

West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-1

§ 59A-42-1. Short title

[Currentness](#)

Chapter 59A, Article 42 NMSA 1978 may be cited as the “Life and Health Insurance Guaranty Association Act”.

Credits

L. 1984, Ch. 127, § 750. Amended by L. 2012, Ch. 9, § 4, eff. July 1, 2012.

[Notes of Decisions \(2\)](#)

NMSA 1978, § 59A-42-1, NM ST § 59A-42-1

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-2

§ 59A-42-2. Purpose

Currentness

The purpose of the Life and Health Insurance Guaranty Association Act is to provide a mechanism to facilitate continuation of coverage and the payment of covered claims under certain insurance policies, to avoid excessive delay in payment and avoid financial loss to claimants or policyholders because of insolvency of an insurer, to assist in detection and prevention of insurer insolvencies and to provide an association to assess the cost of such protection among insurers.

Credits


L. 1984, Ch. 127, § 751. Amended by L. 2012, Ch. 9, § 5, eff. July 1, 2012.

NMSA 1978, § 59A-42-2, NM ST § 59A-42-2

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-3

§ 59A-42-3. Definitions

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-3](#) effective until Jan. 1, 2025.>

As used in the Life and Health Insurance Guaranty Association Act:

- A. “account” means either of the two accounts maintained pursuant to [Section 59A-42-5 NMSA 1978](#);
- B. “association” means the life and health insurance guaranty association created pursuant to [Section 59A-42-5 NMSA 1978](#);
- C. “authorized assessment”, or the term “authorized” when used in the context of assessments, means that a resolution by the board has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed;
- D. “benefit plan” means a specific employee, a union or an association of natural persons benefit plan;
- E. “board” means the board of directors organized pursuant to [Section 59A-42-6 NMSA 1978](#);
- F. “called assessment”, or the term “called” when used in the context of assessments, means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers;
- G. “contractual obligation” means an obligation under a policy or contract or a certificate under a group policy or contract, or portion thereof, for which coverage is provided pursuant to [Section 59A-42-4 NMSA 1978](#);
- H. “covered policy” and “covered contract” means a policy or contract or portion of a policy or contract for which coverage is provided pursuant to [Section 59A-42-4 NMSA 1978](#);

I. “domiciliary state” means the state in which an insurer is incorporated or organized or, as to an alien insurer, the state in which at commencement of delinquency proceedings the larger amount of the insurer’s assets are held in trust or on deposit for the benefit of its policyholders and creditors in the United States;

J. “extra-contractual claims” includes claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorney fees and costs;

K. “health benefit plan” means any hospital or medical expense policy or certificate or health maintenance organization subscriber contract or any other similar health contract. “Health benefit plan” does not include:

(1) accident-only insurance;

(2) credit insurance;

(3) dental-only insurance;

(4) vision-only insurance;

(5) medicare supplement insurance;

(6) benefits for long-term care, home health care, community-based care or any combination thereof;

(7) disability income insurance;

(8) coverage for on-site medical clinics; or

(9) specified disease, hospital confinement indemnity or limited benefit health insurance if the health benefit plans do not provide coordination of benefits and are provided under separate policies or contracts;

L. “impaired insurer” means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is not an insolvent insurer and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction;

M. “insolvent insurer” means a member insurer that, after the effective date of the Life and Health Insurance Guaranty Association Act, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency;

N. “member insurer” means an insurer or health maintenance organization that is licensed or that holds a certificate of authority to transact in this state any kind of insurance or health maintenance organization business for which coverage

is provided pursuant to [Section 59A-42-4 NMSA 1978](#) and includes an insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

- (1) a health care plan, whether profit or nonprofit;
- (2) a prepaid dental plan;
- (3) a fraternal benefit society;
- (4) a mandatory state pooling plan;
- (5) a mutual assessment company or other person that operates on an assessment basis;
- (6) an insurance exchange;
- (7) a charitable organization that is in good standing with the superintendent pursuant to [Section 59A-1-16.1 NMSA 1978](#);
- (8) any insurer that was insolvent or unable to fulfill its contractual obligations as of April 9, 1975; or
- (9) an entity similar to any of the above;

O. “Moody's corporate bond yield average” means the monthly average corporates as published by Moody's investors service, incorporated, or its successor;

P. “owner” of a policy or contract, “policy owner”, “policy holder” and “contract owner” means the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms “owner”, “policy owner”, “policy holder” and “contract owner” do not include persons with a mere beneficial interest in a policy or contract;

Q. “plan sponsor” means:

- (1) the employer in the case of a benefit plan established or maintained by a single employer;
- (2) the employee organization in the case of a benefit plan established or maintained by an employee organization; or

(3) the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan in the case of a benefit plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations;

R. “premiums” means amounts or considerations, by whatever name used, received on covered policies or contracts less returned premiums, considerations and deposits and less dividends and experience credits. “Premiums” does not include:

(1) amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided pursuant to [Subsection E of Section 59A-42-4 NMSA 1978](#), except that assessable premiums shall not be reduced on account of Paragraph (3) of [Subsection E of Section 59A-42-4 NMSA 1978](#), relating to interest limitations, or Paragraph (2) of [Subsection F of Section 59A-42-4 NMSA 1978](#), relating to limitations, with respect to one individual, one participant, one policy holder or one contract owner;

(2) premiums in excess of five million dollars (\$5,000,000) on an unallocated annuity contract not issued under a governmental retirement benefit plan, or its trustee, established pursuant to [Section 401, 403\(b\) or 457 of the federal Internal Revenue Code](#) of 1986; or

(3) with respect to multiple non-group policies of life insurance owned by one owner, whether the policy holder or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of five million dollars (\$5,000,000) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner;

S. “principal place of business” means:

(1) in the case of a plan sponsor or a person other than a natural person, the single state in which the natural person who establishes a policy for the direction, control and coordination of the operations of the entity as a whole primarily exercises that function, as determined by the association in its reasonable judgment by considering the following factors:

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

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

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

(d) the state in which the executive or management committee of the board, or similar governing person or persons, of the entity conducts the majority of its meetings;

(e) the state from which the management of the overall operations of the entity is directed;

(f) in the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the factors in this subsection; and

(g) in the case of a plan sponsor, if more than fifty percent of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor; and

(2) in the case of a plan sponsor of a benefit plan described in Paragraph (3) of Subsection Q of this section, the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties that establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question;

T. “receivership court” means the court in the insolvent or impaired insurer's domiciliary state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer;

U. “resident” means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer. A person may be a resident of only one state, which, in the case of a person other than a natural person, shall be its principal place of business. Citizens of the United States that are either residents of foreign countries or residents of United States possessions, territories or protectorates that do not have an association similar to the association created by the Life and Health Insurance Guaranty Association Act shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts;

V. “structured settlement annuity” means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant;

W. “structured settlement factoring transaction” means a transfer of structured settlement payment rights, including portions of structured settlement payments made for consideration by means of sale, assignment, pledge or other form of encumbrance or alienation;

X. “supplemental contract” means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract; and

Y. “unallocated annuity contract” means an annuity contract or group annuity certificate that is not issued to and owned by an individual, except to the extent of annuity benefits guaranteed to an individual by an insurer under the contract or certificate.

Credits

Added by L. 2012, Ch. 9, § 6, eff. July 1, 2012; L. 2014, Ch. 59, § 49, eff. July 1, 2014; L. 2024, Ch. 36, § 1, eff. Jan. 1, 2025.

[Notes of Decisions \(2\)](#)

NMSA 1978, § 59A-42-3, NM ST § 59A-42-3

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N. M. S. A. 1978, § 59A-42-4

§ 59A-42-4. Coverage; limitations

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-4](#) effective until Jan. 1, 2025.>

A. Coverage shall be provided for the policies and contracts specified in Subsection D of this section:

(1) to persons who, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered pursuant to Paragraph (2) of this subsection;

(2) to persons who are owners of, enrollees or certificate holders under the policies or contracts, other than unallocated annuity contracts and structured settlement annuities, and in each case who:

(a) are residents; or

(b) are not residents, but only under the following conditions: 1) the member insurer that issued the policies or contracts is domiciled in this state; 2) the states in which the persons reside have associations similar to this state's association; and 3) the persons are not eligible for coverage by an association in another state due to the fact that the member insurer or the health maintenance organization was not licensed in that state at the time specified in that state's guaranty association law;

(3) for unallocated annuity contracts specified in Subsection D of this section, to which Paragraphs (1) and (2) of this subsection shall not apply, and except as provided in Subsections B and C of this section:

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

(b) to persons who are the owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents; and

(4) for structured settlement annuities specified in Subsection D of this section, to which Paragraphs (1) and (2) of this subsection shall not apply, and except as provided in Subsections B and C of this section, to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, if the payee:

(a) is a resident, regardless of where the contract owner resides; or

(b) is not a resident, but only under the following conditions: 1) the contract owner of the structured settlement annuity is a resident or is not a resident, but the insurer that issued the structured settlement annuity is domiciled in this state and the state in which the contract owner resides has an association similar to this state's association; and 2) neither the payee, the payee's beneficiary or the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

B. Coverage shall not be provided to:

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

(2) a person covered pursuant to Paragraph (3) of Subsection A of this section, if coverage is provided by the association of another state to that person; or

(3) a person who acquires rights to receive payments through a structured settlement factoring transaction.

C. Coverage is intended to be provided to a person who is a resident of this state and, in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage pursuant to the Life and Health Insurance Guaranty Association Act is provided coverage under the laws of another state, the person shall not be provided coverage in this state. In determining the application of the provisions of this subsection in situations where a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary or assignee, the Life and Health Insurance Guaranty Association Act shall be construed in conjunction with other state laws to result in coverage by only one association.

D. Coverage shall be provided to the persons specified in Subsection A of this section for policies or contracts of direct, non-group life insurance, health insurance, which for the purposes of the Life and Health Insurance Guaranty Association Act includes health maintenance organization subscriber contracts and certificates, or annuities and supplemental contracts to any of these, for certificates under direct group policies and contracts and supplemental contracts to these and for unallocated annuity contracts issued by member insurers, except as limited by the Life and Health Insurance Guaranty Association Act. Annuity contracts and certificates under group annuity contracts include guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and immediate or deferred annuity contracts.

E. Coverage shall not be provided for:

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

(2) a policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(3) a portion of a policy or contract, except for any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefit, to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

(a) averaged over the period of four years prior to the date on which the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier, exceeds the rate of interest determined by subtracting two percentage points from Moody's corporate bond yield average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four years before the member insurer becomes an impaired or insolvent insurer under the Life and Health Insurance Guaranty Association Act, whichever is earlier; and

(b) on and after the date on which the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier, exceeds the rate of interest determined by subtracting three percentage points from Moody's corporate bond yield average as most recently available;

(4) a portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others, to the extent that the plan or program is self-funded or uninsured, including but not limited to benefits payable by an employer, association or other person under:

(a) a multiple employer welfare arrangement;

(b) a minimum premium group insurance plan;

(c) a stop-loss group insurance plan; or

(d) an administrative services only contract;

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

(a) dividends or experience rating credits;

(b) voting rights; or

- (c) payment of fees or allowances to a person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

- (6) a policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue the policy or contract in this state;

- (7) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation, regardless of whether that corporation has yet become liable to make payments with respect to the benefit plan;

- (8) a portion of an unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

- (9) a portion of a policy or contract to the extent that the assessments required by [Section 59A-42-8 NMSA 1978](#) with respect to the policy or contract are preempted by federal or state law;

- (10) an obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:
 - (a) claims based on marketing materials;

 - (b) claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

 - (c) misrepresentations of or regarding policy or contract benefits;

 - (d) extra-contractual claims; or

 - (e) a claim for penalties or consequential or incidental damages;

- (11) a contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

- (12) a portion of a policy or contract to the extent that it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer pursuant to the Life and Health Insurance Guaranty Association Act, whichever is earlier. If a policy or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and that are not subject to forfeiture pursuant to this paragraph, the interest

or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values were the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture;

(13) a policy or contract providing hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter 18 of Chapter 7 of Title 42 of the United States Code, commonly known as medicare Parts C and D, or Subchapter 19 of Chapter 7 of Title 42 of the United States Code, commonly known as medicaid, or any regulations promulgated pursuant to those acts; or

(14) structured settlement annuity benefits to which a payee or beneficiary has transferred the payee's or beneficiary's rights in a structured settlement factoring transaction.

F. The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

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

(2) with respect to one person's life, regardless of the number of policies or contracts:

(a) for life insurance death benefits, three hundred thousand dollars (\$300,000) but not more than one hundred thousand dollars (\$100,000) in net cash surrender and net cash withdrawal values;

(b) for health insurance benefits: 1) one hundred thousand dollars (\$100,000) for coverages not constituting disability income insurance, health benefit plans or long-term care insurance, including net cash surrender and net cash withdrawal values; 2) three hundred thousand dollars (\$300,000) for disability income insurance; 3) three hundred thousand dollars (\$300,000) for long-term care insurance as defined in [Section 59A-23A-4 NMSA 1978](#); and 4) five hundred thousand dollars (\$500,000) for health benefit plans; or

(c) for annuity benefits, two hundred fifty thousand dollars (\$250,000) in present value, including net cash surrender and net cash withdrawal values;

(3) with respect to each individual participating in a governmental retirement benefit plan established pursuant to [Section 401, 403\(b\) or 457 of the federal Internal Revenue Code of 1986](#) covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, two hundred fifty thousand dollars (\$250,000) in present value annuity benefits, including net cash surrender and net cash withdrawal values; or

(4) with respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if the payee is deceased, two hundred fifty thousand dollars (\$250,000) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

G. In no event shall the association be obligated to cover:

(1) more than an aggregate of three hundred thousand dollars (\$300,000) in benefits with respect to one person's life pursuant to Paragraphs (2), (3) and (4) of Subsection F of this section, except with respect to benefits for health benefit plans pursuant to Subparagraph (b) of Paragraph (2) of Subsection F of this section, in which case the aggregate liability of the association shall not exceed five hundred thousand dollars (\$500,000) with respect to one person's life; or

(2) with respect to one owner of multiple non-group policies of life insurance, whether the policy holder or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than five million dollars (\$5,000,000) in benefits, regardless of the number of policies and contracts held by the owner.

H. With respect to either one contract owner provided coverage pursuant to Subparagraph (b) of Paragraph (3) of Subsection A of this section or one plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in Paragraph (3) of Subsection F of this section, the benefits the association may become obligated to cover shall not exceed five million dollars (\$5,000,000) irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts pursuant to the Life and Health Insurance Guaranty Association Act and are owned by a trust or other entity for the benefit of two or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state. In no event shall the association be obligated to cover more than five million dollars (\$5,000,000) in benefits with respect to all of these unallocated contracts.

I. The limitations set forth in Subsections F, G and H of this section are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

J. For purposes of the Life and Health Insurance Guaranty Association Act, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefit as the base life insurance policy or annuity contract to which it relates.

K. In performing its obligations to provide coverage pursuant to this section and [Section 59A-42-7 NMSA 1978](#), the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

Credits

Added by [L. 2012, Ch. 9, § 7, eff. July 1, 2012](#). Amended by [L. 2024, Ch. 36, § 2, eff. Jan. 1, 2025](#).


[Notes of Decisions \(2\)](#)

NMSA 1978, § 59A-42-4, NM ST § 59A-42-4

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N. M. S. A. 1978, § 59A-42-5

§ 59A-42-5. Organization of association; participation

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-5](#) effective until Jan. 1, 2025.>

A. All insurers shall organize and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business covered by [Section 59A-42-4 NMSA 1978](#). The association may take any appropriate form of legal entity available under the laws of this state and approved by the superintendent. The association shall perform its functions under the plan of operation established and approved pursuant to [Section 59A-42-9 NMSA 1978](#) and shall exercise its powers through the board. For purposes of assessment and administration, the association shall maintain two accounts:

(1) the life insurance and annuity account, which includes the following subaccounts:

(a) a life insurance account;

(b) an annuity account, which includes annuity contracts owned by a governmental retirement benefit plan, or its trustee, established pursuant to [Section 401, 403\(b\) or 457 of the federal Internal Revenue Code of 1986](#), but otherwise excludes unallocated annuities; and

(c) an unallocated annuity account, which excludes contracts owned by a governmental retirement benefit plan, or its trustee, established pursuant to [Section 401, 403\(b\) or 457 of the federal Internal Revenue Code of 1986](#); and

(2) the health account.

B. The association shall be supervised by the superintendent and shall be subject to the applicable provisions of the insurance laws of New Mexico. Meetings or records of the association may be opened to the public upon majority vote of the board of the association.

Credits


L. 1984, Ch. 127, § 754; L. 2012, Ch. 9, § 8, eff. July 1, 2012; L. 2024, Ch. 36, § 3, eff. Jan. 1, 2025.

NMSA 1978, § 59A-42-5, NM ST § 59A-42-5

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Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-6

§ 59A-42-6. Board of directors

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-6](#) effective until Jan. 1, 2025.>

A. The board of directors of the association shall consist of not less than seven nor more than eleven member insurers serving terms as established in the plan of operation. The insurer members of the board shall be selected by member insurers subject to the approval of the superintendent. In addition, two persons who are public representatives shall be appointed by the superintendent to the board. A public representative shall not be an officer, director or employee of an insurance company or a health maintenance organization or a person engaged in the business of insurance. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members for member insurers, subject to approval of the superintendent, and by the superintendent for public representatives.

B. In approving insurer member selections, the superintendent shall consider among other things whether all member insurers are fairly represented.

C. Members of the board may be reimbursed from the assets of the association for reasonable and necessary expenses incurred by them as members of the board, but the amount of that reimbursement shall not exceed the guidelines provided by the approved plan of operation.

Credits

L. 1984, Ch. 127, § 755; L. 1993, Ch. 320, § 100; L. 2012, Ch. 9, § 9, eff. July 1, 2012; L. 2024, Ch. 36, § 4, eff. Jan. 1, 2025.

NMSA 1978, § 59A-42-6, NM ST § 59A-42-6

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Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-7

§ 59A-42-7. Powers and duties of the association

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-7](#) effective until Jan. 1, 2025.>

A. If a member insurer is an impaired insurer, the association may, in its discretion, and subject to conditions imposed by the association that do not impair the contractual obligations of the impaired insurer and that are approved by the superintendent:

- (1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; and
- (2) provide such money, pledges, loans, notes, guarantees or other means as are proper to effectuate Paragraph (1) of this subsection and assure payment of the contractual obligations of the impaired insurer pending action pursuant to Paragraph (1) of this subsection.

B. If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

- (1) guarantee, assume, reissue or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer, or assure payment of the contractual obligations of the insolvent insurer, and provide money, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or
- (2) provide benefits and coverages in accordance with the following provisions:
 - (a) with respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred: 1) with respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five days, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies and contracts; and 2) with respect to non-group policies, contracts and annuities, not later than the earlier of the next renewal date, if any, under the policies or contracts or one year, but in no event less than thirty days, from the date on which the association becomes obligated with respect to the policies or contracts;

(b) make diligent efforts to provide all known insureds, enrollees or annuitants, for non-group policies and contracts, or group policy holders or contract owners with respect to group policies and contracts, thirty days' notice of the termination, pursuant to Subparagraph (a) of this paragraph, of the benefits provided;

(c) with respect to non-group policies or contracts covered by the association, and with respect to an individual formerly insured, enrolled or formerly an annuitant under a group policy or contract who is not eligible for replacement group coverage, make available to each known insured, enrollee or annuitant, or owner if other than the insured, enrollee or annuitant, substitute coverage on an individual basis in accordance with the provisions of Subparagraph (d) of this paragraph if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class;

(d) in providing the substitute coverage required pursuant to Subparagraph (c) of this paragraph, the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability and shall not provide for a waiting period or exclusion that would not have applied under the terminated policy or contract. The association may reinsure an alternative or reissued policy or contract;

(e) alternative policies or contracts adopted by the association shall be subject to the approval of the superintendent. The association may adopt alternative policies or contracts of various types for future issuance without regard to a particular impairment or insolvency. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates that it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured but shall not reflect changes in the health of the insured after the original policy or contract was last underwritten. An alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(f) if the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance provided and the age and class of risk, subject to the approval of the superintendent;

(g) the association's obligations with respect to coverage under a policy or contract of the impaired or insolvent insurer or under a reissued or alternative policy or contract shall cease on the date the coverage or policy is replaced by another similar policy by the policy owner, contract owner, enrollee, the insured or the association; and

(h) when proceeding under this subsection with respect to a policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Paragraph (3) of [Subsection E of Section 59A-42-4 NMSA 1978](#).

C. Nonpayment of premiums within thirty-one days after the date required under the terms of a guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or

coverage pursuant to the Life and Health Insurance Guaranty Association Act with respect to the policy, contract or coverage, except with respect to claims incurred or net cash surrender value that may be due in accordance with the provisions of that act.

D. Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of the order.

E. The protection provided by the Life and Health Insurance Guaranty Association Act shall not apply where guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

F. In carrying out its duties pursuant to Subsection B of this section, the association may:

(1) subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guaranty, assumption or reinsurance agreement if the association finds that the amounts that can be assessed are less than the amounts needed to assure full and prompt performance of the association's duties, or if it finds that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens to be in the public interest; or

(2) subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or another right to withdraw funds held in conjunction with policies or contracts, in addition to contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on another right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for the period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

G. A deposit in this state, held pursuant to law or required by the superintendent for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to Chapter 59A, Article 10 NMSA 1978, shall be promptly paid to the association. The association is entitled to retain a portion of an amount paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. An amount paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to the Insurers Conservation, Rehabilitation and Liquidation [Chapter 59A, Article 41 NMSA 1978] or similar provision of the state of domicile of the impaired or insolvent insurer.

H. If the association fails to act within a reasonable period of time with respect to an insolvent insurer, as provided in Subsection B of this section, the superintendent shall have the powers and duties of the association with respect to the insolvent insurer.

I. The association may render assistance and advice to the superintendent, upon the superintendent's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

J. The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated pursuant to the Life and Health Insurance Guaranty Association Act or with jurisdiction over a person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over a person or property against whom the association may have rights through subrogation or otherwise.

K. The association shall have subrogation rights under the Life and Health Insurance Guaranty Association Act as follows:

(1) a person receiving benefits pursuant to the Life and Health Insurance Guaranty Association Act shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising pursuant to, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The association may require an assignment to it of those rights and causes of action by an enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of a right or benefit conferred upon the person;

(2) the subrogation rights of the association pursuant to this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits;

(3) in addition to Paragraphs (1) and (2) of this subsection, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to the policy or contracts;

(4) if Paragraph (1), (2) or (3) of this subsection is invalid or ineffective with respect to a person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by another person with respect to the person or claim that is attributable to the policies or contracts, or to the portion of the policies or contracts, covered by the association; and

(5) if the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts, or to the portion of the policies or contracts, covered by the association.

L. In addition to its other rights and powers, the association may:

(1) enter into contracts that are necessary or proper to carry out the provisions and purposes of the Life and Health Insurance Guaranty Association Act;

(2) sue or be sued, including taking legal actions necessary or proper to recover unpaid assessments pursuant to [Section 59A-42-8 NMSA 1978](#) and to settle claims or potential claims against it;

(3) borrow money to effect the purposes of the Life and Health Insurance Guaranty Association Act. Notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic member insurers and may be carried as admitted assets;

(4) employ or retain those persons necessary or appropriate to handle the financial transactions of the association and to perform other functions as become necessary or proper;

(5) take legal action that may be necessary or appropriate to avoid or recover payment of improper claims;

(6) exercise, to the extent approved by the superintendent, the powers of a domestic life insurer, health maintenance organization or health insurer, but in no case may the association issue policies or contracts other than those issued to perform its obligations pursuant to the Life and Health Insurance Guaranty Association Act;

(7) organize itself as a corporation or in other legal form permitted by the laws of this state;

(8) request information from a person seeking coverage from the association in order to aid the association in determining its obligations with respect to that person, and that person shall promptly comply with the request;

(9) unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for an actuarially justified rate or premium increase for a policy or contract for which it provides coverage under the Life and Health Insurance Guaranty Association Act; and

(10) take other necessary or appropriate action to discharge its duties and obligations or to exercise its powers.

M. The association may join an organization of one or more other state associations with similar purposes to further the purposes and administer the powers and duties of the association.

N. The association may succeed to the rights and obligations of an insolvent insurer as follows:

(1) at any time within one hundred eighty days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under one or more reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. The assumption shall be effective as of the date of the order of liquidation. The

election shall be effected by the association or the national organization of life and health insurance guaranty associations on its behalf sending written notice, return receipt requested, to the affected reinsurers;

(2) to facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available, upon request, to the association or to the national organization of life and health insurance guaranty associations on its behalf, as soon as possible after commencement of formal delinquency proceedings:

(a) copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether those contracts should be assumed; and

(b) notices of defaults under the reinsurance contracts or a known event or condition that with the passage of time could become a default under the reinsurance contracts;

(3) the following shall apply to reinsurance contracts assumed by the association:

(a) the association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case that relate to policies, contracts or annuities covered, in whole or in part, by the association. The association may charge policies, contracts or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

(b) the association shall be entitled to amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the association, provided that, upon receipt of those amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of: 1) the amount received by the association; and 2) the excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event;

(c) within thirty days following the association's election, the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the date of election with respect to policies, contracts or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver amounts due for losses or events prior to the date of the order of liquidation, subject to a setoff for premiums unpaid for periods prior to that date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five days of the completion of the calculation described in this subparagraph. A dispute over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received amounts due the association pursuant to Subparagraph (b) of this paragraph, the receiver shall remit those amounts to the association as promptly as practicable; and

(d) if the association or receiver, on the association's behalf, within sixty days of the election described in Subparagraph (c) of this paragraph, pays the unpaid premiums due for periods both before and after the date of election that relate to policies, contracts or annuities covered, in whole or in part, by the association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premiums insofar as the reinsurance contracts relate to policies, contracts or annuities covered, in whole or in part, by the association, and the reinsurer shall not be entitled to set off unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association, against amounts due the association;

(4) during the period from the date of the order of liquidation, until the election date or, if the election does not occur, until one hundred eighty days after the date of the order of liquidation, neither the association nor the reinsurer shall have rights or obligations pursuant to reinsurance contracts that the association has the right to assume pursuant to Paragraphs (1), (2) and (3) of this subsection, whether for periods prior to or after the date of the order of liquidation, and the reinsurer, the receiver and the association shall, to the extent practicable, provide each other data and records reasonably requested; provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by Paragraphs (1), (2) and (3) of this subsection;

(5) if the association does not elect to assume a reinsurance contract by the election date pursuant to Paragraphs (1), (2) and (3) of this subsection, the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract;

(6) when policies, contracts or annuities, or covered obligations with respect to those policies, contracts or annuities, are transferred to an assuming insurer, reinsurance on the policies or annuities may also be transferred by the association, in the case of contracts assumed pursuant to Paragraphs (1), (2) and (3) of this subsection, subject to the following:

(a) unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover new policies of insurance, contracts or annuities in addition to those transferred;

(b) the obligations described in Paragraphs (1), (2) and (3) of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer; and

(c) notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty days prior to the effective date of the transfer;

(7) the provisions of this subsection shall supersede the provisions of a state law or of an affected reinsurance contract that provides for or requires a payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or another person. The receiver shall remain entitled to amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation, subject to applicable setoff provisions; and

(8) except as otherwise provided in this subsection, the provisions of this subsection shall not:

(a) alter or modify the terms and conditions of a reinsurance contract;

- (b) abrogate or limit the rights of a reinsurer to claim that it is entitled to rescind a reinsurance contract;
- (c) give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract;
- (d) limit or affect the association's rights as a creditor of the estate against the assets of the estate; or
- (e) apply to reinsurance contracts covering property or casualty risks.

O. The board may exercise reasonable business judgment to determine the means by which the association is to provide the benefits of the Life and Health Insurance Guaranty Association Act in an economical and efficient manner.

P. Where the association has arranged or offered to provide benefits to a covered person under a plan or arrangement that fulfills the association's obligations, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

Q. Venue in a suit against the association arising pursuant to the Life and Health Insurance Guaranty Association Act shall be in Santa Fe county. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising pursuant to the Life and Health Insurance Guaranty Association Act.

R. In carrying out its duties in connection with guaranteeing, assuming, reissuing or reinsuring policies or contracts pursuant to Subsection A or B of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

- (1) in lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for a fixed interest rate, payment of dividends with minimum guarantees or a different method for calculating interest or changes in value;
- (2) there is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and
- (3) the alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

Credits

Added by [L. 2012, Ch. 9, § 10, eff. July 1, 2012](#). Amended by [L. 2024, Ch. 36, § 5, eff. Jan. 1, 2025](#).


[Notes of Decisions \(3\)](#)

NMSA 1978, § 59A-42-7, NM ST § 59A-42-7

Current through chapters effective July 1, 2024 of the 2024 Second Regular Session of the 56th Legislature (2023). The Second Regular Session convened January 16, 2024 and adjourned February 15, 2024.

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Proposed Legislation

West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-8

§ 59A-42-8. Assessments

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-8](#) effective until Jan. 1, 2025.>

A. For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board shall assess the member insurers, separately for each account, at a time and for amounts as the board finds necessary. Assessments shall be due not less than thirty days after prior written notice to the member insurers and shall accrue interest at six percent a year on and after the due date.

B. There shall be two classes of assessments as follows:

(1) class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer; and

(2) class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association with regard to an impaired or an insolvent insurer.

C. The amount of a class A assessment shall be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If the class A assessment is authorized and called on a pro rata basis, the board may provide that it be credited against future class B assessments. The amount of a class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account pursuant to an allocation formula that may be based on the premiums or reserves of the impaired or insolvent insurer or another standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

D. The amount of the class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the superintendent. The methodology shall provide for fifty percent of the assessment to be allocated to accident and health member insurers and fifty percent to be allocated to life and annuity member insurers.

E. Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three most recent calendar years for which information is available preceding the year in which the member insurer became insolvent or, in the case of an assessment with respect to an impaired insurer, the three most recent calendar years for which information is available preceding the year in which the member insurer became impaired, bears to premiums received on business in this state for those calendar years by all assessed member insurers.

F. Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of the Life and Health Insurance Guaranty Association Act. Classification of assessments pursuant to Subsection B of this section and computation of assessments pursuant to Subsections C and E of this section shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty days after the assessment is authorized.

G. The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

H. Subject to the provisions of Subsection I of this section, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health insurance account shall not in one calendar year exceed two percent of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

I. If two or more assessments are authorized in one calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in Subsection H of this section shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

J. If the maximum assessment, together with the other assets of the association in an account, does not provide in one year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by the Life and Health Insurance Guaranty Association Act.

K. The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

L. If the maximum assessment for a subaccount of the life and annuity account in one year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to Subsection E of this section, the board shall access the other subaccounts of the life insurance and annuity account for the necessary additional amount, subject to the maximum stated in Subsections H, I and J of this section.

M. The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to that account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in an account to provide funds for the continuing expenses of the association and for a future losses claim.

N. It shall be proper for a member insurer, in determining its premium rates and policyowner dividends as to any kind of insurance or health maintenance organization business within the scope of the Life and Health Insurance Guaranty Association Act, to consider the amount reasonably necessary to meet its assessment obligations under that act.

O. The association shall issue to each member insurer paying an assessment, other than a class A assessment, a certificate of contribution, in a form prescribed by the superintendent, for the amount of the assessment paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in that form and for that amount, if any, and period of time as the superintendent may approve.

P. A protest to an assessment shall occur as follows:

(1) a member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or a subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest;

(2) within sixty days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest;

(3) within thirty days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the superintendent;

(4) in the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the superintendent for a final decision, with or without a recommendation from the association; and

(5) if the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

Q. The association may request information of member insurers in order to aid in the exercise of its power pursuant to this section, and member insurers shall promptly comply with a request.

Credits

Added by L. 2012, Ch. 9, § 11, eff. July 1, 2012. Amended by L. 2024, Ch. 36, § 6, eff. Jan. 1, 2025.

[Notes of Decisions \(1\)](#)

NMSA 1978, § 59A-42-8, NM ST § 59A-42-8

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-9

§ 59A-42-9. Plan of operation

Currentness

A. The association shall submit to the superintendent a plan of operation or amendments to the plan necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation or amendments to the plan shall become effective upon approval in writing by the superintendent or on the thirty-first day after submission to the superintendent if it has not been disapproved within that time.

B. If the association fails to submit suitable amendments to the plan, the superintendent shall, after notice and hearing, promulgate reasonable rules necessary or advisable to effectuate the provisions of the Life and Health Insurance Guaranty Association Act. The rules shall continue in force until modified by the superintendent or superseded by amendments submitted by the association and approved by the superintendent.

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

D. The plan of operation shall include:

- (1) procedures for handling the assets of the association;
- (2) the amount and method of reimbursement for members of the board;
- (3) the regular places and times for meetings, including telephone conference calls of the board;
- (4) procedures for records to be kept of all financial transactions of the association, its agents and the board;
- (5) procedures for selecting members of the board and submitting those selections for approval to the superintendent;
- (6) additional procedures for assessments;
- (7) additional provisions necessary or proper for the execution of the powers and duties of the association;

(8) procedures to remove a director for cause, including the case where a member insurer director becomes an impaired or insolvent insurer; and

(9) policies and procedures for addressing conflicts of interest.

E. The plan of operation may provide that the powers and duties of the association, except those provided in Paragraph (3) of Subsection L of Section 59A-42-7 NMSA 1978 and in Section 59A-42-8 NMSA 1978, may be delegated to a corporation, association or other organization that performs or will perform functions similar to those of the association, or its equivalent, in two or more states. That corporation, association or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of other functions of the association. A delegation pursuant to this subsection shall take effect only with the approval of both the board and the superintendent, and may be made only to a corporation, association or organization that extends protection not substantially less favorable and effective than that provided by the Life and Health Insurance Guaranty Association Act.

Credits


L. 1984, Ch. 127, § 758. Amended by L. 2012, Ch. 9, § 12, eff. July 1, 2012.

NMSA 1978, § 59A-42-9, NM ST § 59A-42-9

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Proposed Legislation

West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-10

§ 59A-42-10. Duties and powers of the superintendent

[Currentness](#)

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-10](#) effective until Jan. 1, 2025.>

A. The superintendent shall:

- (1) notify the association of the existence of an insolvent insurer not later than three days after the superintendent receives notice of the determination of the insolvency;
- (2) upon request of the board, provide the association with a statement of the premiums in this or another state of each member insurer; and
- (3) when an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time. Notice to the impaired insurer shall constitute notice to its shareholders, if any. The failure of the impaired insurer to promptly comply with the demand shall not excuse the association from the performance of its powers and duties pursuant to the Life and Health Insurance Guaranty Association Act.

B. The superintendent may:

- (1) suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of a member insurer that fails to pay an assessment when due or that fails to comply with the plan of operation. As an alternative, the superintendent may levy a fine on a member insurer that fails to pay an assessment when due. The fine shall not exceed five percent of the unpaid assessment a month, except that no fine shall be less than one hundred dollars (\$100) a month; and
- (2) revoke the designation of a servicing facility if the superintendent finds that claims are being handled unsatisfactorily.

Credits


L. 1984, Ch. 127, § 759; L. 2012, Ch. 9, § 13, eff. July 1, 2012; L. 2024, Ch. 36, § 7, eff. Jan. 1, 2025.

NMSA 1978, § 59A-42-10, NM ST § 59A-42-10

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Proposed Legislation

West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-11

§ 59A-42-11. Prevention of insolvencies

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-11](#) effective until Jan. 1, 2025.>

To aid in the detection and prevention of insurance insolvencies:

A. the superintendent shall:

(1) notify the superintendents in other states, within thirty days following the action taken or the date the action occurs, when the superintendent takes any of the following actions against a member insurer:

(a) revokes a license;

(b) suspends a license; or

(c) makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or a part of its business or increase capital, surplus or another account for the security of policy owners, contract owners, certificate holders or creditors;

(2) report to the board when the superintendent has taken an action set forth in Paragraph (1) of this subsection or has received a report from another superintendent indicating that an action has been taken in another state. The report to the board shall contain all significant details of the action taken or of the report received from another superintendent;

(3) report to the board when the superintendent has reasonable cause to believe from an examination, whether completed or in process, of a member insurer that the member insurer may be an impaired or insolvent insurer; and

(4) furnish to the board the national association of insurance commissioners' insurance regulatory information system ratios and listings of companies not included in the ratios developed by the national association of insurance commissioners. The board may use that information in carrying out its duties and responsibilities pursuant to this section. The report shall be kept confidential by the board until it is made public by the superintendent or other lawful authority;

B. the superintendent may seek the advice and recommendations of the board concerning a matter affecting the duties and responsibilities of the superintendent regarding the financial condition of member insurers or health maintenance organizations seeking admission to transact business in this state; and

C. the board may, upon majority vote:

- (1) notify the superintendent of information indicating that a member insurer may be an impaired or insolvent insurer;
- (2) make reports and recommendations to the superintendent upon any matter germane to the solvency, liquidation, rehabilitation or conservation of a member insurer or germane to the solvency of an insurer or health maintenance organization seeking to do business in this state. The reports and recommendations are not public documents; and
- (3) make recommendations to the superintendent for the detection and prevention of member insurers' insolvencies.

Credits

L. 1984, Ch. 127, § 760; L. 2012, Ch. 9, § 14, eff. July 1, 2012; L. 2024, Ch. 36, § 8, eff. Jan. 1, 2025.

NMSA 1978, § 59A-42-11, NM ST § 59A-42-11

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-12

§ 59A-42-12. Appeals

[Currentness](#)

A. A member insurer may appeal to the superintendent from an action of the board by filing with the superintendent a notice of appeal within thirty days after that action.

B. A final order of the superintendent on appeal is subject to judicial review by an action in the district court pursuant to the provisions of [Section 39-3-1.1 NMSA 1978](#).

Credits


L. 1984, Ch. 127, § 761; L. 1998, Ch. 55, § 66, eff. Sept. 1, 1998; L. 1999, Ch. 265, § 69, eff. July 1, 1999; L. 2012, Ch. 9, § 15, eff. July 1, 2012.

NMSA 1978, § 59A-42-12, NM ST § 59A-42-12

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Proposed Legislation

West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-13

§ 59A-42-13. Miscellaneous provisions

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-13](#) effective until Jan. 1, 2025.>

A. The Life and Health Insurance Guaranty Association Act shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

B. Records shall be kept of all meetings of the board to discuss the activities of the association in carrying out its powers and duties. Records of the meetings with respect to an impaired or insolvent insurer shall be made public only upon the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, upon the termination of the insolvency of the member insurer or upon the order of a court of competent jurisdiction. Nothing in this subsection limits the duty of the association to render the reports required by [Section 59A-42-14 NMSA 1978](#).

C. For the purpose of carrying out its obligations, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies or contracts reduced by amounts to which the association is entitled as a subrogee pursuant to [Subsection K of Section 59A-42-7 NMSA 1978](#). Assets of the impaired or insolvent insurer attributable to covered policies or contracts shall be used to continue all covered policies or contracts and pay all contractual obligations of the impaired or insolvent insurer. Assets attributable to covered policies or contracts, as used in this subsection, are that proportion of the assets that the reserves that should have been established for those policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

D. As a creditor of the impaired or insolvent insurer and consistent with the Insurers Conservation, Rehabilitation and Liquidation Law [Chapter 59A, Article 41 NMSA 1978], the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations pursuant to the Life and Health Insurance Guaranty Association Act. If the liquidator has not, within one hundred twenty days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

E. Prior to the termination of a liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer and any other party with a bona fide interest, in making an equitable distribution of

the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders and enrollees of the continuing or successor member insurer.

F. No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties with respect to the member insurer has been fully recovered by the association.

Credits

L. 1984, Ch. 127, § 762; L. 2012, Ch. 9, § 16, eff. July 1, 2012; L. 2024, Ch. 36, § 9, eff. Jan. 1, 2025.

[Notes of Decisions \(1\)](#)

NMSA 1978, § 59A-42-13, NM ST § 59A-42-13

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-14

§ 59A-42-14. Examination of association; annual report

Currentness

The association is subject to examination and regulation by the superintendent. The board shall submit to the superintendent, not later than May 1 each year, a financial report for the preceding calendar year in form approved by the superintendent and a report of its activities during the preceding calendar year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

Credits

L. 1984, Ch. 127, § 763. Amended by L. 2012, Ch. 9, § 17, eff. July 1, 2012.

NMSA 1978, § 59A-42-14, NM ST § 59A-42-14

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-15

§ 59A-42-15. Immunity

[Currentness](#)

There shall be no liability on the part of, and no cause of action shall arise against, a member insurer or its agents or employees, the association or its agents or employees, members of the board or the superintendent or the superintendent's representatives for an act or omission by them in the performance of their powers and duties pursuant to the Life and Health Insurance Guaranty Association Act. This immunity shall extend to the participation in an organization of one or more other state associations with similar purposes and to that organization and its agents or employees.

Credits

L. 1984, Ch. 127, § 764. Amended by [L. 2012, Ch. 9, § 18](#), eff. [July 1, 2012](#).

NMSA 1978, § 59A-42-15, NM ST § 59A-42-15

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-16

§ 59A-42-16. Stay of proceedings; reopening default judgments

Currentness

A proceeding in which an insolvent insurer is a party in a court in this state shall be stayed one hundred eighty days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on matters germane to its powers or duties. As to a judgment under a decision, order, verdict or finding based on default, the association may apply to have the judgment set aside by the same court that made the judgment and shall be permitted to defend against the suit on the merits.

Credits


L. 1984, Ch. 127, § 765. Amended by L. 2012, Ch. 9, § 19, eff. July 1, 2012.

NMSA 1978, § 59A-42-16, NM ST § 59A-42-16

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West's New Mexico Statutes Annotated
Chapter 59A. Insurance Code
Article 42. Life and Health Insurance Guaranty Association

N. M. S. A. 1978, § 59A-42-17

§ 59A-42-17. Prohibited advertisement; notice to policy owners

Currentness

<This version of section effective Jan. 1, 2025. See, also, version of [section 59A-42-17](#) effective until Jan. 1, 2025.>

A. No person, including a member insurer, agent or affiliate of a member insurer, shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over a radio station or television station, or in any other way, an advertisement, announcement or statement, written or oral, that uses the existence of the association for the purpose of sales, solicitation or inducement to purchase insurance or other coverage covered by the Life and Health Insurance Guaranty Association Act. However, this subsection shall not apply to the association or any other entity that does not sell or solicit insurance or coverage by a health maintenance organization.

B. Within one hundred eighty days of the effective date of this act, the association shall prepare a summary document describing the general purposes and current limitations of that act and complying with Subsection C of this section. The document shall be submitted to the superintendent for approval. At the expiration of the sixtieth day after the date on which the superintendent approves the document, a member insurer shall not deliver a policy or contract to a policy owner, contract owner, certificate holder or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the Life and Health Insurance Guaranty Association Act may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder or insured greater rights than those stated in the Life and Health Insurance Guaranty Association Act.

C. The document prepared pursuant to Subsection B of this section shall contain a clear and conspicuous disclaimer on its face. The superintendent shall establish the form and content of the disclaimer. The disclaimer shall:

- (1) state the name and address of the association and insurance department;
- (2) prominently warn the policy owner, contract owner, certificate holder or enrollee that the association may not cover the policy or contract, if coverage is available, that it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

- (3) state the types of policies or contracts for which guaranty funds will provide coverage;
- (4) state that the member insurer and its agents are prohibited by law from using the existence of the association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;
- (5) state that the policy owner, contract owner, certificate holder or enrollee should not rely on coverage pursuant to the Life and Health Insurance Guaranty Association Act when selecting an insurer or health maintenance organization;
- (6) explain rights available and procedures for filing a complaint to allege a violation of the provisions of the Life and Health Insurance Guaranty Association Act; and
- (7) provide other information as directed by the superintendent, including sources for information about the financial condition of insurers, provided that the information is not proprietary and is subject to disclosure pursuant to the Inspection of Public Records Act [Chapter 14, Article 2 NMSA 1978].

D. A member insurer shall retain evidence of compliance with Subsection B of this section for as long as the policy or contract for which the notice is given remains in effect.

Credits

Added by [L. 2012, Ch. 9, § 20, eff. July 1, 2012](#). Amended by [L. 2024, Ch. 36, § 10, eff. Jan. 1, 2025](#).

NMSA 1978, § 59A-42-17, NM ST § 59A-42-17

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