopted pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The schedule shall assess a point valuation to driving experience related violations and shall include assessments for violations of lawful speed limits within such increments as determined by the commissioner,

other moving violations, and at-fault accidents. For the purposes of this section, an "at-fault accident," occurring before the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.), means an at-fault accident which results in payment by the insurer of at least a $500 claim and for accidents occurring on or after the effective date of P.L.2003, c.89 (C.17:30A-2.1 et al.), means an at-fault accident which results in payment by the insurer of at least a $1,000 claim, which amount may be adjusted in $100 or $250 increments periodically by order of the commissioner no more frequently than every 36 months, as the commissioner deems appropriate, to reflect the cumulative increases or decreases in the components of the Consumer Price Index, All Urban Consumers (CPI-U) for the Northeast Region, and the adjusted amount shall apply to automobile accidents occurring at least 120 days after the effective date of the adjustment; except that an at-fault accident shall not mean an accident occurring as a result of operation of any motor vehicle in response to a medical emergency if the operator at the time of the accident was a physician responding to the medical emergency.

65. Section 10 of P.L.1983, c.65 (C.17:29A-39) is amended to read as follows:

C.17:29A-39 Deductibles.

10. a. Unless the named insured selects a lower deductible amount, every private passenger automobile insurance policy providing collision and comprehensive coverages, issued or renewed on or after the effective date of this act, shall provide a deductible in a minimum amount of $500.00 each for collision and comprehensive coverages, except for policies issued on or after the effective date of this section, that deductible amount shall be $750 each for collision and comprehensive coverages. The minimum deductible established by this subsection shall apply to all policies providing collision and comprehensive coverages unless the named insured provides otherwise in writing on a form approved by the commissioner.

b. The commissioner shall promulgate rules and regulations requiring insurers to offer a range of deductibles up to at least $2,000.00 for private passenger automobile collision and comprehensive coverages, which upper range may be adjusted in $100 or $250 increments periodically by order of the commissioner no more frequently than every 36 months, as the commissioner deems appropriate, to reflect the cumulative increases or decreases, since the deductibles were last set, in the components of the Consumer Price Index, All Urban Consumers (CPI-U) for the Northeast Region.

66. Section 16 of P.L.1974, c.17 (C.17:30A-16) is amended to read as follows:

C.17:30A-16 Surcharges.

16. a. The commissioner shall adopt rules permitting member insurers to recoup over a reasonable length of time, a sum reasonably calculated to recoup assessments paid by the member insurer pursuant to paragraph (3) of subsection a. of section 8 of P.L.1974, c.17 (C.17:30A-8) by way of a surcharge on premiums charged for insurance policies to which this act applies. The amount of any surcharge shall be determined by the commissioner. The commissioner may permit an insurer to omit collection of the surcharge from its insureds when the expense of collecting the surcharge would exceed the amount of the surcharge, provided that nothing in this subsection shall relieve the insurer of its obligation to remit the amount of surcharge otherwise collectible.

b. No member insurer shall impose a surcharge on the premiums of any policy to recoup assessments paid pursuant to paragraph (9) of subsection a. of section 8 of P.L.1974, c.17 (C.17:30A-8).

c. Members shall recoup assessments paid by member insurers pursuant to paragraph (11) of section 8 of P.L.1974, c.17 (C.17:30A-8) by way of a surcharge on premiums charged for insurance policies to which this act applies. Members shall recoup these assessments within two years of the date they are paid. The commissioner may permit an insurer to omit collection of the surcharge from its insureds when the expense of collecting the surcharge would exceed the amount of the surcharge, provided that nothing in this subsection shall relieve the insurer of its obligation to remit the amount of the surcharge otherwise collectible.

67. Section 1 of P.L.1988, c.118 (C.17:29A-5.6) is amended to read as follows:

C.17:29A-5.6 Definitions.

1. As used in this act:

a. "Actual investment income" means that portion of income generated by investment of policyholder-supplied funds. Policyholder-supplied funds are the assets that offset the insurer's total New Jersey private passenger automobile insurance unearned premium and loss reserves without regard to whether those funds came from private passenger automobile insurance policyholders or other policyholders or were from policyholder funds from the last seven calendar years or earlier years.

b. "Actuarial gain" means the remainder obtained by subtracting the allowance for profit and contingencies from underwriting income, which remainder may be positive or negative.

c. "AIRE charges" and "AIRE compensation" mean, respectively, amounts paid to or received from the New Jersey Automobile Insurance Risk Exchange pursuant to section 16 of P.L.1983, c.362 (C.39:6A-22).

d. "Anticipated investment income" means the amount obtained by multiplying earned premium by the percentage of premium representing investment income and used in the insurer's approved rate filings or filings made pursuant to section 29 of P.L.1988, c.119 (C.17:29A-42), during the period of the three calendar-accident years being calculated, to calculate the allowance for profit and contingencies.

e. "Calendar-accident year" means the period from January 1 to December 31, during which, in the appropriate context:

(1) premium or investment income was earned;

(2) expenses were incurred; or

(3) accidents occurred which resulted in losses, loss adjustment expenses or AIRE compensation.

f. "Car year" means the unit of exposure equivalent to the insuring of one automobile for 12 months, two automobiles for six months each, three automobiles for four months each, and so forth.

g. "Commissioner" means the Commissioner of Banking and Insurance.

h. "Development adjustment," for a given calendar-accident year, means the difference obtained by subtracting:

(1) The sum of

(a) Losses and loss adjustment expenses for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year preceding the year in which the profits report required by section 2 of this act is due; plus

(b) AIRE compensation for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year in which the profits report is due; from

(2) The sum of

(a) Losses and loss adjustment expenses for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year in which the profits report is due; plus

(b) AIRE compensation for that calendar-accident year, developed to an ultimate basis and evaluated as of March 31 of the year preceding the year in which the profits report is due.

i. "Excess investment income" means the remainder obtained by subtracting the anticipated investment income from the actual investment income earned by the insurer, which remainder may be positive or negative.

j. "Insurer" means an entity authorized or admitted to transact private passenger automobile insurance business in New Jersey.

k. "Private passenger automobile insurance business" means direct insurance on private passenger automobiles as defined in subsection a. of section 2 of P.L.1972, c.70 (C.39:6A-2), excluding personal excess liability insurance and insurance on commercial vehicles.

l. "Total actuarial gain" means the sum of the actuarial gains for the seven calendar-accident years immediately preceding the due date of the profits report required by section 2 of this act, less the development adjustments submitted at the option of the insurer for the calendar-accident years beginning with the eleventh calendar-accident year immediately preceding the due date of the profits report and ending with the eighth calendar-accident year immediately preceding the due date of the profits report.

m. "Underwriting income" means the remainder obtained by subtracting the sum of all losses developed to an ultimate basis, all loss adjustment expenses developed to an ultimate basis, and

all other expenses exclusive of UCJF assessments, from the sum of premiums earned and AIRE compensation developed to an ultimate basis, which remainder may be positive or negative.

n. "UCJF assessments" means amounts paid by insurers to the Unsatisfied Claim and Judgment Fund pursuant to section 3 of P.L.1952, c.174 (C.39:6-63).

o. "UCJF reimbursements" means amounts received by an insurer from the Unsatisfied Claim and Judgment Fund as a result of excess medical expense benefit payments by the insurer pursuant to section 2 of P.L.1977, c.310 (C.39:6-73.1).

68. Section 2 of P.L.1988, c.118 (C.17:29A-5.7) is amended to read as follows:

C.17:29A-5.7 Annual profits report.

2. a. Each insurer, except those exempt from filing pursuant to section 6 of this act, shall annually file with the commissioner, on or before July 1 of each year, a profits report containing the information and calculations required by this section. The information shall be provided with respect to the insurer's New Jersey private passenger automobile insurance business separately for each of the following coverages and for all these coverages combined:

(1) Personal injury protection, including all options;

(2) Bodily injury liability, reported at total limits;

(3) Other liability, consisting of property damage liability and uninsured and underinsured motorist coverages, all reported at total limits;

(4) Physical damage, consisting of comprehensive and collision coverages, including all deductibles.

A separate profits report shall be filed for each insurer and each insurer in an insurance holding company system. Each insurance holding company system shall file a separate combined profits report for all insurers in its system. The excess profits computation for an insurance holding company system shall be performed on its combined profits report, except that the commissioner may order an adjustment in the combined profits report if in his judgment, upon examining each insurer's profits report in the insurance holding company system, one or more of the insurers in that system are excessively subsidizing other insurers in that system.

b. The profits report shall contain the following information, in a manner and for a time period as prescribed by the commissioner by regulation:

(1) Losses paid;

(2) Losses developed to an ultimate basis;

(3) Loss adjustment expenses paid;

(4) Loss adjustment expenses developed to an ultimate basis;

(5) AIRE compensation received; and

(6) AIRE compensation developed to an ultimate basis.

c. The profits report shall contain the following information for the calendar-accident year ending December 31 immediately preceding the date the profits report is due:

(1) Premiums written;

(2) Premiums earned;

(3) All other expenses, itemized separately as follows:

(a) All commissions and all brokerage fees;

(b) All taxes, all licenses and all fees;

(c) All AIRE charges;

(d) All UCJF assessments;

(e) All other acquisition costs and all general expenses;

(f) All policyholder dividends incurred by the insurer, including any excess profits refunded or credited to policyholders;

(g) The net of all catastrophe reinsurance premiums incurred to unaffiliated catastrophe reinsurers and all sums paid or owed by unaffiliated catastrophe reinsurers for losses that occurred during the calendar-accident year, subject to such substantiation of expense as the commissioner may require;

(h) All expenses incurred for the services of a limited assignment distribution carrier pursuant to subsection c. of section 1 of P.L.1970, c.215 (C.17:29D-1);

(4) Allowance for profit and contingencies, calculated by multiplying the premiums earned by the profit and contingency factors authorized for use with the insurer's approved rate

filings, which profit and contingency factors shall be based on the insurer's targeted rate of return, method of doing business, the cost of capital and other relevant economic considerations of the insurer;

(5) Anticipated investment income;

(6) Actual investment income; and

(7) UCJF reimbursements received.

d. The profits report shall include a clear and explicit calculation of each of the following items, in a manner and for a time period as prescribed by the commissioner by regulation:

(1) Underwriting income;

(2) Actuarial gain;

(3) Excess investment income;

(4) Development adjustment;

(5) Total actuarial gain; and

(6) Excess profits.

69. Section 3 of P.L.1988, c.118 (C.17:29A-5.8) is amended to read as follows:

C.17:29A-5.8 Excess profits.

3. Excess profits shall exist if for the seven calendar-accident years immediately preceding the date the profits report is due, the sum of an insurer's total actuarial gain and excess investment income for all private passenger automobile coverages combined exceeds 2.5 percent of earned premiums, except that the effect of a negative excess investment income shall be limited in the computation of excess profits, at the discretion of the commissioner, which discretion shall be exercised pursuant to a standard on the investment of policyholder-supplied funds pursuant to regulations promulgated by the commissioner not later than April 1 of the year in which excess profits reports are filed.

70. Section 2 of P.L.1972, c.200 (C.39:3-29.1) is amended to read as follows:

C.39:3-29.1 Insurance identification cards; rules, regulations.

2. The Commissioner of Banking and Insurance shall, after consultation with the New Jersey Motor Vehicle Commission, promulgate rules and regulations concerning the issuance, design and content of the insurance identification cards required by this act.

The rules and regulations shall contain provisions designed to deter and detect counterfeit or fraudulent insurance identification cards.

C.2C:21-4.4 Findings, declarations relative to insurance fraud.

71. With respect to sections 72 through 74 of P.L.2003, c.89 (C.2C:21-4.5 through C.2C:21-4.7), the Legislature finds and declares:

a. Insurance fraud is inimical to public safety, welfare and order within the State of New Jersey. Insurance fraud is pervasive and expensive, costing consumers and businesses millions of dollars in direct and indirect losses each year. Insurance fraud increases insurance premiums, to the detriment of individual policyholders, small businesses, large corporations and governmental entities. All New Jerseyans ultimately bear the societal burdens and costs caused by those who commit insurance fraud.

b. The problem of insurance fraud must be confronted aggressively by facilitating the detection, investigation and prosecution of such misconduct, as well as by reducing its occurrence and achieving deterrence through the implementation of measures that more precisely target specific conduct constituting insurance fraud.

c. To enable more efficient prosecution of criminally culpable persons who knowingly commit or assist or conspire with others in committing fraud against insurance companies, it is necessary to establish a crime of "insurance fraud" to directly and comprehensively criminalize this type of harmful conduct, with substantial criminal penalties to punish wrongdoers and to appropriately deter others from such illicit activity.

d. In addition to criminal penalties, in order to maintain the public trust and ensure the integrity of professional licensees and certificate-holders who by virtue of their professions are involved in insurance transactions, it is appropriate to provide civil remedial provisions

governing license or certificate forfeiture and suspension tailored to this new crime of insurance fraud and other criminal insurance-related activities.

e. To enhance the State's ability to detect insurance fraud, which will lead to more productive investigations and, ultimately, more successful criminal prosecutions, it is appropriate to provide members of the public with significant incentives to come forward when they may have reasonable suspicions or knowledge of a person or persons committing insurance fraud. The establishment of an Insurance Fraud Detection Reward Program will enable the Insurance Fraud Prosecutor to obtain information which may lead to the arrest, prosecution and conviction of persons or entities who have committed insurance-related fraud.

C.2C:21-4.5 Definitions relative to insurance fraud.

72. As used in sections 73 and 74 of P.L.2003, c.89 (C.2C:21-4.6 and C.2C:21-4.7), unless the context otherwise requires, the following words and terms shall have the following meanings:

"Insurance company" means any person, company, corporation, unincorporated association, partnership, professional corporation, agency of government and any other entity authorized or permitted to do business in New Jersey, subject to regulation by the State, or incorporated or organized under the laws of any other state of the United States or of any foreign nation or of any province or territory thereof, to indemnify another against loss, damage, risk or liability arising from a contingent or unknown event. "Insurance company" includes, but is not limited to, an insurance company as that term is defined in section 3 of P.L.1983, c.320 (C.17:33A-3), self-insurer, re-insurer, reciprocal exchange, inter-insurer, hospital, medical or health service corporation, health maintenance organization, surety, assigned risk plan, joint insurance fund, and any other entity legally engaged in the business of insurance as authorized or permitted by the State of New Jersey, including but not limited to any such entity incorporated or organized under the laws of any other state of the United States or of any foreign nation or of any province or territory thereof.

"Insurance policy" means the instrument, in writing, electronically or in any other form, in which are set forth the terms of any certificate of insurance, binder of coverage, contract of insurance or contract of re-insurance, issued by an insurance company, including, but not limited to, a State-assigned risk plan, plan of indemnity protection provided by or on behalf of a joint insurance fund or benefit plan, motor club service plan, or guaranty bond, surety bond, cash bond or any other alternative to insurance authorized or permitted by the State of New Jersey.

"Insurance transaction" means a transaction by, between, or among (1) an insurance company and (2) an insured, claimant, applicant for insurance, public adjuster, insurance professional, practitioner as defined by section 2 of P.L.1997, c.353 (C.2C:21-4.2), attorney, or any person who acts on behalf of any of the foregoing for the purpose of obtaining insurance or reinsurance, calculating insurance premiums, submitting a claim, negotiating or adjusting a claim, or otherwise obtaining insurance, self insurance, or reinsurance, or obtaining the benefits or annuities thereof or therefrom.

"Premium finance transaction" means a transaction involving or related to insurance premium financing which is subject to the "Insurance Premium Finance Company Act," P.L.1968, c.221 (C.17:16D-1 et seq.).

C.2C:21-4.6 Crime of insurance fraud.

73. a. A person is guilty of the crime of insurance fraud if that person knowingly makes, or causes to be made, a false, fictitious, fraudulent, or misleading statement of material fact in, or omits a material fact from, or causes a material fact to be omitted from, any record, bill, claim or other document, in writing, electronically, orally or in any other form, that a person attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted as part of, in support of or opposition to or in connection with: (1) a claim for payment, reimbursement or other benefit pursuant to an insurance policy, or from an insurance company or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (C.39:6-61 et seq.); (2) an application to obtain or renew an insurance policy; (3) any payment made or to be made in accordance with the terms of an insurance policy or premium finance transaction; or (4) an affidavit, certification, record or other document used in any insurance or premium finance transaction.

b. Insurance fraud constitutes a crime of the second degree if the person knowingly commits five or more acts of insurance fraud, including acts of health care claims fraud pursuant to

section 2 of P.L.1997, c.353 (C.2C:21-4.2) and if the aggregate value of property, services or other benefit wrongfully obtained or sought to be obtained is at least $1,000. Otherwise, insurance fraud is a crime of the third degree. Each act of insurance fraud shall constitute an additional, separate and distinct offense, except that five or more separate acts may be aggregated for the purpose of establishing liability pursuant to this subsection. Multiple acts of insurance fraud which are contained in a single record, bill, claim, application, payment, affidavit, certification or other document shall each constitute an additional, separate and distinct offense for purposes of this subsection.

c. Proof that a person has signed or initialed an application, bill, claim, affidavit, certification, record or other document may give rise to an inference that the person has read and reviewed the application, bill, claim, affidavit, certification, record or other document.

d. In order to promote the uniform enforcement of this act, the Attorney General shall develop insurance fraud prosecution guidelines and disseminate them to county prosecutors within 180 days of the effective date of this act.

e. Nothing in this act shall preclude an indictment and conviction for any other offense defined by the laws of this State.

f. Nothing in this act shall preclude an assignment judge from dismissing a prosecution of insurance fraud if the assignment judge determines, pursuant to N.J.S.2C:2-11, the conduct charged to be a de minimis infraction.

C.2C:21-4.7 Insurance Fraud Detection Reward Program.

74. a. There is established within the Office of the Insurance Fraud Prosecutor an Insurance Fraud Detection Reward Program, to be funded from surcharges imposed pursuant to section 53 of P.L.2002, c.34 (C.17:33A-5.1) and supplemented as necessary and appropriate by amounts budgeted for the operation of the office.

b. A member of the public who has knowledge of or who believes that an act of health care claims fraud, insurance fraud or any other criminal offense involving or related to an insurance transaction is being or has been committed may provide the Insurance Fraud Prosecutor with a report or information pertinent to that knowledge or belief and may provide additional information that the Insurance Fraud Prosecutor requests.

c. The Insurance Fraud Prosecutor shall maintain a 24-hour toll-free insurance fraud hotline to receive information from members of the public who have knowledge of or who believe that an act of health care claims fraud, insurance fraud or any other criminal offense involving or related to an insurance transaction is being or has been committed.

d. The Attorney General, through the Insurance Fraud Prosecutor, is authorized to pay a reward of up to $25,000 to persons providing information leading to the arrest, prosecution and conviction of persons or entities who have committed health care claims fraud, insurance fraud or any other criminal offense related to an insurance transaction. Only a single reward amount may be paid by the Insurance Fraud Prosecutor for claims arising out of the same transaction or occurrence, regardless of the number of persons arrested, prosecuted and convicted and regardless of the number of persons submitting claims for the reward. The reward may be divided and disbursed among more than one person in amounts determined by the Insurance Fraud Prosecutor, in accordance with the provisions of this subsection. The decision of the Insurance Fraud Prosecutor as to the person or persons entitled to the reward shall be final unless the reward recipients shall disagree, in which event, the matter shall be referred to the Attorney General whose decision shall be final and shall not be subject to judicial review.

e. Any person acting in good faith who provides information in accordance with subsection b. of this section shall have immunity from any liability, civil or criminal, that might otherwise be incurred or imposed as a result of such act.

f. The Attorney General shall promulgate and adopt rules and regulations which set forth the reward program application and approval process, including the criteria against which claims shall be evaluated, the basis for determining specific reward amounts, and the manner of reward disbursement. Applications for rewards authorized by this section must be submitted in accordance with rules established by the Attorney General.

75. Section 3 of P.L.1997, c.353 (C.2C:21-4.3) is amended to read as follows:

C.2C:21-4.3 Health care claims fraud, degree of crime; prosecution guidelines.

3. a. A practitioner is guilty of a crime of the second degree if that person knowingly commits health care claims fraud in the course of providing professional services. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

b. A practitioner is guilty of a crime of the third degree if that person recklessly commits health care claims fraud in the course of providing professional services. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

c. A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, is guilty of a crime of the third degree if that person knowingly commits health care claims fraud. A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, is guilty of a crime of the second degree if that person knowingly commits five or more acts of health care claims fraud and the aggregate pecuniary benefit obtained or sought to be obtained is at least $1,000. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

d. A person, who is not a practitioner subject to the provisions of subsection a. or b. of this section, is guilty of a crime of the fourth degree if that person recklessly commits health care claims fraud. In addition to all other criminal penalties allowed by law, a person convicted under this subsection may be subject to a fine of up to five times the pecuniary benefit obtained or sought to be obtained.

e. Each act of health care claims fraud shall constitute an additional, separate and distinct offense, except that five or more separate acts may be aggregated for the purpose of establishing liability pursuant to subsection c. of this section. Multiple acts of health care claims fraud which are contained in a single record, bill, claim, application, payment, affidavit, certification or other document shall each constitute an additional, separate and distinct offense for purposes of this section.

f. (1) The falsity, fictitiousness, fraudulence or misleading nature of a statement may be inferred by the trier of fact in the case of a practitioner who attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted, any record, bill, claim or other document for treatment or procedure without the practitioner, or an associate of the practitioner, having performed an assessment of the physical or mental condition of the patient or client necessary to determine the appropriate course of treatment.

(2) The falsity, fictitiousness, fraudulence or misleading nature of a statement may be inferred by the trier of fact in the case of a person who attempts to submit, submits, causes to be submitted, or attempts to cause to be submitted any record, bill, claim or other document for more treatments or procedures than can be performed during the time in which the treatments or procedures were represented to have been performed.

(3) Proof that a practitioner has signed or initialed a record, bill, claim or other document gives rise to an inference that the practitioner has read and reviewed that record, bill, claim or other document.

g. In order to promote the uniform enforcement of this act, the Attorney General shall develop health care claims fraud prosecution guidelines and disseminate them to the county prosecutors within 120 days of the effective date of this act.

h. For the purposes of this section, a person acts recklessly with respect to a material element of an offense when he consciously disregards a substantial and unjustifiable risk that the material element exists or will result from his conduct. The risk must be of such a nature and degree that, considering the nature and purpose of the actor's conduct and the circumstances known to him, its disregard involves a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation.

i. (1) Nothing in this act shall preclude an indictment and conviction for any other offense defined by the laws of this State.

(2) Nothing in this act shall preclude an assignment judge from dismissing a prosecution of health care claims fraud if the assignment judge determines, pursuant to N.J.S.2C:2-11, the conduct charged to be a de minimis infraction.

76. Section 4 of P.L.1997, c.353 (C.2C:51-5) is amended to read as follows:

C.2C:51-5 Forfeiture, suspension of license, certificate; exceptions.

4. a. (1) A practitioner convicted of health care claims fraud pursuant to subsection a. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States shall forfeit his license and be forever barred from the practice of the profession unless the court finds that such license forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in such case the court shall determine an appropriate period of license suspension which shall be for a period of not less than one year. If the court does not permanently forfeit such license pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of such sentence by the prosecution.

(2) Upon a first conviction of health care claims fraud pursuant to subsection b. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States, a practitioner shall have his license suspended and be barred from the practice of the profession for a period of at least one year.

(3) Upon a second conviction of health care claims fraud pursuant to subsection b. of section 3 of P.L.1997, c.353 (C.2C:21-4.3) or a substantially similar crime under the laws of another state or the United States, a practitioner shall forfeit his license and be forever barred from the practice of the profession.

(4) A person convicted of second degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, or vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall forfeit that license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business if the act or acts of insurance fraud were related to or performed while engaged in the practice of that profession, occupation, trade, vocation or business, unless the court finds that such license or certificate forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in that case the court shall determine an appropriate period of license or certificate suspension which shall be for a period of not less than one year. If the court does not permanently forfeit such license or certificate pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of that sentence by the prosecution.

(5) A person convicted of third degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall have his license or certificate suspended and be barred from the practice of that profession, occupation, trade, vocation or business for a period of at least one year if the act or acts of insurance fraud were related to or performed while engaged in the practice of that profession, occupation, trade, vocation or business.

(6) Upon a second conviction of third degree insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6) or a substantially similar crime under the laws of another state or the United States which meets the criteria of paragraph (2) of this subsection, a person shall forfeit his license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business.

(7) Upon application of the county prosecutor or the Attorney General, a person convicted of any crime of the second degree or above enumerated in chapter 20 or 21 of Title 2C of the New Jersey Statutes or a substantially similar crime under the laws of another state or the United States who holds a license or certificate or authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall forfeit such license or certificate and be forever barred from the practice of that profession, occupation, trade, vocation or business if the act or acts underlying the conviction involved or were related to an insurance transaction as defined in section 72 of P.L.2003, c.89 (C.2C:21-4.5) and touched upon or were performed

while engaged in the practice of that profession, occupation, trade, vocation or business, unless the court finds that the license or certificate forfeiture would be a serious injustice which overrides the need to deter such conduct by others and in that case the court shall determine an appropriate period of license or certificate suspension which shall be for a period of not less than one year. If the court does not permanently forfeit that license or certificate pursuant to this paragraph, the sentence shall not become final for 10 days in order to permit the appeal of that sentence by the prosecution.

(8) Upon application of the county prosecutor or the Attorney General, a person convicted of any crime of the third degree enumerated in chapter 20 or 21 of Title 2C of the New Jersey Statutes or a substantially similar crime under the laws of another state or the United States who holds a license or certificate of authority or qualification to engage in the practice of a profession, occupation, trade, vocation or business, including but not limited to a practitioner as defined in section 2 of P.L.1997, c.353 (C.2C:21-4.2), shall have his license or certificate suspended and be barred from the practice of that profession, occupation, trade, vocation or business for a period of at least one year if the act or acts underlying the conviction involved or were related to an insurance transaction as defined in section 72 of P.L.2003, c.89 (C.2C:21-4.5) and touched upon or were performed while engaged in the practice of that profession, occupation, trade, vocation or business.

b. A court of this State shall enter an order of license or certificate forfeiture or suspension pursuant to subsection a. of this section:

(1) Immediately upon a finding of guilt by the trier of fact or a plea of guilty entered in any court of this State; or

(2) Upon application of the county prosecutor or the Attorney General, when the license or certificate forfeiture or suspension is made pursuant to paragraph (4) of subsection a. of this section or is based upon a conviction of an offense under the laws of another state or of the United States. An order of license or certificate forfeiture or suspension pursuant to this paragraph shall be effective as of the date the person is found guilty by the trier of fact or pleads guilty to the offense.

This application may also be made in the alternative by the Attorney General to the appropriate licensing agency.

The court shall provide notice of the forfeiture or suspension to the appropriate licensing agency within 10 days of the date an order of forfeiture or suspension is entered.

c. No court shall grant a stay of an order of license or certificate forfeiture or suspension pending appeal of a conviction or forfeiture or suspension order unless the court is clearly convinced that there is a substantial likelihood of success on the merits. If the conviction is reversed or the order of license or certificate forfeiture or suspension is overturned, the court shall provide notice of reinstatement to the appropriate licensing agency within 10 days of the date of the order of reinstatement. The license or certificate shall be restored, in accordance with applicable procedures, unless the appropriate licensing agency determines to suspend or revoke the license or certificate.

d. In any case in which the issue of license or certificate forfeiture or suspension is not raised in a court of this State at the time of a finding of guilt, entry of a guilty plea or sentencing, a license or certificate forfeiture or suspension required by this section may be ordered by a court or by the appropriate licensing agency of this State upon application of the county prosecutor or the Attorney General or upon application of the appropriate licensing agency having authority to revoke or suspend the professional's license or certificate. The fact that a court has declined to order license or certificate forfeiture or suspension shall not preclude the appropriate licensing agency having authority to revoke or suspend the professional's license or certificate from seeking to do so on the ground that the conduct giving rise to the conviction demonstrates that the person is unfit to hold the license or certificate or is otherwise liable for an offense as specified in section 8 of P.L.1978, c.73 (C.45:1-21).

e. If the Supreme Court of the State of New Jersey issues Rules of Court pursuant to this act, the Supreme Court may revoke the license to practice law of any attorney who has been convicted, under the laws of this State, of health care claims fraud pursuant to section 3 of P.L.1997, c.353 (C.2C:21-4.3), or an offense which, if committed in this State, would constitute health care claims fraud, insurance fraud pursuant to section 73 of P.L.2003, c.89 (C.2C:21-4.6), or an offense which, if committed in this State, would constitute insurance fraud.

f. Nothing in this section shall be construed to prevent or limit the appropriate licensing agency or any other party from taking any other action permitted by law against the practitioner.

77. Section 5 of P.L.1997, c.353 (C.2C:52-27.1) is amended to read as follows:

C.2C:52-27.1 Petition to rescind order of debarment for health care claims fraud; restoration.

5. a. If an order of expungement of records of conviction under the provisions of chapter 52 of Title 2C of the New Jersey Statutes is granted by the court to a person convicted of health care claims fraud in which the court had ordered the offender's professional license or certificate be forfeited and the person be forever barred from the practice of the profession, occupation, trade, vocation or business pursuant to subsection a. of section 4 of P.L.1997, c.353 (C.2C:51-5), the person may petition the court for an order to rescind the court's order of debarment if the person can demonstrate that the person is sufficiently rehabilitated.

b. If an order to rescind the court's order of debarment is granted, the person granted the order may apply to be licensed or certified to practice the profession, occupation, trade, vocation or business from which the offender was barred.

78. R.S.39:3-29 is amended to read as follows:

License, registration certificate and insurance identification card; possession; exhibit upon request; violations; fine; defense.

39:3-29. The driver's license, the registration certificate of a motor vehicle and an insurance identification card shall be in the possession of the driver or operator at all times when he is in charge of a motor vehicle on the highways of this State.

The driver or operator shall exhibit his driver's license and an insurance identification card, and the holder of a registration certificate or the operator or driver of a motor vehicle for which a registration certificate has been issued, whether or not the holder, driver or operator is a resident of this State, shall also exhibit the registration certificate, when requested so to do by a police officer or judge, while in the performance of the duties of his office, and shall write his name in the presence of the officer, so that the officer may thereby determine the identity of the licensee and at the same time determine the correctness of the registration certificate, as it relates to the registration number and number plates of the motor vehicle for which it was issued; and the correctness of the evidence of a policy of insurance, as it relates to the coverage of the motor vehicle for which it was issued.

Any person violating this section shall be subject to a fine of $150, of which $25 shall be deposited in the Uninsured Motorist Prevention Fund established by section 2 of P.L.1983, c.141 (C.39:6B-3).

If a person charged with a violation of this section can exhibit his driver's license, insurance identification card and registration certificate, which were valid on the day he was charged, to the judge of the municipal court before whom he is summoned to answer to the charge, such judge may dismiss the charge. However, the judge may impose court costs.

C.39:3-29.1a Provision of proof of insurance; impoundment of vehicle.

79. a. Upon the issuance of a summons for failing to possess or exhibit an insurance identification card in violation of R.S.39:3-29, the violator or registrant shall have 24 hours from the time of the citation to provide the issuing law enforcement agency with the insurance identification card, or other satisfactory proof of insurance. Failure to provide the insurance identification card or other satisfactory proof of insurance within the 24-hour time frame shall result in the issuance of a warrant for the immediate impoundment of the vehicle that was being operated when the summons was issued. A motor vehicle impounded pursuant to the provisions of this subsection shall be removed to a storage space or garage. The registrant shall be responsible for the cost of the removal and storage of the impounded motor vehicle.

b. (1) If the registrant fails to claim a motor vehicle impounded pursuant to subsection a. of this section and pay the reasonable costs of removal and storage by midnight of the 30th day following impoundment, along with a fine of $100 to cover the administrative costs of the municipality wherein the violation occurred, and after a hearing, the municipality may sell the motor vehicle at public auction. The municipality shall give notice of the sale by certified mail

to the registrant of the motor vehicle and to the holder of any security interest filed with the New Jersey Motor Vehicle Commission, and by publication in a form to be prescribed by the director by one insertion, at least five days before the date of the sale, in one or more newspapers published in this State and circulating in the municipality in which the motor vehicle has been impounded.

(2) At any time prior to the sale, the registrant or other person entitled to the motor vehicle may reclaim possession of it upon providing satisfactory proof of motor vehicle liability insurance coverage and payment of the reasonable costs of removal and storage of the motor vehicle and any outstanding fines or penalties; provided, however, if the other person entitled to the motor vehicle is a lessor or the holder of a lien on the motor vehicle, he may reclaim the motor vehicle without payment. In such cases, the registrant shall be liable for all outstanding costs, fines and penalties, and the municipality shall have a lien against the property and income of that registrant for the total amount of those outstanding costs, fines and penalties.

(3) Any proceeds obtained from the sale of a motor vehicle at public auction pursuant to paragraph (1) of this subsection in excess of the amount owed to the municipality for the reasonable costs of removal and storage of the motor vehicle and any outstanding fines or penalties shall be returned to the registrant of the vehicle.

80. Section 2 of P.L.1983. c.141 (C.39:6B-3) is amended to read as follows:

C.39:6B-3 Uninsured Motorist Prevention Fund.

2. The Uninsured Motorist Prevention Fund (hereinafter referred to as the "fund") is established as a nonlapsing, revolving fund into which shall be deposited all revenues from the fines imposed pursuant to section 2 of P.L.1972, c.197 (C.39:6B-2) and $25 from each fine imposed pursuant to R.S.39:3-29. Interest received on moneys in the fund shall be credited to the fund. The fund shall be administered by the New Jersey Motor Vehicle Commission. Moneys in the fund shall be allocated and used for the purpose of the administrative expenses of the fund and enforcement of the compulsory motor vehicle insurance law, P.L.1972, c.197 (C.39:6B-1 et seq.) by the New Jersey Motor Vehicle Commission.

81. Section 5 of P.L.1984, c.101 (C.17:22-6.74) is amended to read as follows:

C.17:22-6.74 Powers, duties and obligations of the Surplus Lines Insurance Guaranty Fund.

5. a. The fund shall:

(1) Be obligated to the extent of the covered claims against an insolvent insurer incurred prior to or 30 days after the determination of insolvency, or before the policy expiration date, if less than 30 days after that determination, or before the policyholder replaces the policy or causes its cancellation, if he does so within 30 days of the determination. The fund's obligation for covered claims shall not be greater than $300,000.00 per occurrence, subject to any applicable deductible contained in the policy. The commissioner may adjust the fund's obligations for covered claims based on the moneys available in the fund. In no event shall the fund be obligated to a policyholder or claimant in excess of the limits of liability of the insolvent insurer stated in the policy from which the claim arises;

(2) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent;

(3) Assess member insurers in accordance with section 6 of this act in amounts necessary to pay:

(a) Obligations of the fund under paragraph (1) of this subsection,

(b) Expenses of handling covered claims,

(c) Any other expenses incurred in the implementation of the provisions of this act;

(4) Investigate claims brought against the fund; and adjust, compromise, settle, and pay covered claims to the extent of the fund's obligation; and deny all other claims; and may review settlements, releases and judgments to which the insolvent insurer or its policyholders were parties to determine the extent to which the settlements, releases and judgments may be properly contested;

(5) Notify those persons as the commissioner directs under section 8 of this act;

(6) Handle claims through the association's employees or representatives, or through one or more insurers or other persons designated as servicing facilities;

(7) Pay the other expenses of the association in administering the provisions of this act; and

(8) Within 60 days of enactment of P.L.2002, c.30 (C.17:22-6.70a et al.), transfer to the General Fund any and all moneys in excess of $40,000,000 in the fund as of June 24, 2002.

b. The fund may:

(1) Sue or be sued;

(2) Negotiate and become a party to those contracts which are necessary to carry out the purpose of this act;

(3) Perform those other acts which are necessary or appropriate to effectuate the purpose of this act;

(4) (Deleted by amendment, P.L.2002, c.30.)

(5) With the approval of the commissioner, borrow and separately account for moneys from any source, including but not limited to the New Jersey Property-Liability Insurance Guaranty Association and the Unsatisfied Claim and Judgment Fund, in such amounts and on such terms as the New Jersey Property-Liability Insurance Guaranty Association may determine are necessary or appropriate to effectuate the purposes of P.L.2003, c.89 (C.17:30A-2.1 et al.) in accordance with the association's plan of operation; and

(6) Make loans, in such amounts and on such terms as the association may determine are necessary or appropriate, to the New Jersey Property-Liability Insurance Guaranty Association in accordance with the provisions of the "New Jersey Property-Liability Insurance Guaranty Association Act," P.L.1974, c.17 (C.17:30A-1 et seq.) and the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (C.39:6-61 et seq.).

82. Section 7 of P.L.1988, c.118 (C.17:29A-5.12) is amended to read as follows:

C.17:29A-5.12 Plan for refund, credit.

7. If the commissioner finds that an insurer has excess profits, the insurer shall establish, subject to the approval of the commissioner, a fair, practicable, and nondiscriminatory plan for the refund or credit of the excess profits to such group or groups of policyholders as the commissioner may determine to be reasonable in consideration of the insurer's financial and business circumstances.

83. R.S.17:17-10 is amended to read as follows:

Certificate authorizing company to commence business; issuance, surrender; replacement carrier.

17:17-10. a. When satisfied that a company has complied with all the requirements of this subtitle to entitle it to engage in business and that the proposed methods of operation of the company are not such as would render its operation hazardous to the public or its policyholders, the commissioner shall issue to the company a certificate authorizing it to commence business, specifying in the certificate the particular kind or kinds of insurance it is authorized to transact. The commissioner may refuse to issue a certificate of authority if he finds that any of the company's directors or officers has been convicted of a crime involving fraud, dishonesty, or like moral turpitude or that said persons are not persons of good character and integrity. No company shall transact the business for which it is incorporated until it has received the certificate from the commissioner. If any company fails to obtain the certificate of authority within one year from the date of the certificate of the Attorney General to its certificate of incorporation, as provided in R.S.17:17-5, the company shall, ipso facto, be dissolved and its certificate of incorporation be null and void.

b. No company licensed to transact insurance business in this State pursuant to chapter 17 of Title 17 of the Revised Statutes may surrender its certificate of authority or discontinue writing or renewing any kind or kinds of insurance specified in the certificate, except in accordance with an informational filing submitted to the commissioner, which filing shall be subject to the following provisions regarding any withdrawals:

(1) the company shall send a notice to policyholders of the proposed withdrawal no later than thirty days following the submission of the informational filing to the commissioner,

which shall state that the insurer intends to withdraw and has filed its intention to withdraw with the commissioner, the terms of the withdrawal, including the date of the proposed commencement of nonrenewal of policies, and the proposed duration of the nonrenewal of the company's book of business;

(2) nonrenewals shall not commence prior to one calendar year and ninety days following the submission of the informational filing;

(3) the company shall send a notice of nonrenewal to every policyholder (a) no later than one calendar year preceding the date of nonrenewal and (b) a subsequent notice of nonrenewal in accordance with any time limit otherwise established by law for that line of insurance;

(4) nonrenewals shall take place in a manner so as to be applicable to all insureds on an equitable basis with respect to risk classification and territorial or other form of rating factor, and shall be effectuated at a uniform rate over a period not exceeding three calendar years, commencing with the date established in paragraph (2) of this subsection; provided, however, that if more than one company files for withdrawal for the same line of business and the companies, in the aggregate, write more than 25% of the market share for that line of business, the commissioner may extend the period of withdrawal provided for herein to five years.

The commissioner's authority with respect to withdrawals as provided for herein shall be limited to enforcing compliance with this subsection and enforcing the terms of the withdrawal plan proposed in the informational filing.

c. Upon receiving the informational filing provided for in subsection b. of this section, the commissioner shall consider, and may require as a condition of approval, whether some or all of the company's other certificates of authority issued pursuant to Title 17 of the Revised Statutes held by the company or other companies within the same holding company system as the company submitting the plan shall be required to be surrendered.

d. Notwithstanding the provisions of subsection b. of this section, if the company finds a replacement carrier for the business that will not be renewed as the result of the withdrawal either prior to or after the date of the informational filing, the insurer may apply to the commissioner for approval to transfer the business to a replacement carrier or carriers. If the commissioner approves the replacement carrier or carriers, notwithstanding the provisions of paragraphs (1), (2), and (3) of subsection b. of this section, the notice of nonrenewal shall be in compliance with the time limits provided by law for that line of insurance, and the company shall offer every insured coverage with the replacement carrier prior to the effective date of the nonrenewal. The commissioner shall not withhold approval of a replacement carrier or carriers if that insurer is authorized to do business in the same line of business in New Jersey and has the financial and business capability to write and service the business being transferred to it by the withdrawing company. The commissioner shall approve or disapprove the replacement carrier or carriers within 60 days of (1) the date of the filing by both the withdrawing insurer requesting approval of a replacement carrier or carrier or (2) the filing by the replacement carrier or carriers requesting to be a replacement carrier, whichever is later.

e. Notwithstanding the provisions of subsection b. of this section, the commissioner may waive the requirements of paragraph (2) of that subsection, and the one-year nonrenewal notice of paragraph (3) of that subsection, as well as the three-year minimum nonrenewal period provided in paragraph (4) of that subsection if the commissioner deems a waiver to be necessary to protect the solvency of the insurer making the informational filing or if the commissioner deems the withdrawal to have a limited impact on the market.

84. Section 72 of P.L.1990, c.8 (C.17:33B-30) is amended to read as follows:

C.17:33B-30 Out-of-State insurance company, surrender of certificate.

72. a. An insurance company of another state or foreign country authorized under chapter 32 of Title 17 of the Revised Statutes to transact insurance business in this State may surrender to the commissioner its certificate of authority and thereafter cease to transact insurance in this State, or discontinue the writing or renewal of private passenger automobile insurance specified in the certificate of authority only after the submission of an informational filing submitted to the commissioner, which filing shall be subject to the following provisions:

(1) the company shall send a notice to policyholders of the proposed withdrawal no

later than thirty days following the submission of the informational filing to the commissioner, which shall state that the insurer intends to withdraw and has filed its intention to withdraw with the commissioner, the terms of the withdrawal, including the date of the proposed commencement of nonrenewal of policies, and the proposed duration of the nonrenewal of the company's book of business;

(2) nonrenewals shall not commence prior to one calendar year and ninety days following the submission of the informational filing;

(3) the company shall send a notice of nonrenewal to every policyholder (a) no later than one calendar year preceding the date of nonrenewal and (b) a subsequent notice of nonrenewal in accordance with any time limit otherwise established by law for that line of insurance;

(4) nonrenewals shall take place in a manner so as to be applicable to all insureds on an equitable basis with respect to risk classification and territorial or other form of rating factor, and shall be effectuated at a uniform rate over a period not exceeding three calendar years, commencing with the date established in paragraph (2) of this subsection; provided, however, that if more than one company files for withdrawal for the same line of business and the companies, in the aggregate, write more than 25% of the market share for that line of business, the commissioner may extend the period of withdrawal provided for herein to five years.

The commissioner's authority with respect to withdrawals as provided for herein shall be limited to enforcing compliance with this subsection and enforcing the terms of the withdrawal plan proposed in the informational filing.

b. Upon receiving the informational filing provided for in subsection a. of this section, the commissioner shall consider, and may require as a condition of approval, whether some or all of the company's other certificates of authority issued pursuant to Title 17 of the Revised Statutes held by the company or other companies within the same holding company system as the company submitting the plan shall be required to be surrendered.

c. Notwithstanding the provisions of subsection a. of this section, if the company finds a replacement carrier for the business that will not be renewed as the result of the withdrawal either prior to or after the date of the informational filing, the insurer may apply to the commissioner for approval to transfer the business to a replacement carrier or carriers. If the commissioner approves the replacement carrier or carriers, notwithstanding the provisions of paragraphs (1), (2), and (3) of subsection a. of this section, the notice of nonrenewal shall be in compliance with the time limits provided by law for that line of insurance, and the company shall offer every insured coverage with the replacement carrier prior to the effective date of the nonrenewal. The commissioner shall not withhold approval of a replacement carrier or carriers if that insurer is authorized to do business in the same line of business in New Jersey and has the financial and business capability to write and service the business being transferred to it by the withdrawing company. The commissioner shall approve or disapprove the replacement carrier or carriers within 60 days of (1) the date of the filing by both the withdrawing insurer requesting approval of a replacement carrier or carrier or (2) the filing by the replacement carrier or carriers requesting to be a replacement carrier, whichever is later.

d. Notwithstanding the provisions of subsection a. of this section, the commissioner may waive the requirements of paragraph (2) of that subsection, and the one-year nonrenewal notice of paragraph (3) of that subsection, as well as the three-year minimum nonrenewal period provided in paragraph (4) of that subsection if the commissioner deems a waiver to be necessary to protect the solvency of the insurer making the informational filing or if the commissioner deems the withdrawal to have a limited impact on the market.

Repealer.

85. The following are repealed:

a. Sections 4, 6, 15, 29 and 31 of P.L.1952, c.174 (C.39:6-64, 39:6-66, 39:6-75, 39:6-89 and 39:6-91);

b. Sections 1 and 2 of P.L.1985, c.148 (C.39:6-64a and 39:6-64b);

c. Section 23 of P.L.1990, c.8 (C.17:33B-5).

86. This act shall take effect immediately, except that section 38 shall take effect on January 1, 2004, section 45 shall take effect on the earlier of the 120th day next following enactment or

the adoption of regulations by the Commissioner of Banking and Insurance to implement that section, section 65 shall take effect upon the adoption of regulations by the Commissioner of Banking and Insurance, sections 83 and 84 shall take effect on January 1, 2007, and section 79 shall take effect on 365th day next following enactment.

Approved June 9, 2003.