TITLE 13 INSURANCE
CHAPTER 18 CREDIT INSURANCE
PART 2 CREDIT LIFE AND CREDIT HEALTH INSURANCE

13.18.2.1 ISSUING AGENCY: Office of Superintendent of Insurance
[13.18.2.1 NMAC – Rp, 13.18.2.1 NMAC, 3/11/2025]

13.18.2.2 SCOPE: This rule applies to all life insurance and accident and health insurance sold in connection with loans or other credit transactions, except such insurance sold in connection with a loan or other credit transaction of more than 10 years' duration, and except for such insurance the issuance of which is an isolated transaction on the part of the insurer not related to an agreement or plan for insuring debtors of the creditor.
[13.18.2.2 NMAC – Rp, 13.18.2.2 NMAC, 3/11/2025]

13.18.2.3 STATUTORY AUTHORITY: Sections 59A-2-9, and 59A-25-1 to 59A-25-14 NMSA 1978.
[13.18.2.3 NMAC – Rp, 13.18.2.3 NMAC, 3/11/2025]

13.18.2.4 DURATION: Permanent.
[13.18.2.4 NMAC - Rp, 13.18.2.4 NMAC, 3/11/2025]

13.18.2.5 EFFECTIVE DATE: March 11, 2025, unless a later date is cited at the end of a section.
[13.18.2.5 NMAC - Rp, 13.18.2.5 NMAC, 3/11/2025]

13.18.2.6 OBJECTIVE: The purpose of this rule is to implement the Law for Regulation of Credit Life Insurance and Credit Health Insurance, Sections 59A-25-1 to 59A-25-14 NMSA 1978.
[13.18.2.6 NMAC - Rp, 13.18.2.6 NMAC, 3/11/2025]

13.18.2.7 DEFINITIONS:

A. "Account" means the aggregate credit life insurance or credit accident and health coverage for a single plan of insurance for a single class of business written through a single creditor, or written through more than one creditor under common control or ownership, by the insurer, whether coverage is written on a group or individual basis.

B. "Average number of life years" means the average of the number of group certificates or individual policies in force each month during the experience period (without regard to multiple coverage) times the number of years in the experience period.

C. "Case" means either a single account case or a multiple account case as follows.

(1) Single account case means an account that is at least twenty-five percent credible or, at the option of the insurer, any higher percentage as determined by the credibility table. An insurer exercising this option must notify the superintendent, in writing, of the credibility factor it will use to define a single account case. Once the superintendent is so notified, the credibility factor will remain in effect for the insurer until a different election has been filed in writing by the insurer and approved by the superintendent.

(2) Multiple account case means a combination of all the insurer's accounts of the same plan of insurance and class of business which combination has experience in this state, excluding all single account cases defined in (1) above, or with the approval of the superintendent, multiple account case also means two or more accounts of the insurer having like underwriting characteristics which are combined by the insurer for premium rating purposes, excluding all single account cases defined in (1) above and other multiple account cases defined above.

D. "Claims incurred" means the liability resulting from the happening of the contingency insured against, whether paid, reported, not reported or resisted on accounting dates, valued by the date of accounts and or amounts, excluding claims expenses, sufficient to discharge the company from all liability.

E. "Class of business" means one of the following determined by the source of the business:

(1) credit unions;
(2) commercial banks and savings and loan association;
(3) finance companies;
(4) motor vehicle dealers;
(5) other sales finance;
(6) production credit associations;

(7) bank agricultural loans; or

(8) all others.

F. "Credibility factor" means the degree to which the past experience of a case can be expected to occur in the future. The credibility factor is based either on the average number of life years or the incurred claim count during the experience period as shown in the credibility table below. The insurer shall notify the superintendent, in writing, which of these two methods it will use in measuring credibility. Once the superintendent is so notified, the method will remain in effect for the insurer until a change has been filed and approved by the superintendent.

G. "Credit accident health insurance" has the same meaning as defined in Subsection B of Section 59A-25-3 NMSA 1978.

H. "Credit life insurance" has the same meaning as defined in Subsection A of Section 59A-25-3 NMSA 1978.

I. "Credit transaction" has the meaning as defined in Subsection D of Section 59A-25-3 NMSA 1978.

J. "Creditor" has the same meaning as defined in Subsection C of Section 59A-25-3 NMSA 1978.

K. "Debtor" has the same meaning as defined in Subsection E of Section 59A-25-3 NMSA 1978.

L. "Earned premium" means premium earned during the experience period at the presumptive rate.

M. "Experience" means the earned premium and incurred claims for a single or multiple account case. Experience will be the most recent experience in this state for a plan of insurance of a class of business, and may include the experience of the case while with a prior insurer to the extent necessary to achieve credibility.

N. "Experience period" means the period of time for which experience is reported, but not for a period longer than three years.

O. "Incurred claims" means the total claims incurred during the experience period.

P. "Incurred claim count" means the number of claims incurred for the case during the experience period. This means the total number of claims reported during the experience period (whether paid or in the process of payment) plus any incurred but not reported at the end of the experience period less the number of claims incurred but not reported at the beginning of the experience period. If a debtor has been issued more than one certificate for the same plan of insurance, only one claim is counted. If a debtor receives disability benefits, only the initial claim payment for that period of disability is counted.

Q. "Indebtedness" has the same meaning as defined in Subsection F of Section 59A-25-3 NMSA 1978.

R. "OSI" means the office of superintendent of insurance.

S. "Open-end credit" means consumer credit extended by a creditor under a plan in which:

(1) the creditor reasonably contemplates repeated transactions;

(2) the creditor may impose a finance charge from time to time on an outstanding unpaid balance; and

(3) the amount of credit that may be extended to the consumer during the term of the plan (up to any limit set by the creditor) is generally made available to the extent that any outstanding balance is repaid.

T. "Plan of insurance" means a plan of credit life insurance or a plan of credit accident and health insurance for which rates are prescribed in 13.18.2.18 NMAC or 13.18.2.26 NMAC.

U. "Premiums earned" means the total gross premiums which become due the insurance company, adjusted only to reflect premiums refunded or adjusted on account of termination of coverage, appropriately adjusted for charges in unearned premiums. Unearned premiums, for the purpose of determining premiums earned shall be calculated as described in 13.18.2.35 NMAC for the purpose of determining refunds.

V. "Superintendent" means the superintendent of insurance or designee.

[13.18.2.7 NMAC - Rp, 13.18.2.7 NMAC, 3/11/2025]

13.18.2.8 TERMINATION UPON DISCHARGE OF INDEBTEDNESS: Each individual policy or group certificate of credit life insurance or credit accident and health insurance delivered or issued for delivery in this state shall, in addition to the other requirements of law, contain a statement indicating that upon discharge of the indebtedness the insurance shall be terminated, but without prejudice to any claim originating prior to such termination, and that in all cases of termination prior to scheduled maturity, a refund of any unearned premium paid by or charged to the debtor for insurance shall be made in accordance with the appropriate formula set forth in 13.18.2.35 NMAC. Such refund shall be paid or credited to the debtor or paid to the second beneficiary if the debtor is not living. No such refund is required if the total amount of the refund is three dollars ($3.00) or less.

[13.18.2.8 NMAC - Rp, 13.18.2.8 NMAC, 3/11/2025]

13.18.2.9 CONTINUATION OF ACCIDENT AND HEALTH INSURANCE BENEFITS: If an accident and health insurance claim is in progress at the time of discharge of indebtedness, such claim shall continue during the originally scheduled term of insurance, as if there has been no such discharge of indebtedness.
[13.18.2.9 NMAC - Rp, 13.18.2.9 NMAC, 3/11/2025]

13.18.2.10 REFUND OF PREMIUMS:

A. Upon the termination of such continuing claim within the original scheduled term of insurance a refund shall be made of any then unearned premium. If, however, during the pendency of an accident and health insurance claim the insurer elects to prepay and discharge the full remaining balance thereon immediately in one payment, the accident and health premium paid or then due and payable to the insurer is earned and no refund is required.

B. In the case of termination of credit life insurance in which death benefits are not payable due to the exclusions in the policy, the insurer will refund the unearned premium in accordance with 13.18.2.35 NMAC. In the case of termination of credit life insurance by payment of death benefits, the life insurance premiums paid or then due and payable to the insurer are deemed earned and no refund thereof is required; however, in such instances the accident and health premium is not deemed earned and shall be refunded to the second beneficiary in accordance with 13.18.2.35 NMAC.
[13.18.2.10 NMAC - Rp, 13.18.2.10 NMAC, 3/11/2025]

13.18.2.11 PAYMENTS OF BENEFITS TO THE INSURED:

A. Excess benefit checks or drafts made in accordance with Subsection B of Section 59A-25-7 NMSA 1978 shall be delivered only by the insurer or, at the option of the insurer, by the creditor. In any case, the insurer shall be responsible for the delivery of such excess benefit checks or drafts. Electronic funds transfers may be used.

B. The creditor agent or group policyholder shall not require that any benefit be applied to the reduction of any indebtedness other than the indebtedness in connection with which the insurance was written.

C. Notice of payments under credit life insurance shall be provided to the insureds' estate. The insured shall be provided notice of initiation of benefits under a credit accident and health insurance policy along with a statement that such benefits will continue while the insured is disabled under the terms of the insurance policy. The insurer shall be responsible for such notice; however, such duty may be delegated to the creditor provided the insurer maintains the responsibility for seeing that these notice requirements are met.

D. Benefit checks or drafts payable to a beneficiary or an insured may not be offset by any insurer against amounts due from a creditor or an agent to the insurer or anyone acting on behalf of the insurer unless the benefit check or draft is endorsed by the beneficiary or the insured to whom it was made payable.
[13.18.2.11 NMAC - Rp, 13.18.2.11 NMAC, 3/11/2025]

13.18.2.12 POLICY PROVISIONS:

A. The policy or certificate shall not contain provisions which would encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive, or contrary to the law of this state.

B. Provisions in individual policies or group certificates pertaining to underwriting rules, conditions of eligibility or issue, or maximum amounts or terms of insurance may be used only to determine initial eligibility and may not, except as provided herein, be used as the basis for the termination or reduction of coverage or the denial of claims.

C. The policy may state that if coverage is issued in excess of a maximum amount or term limitation, the insurer has the right, within 90 days of effective date of coverage, to reduce the excess coverage and refund the charge for excess insurance, or terminate the coverage and refund the full charge for insurance, provided such adjustment is accomplished and the appropriate refund is made prior to the incurred date of any claim under such coverage.

D. The policy may state that if a debtor exceeds the eligibility age defined in Subsection B of 13.18.2.22 NMAC for credit life and Subsection D of 13.18.2.27 NMAC for credit accident and health, and has not incorrectly stated his or her age in writing, and the coverage is issued in error, the insurer has the right, within ninety days of the effective date of coverage, to terminate the coverage and refund the full charge for insurance, provided such termination is accomplished and the appropriate refund is made prior to the incurred dated of any claim under such coverage.

E. Coverage issued in connection with open-end transactions may contain provisions limiting the

maximum amount of insurance which may become effective thereunder, and may contain provisions for automatic termination of coverage upon the attainment of a specified age of 72.

F. Nothing herein is intended to preclude an insurer, during the contestable period, from contesting coverage on the basis of a material misstatement by a debtor, subject to the requirement that the misstatement must be contained in a written statement signed by the debtor, and a copy of the statement must be furnished to the debtor or to his or her beneficiary.

[13.18.2.12 NMAC - Rp, 13.18.2.12 NMAC, 3/11/2025]

13.18.2.13 INSURANCE FOR PERIODS BEYOND PAYMENT PERIOD OF THE POLICY:

A. If a group certificate of insurance is issued to a debtor under any plan charging the debtor an identifiable amount for insurance for a period of time greater than that of the shortest premium payment period of the group policy issued to the creditor, the following rules shall apply.

B. The certificate shall in addition to all other requirements of this rule and the laws of this state, clearly and prominently set forth that:

(1) the creditor alone is liable for such excess charges as are unearned;

(2) the insurance company is not liable for such excess unearned charges not received;

(3) the liability of the insurance company for the benefit is on a month to month basis, or otherwise as set out in the group policy of insurance;

(4) the coverage may be terminated by the insurance company or the creditor upon thirty days written notice to the debtor;

(5) the insurer is not liable for claims beyond such interval; and

(6) the certificate shall be so phrased as not to violate the public policy of the state of New Mexico not to indicate to the ordinary debtor that the insurance coverage had been provided commensurate to the identifiable charge appearing upon the certificate for the full term of the indebtedness nor that the insurer would be obligated to the debtor for any such excess unearned charges.

[13.18.2.13 NMAC - Rp, 13.18.2.13 NMAC, 3/11//2025]

13.18.2.14 GROUP POLICY TERMINATION PROVISIONS: The following provisions apply to termination of coverage under a group policy.

A. If a debtor is covered by a group credit insurance policy providing for the payment of a single premium to the insurer, the master policy and certificate shall provide that in the event of termination of the group policy for any reason, insurance coverage with respect to any debtor then insured under such policy shall be continued for the entire period for which the single premium has been paid, subject to the provisions of the policy relative to early termination of a debtor's insurance.

B. If a debtor is covered by a group credit insurance policy providing for payment of premium to the insurer on a monthly outstanding balance basis, then the policy and certificate shall provide that, in the event of termination of such group policy for any reason, the insured debtor shall be given written notice that coverage will continue for 30 days from the date of such notice, except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without interruption of coverage and a new certificate reflecting such replacement coverage is delivered to such debtor. The notice of termination required by this paragraph shall be given by the insurer or, at the option of the insurer, by the creditor.

[13.18.2.14 NMAC - Rp, 13.18.2.14 NMAC, 3/11/2025]

13.18.2.15 INSURED FINANCE CHARGES, ETC: If the creditor adds identifiable insurance charge or premiums for credit insurance to the indebtedness, and any direct or indirect finance, carrying credit or service charge is made to the debtor on such insurance charge or premiums, the charge to the debtor shall be of the same mode and in an amount not to exceed the insurer's charge.

[13.18.2.15 NMAC - Rp, 13.18.2.15 NMAC, 3/11/2025]

13.18.2.16 OPEN END TRANSACTIONS: The following rules shall apply to open-end transaction forms.

A. The policy and certificate must be identified when used for open-end transactions by either a form number followed by the suffix (25-OE) or a check-off block and may be used for coverage of any other types of indebtedness if previously approved by the superintendent.

B. The premiums paid by the creditor and any insurance charges paid by the debtor for such insurance must be at the same mode.

C. If the insurer imposes conditions of insurability for an increase in coverage, then the policy must

state such conditions. The conditions must be consistent with 13.18.2.25 NMAC and 13.18.2.28 NMAC of this rule.

D. If the disability benefit for an open-end indebtedness is based upon a minimum payment, then the method of determining the minimum payment must be stated in the policy.

[13.18.2.16 NMAC - Rp, 13.18.2.16 NMAC, 3/11//2025]

13.18.2.17 FILING OF FORMS AND RATES:

A. Every insurance company, when submitting a schedule of rates for consideration by the superintendent of insurance, shall identify the rates to be used with the policy form submitted for approval. In the alternative, specific reference in the case of each submission shall be made to the particular schedule of rates, or portions thereof, which are applicable to the specific policy form. The face and face page of every form or schedule submitted to the superintendent of insurance for his consideration under Article 25, New Mexico Insurance Code, shall have added to its identifying number the additional identification (25). Such additional identification shall appear on issued copies of such forms.

B. Tests for reasonableness of premiums.

(1) The benefits of credit life insurance, individual or group, shall be considered to be reasonable in relation to the premium charged if it can reasonably be anticipated that a loss ratio of claims incurred to premiums earned of not less than fifty-five percent will be developed.

(2) The benefits of credit accident and health insurance, individual or group, shall be considered to be reasonable in relation to the premiums charged if it can reasonably be anticipated that a loss ratio of claims incurred to premiums earned of not less than fifty-five percent will be developed.

C. Any individual policy, application, group policy, group certificate, or notice or proposed insurance shall be in full compliance with the law and this rule.

D. Any insurer contracting with creditor policyholders, agents, general agents, sub-agents, or any other representative(s) who in the aggregate are paid based upon the production of credit life or credit accident and health insurance premiums, individual or group, if the compensation is based upon production of such insurance where the aggregate of all such compensation exceeds forty-five percent of the aggregate premiums within a calendar year shall be presumed by the superintendent to be in automatic violation of the required minimum loss ratios stated in this rule without the need of any other proof.

E. Each violation of the minimum loss ratios required by now Paragraph (1) of Subsection B of 13.18.2.17 NMAC for credit life insurance or Paragraph (2) of Subsection B of 13.18.2.17 NMAC for credit accident and health insurance that occurs due to compensation exceeding the amount set out in Subsection D of 13.18.2.17 NMAC is subject to the penalties of Section 59A-1-18 NMSA 1978.

F. The prima facie rates will be revised periodically as necessary in a bulletin issued by the superintendent.

[13.18.2.17 NMAC - Rp, 13.18.2.17 NMAC, 3/11/2025]

13.18.2.18 PRESUMPTIVELY ACCEPTABLE CREDIT LIFE INSURANCE PREMIUMS (PRIMA FACIE RATES): The superintendent of insurance may presume (subject, however, to a rebuttal of the presumption) that the benefits of a credit life insurance policy are reasonable in relation to the premium charged if the premium rate for death benefits as filed does not exceed an amount equal, or actuarially equivalent, to the following rates:

A. Coverage on a single life provided on the outstanding indebtedness basis will be determined by the superintendent as necessary via bulletin, by an amount per month per $1,000.00 of outstanding balance indebtedness.

B. Coverage on a single life on the single premium basis will be determined by the superintendent as necessary via bulletin, by:

(1) an amount per year of coverage per $100.00 of initial insured indebtedness for all credit transactions when the insured indebtedness is payable in substantially equal monthly installments during the term of coverage; and

(2) an amount per year of coverage per $100.00 of level life insurance where the amount of insured indebtedness remains level during the term of coverage and is repayable in a single sum at the end of the term.

C. Coverage on joint lives on the outstanding indebtedness basis will be determined by the superintendent as necessary via bulletin, by an amount per month per $1,000.00 of outstanding balance indebtedness.

D. Coverage for joint lives on the single premium basis will be determined by the superintendent as

necessary via bulletin, by:

(1) an amount per year of coverage per $100.00 of initial insured indebtedness for all credit transactions when the insured indebtedness is repayable in substantially equal monthly installments during the term of coverage; and

(2) an amount per year of coverage per $100.00 of level life insurance where the amount of insured indebtedness remains level during the term of coverage and is repayable in a single sum at the end of the term.

[13.18.2.18 NMAC - Rp, 13.18.2.18 NMAC, 3/11/2025]

13.18.2.19 USE OF JOINT CREDIT LIFE INSURANCE: Joint lives as used in Subsections C and D of 13.18.2.18 NMAC above means only spouses or business partners, and such person must be jointly and severally liable for repayment of the single indebtedness and be joint signers of the instrument of indebtedness. Endorsers and guarantors are not eligible for credit insurance coverage. Joint life coverage shall not be written covering more than two lives. Jointly indebted persons shall not both be covered separately at single life rates.

[13.18.2.19 NMAC - Rp, 13.18.2.19 NMAC, 3/11/2025]

13.18.2.20 COMPOSITE SINGLE JOINT OUTSTANDING BALANCE RATE (PRIMA FACIE):

A. Joint life rates may not be charged for single life coverage, except that a composite single joint outstanding balance life rate may be used for open-end accounts where more than fifty percent of a creditor's open-end accounts are held jointly. Such rate shall be completed as follows and will be determined by the superintendent as necessary via bulletin, by: COB = an amount of (PSA) - an amount of (PJA), where:

(1) COB = composite outstanding balance life rate per $1,000 per month;

(2) PSA = percentage of open-end accounts held by a single person expressed as a decimal fraction (for the first year, use all accounts; for subsequent years, use insured accounts);

(3) PJA = percentage of revolving accounts held jointly expressed as a decimal fraction (for the first year, use all accounts; for subsequent years, use insured accounts).

B. Composite rates shall be recomputed when the percentage of insured account jointly held drops by more than ten percentage points below the percentage used to compute the composite rate. Composite rates shall be discontinued when the percentage of insured accounts jointly held drops below fifty percent. Recomputation or discontinuance shall be effective within six months of the end of the policy year in which the changes requiring such action occurred.

[13.18.2.20 NMAC - Rp, 13.18.2.20, 3/11/2025]

13.18.2.21 ACTUARIAL EQUIVALENT PREMIUM FOR UNEQUAL MONTHLY INSTALLMENTS: Premiums and premium rates for insurance concerning obligations payable in other than substantially equal monthly installments during the period of coverage, or for coverage which declines on other than a straight line basis, shall be determined in a manner which produces a rate not exceeding the actuarial equivalent of the foregoing rates.

[13.18.2.21 NMAC - Rp, 13.18.2.21 NMAC, 3/11/2025]

13.18.2.22 INSURABILITY REQUIREMENTS PERMITTED: The presumptively reasonable premiums for credit life insurance shall apply only to plans containing provisions consistent with the following.

A. That the credit life insurance contract may require submission of the debtor's written and signed evidence of the debtor's insurability or that the debtor be in gainful employment at the time the insurance becomes effective, or both, on a form filed with and approved by the superintendent of insurance, and that such contract contains no conditions for validity of insurance more restrictive than contestability based on material misrepresentation and no exclusions other than for suicide, flight in nonscheduled aircraft, and war or military hazard.

B. The insurer must require and be responsible in its contract with the group policyholder and the creditor that proof be retained for three years following the offer by the creditor, group policyholder or the insurer and made available for examination by the superintendent that credit life insurance coverage is provided or offered to all debtors not older than the applicable age limit without age discrimination. The applicable age limit for credit life using presumptively acceptable credit life premiums shall not be less than the attained age of 70 years if such limit applies to the age when the insurance is issued, or not less than the attained age of 72 if such limit applies to the age on the scheduled maturity date of debt. Coverage issued in connection with open-end transactions may contain a provision for automatic termination of coverage upon attainment of a specified age, which shall not be less

than 72. The use of any other age limits will require that premiums be filed under the deviation procedures in this rule.
[13.18.2.22 NMAC - Rp, 13.18.2.22 NMAC, 3/11/2025]

13.18.2.23 PREMIUM RATE ADJUSTMENTS FOR AGE BRACKETS: If the premiums are determined according to the age of the insured debtor or by age brackets, appropriate adjustments in the rate and premium may be made according to age if such adjustments are actuarially consistent with the foregoing rates when applied regardless of actual age at issue and if such adjustments produce an aggregate premium not greater than that produced by the foregoing rates, and such rates and actuarially consistent computations are filed with and approved by the superintendent of insurance.
[13.18.2.23 NMAC - Rp, 13.18.2.23 NMAC, 3/11/2025]

13.18.2.24 PREMIUM RATES FOR OTHER LAWFUL BENEFITS: If a contract of insurance includes other lawful benefit or benefits for which standards of reasonableness of benefits in relation to premiums are not elsewhere in this rule determined or described, any premium charged therefor shall be shown to the satisfaction of the superintendent of insurance to be based upon credible data and shall meet the basic test of reasonableness described in Subsection B of 13.18.2.17 NMAC of this rule.
[13.18.2.24 NMAC - Rp, 13.18.2.24 NMAC, 3/11/2025]

13.18.2.25 INSURABILITY REQUIREMENTS PERMITTED FOR INCREASED OPEN-ENDED CREDIT LIFE INSURANCE: If a debtor has credit life insurance under an open-end outstanding balance policy, the policy may provide that an increase in the amount of insurance because of an increase in the amount of indebtedness will be subject to conditions of insurability. Any policy provision regarding evidence of insurability for an increase will comply with the following.

A. No charge for or cost of any such additional coverage will be incurred by any debtor, except by voluntary acceptance of the coverage and submission of such lawful statement as is required by the insurer. Voluntary acceptance will not be deemed to have occurred except by a specific positive written response by the debtor to a notice of availability of the coverage; it may not be automatic subject to an act of rejection or notification by the debtor.

B. The effective date of any such increase in coverage may be either of the following:

(1) the date on which the indebtedness is increased. In this event, however, if specific positive written response is not received within 75 days of such increase, or if such response is not satisfactory to the insurer, then the additional insurance shall not be effective, and any premium which has been paid therefore shall be refunded or credited to the account of the debtor not more than 90 days after the increase in indebtedness; any claim which occurs when positive response has not been received, but before the date by which such response must be received, will be paid if the debtor was eligible for the insurance under the terms of the policy; if the premium has been paid, but not refunded or credited to the account of the debtor not more than 90 days after the increase in indebtedness, the insurance shall be effective regardless of the eligibility of the debtor; or

(2) the date on which specific positive written response satisfactory to the insurer is received by the insurer;

(3) nothing herein shall preclude a policy provision prohibiting any increases in the amount of insurance while the insured is disabled.
[13.18.2.25 NMAC - Rp, 13.18.2.25 NMAC, 3/11/2025]

13.18.2.26 PRESUMPTIVELY ACCEPTABLE RELATION OF CREDIT ACCIDENT AND HEALTH BENEFITS TO PREMIUMS (PRIMA FACIE):

A. The superintendent may presume (subject, however, to a rebuttal of the presumption) that the benefits of an accident and health insurance form are reasonable in relation to the premium charged if the premium rate schedule for such accident and health benefits, as filed, does not exceed an amount equal to, or actuarially consistent with the following rate structure where rates will be determined by the superintendent as necessary via bulletin, by:

(1) Original number of equal monthly installments;

(2) Benefits payable after the 14th day of disability indicating:

(a) Retroactive; and

(b) Non-retroactive;

(3) Benefits payable after the 30th day of disability indicating:

(a) Retroactive; and

(b) Non-retroactive.

B. A monthly premium will be determined by the superintendent as necessary via bulletin, by an amount per $100 of outstanding balance may be presumed reasonable for a disability benefit which consists of a lump sum payment of the amount of indebtedness covered at the beginning of disability, such payment to be made after disability has continued for 90 consecutive days. A daily benefit does not apply to this coverage.

C. Except for credit accident and health insurance sold in connection with open-end loans, the rates for premiums payable on other than a single premium basis shall be actuarially consistent with the rates set forth in Subsection A of 13.18.2.26 NMAC above. Such premium rates will be deemed actuarially consistent with the foregoing single premium rates if such rates produce a total premium for any duration and amount of insurance equal to the corresponding single premium for the same duration and amount of insurance. Rates computed according to the following formula are presumed to satisfy this requirement: Op = 20SPn/n+1, where:

(1) *SPn* = single premium rate per $100 of initial indebtedness repayable in "n" installments;

(2) *Op* = monthly outstanding balance premium rate per $1,000;

(3) *n* = original repayment period, in months.

D. In credit accident and health insurance sold in connection with open-end transactions or monthly closed-end transactions, the superintendent may presume (subject, however, to a rebuttal of the presumption) that the benefits are reasonable in relation to the premium charged if the premium rate schedule for such accident and health insurance transactions does not exceed an amount equal to, or actuarially consistent with, the following rates that will be determined by the superintendent as necessary via bulletin, by:

(1) benefits payable after the 14th day of disability:

(a) retroactive to first day: an amount per month per $100 of outstanding balance insured indebtedness;

(b) non-retroactive: an amount per month per $100 of outstanding balance insured indebtedness;

(2) benefits payable after the 30th day of disability:

(a) retroactive to first day: an amount per month per $100 of outstanding balance insured indebtedness;

(b) non-retroactive: an amount per month per $100 of outstanding balance insured indebtedness.

E. The premium in Paragraphs (1) and (2) of Subsection D of 13.18.2.26 NMAC above are based upon the assumption that benefits will be paid as long as there is an outstanding balance and the insured is disabled. If there is a provision that benefit payment may cease during the disability of the insured before the indebtedness outstanding on the date of disability, including interest on such indebtedness, is retired, then these premiums will be adjusted to reflect, in the opinion of the superintendent of insurance, the effect of such provision.

F. If a contract of insurance includes other lawful benefit or benefits for which standards of reasonableness of benefits in relation to premium are not elsewhere in this rule determined or described, any premium charged therefor shall be shown to the satisfaction of the superintendent to be based upon credible data and shall meet the basic tests of reasonableness described in Paragraphs (1) and (2) of Subsection B of 13.18.2.17 NMAC.

[13.18.2.26 NMAC - Rp, 13.18.2.26 NMAC, 3/11/2025]

13.18.2.27 STANDARD OF BENEFITS FOR CREDIT ACCIDENT AND HEALTH INSURANCE: The standards and principles for the application of the rates set forth for credit accident and health insurance are as follows.

A. The initial amount of insured indebtedness to which the rate is applied shall not exceed the aggregate of the insured portion of the periodic scheduled unpaid installments of the indebtedness.

B. Except for open-end accounts, the indebtedness must be payable in substantially equal monthly or other periodic installments during the period of coverage.

C. The credit accident and health insurance contract may require written and signed evidence of insurability and, where offered, shall be offered to all eligible debtors and shall contain:

(1) no provision for validity of insurance more restrictive than contestability based on material misrepresentation; an insurer may not rely on material misrepresentation as a defense against the payment of a claim unless the insurer required the insured to sign a written statement in which the alleged misrepresentation was made;

(2) no provision which excludes or restricts liability in the event of disability caused in a

specific manner or under specific condition, except that it may contain provisions excluding or restricting coverage in the event of:

(a) elective abortion;

(b) normal pregnancy, except complications of pregnancy;

(c) intentionally self-inflicted injuries;

(d) flight in nonscheduled aircraft;

(e) loss resulting from war or military service;

(3) provision for a daily benefit equal in amount to one-thirtieth (or other applicable fraction) of the scheduled monthly (or other specified mode of installment) payment or indebtedness;

(4) for the purpose of total disability insurance, a definition of total disability which provides coverage during the first 12 months of such disability even though the insured is able to perform an occupation other than the one he held at the time such disability occurred; during the first 12 months of each disability, the definition of total disability must relate such disability to the occupation of the debtor at the time the disability commenced; after disability continues for more than 12 months, the definition of total disability may relate such continuing disability to the inability to perform any occupation for which the debtor is reasonably fitted by education, training or experience.

D. The credit accident and health insurance must be offered to all debtors regardless of age, or to all debtors not older than the applicable age limit. The applicable age limit shall not be less than the attained age of 66 years if such limit applies to the age when the insurance is issued, or not less than attained age 67 if such limit applies to the age on the scheduled maturity date of the debt. Coverage issued in connection with open-end transactions may contain a provision for the automatic termination of coverage upon the attainment of a specified age, which shall not be less than 67. The use of any other age limits will require that premiums be filed under the deviation procedures in this rule.

E. There shall be no provisions excluding or denying a claim for disability under credit accident and health insurance resulting from pre-existing conditions except for those conditions for which the insured debtor received medical diagnosis or treatment within six months immediately preceding the effective date of the debtor's coverage and which caused a period of loss within six months following the effective date of coverage; provided, however, that any subsequent period of disability resulting from such condition that commences or recommences more than six months after the effective date of the coverage shall be covered under the provisions of the policy. The effective date for each part of the insurance attributable to a different advance or charge to the account is the date on which the advance or charge is posted to the account of the debtor.

[13.18.2.27 NMAC - Rp, 13.18.2.27 NMAC, 3/11/2025]

13.18.2.28 INCREASES IN OUTSTANDING BALANCE OPEN-END COVERAGE:

A. If a debtor has credit accident and health insurance under an open-end outstanding balance policy, the policy may provide that an increase in the insurance benefits because of an increase in the indebtedness will be subject to conditions of insurability. Any policy provision regarding evidence of insurability for an increase will comply with the following.

(1) No charge for or cost of any such additional coverage will be incurred by a debtor except by voluntary acceptance of the coverage and submission of such lawful statement as is required by the insurer. Voluntary acceptance will not be deemed to have occurred except by a specific positive written response by the debtor to a notice of availability of the coverage; it may not be made automatic subject to an act of a rejection or notification by the debtor.

(2) The effective date of any such increase in coverage may be either of the following:

(a) the date on which the indebtedness is increased: In this event, however, if specific positive response is not received within 75 days of such increase, or if such response is not satisfactory to the insurer, then the additional insurance shall not be effective, and any premium which has been paid therefore shall be refunded or credited to the account of the debtor not more than 90 days after the increase in indebtedness; any claim which occurs when specific positive written response has not been received, but before the date by which such response must be received, will be paid if the debtor was eligible for the insurance under the terms of the policy; if the premium has been paid but not refunded or credited to the account of the debtor within 90 days after the increase in indebtedness the insurance shall be effective regardless of the eligibility of the debtor; or

(b) the date on which specific positive written response satisfactory to the insurer is received by the insurer.

B. Nothing herein shall preclude a policy provision prohibiting any increases in the amount of insurance while the debtor is disabled.

[13.18.2.28 NMAC - Rp, 13.18.2.28 NMAC, 3/11/2025]

13.18.2.29 DEVIATION PROCEDURES:

A. Notwithstanding the determination of presumptively acceptable maximum rates which are reasonable in relation to the benefits of a policy providing the coverage to which the rates are applicable:

(1) an insurer who has experienced excessive loss ratios for a case consisting of a single account or combination of accounts, as account is defined herein, will be permitted, at its own request, to adjust the premium rate or premium rate schedule for such case in accordance with the deviation procedures set out in the following; and

(2) an insurer who fails, on upward deviated accounts, or downward deviated accounts that modify the age limits downward as allowed in this rule to develop the minimum loss ratios as defined in Subsection B of 13.18.2.17 NMAC, for a case consisting of a single account or combination of accounts, as accounts is defined in this rule, will be required by the superintendent to adjust the premium rate or premium rate schedule for such case in accordance with the deviation procedures in this rule.

B. A request for a deviated rate must be made in writing and shall include all of the information which is required under this rule.

C. It must be accompanied by a list of the creditors whose experience is the basis for such request, and must be attested to by an officer of the insurer. The use of any deviation approved by the superintendent is limited to those creditors whose names appear on such list. No rate deviation may be used unless and until approved by the superintendent in writing. Any request for deviated presumptive rates shall be submitted to the superintendent in the manner prescribed on Form CI-DRF.

[13.18.2.29 NMAC - Rp, 13.18.2.29 NMAC, 3/11/2025]

13.18.2.30 DEVIATION CREDIBILITY TABLE:

AVERAGE NUMBER OF LIFE YEARS

CREDIT LIFE	CREDIT ACCIDENT AND HEALTH PLANS RETROACTIVE AND NON-RETROACTIVE		INCURRED CLAIM COUNT	CREDIBILITY FACTOR
	14 DAY	30 Day		
1	1	1	1	.00
1,800	141	209	9	.25
2,400	188	279	12	.30
3,000	234	349	15	.35
3,600	281	419	18	.40
4,600	359	535	23	.45
5,600	438	651	28	.50
6,600	516	767	33	.55
7,600	394	884	38	.60
9,600	750	1,116	48	.65
11,600	906	1,349	58	.70
14,600	1,141	1,698	73	.75
17,600	1,375	2,047	88	.80
20,600	1,609	2,395	105	.85
25,600	2,000	2,977	123	.90
30,600	2,391	3,558	153	.95
40,000	3,125	4,651	200	1.00

A. For credit life insurance, the currently charged premium rates will be considered the case rates if the single premium (or its equivalent) case rate per $100 of initial amount of insured indebtedness repayable in 12 equal monthly installments as determined by the method described herein is within 5 percent of the corresponding premium under the currently charged premium rates for the case.

B. For credit accident and health insurance, the currently charged premium rates will be considered the case rate if the case rate as determined by the method described herein is within 5 percent of the currently

charged premium rates for the case.

C. The effective date for any rate deviation shall be no earlier than 90 days or later than 180 days after the date of approval in writing by the superintendent.

D. An upward or downward deviated single account case rate remains with the case, regardless of any change of insurers, and shall continue for a period equal to the experience period on which it was based, not to exceed three years.

E. For cases which are not of credible size, or have no experience, no deviation shall be made in the presumptive rates under these deviation procedures; except that nothing herein shall be construed as preventing any insurer from filing its rate schedules as otherwise provided in Article 25 of the New Mexico Insurance Code.

F. For purpose of this rule, if the coverage for a single creditor which qualifies as a case has been in force with the insurer for less than the experience period;

(1) the claim experience of the creditor while covered by any prior insurer shall be included to the extent necessary in determining the appropriate case ratios; and

(2) the experience considered in the determination of multiple state case rates shall be New Mexico experience unless the insurer makes the one-time election to use nationwide experience; the election to use only nationwide experience must be accompanied by a certification that the insurer uses the same nationwide basis in determining the case ratios in each state in which the case has experience; a grouping of states may be used subject to the same requirements of consistency and certification.

G. When submitting form CI-DRF as required herein, the insurer shall also file a schedule of new case rates, as determined by form CI-DRF.

H. Any request for deviated presumptive rates shall be submitted to the superintendent in the manner presented by the forms in 13.18.2.31 NMAC.

[13.18.2.30 NMAC - Rp, 13.18.2.30 NMAC, 3/11/2025]

13.18.2.31 FORM CI-DRF: PART A - GENERAL INFORMATION:

Company Code_____

Company Name_____

Creditor Name_____

This deviation request form must be completed separately for each plan of credit life or credit disability insurance written by the creditor or group of creditors requesting the deviation. Experience of accounts may be combined only within the same plan of benefits and class of business. If experience of accounts is combined, attach a list of those included.

Based on the Experience Period commencing _____ and ending _____.
(month/day/year) (month/day/year)

Class of Business:
(1) ( ) Credit Unions
(2) ( ) Commercial Banks and Savings and Loan Associations
(3) ( ) Finance Companies
(4) ( ) Motor Vehicle Dealers
(5) ( ) Other Sales Finance
(6) ( ) Production Credit Association Bank Agricultural Loans
(7) ( ) All Others

Plan of Benefits: ( ) Credit Life, Death Benefits Only
( ) Credit Disability
_____ days
_____ RETRO _____ NON RETRO

[13.18.2.31 NMAC - Rp, 13.18.2.31 NMAC, 3/11/2025]

13.18.2.32 FORM CI-DRF: PART B - CASE EXPERIENCE:

19___ 19___ 19___ 19___

1. Actual Earned Premiums

a. Net Written Premiums*	_____	_____	_____	_____
b. Premium Reserve Beginning of Period	_____	_____	_____	_____
c. Premium Reserve End of Period	_____	_____	_____	_____
d. Earned Premiums (a+b-c)	_____	_____	_____	_____
2. Earned Premiums at Presumptive Rates	_____	_____	_____	_____
3. Incurred Claims				
a. Claims Paid	_____	_____	_____	_____
b. Unreported Claims, Beginning of Period	_____	_____	_____	_____
c. Unreported Claims, End of Period	_____	_____	_____	_____
d. Claim Reserve, Beginning of Period	_____	_____	_____	_____
e. Claim Reserve, End of Period	_____	_____	_____	_____
f. Incurred Claims, (a+b+c-d-e)	_____	_____	_____	_____
4. Actual Loss Ratio for Case at Presumptive Rates: 3(f) [divided by] 2	_____	_____	_____	_____
5. Average Number of Life Years	_____	_____	_____	_____
6. Incurred Claim Count**	_____	_____	_____	_____

*Net written premiums are to be determined as Gross Premium written (before deductions for dividends and experience rating credits) less refunds on terminations.
**Entries on 5. and 6. should be based on the Credibility Table elected by the insurer.
[13.18.2.32 NMAC - Rp, 13.18.2.32 NMAC, 3/11/2025]

13.18.2.33 FORM CI-DRF: PART C - DETERMINATION OF DEVIATED PRESUMPTIVE CASE RATE:

A. Single account cases: If the account is one-hundred percent credible or if it is within the definition of single account case as filed by the insurer, the deviated presumptive case rate for the account will be determined by the appropriate formula set forth in Subsection C of 13.18.2.33 NMAC below.

B. Multiple account cases: If the account is in a multiple account case, the deviated presumptive case rate for the account will be the case rate for that multiple account case determined by the appropriate formula set forth in Subsection C of 13.18.2.33 NMAC below.

C. Calculation of deviated presumptive case rates.

(1) Symbols and definitions:

(a) NCR = new case rate;

(b) PFR = presumptive rate;

(c) ALR = actual loss ratio for case at presumptive rate basis;

(d) ELR = expected loss ratio at presumptive rate basis;

(e) Z = credibility factor for case;

(f) CLR = credibility adjusted case loss ratio at presumptive basis = Z(ALR) = (1-Z)(ELR).

(2) New case rate: credit life insurance:

(a) if CLR is greater than ELR, NCR = PFR [1 + 1.1. (CLR - ELR)];

(b) if CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)].

(3) New case rate: credit disability insurance:

(a) if CLR is greater than ELR, NCR = PFR [1 + 1.2 (CLR ELR)];

(b) if CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)].

[13.18.2.33 NMAC - Rp, 13.18.2.33 NMAC, 3/11/2025]

13.18.2.34 STATISTICAL DATA: Insurers writing credit life insurance and/or credit accident and health insurance in New Mexico shall keep statistical data in such form and manner as necessary to enable the superintendent to determine if rates are reasonable in relation to the benefits afforded by the various policy contracts. Every company shall file with the superintendent and the national association of insurance commissioner (NAIC) support and service offices, on or before the first of April of each year, statistics on these kinds of insurance for the year ending December 31 immediately preceding. Such statistics shall be filed on forms designated as the credit insurance supplement - annual statement blank approved by the NAIC unless modified by the superintendent.
[13.18.2.34 NMAC - Rp, 13.18.2.34 NMAC, 3/11/2025]

13.18.2.35 PREMIUM REFUNDS:

A. With respect to the policies issued and certificates delivered after the effective date of these rules.

(1) The refund of an unearned amount paid by or charged to a debtor for reducing term credit life insurance, or for credit accident and health insurance, on which charges to the debtor are payable by other than a single sum, and for level term credit life insurance, must be not less than the pro rata gross unearned amount charged.

(2) The refund of an unearned amount paid by or charged to a debtor for uniformly reducing term credit life insurance on which the insurance charges to the debtor are paid in single sum must not be less than the single premium for the scheduled remaining insured amount and the remaining term of coverage using the premium rate schedule applicable at the time the original premium was determined.

(3) The refund of an unearned amount paid by or charged to a debtor for credit life insurance which is neither level nor uniformly reducing, on which the insurance charges to the debtor are paid in a single sum, must be based upon a formula approved by the superintendent of insurance.

(4) The refund of an unearned amount paid by or charged to a debtor for credit accident and health insurance on which the insurance charges to the debtor are paid in a single sum must be not less than the mean of the pro rata gross unearned amount charged and the amount of unearned premium computed by the Rule of 78.

B. Upon termination of insurance prior to maturity, and in accordance with the refund formulas presented in this rule, and in accordance with the insurer's established refund procedures, each insured debtor shall receive from the insurer any refund or unearned identifiable insurance charge either in cash, or by check, electronic funds transfer, or credit to and against the insured debtor's indebtedness (provided that such credit shall be applied only to the indebtedness to which the insurance charges are attributable). Insurers shall be responsible for the establishment of procedures by which refunds or credits are to be made, and shall furnish to the creditors schedules for refunds or credits to be made in the event of termination of insurance. Insurers also shall furnish instructions to creditors with respect to the duties in the making of such refunds or credits.

C. Where insurance charges or premiums were paid by or charged to the debtor and such funds are paid to the insurer, the insurer is responsible for making the refund to the debtor (or to the debtor's estate). Where discharge of the insurer's responsibility for completion of such refunds is delegated by the insurer to the creditor, the actions of such creditor will be deemed by the superintendent of insurance to be acts of the insurer.

D. The requirement for filing refund formulas will be satisfied if the formulas are set forth in the individual policy or group policy filed with the superintendent and not disapproved. If the refund formula, or part of the refund formula is the sum of the digits formula, commonly known as the Rule of 78, it shall be sufficient to so refer to such formula by either description in the policy.

E. A premium refund or credit need not be made if the amount of the refund is three dollars ($3.00) or less.

F. In calculating such refunds, partial months may be treated as though the insurance had terminated on the last day of the premium month in which the insurance is terminated.

G. The insurer shall provide a statement of refund directly to the insured debtor. The statement of refund form shall:

(1) disclose, separately, the amount of credit life premium and the amount of credit disability premium being refunded; and

(2) provide a statement which will inform the insured debtor as to how the refund of premiums was disposed or applied.

[13.18.2.35 NMAC - Rp, 13.18.2.35 NMAC, 3/11/2025]

13.18.2.36 RESPONSIBILITIES AND OBLIGATIONS OF INSURANCE COMPANIES: Each insurer transacting credit insurance business in this state shall in compliance with the laws of this state and this rule promulgated thereunder, be responsible for:

A. the approval, production, reproduction, amendment, and modification of its policies, certificates of insurance, and other insurance forms, including rate schedules, and for the issuance, cancellation, or termination of such policies, certificates, or forms;

B. the election and appointment of its agents and representatives;

C. the proper charge, collection, remittance, and refund of credit insurance premiums;

D. the receipt of copies of all certificates of insurance and other insurance forms issued in its name by its agents and representatives or the receipt of electronic or other data therefore which can be substantiated by certificates of insurance or other insurance forms;

E. the computation and maintenance of policy and claim liabilities in accordance with 13.18.2.42 NMAC; and

F. the investigation of claims or written complaints filed against the insurer and the payment, adjustment, settlement, or denial of such claims;

G. none of the foregoing responsibilities of the insurer may be delegated, nor may the performance of such responsibilities be assigned to any creditor or to any agent or representative selected and appointed by the insurer, except as provided in these rules.

[13.18.2.36 NMAC - Rp, 13.18.2.36 NMAC, 3/11/2025]

13.18.2.37 RESPONSIBILITIES AND OBLIGATIONS THAT MAY BE DELEGATED TO THE GROUP POLICY CREDITOR OR AGENT: The insurer, by its group policy, may authorize the group policy creditor to issue certificates of group insurance or may authorize a legally appointed insurance agent of the insurer to issue certificates of insurance or policies of insurance, and respectively, to collect the insurance charge under the group policy, or premium therefore under an individual policy, provided that the master group insurance policy with the creditor or agent's agreement with the agent under which such authority is granted shall require that:

A. the creditor issue such group certificate, or the agent issue such certificate of insurance or insurance policy in the name of the insurer, and payment of the respective policy premium shall be by a check payable to the insurer or by a deposit to an account of the insurer under the sole control of the insurer;

B. a copy of each certificate or policy so issued, or electronic or other data therefore which can be substantiated by such certificate or policy, together with the premium therefore, shall be delivered to the insurer within 30 days after the close of the calendar month in which the certificate or policy is issued;

C. refunds of unearned premiums shall be made in accordance with 13.18.2.35 NMAC of this rule;

D. no insurer may authorize, and no insurance agent or group policyholder, within their respective capacities, may issue any policy or certificate of insurance or collect any premium or insurance charge therefore or make any refund of premium except only pursuant to and in accordance with either a master group insurance policy or an agents' agreement in compliance with this rule;

E. any changes in the amount of coverage, premium or term of coverage after issuance of the original group certificate, a certificate of insurance or the insurance policy issued on a single premium basis shall cause the insurer to issue a new certificate or individual policy, a copy of which must be provided to the insured(s), along with a statement of additional charges or any credits or refunds in premiums; this includes any coverage changes in 13.18.2.12 NMAC;

F. copies of all records pertaining to each risk shall be provided to the insurer or be maintained for examination by the superintendent though the next examination period.

[13.18.2.37 NMAC - Rp, 13.18.2.37 NMAC, 3/11/2025]

13.18.2.38 CREDITOR MUST BE FIRST BENEFICIARY: No group policy may be issued to other than a creditor. No first beneficiary may be designated except a creditor. No creditor may be designated as owner of the individual policy nor have any rights thereunder other than that of first beneficiary as specifically authorized by law.

[13.18.2.38 NMAC - Rp, 13.18.2.38 NMAC, 3/11/2025]

13.18.2.39 AUTHORIZED REPRESENTATIVES OF THE INSURER: The insurer may designate or engage one or more representatives for the purpose of investigating or settling claims and complaints, processing production reports, calculating reserves, printing of approved forms, and providing other administrative services authorized by law, provided:

A. such services are performed under the supervision and direction of the insurer, and the insurer shall remain responsible for their proper performance;

B. the work product of representatives of the insurer are the property of the insurer and shall be available for examination by the superintendent, together with the supporting data used in their preparation;

C. all claims shall be promptly reported to the insurance company, or its designated claim representative, and all claims shall be settled as soon as reasonably possible and in accordance with the terms of the insurance contract.

[13.18.2.39 NMAC - Rp, 13.18.2.39 NMAC, 3/11/2025]

13.18.2.40 REQUIREMENTS FOR HANDLING CLAIMS:

A. The insurance company shall establish an adequate claims register and claim files, which may be reviewed and examined by the superintendent of insurance.

B. Adequate proofs of loss must be in the possession of the insurance company at the time its funds are disbursed in payment of claims, except as provided in Subsection D of 13.18.2.40 NMAC below. Such proofs of loss shall include data sufficient for the insurer to determine proper amounts of any excess benefits payable to a beneficiary other than the creditor.

C. All claims shall be paid either by draft drawn on the insurer, electronic funds transfer, or check of the insurer to the specific beneficiary to whom payment of the claim is due.

D. No plan or arrangement shall be used whereby any person, firm, or corporation other than the insurer or its designated claim representatives shall be authorized to settle or adjust claims. The creditor shall not be designated as a claim representative for the insurer in settling or adjusting claims; however, a group policyholder may, by arrangement with the group insurer, draw drafts or checks or use electronic funds transfer for payment of claims due only to the group policyholder or other beneficiary, subject to audit and review by the insurer. Nothing in this section may be construed to relieve the insurance company of the responsibility for the proper settlement, adjustment and payment of all claims to proper beneficiaries in accordance with the terms of the insurance contract.
[13.18.2.40 NMAC - Rp, 13.18.2.40 NMAC, 3/11/2025]

13.18.2.41 CLAIM RESERVES:

A. The insurer shall set up adequate liabilities for claims for credit life and credit accident and health insurance, in addition to the policy reserves already described. Such liabilities shall be based upon appropriate consideration for each of the following categories:

(1) the liability for claims which are known to be due and payable, but which have not yet been paid;

(2) the reserve for continuing disability benefits which have been reported and on which future payments will be due during the continuance of this disability;

(3) the liability for claims which have been insured but not yet reported, with benefits now due;

(4) the reserve for disability benefits which are incurred but not yet reported, and on which future payments will be due during the continuance of this disability.

B. The company may rely upon credible experience developed by its own claim experience, industry wide experience, or any other available source which produces an adequate liability for claims.
[13.18.2.41 NMAC – Rp, 13.18.2.41 NMAC, 3/11/2025]

13.18.2.42 APPROVAL AND RE-FILING OF FORMS: Pursuant to Section 59A-25-8 NMSA 1978, all forms to be used in connection with credit life and/or credit accident and health insurance shall be filed by the insurer with the superintendent of insurance. Any such forms which were approved by the superintendent prior to the effective date of this rule shall be made to conform with the requirements of this rule and re-filed with the superintendent for approval within 180 days after the effective date of this rule. If an insurer fails to re-file within the prescribed period of time, the superintendent shall initiate actions to propose a withdrawal of that insurer's forms under Subsection D of Section 59A-25-8 NMSA 1978 and may take any other appropriate actions under the penalty provisions of the New Mexico Insurance Code to respond to the insurer's failure to comply with the lawful rule of the superintendent.
[13.18.2.42 NMAC - Rp, 13.18.2.42 NMAC, 3/11/2025]

13.18.2.43 PREEXISTING CONDITIONS ON CREDIT LIFE INSURANCE ON OPEN-ENDED CREDIT: There shall be no provisions excluding or denying a claim for death from pre-existing conditions, except that on insurance written in connection with open-end outstanding balance accounts, a provision will be permitted that excludes or denies a claim resulting from a medical condition for which the debtor received medical diagnosis or treatment within six months immediately preceding the effective date of coverage and which caused or substantially contributed to the death of the insured debtor within six months following the effective date of coverage. The effective date of coverage for each part of the insurance attributable to a different advance or charge to the account is the date on which the advance or charge is posted to the account.
[13.18.2.43 NMAC - Rp, 13.18.2.43 NMAC, 3/11/2025]

13.18.2.44 ADJUSTMENT OF PRESUMPTIVELY ACCEPTABLE CREDIT LIFE INSURANCE PREMIUMS: If for the calendar year 2000 as filed in the statistical statement, or following any even calendar year thereafter, the combined loss ratios of all insurers writing credit life insurance, individual or group, does not equal or exceed ninety percent of the loss ratio stated in Paragraph (1) of Subsection B of 13.18.2.17 NMAC then the credit

life insurance premiums referenced in Subsections A through D of 13.18.2.18 NMAC and Subsection A of 13.18.2.20 NMAC shall be reduced by ten percent with the results rounded to the higher whole cent and shall be effective at the beginning of the next calendar year as the prima facie rate.
[13.18.2.44 NMAC - Rp, 13.18.2.44 NMAC, 3/11/2025]

13.18.2.45 ADJUSTMENT OF PRESUMPTIVELY ACCEPTABLE CREDIT ACCIDENT AND HEALTH INSURANCE PREMIUMS: If for the calendar year 2000 as filed in the statistical statement, or following any even calendar year thereafter, the combined loss ratios of all insurers writing credit accident and health insurance, individual or group, does not equal or exceed ninety percent of the loss ratio stated in Paragraph (2) of Subsection B of 13.18.2.17 NMAC then the credit accident and health insurance premiums as referenced in Subsections A and B of 13.18.2.26 NMAC, Subparagraphs (a) and (b) of Paragraph (1) Subsection D of 13.18.2.26 NMAC and Subparagraphs (a) and (b) of Paragraph (2) of Subsection D of 13.18.2.26 NMAC shall be reduced by ten percent with the results rounded to the higher whole cent and shall be effective at the beginning of the next calendar year as the prima facie rate.
[13.18.2.45 NMAC - Rp, 13.18.2.45 NMAC, 3/11/2025]

HISTORY OF 13.18.2 NMAC:
Pre-NMAC History: The material in this rule was previously filed with the commission of public records, state records center as:
ID 67-1, Sections 26-1-1 through 26-1-15, New Mexico Official Administrative Rules and Regulations Code filed 12/1/1967.
SCC-85-12, Insurance Department Regulation 25, Credit Life and Credit Health Insurance filed 11/4/1985.
Rule No. SCC-87-1, Insurance Department Regulation 25, Credit Life and Credit Health Insurance filed 2/4/1987.

History of Repealed Material: [**RESERVED**]

Other History:
Rule No. SCC-87-1, Insurance Department Regulation 25, Credit Life and Credit Health Insurance (filed 2/4/1987) was renumbered, reformatted and replaced by 13 NMAC 18.2, Credit Life and Credit Health Insurance, effective 7/1/1997.
13 NMAC 18.2, Credit Life and Credit Health Insurance (filed 5/27/1997) was renumbered, reformatted, amended and replaced by 13.18.2 NMAC, Credit Life and Credit Health Insurance, effective 12/31/2007.
13.18.2 NMAC, Credit Life and Credit Health Insurance, filed 12/31/2007 was repealed and replaced by 13.18.2 NMAC, Credit Life and Credit Health Insurance, effective 03/11/2025.