DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

PRE-LICENSURE EDUCATION REQUIREMENTS

R 500.1
Source: 2019 AACS.

R 500.2
Source: 2019 AACS.

R 500.3
Source: 2019 AACS.

R 500.4
Source: 2019 AACS.

R 500.5
Source: 2019 AACS.

R 500.6
Source: 2019 AACS.

DISCLOSURE OF MATERIAL TRANSACTIONS

R 500.51
Source: 1996 AACS.

R 500.52
Source: 1996 AACS.

R 500.53
Source: 1996 AACS.

R 500.54
Source: 1996 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

UTILIZATION REVIEW

PART 1. GENERAL

R 500.61
Source: 2020 AACS.

R 500.62
Source: 2020 AACS.

PART 2. REQUESTS FOR EXPLANATION AND RECORD RETENTION

R 500.63
Source: 2020 AACS.

PART 3. INSURER AND ASSOCIATION DETERMINATIONS AND PROVIDER APPEALS

R 500.64
Source: 2020 AACS.

R 500.65
Source: 2020 AACS.

PART 4. INSURER UTILIZATION REVIEW PROGRAM

R 500.66
Source: 2020 AACS.

R 500.67
Source: 2020 AACS.

PART 5. ANNUAL REPORT AND RECORD RETENTION

R 500.68
Source: 2020 AACS.

R 500.69
Source: 2020 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

CAPTIVE INSURANCE COMPANY RULES

R 500.101
Source: 2015 AACS.

R 500.102
Source: 2015 AACS.

R 500.103
Source: 2015 AACS.

R 500.104
Source: 2015 AACS.

R 500.105
Source: 2015 AACS.

R 500.106
Source: 2015 AACS.

R 500.107
Source: 2015 AACS.

R 500.108
Source: 2015 AACS.

R 500.109
Source: 2015 AACS.

R 500.110
Source: 2015 AACS.

R 500.111
Source: 2015 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

NO-FAULT FEE SCHEDULE

R 500.201 Definitions.
Rule 1. As used in these rules:
(a) "Act" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.
(b) "Charge description master" means that term as defined in section 3157(15)(a) of the act, MCL 500.3157.
(c) "Department" means the department of insurance and financial services.
(d) "Director" means the director of the department.
(e) "Medicare" means that term as defined in section 3157(15)(f) of the act, MCL 500.3157.
(f) "Neurological rehabilitation clinic" means that term as defined in section 3157(15)(g) of the act, MCL 500.3157.
(g) "Provider" means a physician, hospital, clinic, or other person lawfully rendering a service to an injured person.
(h) "Fee schedule" means, as applicable, the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered. The applicable fee schedule applies to services rendered during that service year, notwithstanding any subsequent change made to the fee schedule.
(i) "Service" means "treatment," as that term is defined in section 3157(15)(k) of the act, MCL 500.3157, and also includes training and rehabilitative occupational training, as described in section 3157 of the act, MCL 500.3157.
(j) "Service year" means the period from July 2 through July 1 of the following year.
History: 2021 MR 18, Eff. Oct. 1, 2021.

R 500.202 Scope and applicability.
Rule 2. These rules do the following:
(a) Define the applicable Medicare fee schedule.
(b) Establish procedures for determining which providers are eligible for enhanced reimbursement.
(c) Establish procedures for the department to collect information related to amounts charged by providers as of January 1, 2019, for the purposes of resolving provider appeals under R 500.65.
(d) Establish a date and methodology for determining the adjustment of payment or reimbursement under section 3157(9) of the act, MCL 500.3157.
(e) Establish procedures for the department to administer the accreditation requirements under section 3157(12) of the act, MCL 500.3157.
History: 2021 MR 18, Eff. Oct. 1, 2021.

R 500.203 Medicare calculation.
Rule 3. When calculating the amount payable to a provider for a service under Medicare part A or part B, as referenced in section 3157 of the act, MCL 500.3157, the amounts payable to participating providers under the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for the service on January 1, 2019.
History: 2021 MR 18, Eff. Oct. 1, 2021.

R 500.204 Eligibility for enhanced reimbursement.
Rule 4. (1) No less frequently than annually, the department shall issue a bulletin designating not more than 2 freestanding rehabilitation facilities pursuant to section 3157(4)(b) of the act, MCL 500.3157. A freestanding rehabilitation clinic that seeks to be recognized by the department shall submit an application for recognition on a form prescribed by the department. The department's designation remains in effect until revoked by the department. (2) No less frequently than annually, the department shall issue a bulletin that lists which providers are entitled to enhanced reimbursement under section 3157(4)(a) or section 3157(5) of the act, MCL 500.3157. To determine whether a provider qualifies for enhanced reimbursement under section 3157(4)(a) or section 3157(5) of the act, MCL 500.3157, the department shall rely on data provided by the department of health and human services related to the provider's indigent volume factor as of July 1 of the immediately preceding year.

(3) No less frequently than annually, the department shall issue a bulletin that lists which hospitals are Level I or Level II trauma centers for purposes of enhanced reimbursement under section 3157(6) of the act, MCL 500.3157. This list must be based on the hospital's designation on January 1 of that year.
History: 2021 MR 18, Eff. Oct. 1, 2021.

R 500.205 Charge description master; average amount charged; average charge; submissions to department in connection with an appeal under R 500.65.
Rule 5. (1) Upon the department's request, a provider that appeals a determination to the department under R 500.65, shall make the following submissions to the department, in a form and manner prescribed by the department, as applicable:
(a) If a provider has a charge description master that was in effect on January 1, 2019, the provider shall submit to the department the provider's charge description master that was in effect on January 1, 2019.
(b) If a provider offered or rendered services on January 1, 2019, and does not have a charge description master that was in effect on January 1, 2019, or has a charge description master that was in effect on January 1, 2019 that does not list all of the provider's services offered or rendered on January 1, 2019, the provider shall submit to the department the provider's average amount charged for any service offered or rendered on January 1, 2019, that is not included in a charge description master submitted to the department under subdivision (a) of this subrule.
(c) If a provider does not meet the criteria under subdivision (a) or (b) of this subrule, the department shall consult the FAIR Health benchmarking database to determine the average amount charged in the applicable geozip for the service or services at issue based on FAIR Health's most recently published data that includes dates of service on January 1, 2019, as adjusted in accordance with subrule (6) of this rule.
(2) A provider that submits information under subrules (1)(a) or (b) must also submit an attestation that the information provided is accurate.
(3) A provider must retain its charge description master in effect on January 1, 2019 and documentation containing the average amount charged for services on January 1, 2019, as applicable, until the provider permanently ceases to render services to injured persons for accidental bodily injuries covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179.
(4) Upon request by the department, a provider submitting its charge description master in effect on January 1, 2019 or average amount charged for services on January 1, 2019 shall also submit to the department any documents, materials, and information the department considers necessary to assess the submission's accuracy and to resolve the provider's appeal under R 500.65.
(5) Any proprietary information or sensitive personally identifiable information regarding a patient that is submitted to the department under this rule must be afforded the same level of protection by the department as the information described under section 3157b of the act, MCL 500.3157b.
(6) An average amount charged for each service on January 1, 2019, or amount listed on a charge description master in effect on January 1, 2019, must be adjusted annually by the percentage change in the medical care component of the consumer price index for the year preceding the adjustment. Beginning in 2021, and annually thereafter, the department shall issue a bulletin no later than March 1 of each year setting forth the applicable percentage change in the medical care component of the consumer price index for the year preceding the adjustment. This percentage change applies to services rendered between July 2 of that year and July 1 of the following year.
History: 2021 MR 18, Eff. Oct. 1, 2021.

R 500.206 Neurological rehabilitation clinic accreditation; information submission.
Rule 6. (1) The department shall issue a bulletin recognizing the organizations it deems similar to the Commission on Accreditation of Rehabilitation Facilities (CARF) for the accreditation of neurological rehabilitation clinics pursuant to section 3157(12) of the act, MCL 500.3157. The department's recognition remains in effect until revoked.
(2) A neurological rehabilitation clinic that seeks payment or reimbursement for services rendered to an injured person for an accidental bodily injury covered by personal protection insurance under chapter 31 of the act, MCL 500.3101 to 500.3179, shall, upon the department's request, submit on a form prescribed by the department the following information, as applicable:
(a) Proof of accreditation by CARF or a similar organization recognized by the director as referenced in subrule (1) of this rule.
(b) If a neurological rehabilitation clinic is in the process of becoming accredited on July 1, 2021, information concerning its status in the accreditation process with updates provided to the department every 6 months thereafter until the neurological rehabilitation clinic is accredited.
(3) A neurological rehabilitation clinic that is in the process of becoming accredited on July 1, 2021, is entitled to payment or reimbursement for services for 3 years after the date on which the neurological rehabilitation clinic submitted its application for accreditation. A neurological rehabilitation clinic is not entitled to payment or reimbursement after three years have

elapsed since the date its application for accreditation was submitted and is not entitled to payment or reimbursement unless and until it becomes accredited.
History: 2021 MR 18, Eff. Oct. 1, 2021.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

SURPRISE MEDICAL BILLING

R 500.241 Definitions.
Rule 1. (1) As used in these rules:
(a) "Act" means the public health code, 1978 PA 368, MCL 333.1101 to 333.25211.
(b) "Median amount" means the median amount negotiated by the carrier for the region and provider specialty, excluding any in-network coinsurance, copayments, or deductibles. The carrier shall determine the region and provider specialty.
(2) A term defined in the act for the purposes of article 18 of the act, MCL 333.24501 to 333.24517, has the same meaning when used in these rules.
History: 2021 MR 12, Eff. June 24, 2021.

R 500.242 Scope and applicability.
Rule 2. These rules do the following:
(a) Establish procedures for the department to review and resolve requests for calculation review submitted pursuant to section 24510 of the act, MCL 333.24510.
(b) Establish procedures for approving arbitrators to provide binding arbitration pursuant to section 24511 of the act, MCL 333.24511.
History: 2021 MR 12, Eff. June 24, 2021.

R 500.243 Requests for calculation review.
Rule 3. (1) A nonparticipating provider must make a request for a review of the calculation described in section 24510(1) of the act, MCL 333.24510, on a form provided by the department.
(2) In response to a request from a nonparticipating provider for a calculation review under section 24510 of the act, MCL 333.24510, the department shall do the following within 14 days of the date of the request:
(a) Notify the carrier of the request for a calculation review.
(b) Request data on the carrier's median amount or any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510.
(3) A carrier must respond within 14 days of the date of the department's request under subrule (2)(b) of this rule. If the information provided is incomplete, the department may, at its discretion, request additional information, or issue a determination based solely on the information provided as of the date on which the carrier's response was due. If the department makes 1 or more requests for additional information, the carrier must respond within 14 days of the date of the department's request.
(4) The department shall issue a determination resolving the request for a calculation review no later than 14 days after the carrier submits a timely and complete response under subrule (3) of this rule or after the expiration of the time period within which the carrier was required to respond, including any extensions provided following the department's request for additional information under subrule (3) of this rule.
History: 2021 MR 12, Eff. June 24, 2021.

R 500.244 Median amount; access to database.
Rule 4. (1) Subject to subrule (3) of this rule, a carrier may satisfy the requirement under R 500.243 by providing the department with access to a database that contains all of the carrier's median amounts. The database must meet all of the following requirements:
(a) Be updated no less frequently than quarterly.
(b) Be searchable by region, provider specialty, and health care service.
(c) Include negotiated rates for all health care services covered by the carrier.
(d) Be continuously accessible to the department.
(2) For the purposes of conducting a calculation review under section 24510 of the act, MCL 333.24510, the department may,

at its discretion, consult any external database described under section 24510(2) of the act, MCL 333.24510, without regard to whether a carrier made the database accessible to the department or whether the database otherwise meets the requirements under subrule (1) of this rule.
(3) A carrier's provision of access to a database under this rule does not preclude the department from requesting any documents, materials, or other information the department believes is necessary to assist in reviewing the calculation described in section 24510(1) of the act, MCL 333.24510.
History: 2021 MR 12, Eff. June 24, 2021.

R 500.245 Approval of arbitrators.
Rule 5. (1) The department shall create and maintain a list of arbitrators trained by the American Arbitration Association or American Health Lawyers Association and approved by the director. This list must be updated no less frequently than annually and must be posted on the department's website.
(2) Arbitrators seeking to be included in the list under subrule (1) of this rule must apply on a form prescribed by the department.
(3) The department shall approve or disapprove an application no later than 60 days after the date of receipt of the application. Applicants whose application has been disapproved may reapply at any time.
(4) If approved for inclusion in the list under subrule (1) of this rule, arbitrators must annually provide to the department, on a form prescribed by the department, an attestation acknowledging that the information provided to the department in the arbitrator's application under subrule (2) of this rule remains complete and accurate.
(5) Arbitrators included on the department's list under subrule (1) of this rule must notify the department of any changes to the information contained in the arbitrator's application under subrule (2) of this rule within 30 days of the change. An arbitrator's failure to inform the department of these changes may result in revocation of the arbitrator's approval and removal from the list under subrule (1) of this rule.
History: 2021 MR 12, Eff. June 24, 2021.

UNEARNED PREMIUM ADJUSTMENT

R 500.351
Source: 1982 AACS.

ELECTRONIC DATA PROCESSING EQUIPMENT DEFINITION

R 500.401
Source: 1997 AACS.

GENERAL RULES

R 500.402
Source: 1997 AACS.

PROXIES, CONSENTS, AND AUTHORIZATIONS OF DOMESTIC STOCK COMPANIES

R 500.451
Source: 1997 AACS.

R 500.452
Source: 1997 AACS.

R 500.453
Source: 1997 AACS.

R 500.454
Source: 1997 AACS.

R 500.455

Source: 1997 AACS.

R 500.456
Source: 1997 AACS.

R 500.457
Source: 1997 AACS.

R 500.458
Source: 1997 AACS.

R 500.459
Source: 1997 AACS.

R 500.460
Source: 1997 AACS.

R 500.461
Source: 1997 AACS.

R 500.462
Source: 1997 AACS.

R 500.463
Source: 1997 AACS.

R 500.464
Source: 1997 AACS.

R 500.465
Source: 1997 AACS.

R 500.466
Source: 1997 AACS.

INSIDER TRADING OF EQUITY SECURITIES OF DOMESTIC STOCK INSURANCE COMPANIES

GENERAL PROVISIONS

R 500.501
Source: 1997 AACS.

R 500.502
Source: 1997 AACS.

R 500.503
Source: 1997 AACS.

R 500.504
Source: 1997 AACS.

R 500.505
Source: 1997 AACS.

R 500.506
Source: 1997 AACS.

R 500.507

Source: 1997 AACS.

R 500.508
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R 500.516
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R 500.517
Source: 1997 AACS.

R 500.518
Source: 1997 AACS.

R 500.519
Source: 1997 AACS.

REGULATIONS UNDER SECTION 5283 OF THE ACT

R 500.521
Source: 1979 AC.

R 500.522
Source: 1979 AC.

R 500.523
Source: 1979 AC.

R 500.524
Source: 1979 AC.

R 500.525
Source: 1979 AC.

R 500.526
Source: 1979 AC.

R 500.527
Source: 1979 AC.

R 500.528
Source: 1979 AC.

R 500.529
Source: 1979 AC.

R 500.530
Source: 1979 AC.

R 500.531
Source: 1979 AC.

R 500.532
Source: 1979 AC.

R 500.541
Source: 1979 AC.

R 500.542
Source: 1979 AC.

R 500.543
Source: 1979 AC.

R 500.544
Source: 1979 AC.

R 500.545
Source: 1979 AC.

STANDARDS FOR SAFEGUARDING CUSTOMER INFORMATION

R 500.551
Source: 2004 AACS.

R 500.552
Source: 2004 AACS.

R 500.553
Source: 2004 AACS.

R 500.554
Source: 2004 AACS.

R 500.555
Source: 2004 AACS.

R 500.556
Source: 2004 AACS.

R 500.557
Source: 2004 AACS.

R 500.558
Source: 2004 AACS.

R 500.559
Source: 2004 AACS.

R 500.560
Source: 2004 AACS.

REPLACEMENT OF LIFE INSURANCE POLICIES

R 500.601
Source: 1984 AACS.

R 500.602
Source: 1984 AACS.

R 500.603
Source: 1984 AACS.

R 500.604
Source: 1984 AACS.

R 500.605
Source: 1984 AACS.

R 500.606
Source: 1984 AACS.

DISCRETIONARY GROUP LIFE INSURANCE AND GROUP LIFE INSURANCE

R 500.611
Source: 1981 AACS.

R 500.612
Source: 1997 AACS.

R 500.615
Source: 1979 AC.

R 500.616
Source: 2017 AACS.

VARIABLE CONTRACTS

R 500.621
Source: 1979 AC.

R 500.622
Source: 1979 AC.

R 500.623
Source: 1979 AC.

R 500.624
Source: 1979 AC.

R 500.625
Source: 1979 AC.

R 500.626
Source: 1979 AC.

R 500.627
Source: 1979 AC.

R 500.628
Source: 1979 AC.

R 500.629
Source: 1988 AACS.

R 500.632
Source: 1979 AC.

R 500.633
Source: 1979 AC.

R 500.634
Source: 1979 AC.

R 500.635
Source: 1979 AC.

R 500.636
Source: 1979 AC.

R 500.637
Source: 1979 AC.

SUSPENSION OR MODIFICATION OF FILING REQUIREMENTS BY THE COMMISSIONER OF INSURANCE

R 500.641
Source: 1981 AACS.

ACCIDENT AND SICKNESS INSURANCE ADVERTISING

R 500.651
Source: 1991 AACS.

R 500.652
Source: 1991 AACS.

R 500.653
Source: 1979 AC.

R 500.654
Source: 1991 AACS.

R 500.655
Source: 1991 AACS.

R 500.655a
Source: 1991 AACS.

R 500.656
Source: 1991 AACS.

R 500.657
Source: 1991 AACS.

R 500.658
Source: 1991 AACS.

R 500.659
Source: 1997 AACS.

R 500.660
Source: 1991 AACS.

R 500.661
Source: 1979 AC.

R 500.662
Source: 1979 AC.

R 500.663
Source: 1991 AACS.

R 500.664
Source: 1991 AACS.

R 500.665
Source: 1991 AACS.

R 500.666
Source: 1991 AACS.

R 500.667
Source: 1979 AC.

R 500.668
Source: 1997 AACS.

R 500.669
Source: 1997 AACS.

LOSS RATIOS APPLICABLE TO INDIVIDUAL OR FAMILY EXPENSE COVERAGE

R 500.801
Source: 1979 AC.

R 500.802
Source: 1979 AC.

R 500.803
Source: 1979 AC.

R 500.804
Source: 1979 AC.

R 500.805
Source: 1979 AC.

R 500.806
Source: 1979 AC.

PERSONAL PROTECTION INSURANCE

R 500.811
Source: 1979 AC.

EXCESS LOSS INSURANCE FOR MULTIPLE EMPLOYER WELFARE ARRANGEMENTS (MEWAS)

R 500.821
Source: 1990 AACS.

R 500.822
Source: 1990 AACS.

R 500.823
Source: 1990 AACS.

R 500.824
Source: 1990 AACS.

SALVAGE AND SUBROGATION RECOVERIES

R 500.831
Source: 1998-2000 AACS.

LIFE INSURANCE CONTRACTS ON VARIABLE BASIS

R 500.841
Source: 1988 AACS.

R 500.843
Source: 1988 AACS.

R 500.844
Source: 1988 AACS.

R 500.845
Source: 1997 AACS.

R 500.845a
Source: 1988 AACS.

R 500.846
Source: 1979 AC.

R 500.847
Source: 1979 AC.

R 500.848
Source: 1988 AACS.

R 500.849
Source: 1988 AACS.

R 500.849a
Source: 1988 AACS.

R 500.850
Source: 1988 AACS.

R 500.851
Source: 1988 AACS.

R 500.852
Source: 1988 AACS.

R 500.853
Source: 1988 AACS.

R 500.854
Source: 1979 AC.

R 500.855
Source: 1988 AACS.

R 500.856
Source: 1988 AACS.

R 500.857
Source: 1979 AC.

R 500.858
Source: 1979 AC.

R 500.859
Source: 1988 AACS.

R 500.860
Source: 1988 AACS.

R 500.861
Source: 1979 AC.

R 500.863
Source: 1988 AACS.

R 500.864
Source: 1988 AACS.

R 500.865
Source: 1988 AACS.

R 500.866
Source: 1979 AC.

ACTUARIAL OPINION AND MEMORANDUM UNDER STANDARD VALUATION LAW

R 500.881
Source: 2006 AACS.

R 500.882
Source: 2006 AACS.

R 500.883
Source: 2006 AACS.

R 500.884
Source: 2006 AACS.

R 500.885
Source: 2006 AACS.

R 500.886
Source: 2006 AACS.

R 500.887
Source: 2006 AACS.

R 500.888
Source: 2006 AACS.

R 500.889
Source: 2006 AACS.

R 500.991
Source: 2006 AACS.

R 500.992
Source: 2006 AACS.

R 500.993
Source: 2006 AACS.

R 500.994
Source: 2006 AACS.

R 500.995
Source: 2006 AACS.

R 500.996
Source: 2006 AACS.

R 500.997
Source: 2006 AACS.

STANDARDS FOR RATE FILINGS FOR PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

R 500.901
Source: 2015 AACS.

R 500.902
Source: 2015 AACS.

R 500.903
Source: 2015 AACS.

R 500.904
Source: 2015 AACS.

R 500.905
Source: 2015 AACS.

R 500.906
Source: 2015 AACS.

R 500.907
Source: 2015 AACS.

R 500.908
Source: 2015 AACS.
R 500.909
Source: 2015 AACS.

DECLARATORY RULINGS

R 500.1041
Source: 1985 AACS.

R 500.1042
Source: 1985 AACS.

R 500.1043
Source: 1985 AACS.

UNIFORM TRADE PRACTICES - INDEPENDENT HEARING OFFICER

R 500.1051
Source: 1983 AACS.

R 500.1053
Source: 1983 AACS.

R 500.1055
Source: 1983 AACS.

R 500.1057
Source: 1983 AACS.

R 500.1059
Source: 1983 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

CREDIT FOR REINSURANCE

R 500.1121
Source: 2019 AACS.

R 500.1122 Definitions.
Rule 2. (1) As used in these rules:
(a) "Beneficiary" means the entity for whose sole benefit a trust or letter of credit has been established and any successor of the beneficiary by operation of law. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver (including conservator, rehabilitator, or liquidator).
(b) "Code" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.

(c) "Department" means the Michigan department of insurance and financial services.
(d) "Director" means the director of the department.
(e) "Grantor" means the entity that has established a trust for the sole benefit of the beneficiary. When a trust is established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.
(f) "Liabilities" means the assuming insurer's gross liabilities attributable to reinsurance ceded by United States domiciled insurers**,** excluding liabilities that are otherwise secured by acceptable means, and includes all of the following:
(i) For business ceded by domestic insurers authorized to write accident and health, and property and casualty insurance all of the following:
(A) Losses and allocated loss expenses paid by the ceding insurer, recoverable from the assuming insurer.
(B) Reserves for losses reported and outstanding.
(C) Reserves for losses incurred but not reported.
(D) Reserves for allocated loss expenses.
(E) Unearned premiums.
(ii) For business ceded by domestic insurers authorized to write life, health, and annuity insurance all of the following:
(A) Aggregate reserves for life policies and contracts net of policy loans and net due and deferred premiums.
(B) Aggregate reserves for accident and health policies.
(C) Deposit funds and other liabilities without life or disability contingencies.
(D) Liabilities for policy and contract claims.
(g) "NAIC" means the National Association of Insurance Commissioners.
(h) "Obligations" means any of the following:
(i) Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer.
(ii) Reserves for reinsured losses reported and outstanding.
(iii) Reserves for reinsured losses incurred but not reported.
(iv) Reserves for allocated reinsured loss expenses and unearned premiums.
(i) "Solvent scheme of arrangement" means a foreign or alien statutory or regulatory compromise procedure that is subject to requisite majority creditor approval and judicial sanction in the assuming insurer's home jurisdiction either to finally commute liabilities of duly noticed classed members or creditors of a solvent debtor or to reorganize or restructure the debts and obligations of a solvent debtor on a final basis and that may be subject to judicial recognition and enforcement of the arrangement by a governing authority outside the ceding insurer's home jurisdiction.
(2) A term defined in the code has the same meaning when used in these rules.
History: 1996 AC; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1123 Conditions applicable to a reinsurance agreement in conjunction with a trust agreement under section 1105 of the code, MCL 500.1105.
Rule 3. (1) A reinsurance agreement that is entered into in conjunction with a trust agreement under section 1105 of the code, MCL 500.1105, may contain any of the following provisions:
(a) A requirement that the assuming insurer enter into a trust agreement, establish a trust account for the benefit of the ceding insurer, and specify what the agreement is to cover.
(b) A stipulation that assets deposited in the trust account must be valued according to their current fair market value and consist only of cash (United States legal tender), certificates of deposit issued by a United States bank and payable in United States legal tender, and investments of the types permitted by chapter 9 of the code, MCL 500.901 to 500.947, or any combination of cash, certificates of deposit, or investments specified in this subrule, if the investments are issued by an entity that is not the parent, subsidiary, or affiliate of either the grantor or the beneficiary. The reinsurance agreement may further specify the types of investments to be deposited. If a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, then the trust agreement may contain the provisions required by this subdivision instead of including the provisions in the reinsurance agreement.
(c) A requirement that the assuming insurer, before depositing assets with the trustee, execute assignments or endorsements in blank or transfer legal title to the trustee of all shares, obligations, or any other assets requiring assignments, so that the ceding insurer, or the trustee upon the direction of the ceding insurer, may, if necessary, negotiate the assets without the consent or signature from the assuming insurer or any other entity.
(d) A requirement that all settlements of account between the ceding insurer and the assuming insurer be made in cash or its equivalent.
(e) A stipulation that the assuming insurer and the ceding insurer agree that the assets in the trust account established pursuant to the provisions of the reinsurance agreement may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and must be used and applied by the ceding insurer or its successors in interest by operation of law, including, without limitation, any liquidator, rehabilitator, receiver, or conservator of the company,

without diminution because of insolvency on the part of the ceding insurer or the assuming insurer, only for 1 or more of the following purposes:

(i) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement because of cancellation of the policies.

(ii) To pay or reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement.

(iii) To pay or reimburse the ceding insurer for any other amounts necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(iv) To make payment to the assuming insurer of amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(2) The reinsurance agreement may also do any of the following:

(a) Give the assuming insurer the right to seek approval from the ceding insurer, which must not be unreasonably or arbitrarily withheld, to withdraw from the trust account all or any part of the trust assets and transfer the assets to the assuming insurer, if either of the following provisions is satisfied:

(i) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets that have a current fair market value equal to the market value of the assets withdrawn so as to maintain, at all times, the deposit in the required amount.

(ii) After withdrawal and transfer, the current fair market value of the trust account is not less than 102% of the required amount.

(b) Provide for the return of any amount withdrawn in excess of the actual amounts required under subrule (1)(e) of this rule.

(c) Provide for interest payments, at a rate that is not more than the prime rate of interest, on the amounts held pursuant to subrule (1)(e) of this rule.

(d) Permit the award by any arbitration panel or court of competent jurisdiction of any of the following:

(i) Interest at a rate different from that provided in subdivision (c) of this subrule.

(ii) Court or arbitration costs.

(iii) Attorney fees.

(iv) Any other reasonable expenses.

(3) A trust agreement that complies with these rules may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer in financial statements required to be filed with the director if established on or before the date of filing of the financial statement of the ceding insurer. Further, the amount of the reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but the reduction must not be more than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(4) Notwithstanding the effective date of this rule, any trust agreement or underlying reinsurance agreement in existence before July 1, 1996, is acceptable until June 30, 1997, at which time the agreements must be in full compliance with this rule for the trust agreement to be acceptable.

(5) The failure of any trust agreement to specifically identify the beneficiary must not be construed to affect any actions or rights that the director may take or possess pursuant to the laws of this state.

History: 1996 AC; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1124 Letters of credit under section 1105 of the code, MCL 500.1105.

Rule 4. (1) A letter of credit used to reduce any liability for reinsurance ceded to an unauthorized reinsurer under section 1105 of the code, MCL 500.1105, must be clean, irrevocable, unconditional, and issued or confirmed by a qualified United States financial institution. The letter of credit must contain an issue date and date of expiration and stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document needs to be presented. The letter of credit must also indicate that it is not subject to any condition or qualifications outside of the letter of credit. In addition, the letter of credit itself must not contain reference to any other agreements, documents, or entities, except as provided in R 500.1125(1).

(2) The heading of the letter of credit may include a boxed section that contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section must be clearly marked to indicate that the information is for internal identification purposes only.

(3) The letter of credit must contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is not contingent upon reimbursement with respect thereto.

(4) The term of the letter of credit must be for at least 1 year and contain an "evergreen clause" that prevents the expiration of the letter of credit without due notice from the issuer. The "evergreen clause" must provide for a period of not less than 30

days' notice before the expiration date or nonrenewal of the letter of credit.
(5) The letter of credit must state whether it is subject to and governed by the laws of this state, publication 600 of the International Chamber of Commerce entitled the Uniform Customs and Practice for Documentary Credits (UCP 600), or publication 590 of the International Chamber of Commerce entitled International Standby Practices (ISP 98), or any successor publication, and all drafts drawn thereunder must be presentable at an office in the United States of a qualified United States financial institution.
(6) If the letter of credit is made subject to publication 600 of the International Chamber of Commerce entitled the Uniform Customs and Practice for Documentary Credits (UCP 600), or publication 590 of the International Chamber of Commerce entitled International Standby Practices (ISP 98), or any successor publication, then the letter of credit must specifically address and make provision for an extension of time to draw against the letter of credit if 1 or more of the occurrences specified in article 36 of publication 600, or any successor publication, occur.
(7) If the letter of credit is issued by a financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in subrule (1) of this rule, then both of the following additional requirements must be met:
(a) The issuing financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts.
(b) The "evergreen clause" must provide for 30 days' notice before the expiration date or nonrenewal of the letter of credit.
History: 1996 AC; 2011 AACS; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1125 Conditions applicable to reinsurance agreement in conjunction with letter of credit under section 1105 of the code, MCL 500.1105.
Rule 5. (1) A reinsurance agreement in conjunction with which a letter of credit is obtained under section 1105 of the code, MCL 500.1105, may contain any of the following provisions:
(a) A requirement that the assuming insurer provide letters of credit to the ceding insurer and specify what they are to cover.
(b) A stipulation that the assuming insurer and ceding insurer agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and must be utilized by the ceding insurer or its successors in interest only for 1 or more of the following reasons:
(i) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement, of premiums returned, but not yet recovered from the assuming insurers, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies.
(ii) To pay or reimburse the ceding insurer for the assuming insurer's share, under the specific reinsurance agreement, of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurers, under the terms and provisions of the policies reinsured under the reinsurance agreement.
(iii) To pay or reimburse the ceding insurer in an amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.
(iv) Where the letter of credit will expire without renewal or be reduced or replaced by a letter of credit for a reduced amount and where the assuming insurer's entire obligations under the reinsurance agreement remain unliquidated and undischarged 10 days before the termination date, to withdraw amounts equal to the assuming insurer's share of the liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer and exceed the amount of any reduced or replacement letter of credit, and deposit those amounts in a separate account in the name of the ceding insurer in a qualified United States financial institution apart from its general assets, in trust for those uses and purposes specified in paragraphs (i) to (iii) of this subdivision as may remain after withdrawal and for any period after the termination date.
(c) A requirement that all of the provisions of this subrule must be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.
(2) Nothing contained in subrule (1) of this rule precludes the ceding insurer and assuming insurer from providing for either or both of the following:
(a) An interest payment, at a rate not more than the prime rate of interest, on the amounts held pursuant to subrule (1)(b) of this rule.
(b) The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for subrule (1)(b) of this rule, or any amounts that are subsequently determined not to be due.
History: 1996 AC; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1126
Source: 2019 AACS.

R 500.1127 Reinsurance contract.
Rule 7. Credit must not be granted, nor an asset or reduction from liability allowed, to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of section 1103 of the code, MCL 500.1103, not including section 1103(5), or section 1105 of the code, MCL 500.1105, and applicable rules, or otherwise in compliance with section 1103 of the code, MCL 500.1103, after the effective date of these rules, unless the reinsurance agreement includes all of the following:
(a) A proper insolvency clause**,** which stipulates that reinsurance is payable directly to the liquidator or successor without diminution regardless of the status of the ceding company.
(b) A provision pursuant to section 1103 of the code, MCL 500.1103, whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give the court or panel jurisdiction, has designated an agent upon whom service of process may be served, and has agreed to abide by the final decision of the court or panel.
History: 1996 AC; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1128 Contracts affected.
Rule 8. All new and renewal reinsurance transactions entered into on or after January 1, 2019 must conform to the requirements of the code and these rules if credit is to be given to the ceding insurer for the reinsurance.
History: 1996 AC; 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1129
Source: 2019 AACS.

R 500.1130 Credit for reinsurance; reinsurer licensed in this state.
Rule 10. Pursuant to section 1103(1) of the code, MCL 500.1103, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that was licensed in this state as of any date on which statutory financial statement credit for reinsurance is claimed.
History: 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1131 Credit for reinsurance; certified reinsurers.
Rule 11. (1) Pursuant to section 1103(6) of the code, MCL 500.1103, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that has been certified as a reinsurer in this state at all times for which statutory financial statement credit for reinsurance is claimed under this rule. The credit allowed must be based upon the security held by or on behalf of the ceding insurer in accordance with a rating assigned to the certified reinsurer by the director. The security must be in a form consistent with sections 1103(6) and 1105 of the code, MCL 500.1103 and MCL 500.1105, and the requirements, as applicable, under R 500.1123, R 500.1124, R 500.1125, R 500.1126, and R 500.1133. The amount of security required in order for full credit to be allowed must correspond with the following requirements:

Ratings	Security Required
Secure—1	0%
Secure—2	10%
Secure—3	20%
Secure—4	50%
Secure—5	75%
Vulnerable—6	100%

(2) Affiliated reinsurance transactions must receive the same opportunity for reduced security requirements as all other reinsurance transactions.
(3) The director shall require the certified reinsurer to post 100% security, for the benefit of the ceding insurer or its estate, upon the entry of an order of rehabilitation, liquidation, or conservation against the ceding insurer.
(4) In order to facilitate the prompt payment of claims, a certified reinsurer must not be required to post security for catastrophe recoverables for a period of one year from the date of the first instance of a liability reserve entry by the ceding company as a result of a loss from a catastrophic occurrence as recognized by the director. The one-year deferral period is contingent upon the certified reinsurer continuing to pay claims in a timely manner. Reinsurance recoverables for only the following lines of business as reported on the NAIC annual financial statement related specifically to the catastrophic occurrence will be included in the deferral:

(a) Line 1: Fire.
(b) Line 2: Allied Lines.
(c) Line 3: Farmowners multiple peril.
(d) Line 4: Homeowners multiple peril.
(e) Line 5: Commercial multiple peril.
(f) Line 9: Inland Marine.
(g) Line 12: Earthquake.
(h) Line 21: Auto physical damage.

(5) Credit for reinsurance under this rule only applies to reinsurance contracts entered into or renewed on or after the effective date of the certification of the assuming insurer. Any reinsurance contract entered into before the effective date of the certification of the assuming insurer that is subsequently amended after the effective date of the certification of the assuming insurer, or a new reinsurance contract, covering any risk for which collateral was provided previously, is only subject to this rule with respect to the losses incurred and reserves reported from and after the effective date of the amendment or new contract.

(6) Nothing in this rule prohibits the parties to a reinsurance agreement from agreeing to provisions establishing security requirements that exceed the minimum security requirements established for certified reinsurers under this rule.

(7) The director shall post notice on the department's website promptly upon receipt of any application for certification, including instructions on how members of the public may respond to the application. The director may not take final action on the application until at least 30 days after posting the notice required by this subrule.

(8) The director shall issue written notice to an assuming insurer that has applied and been approved as a certified reinsurer. The notice must include the rating assigned the certified reinsurer pursuant to subrules (1) to (6) of this rule. The director shall publish a list of all certified reinsurers and their ratings.

(9) In order to be eligible for certification, the assuming insurer shall meet all of the following requirements:

(a) The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the director pursuant to subrule (15) of this rule.

(b) The assuming insurer must maintain capital and surplus, or its equivalent, of no less than $250,000,000.00 calculated pursuant to subrule (10)(h) of this rule. This requirement may also be satisfied by an association including incorporated and individual unincorporated underwriters having minimum capital and surplus equivalents (net of liabilities) of at least $250,000,000.00 and a central fund containing a balance of at least $250,000,000.00.

(c) The assuming insurer must maintain financial strength ratings from 2 or more rating agencies considered acceptable by the director. These ratings must be based on interactive communication between the rating agency and the assuming insurer and must not be based solely on publicly available information. These financial strength ratings will be one factor used by the director in determining the rating that is assigned to the assuming insurer. Acceptable rating agencies include all of the following:

(i) Standard & Poor's.
(ii) Moody's Investors Service.
(iii) Fitch Ratings.
(iv) A.M. Best Company.
(v) Any other nationally recognized statistical rating organization.

(d) The certified reinsurer must comply with any other requirements reasonably imposed by the director.

(10) Each certified reinsurer must be rated on a legal entity basis, with due consideration being given to the group rating where appropriate, except that an association including incorporated and individual unincorporated underwriters that has been approved to do business as a single certified reinsurer may be evaluated on the basis of its group rating. Factors that may be considered as part of the evaluation process include, but are not limited to, all of the following:

(a) The certified reinsurer's financial strength rating from an acceptable rating agency. The maximum rating that a certified reinsurer may be assigned will correspond to its financial strength rating as outlined in the table below. The director shall use the lowest financial strength rating received from an approved rating agency in establishing the maximum rating of a certified reinsurer. A failure to obtain or maintain at least 2 financial strength ratings from acceptable rating agencies will result in loss of eligibility for certification.

Ratings	Best	S&P	Moody's	Fitch
Secure—1	A++	AAA	Aaa	AAA
Secure—2	A+	AA+,AA, AA-	Aa1, Aa2, Aa3	AA+,AA, AA-
Secure—3	A	A+, A	A1, A2	A+, A
Secure—4	A-	A-	A3	A-
Secure—5	B++, B+	BBB+,BBB, BBB-	Baa1,Baa2, Baa3	BBB+,BBB, BBB-

Vulnerable—6	B, B-C++, C+, C, C-, D, E, F	BB+, BB, BB-, B+, B, B-, CCC, CC, C, D, R	Ba1, Ba2, Ba3, B1, B2, B3, Caa, Ca, C	BB+, BB, BB-, B+, B, B-, CCC+, CC, CCC-, DD

(b) The business practices of the certified reinsurer in dealing with its ceding insurers, including its record of compliance with reinsurance contractual terms and obligations.
(c) For certified reinsurers domiciled in the United States, a review of the most recent applicable NAIC Annual Statement Blank, either Schedule F (for property/casualty reinsurers) or Schedule S (for life and health reinsurers).
(d) For certified reinsurers not domiciled in the United States, a review annually of a form approved by the director.
(e) The reputation of the certified reinsurer for prompt payment of claims under reinsurance agreements, based on an analysis of ceding insurers' Schedule F reporting of overdue reinsurance recoverables, including the proportion of obligations that are more than 90 days past due or are in dispute, with specific attention given to obligations payable to companies that are in administrative supervision or receivership.
(f) Regulatory actions against the certified reinsurer.
(g) The report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subdivision (h) of this subrule.
(h) For certified reinsurers not domiciled in the United States, audited financial statements, regulatory filings, and actuarial opinion (as filed with the non-United States jurisdiction supervisor, with a translation into English). Upon the initial application for certification, the director will consider audited financial statements for the last 2 years filed with its non-United States jurisdiction supervisor.
(i) The liquidation priority of obligations to a ceding insurer in the certified reinsurer's domiciliary jurisdiction in the context of an insolvency proceeding.
(j) A certified reinsurer's participation in any solvent scheme of arrangement, or similar procedure, that involves United States ceding insurers. The director shall receive prior notice from a certified reinsurer that proposes participation by the certified reinsurer in a solvent scheme of arrangement.
(k) Any other information considered relevant by the director.
(11) Based on the analysis conducted under subrule (10)(e) of this rule of a certified reinsurer's reputation for prompt payment of claims, the director may make appropriate adjustments in the security the certified reinsurer is required to post to protect its liabilities to United States ceding insurers as long as the director, at a minimum, increases the security the certified reinsurer is required to post by 1 rating level under subrule (10)(a) of this rule if the director finds either of the following:
(a) More than 15% of the certified reinsurer's ceding insurance clients have overdue reinsurance recoverables on paid losses of 90 days or more that are not in dispute and exceed $100,000.00 for each cedent.
(b) The aggregate amount of reinsurance recoverables on paid losses that are not in dispute that are overdue by 90 days or more exceeds $50,000,000.00.
(12) The assuming insurer must submit a properly executed form approved by the director as evidence of its submission to the jurisdiction of this state, appointment of the director as an agent for service of process in this state, and agreement to provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment. The director shall not certify any assuming insurer that is domiciled in a jurisdiction that the director has determined does not adequately and promptly enforce final United States judgments or arbitration awards.
(13) The certified reinsurer must agree to meet applicable information filing requirements as determined by the director, both with respect to an initial application for certification and on an ongoing basis. All information submitted by certified reinsurers that are not otherwise public information subject to disclosure are exempted from disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246, and must be withheld from public disclosure. The applicable information filing requirements include all of the following:
(a) Notification within 10 days of any regulatory actions taken against the certified reinsurer, any change in the provisions of its domiciliary license or any change in rating by an approved rating agency, including a statement describing the changes and the reasons for the changes.
(b) Annually, the filing of a form approved by the director.
(c) Annually, the report of the independent auditor on the financial statements of the insurance enterprise, on the basis described in subdivision (d) of this subrule.
(d) Annually, the most recent audited financial statements, regulatory filings, and actuarial opinion (as filed with the certified reinsurer's supervisor, with a translation into English). Upon the initial certification, audited financial statements for the last 2 years filed with the certified reinsurer's supervisor.
(e) At least annually, an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from United States domestic ceding insurers.

(f) A certification from the certified reinsurer's domestic regulator that the certified reinsurer is in good standing and maintains capital in excess of the jurisdiction's highest regulatory action level.
(g) Any other information that the director may reasonably require.
(14) All of the following apply to a change in rating or revocation of certification, as applicable:
(a) In the case of a downgrade by a rating agency or other disqualifying circumstance, the director shall upon written notice assign a new rating to the certified reinsurer pursuant to the requirements of subrule (10)(a) of this rule.
(b) The director has the authority to suspend, revoke, or otherwise modify a certified reinsurer's certification at any time if the certified reinsurer fails to meet its obligations or security requirements under this rule, or if other financial or operating results of the certified reinsurer, or documented significant delays in payment by the certified reinsurer, lead the director to reconsider the certified reinsurer's ability or willingness to meet its contractual obligations.
(c) If the rating of a certified reinsurer is upgraded by the director, the certified reinsurer may meet the security requirements applicable to its new rating on a prospective basis, but the director shall require the certified reinsurer to post security under the previously applicable security requirements as to all contracts in force on or before the effective date of the upgraded rating. If the rating of a certified reinsurer is downgraded by the director, the director shall require the certified reinsurer to meet the security requirements applicable to its new rating for all business it has assumed as a certified reinsurer.
(d) Upon revocation of the certification of a certified reinsurer by the director, the assuming insurer shall post security pursuant to section 1105 of the code, MCL 500.1105, in order for the ceding insurer to continue to take credit for reinsurance ceded to the assuming insurer. If funds continue to be held in trust pursuant to section 1103(4) of the code, MCL 500.1103, and R 500.1132, the director may allow additional credit equal to the ceding insurer's pro rata share of such funds, discounted to reflect the risk of uncollectibility and anticipated expenses of trust administration. Notwithstanding the change of a certified reinsurer's rating or revocation of its certification, a domestic insurer that has ceded reinsurance to that certified reinsurer may not be denied credit for reinsurance for a period of 3 months for all reinsurance ceded to that certified reinsurer, unless the reinsurance is found by the director to be at high risk of uncollectibility.
(15) All of the following apply to the recognition of a jurisdiction as a qualified jurisdiction:
(a) If, upon conducting an evaluation under this rule with respect to the reinsurance supervisory system of any non-United States assuming insurer, the director determines that the jurisdiction qualifies to be recognized as a qualified jurisdiction, the director shall publish notice and evidence of such recognition in an appropriate manner. The director may establish a procedure to withdraw recognition of those jurisdictions that are no longer qualified.
(b) In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the director shall evaluate the reinsurance supervisory system of the non-United States jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. The director shall determine the appropriate approach for evaluating the qualifications of those jurisdictions and create and publish a list of jurisdictions for which reinsurers may be approved by the director as eligible for certification. A qualified jurisdiction must agree to share information and cooperate with the director with respect to all certified reinsurers domiciled within that jurisdiction. Additional factors to be considered in determining whether to recognize a qualified jurisdiction, in the discretion of the director, include, but are not limited to, all of the following:
(i) The framework under which the assuming insurer is regulated.
(ii) The structure and authority of the domiciliary regulator with regard to solvency regulation requirements and financial surveillance.
(iii) The substance of financial and operating standards for assuming insurers in the domiciliary jurisdiction.
(iv) The form and substance of financial reports required to be filed or made publicly available by reinsurers in the domiciliary jurisdiction and the accounting principles used.
(v) The domiciliary regulator's willingness to cooperate with United States regulators in general and the director in particular.
(vi) The history of performance by assuming insurers in the domiciliary jurisdiction.
(vii) Any documented evidence of substantial problems with the enforcement of final United States judgments in the domiciliary jurisdiction. A jurisdiction is not considered to be a qualified jurisdiction if the director has determined that it does not adequately and promptly enforce final United States judgments or arbitration awards.
(viii) Any relevant international standards or guidance with respect to mutual recognition of reinsurance supervision adopted by the International Association of Insurance Supervisors or successor organization.
(ix) Any other matters considered relevant by the director.
(c) A list of qualified jurisdictions is published through the NAIC committee process. The director shall consider this list in determining qualified jurisdictions. If the director approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the director shall provide thoroughly documented justification with respect to the criteria provided under subdivision (b)(i) to (ix) of this subrule.

(d) United States jurisdictions that meet the requirements for accreditation under the NAIC financial standards and accreditation program must be recognized as qualified jurisdictions.

(16) All of the following apply to the recognition of certification issued by an NAIC accredited jurisdiction:

(a) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the director has the discretion to defer to that jurisdiction's certification, and to defer to the rating assigned by that jurisdiction, if the assuming insurer submits a properly executed form approved by the director and additional information as the director requires. The assuming insurer must be considered to be a certified reinsurer in this state.

(b) Any change in the certified reinsurer's status or rating in the other jurisdiction applies automatically in this state as of the date it takes effect in the other jurisdiction. The certified reinsurer shall notify the director of any change in its status or rating within 10 days after receiving notice of the change.

(c) The director may withdraw recognition of the other jurisdiction's rating at any time and assign a new rating pursuant to subrule (14)(a) of this rule.

(d) The director may withdraw recognition of the other jurisdiction's certification at any time, with written notice to the certified reinsurer. Unless the director suspends or revokes the certified reinsurer's certification under subrule (14)(a) of this rule, the certified reinsurer's certification remains in good standing in this state for a period of 3 months, which must be extended if additional time is necessary to consider the assuming insurer's application for certification in this state.

(17) In addition to the clauses required under R 500.1127, reinsurance contracts entered into or renewed under this rule must include a proper funding clause requiring the certified reinsurer to provide and maintain security in an amount sufficient to avoid the imposition of any financial statement penalty on the ceding insurer under this rule for reinsurance ceded to the certified reinsurer.

(18) The director shall comply with all reporting and notification requirements that may be established by the NAIC with respect to certified reinsurers and qualified jurisdictions.

History: 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1132 Requirements for assets deposited in trusts established under section 1103 of the code, MCL 500.1103; specific security provided under section 1105 of the code, MCL 500.1105.

Rule 12. (1) Assets deposited in trusts established pursuant to section 1103 of the code, MCL 500.1103, and this rule must be valued according to their current fair market value and consist only of 1 or more of the following:

(a) Cash in United States dollars.

(b) Certificates of deposit issued by a qualified United States financial institution.

(c) Clean, irrevocable, unconditional, and "evergreen" letters of credit issued or confirmed by a qualified United States financial institution.

(d) Investments of the type specified in this rule if the investments meet all of the following criteria:

(i) Investments in or issued by an entity controlling, controlled by or under common control with either the grantor or beneficiary of the trust does not exceed 5% of total investments.

(ii) No more than 20% of the total of the investments in the trust are foreign investments authorized under subrule (2)(a)(v), (c), (d)(ii), or (e) of this rule, and no more than 10% of the total of the investments in the trust are securities denominated in foreign currencies. For purposes of applying the preceding sentence, a depository receipt denominated in United States dollars and representing rights conferred by a foreign security must be classified as a foreign investment denominated in a foreign currency.

(2) The assets of a trust established to satisfy the requirements of section 1103 of the code, MCL 500.1103, must be invested only in 1 or more of the following investments:

(a) Government obligations that are not in default as to principal or interest, that are valid and legally authorized, and that are issued, assumed, or guaranteed by any of the following:

(i) The United States or any agency or instrumentality of the United States.

(ii) A state of the United States.

(iii) A territory, possession**,** or other governmental unit of the United States.

(iv) An agency or instrumentality of a governmental unit referred to in paragraphs (ii) and (iii) of this subdivision if the obligations are by law (statutory or otherwise) payable, as to both principal and interest, from taxes levied**,** or by law required to be levied, or from adequate special revenues pledged or otherwise appropriated or by law required to be provided for making these payments, but must not be obligations eligible for investment under this paragraph if payable solely out of special assessments on properties benefited by local improvements.

(v) The government of any other country that is a member of the Organization for Economic Cooperation and Development and whose government obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(b) Obligations that are issued in the United States, or that are dollar denominated and issued in a non-United States market

by a solvent United States institution (other than an insurance company) or that are assumed or guaranteed by a solvent United States institution (other than an insurance company) and that are not in default as to principal or interest if the obligations meet 1 of the following requirements:

(i) Are rated A or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC, or if not so rated~~.~~**,** are similar in structure and other material respects to other obligations of the same institution that are so rated.

(ii) Are insured by at least one authorized insurer (other than the investing insurer or a parent~~.~~ subsidiary or affiliate of the investing insurer) licensed to insure obligations in this state and, after considering the insurance~~.~~**,** are rated AAA (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC.

(iii) Have been designated as Class One or Class Two by the Securities Valuation Office of the NAIC.

(c) Obligations issued, assumed, or guaranteed by a solvent non-United States institution chartered in a country that is a member of the Organization for Economic Cooperation and Development or obligations of United States corporations issued in a non-United States currency if in either case the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(d) Equity interests to which the following apply, as applicable:

(i) Investments in common shares or partnership interests of a solvent United States institution are permissible if both of the following requirements are met:

(A) Its obligations and preferred shares, if any, are eligible as investments under this rule.

(B) The equity interests of the institution (except an insurance company) are registered on a national securities exchange as provided in the securities exchange act of 1934, 15 USC 78a to 78qq, or otherwise registered pursuant to that act, and if otherwise registered, price quotations for them are furnished through a nationwide automated quotations system approved by the Financial Industry Regulatory Authority, or successor organization. A trust must not invest in equity interests under this subparagraph in an amount exceeding 1% of the assets of the trust even though the equity interests are not so registered and are not issued by an insurance company.

(ii) Investments in common shares of a solvent institution organized under the laws of a country that is a member of the Organization for Economic Cooperation and Development are permissible if both of the following requirements are met:

(A) All its obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(B) The equity interests of the institution are registered on a securities exchange regulated by the government of a country that is a member of the Organization for Economic Cooperation and Development.

(iii) An investment in or loan upon any one institution's outstanding equity interests must not exceed 1% of the assets of the trust. The cost of an investment in equity interests made pursuant to this paragraph, when added to the aggregate cost of other investments in equity interests then held pursuant to this paragraph, must not exceed 10% of the assets in the trust.

(e) Obligations issued, assumed, or guaranteed by a multinational development bank, if the obligations are rated A or higher, or the equivalent, by a rating agency recognized by the Securities Valuation Office of the NAIC.

(f) Investment companies to which the following apply, as applicable:

(i) Securities of an investment company registered pursuant to the investment company act of 1940, 15 USC 80a-1 to 80a-64, are permissible investments if the investment company meets either of the following:

(A) Invests at least 90% of its assets in the types of securities that qualify as an investment under subdivision (a), (b), or (c) of this subrule or invests in securities that are determined by the director to be substantively similar to the types of securities set forth in subdivision (a), (b), or (c) of this subrule.

(B) Invests at least 90% of its assets in the types of equity interests that qualify as an investment under subdivision (d)(i) of this subrule.

(ii) Investments made by a trust in investment companies under this subdivision must not exceed either of the following limitations:

(A) An investment in an investment company qualifying under paragraph (i)(A) of this subdivision must not exceed 10% of the assets in the trust**,** and the aggregate amount of investment in qualifying investment companies must not exceed 25% of the assets in the trust.

(B) Investments in an investment company qualifying under paragraph (i)(B) of this subdivision must not exceed 5% of the assets in the trust, and the aggregate amount of investment in qualifying investment companies must be included when calculating the permissible aggregate value of equity interests pursuant to subdivision (d)(i) of this subrule.

(g) Letters of credit to which all of the following apply:

(i) In order for a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement (as duly approved by the director) to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(ii) The trust agreement must provide that the trustee is liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where the draw would be required must be considered to be negligence, willful misconduct, or both.

(3) A specific security provided to a ceding insurer by an assuming insurer pursuant to section 1105 of the code, MCL 500.1105, must be applied, until exhausted, to the payment of liabilities of the assuming insurer to the ceding insurer holding the specific security before, and as a condition precedent for, presentation of a claim by the ceding insurer for payment by a trustee of a trust established by the assuming insurer pursuant to this rule.

(4) An investment made pursuant to the provisions of subrule (2)(a), (b), or (c) of this rule is subject to all of the following additional limitations:

(a) An investment in or loan upon the obligations of an institution other than an institution that issues mortgage-related securities must not exceed 5% of the assets of the trust.

(b) An investment in any one mortgage-related security must not exceed 5% of the assets of the trust.

(c) The aggregate total investment in mortgage-related securities must not exceed 25% of the assets of the trust.

(d) Preferred or guaranteed shares issued or guaranteed by a solvent United States institution are permissible investments if all of the institution's obligations are eligible as investments under subrule (2)(b)(i) and (iii) of this rule, but must not exceed 2% of the assets of the trust.

(5) As used in this rule:

(a) "Mortgage-related security" means an obligation that is rated AA or higher (or the equivalent) by a securities rating agency recognized by the Securities Valuation Office of the NAIC and that meets either of the following provisions:

(i) Represents ownership of 1 or more promissory notes or certificates of interest or participation in the notes (including any rights designed to assure servicing of, or the receipt or timeliness of receipt by the holders of the notes, certificates, or participation of amounts payable under the notes, certificates**,** or participation), that meet both of the following requirements:

(A) Are directly secured by a first lien on a single parcel of real estate, including stock allocated to a dwelling unit in a residential cooperative housing corporation, upon which is located a dwelling or mixed residential and commercial structure, or on a residential manufactured home as defined in 42 USC 5402(6), whether the manufactured home is considered real or personal property under the laws of the state in which it is located.

(B) Were originated by a savings and loan association, savings bank, commercial bank, credit union, insurance company, or similar institution that is supervised and examined by a federal or state housing authority, or by a mortgagee approved by the Secretary of Housing and Urban Development pursuant to 12 USC 1709 and 1715b, or, where the notes involve a lien on the manufactured home by an institution or by a financial institution approved for insurance by the Secretary of Housing and Urban Development pursuant to 12 USC 1703.

(ii) Is secured by 1 or more promissory notes or certificates of deposit or participations in the notes (with or without recourse to the insurer of the notes) and, by its terms, provides for payments of principal in relation to payments, or reasonable projections of payments, or notes meeting the requirements of paragraph (i)(A) and (B) of this subdivision.

(b) "Promissory note" when used in connection with a manufactured home, also includes a loan, advance**,** or credit sale as evidenced by a retail installment sales contract or other instrument.

History: 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1133 Trust agreements under section 1105 of the code, MCL 500.1105.

Rule 13. (1) Reinsurance trusts established under section 1105 of the code, MCL 500.1105, must comply with the requirements of R 500.1123 and this rule.

(2) The trust agreement must be entered into between the beneficiary, the grantor, and a trustee. The trustee must be a qualified United States financial institution.

(3) The trust agreement must create a trust account into which assets must be deposited.

(4) All assets in the trust account must be held by the trustee at the trustee's office in the United States.

(5) The trust agreement must provide for all of the following:

(a) The beneficiary has the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustee.

(b) No other statement or document is required to be presented to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets.

(c) The trust agreement must not be subject to any conditions or qualifications outside of the trust agreement.

(d) The trust agreement must not contain references to any other agreements or documents, except as provided for under subrules (12) and (13) of this rule.

(6) The trust agreement must be established for the sole benefit of the beneficiary.

(7) The trust agreement must require the trustee to do all of the following:

(a) Receive assets and hold all assets in a safe place.

(b) Determine that all assets are in a form that the beneficiary, or the trustee upon the direction of the beneficiary, may, when

necessary, negotiate the assets without the consent of, or a signature from, the grantor or any other person or entity.

(c) Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals not less frequent than the end of each calendar quarter.

(d) Notify the grantor and the beneficiary within 10 days of any deposits to, or withdrawals from, the trust account.

(e) Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title, and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary.

(f) Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary. However, the trustee may, without the consent of, but with notice to, the beneficiary, upon call or maturity of any trust asset, withdraw the asset upon the condition that the proceeds are paid into the trust account.

(8) The trust agreement must provide that written notice of termination must be delivered by the trustee to the beneficiary not less than 30 days, but not more than 45 days, before termination of the trust account.

(9) The trust agreement must be made subject to and governed by the laws of the state in which the trust is domiciled.

(10) The trust agreement must prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee. For a letter of credit to qualify as an asset of the trust, the trustee shall have the right and the obligation pursuant to the deed of trust or some other binding agreement, as duly approved by the director, to immediately draw down the full amount of the letter of credit and hold the proceeds in trust for the beneficiaries of the trust if the letter of credit will otherwise expire without being renewed or replaced.

(11) The trust agreement must provide that the trustee is liable for its negligence, willful misconduct, or lack of good faith. The failure of the trustee to draw against the letter of credit in circumstances where the draw would be required is considered to be negligence, willful misconduct, or both.

(12) Notwithstanding other provisions of these rules, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities, and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, for any of the following purposes:

(a) To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer.

(b) To make payment to the assuming insurer of any amounts held in the trust account that are more than 102% of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement.

(c) Where the ceding insurer has received notification of termination of the trust account and the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days before the termination date, to withdraw amounts equal to the obligations and deposit the amounts in a separate account apart from its general assets in the name of the ceding insurer in any qualified United States financial institution in trust for the uses and purposes specified in subdivisions (a) and (b) of this subrule as may remain executory after the withdrawal and for any period after the termination date.

(13) Notwithstanding other provisions of these rules, when a trust agreement is established in conjunction with a reinsurance agreement covering life, annuities, or accident and health risks, where it is customary to provide a trust agreement for a specific purpose, the trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer, only for 1 or more of the following purposes:

(a) To pay or reimburse the ceding insurer for either or both of the following:

(i) The assuming insurer's share under the specific reinsurance agreement of premiums returned, but not yet recovered from the assuming insurer, to the owners of policies reinsured under the reinsurance agreement on account of cancellations of the policies.

(ii) The assuming insurer's share under the specific reinsurance agreement of surrenders and benefits or losses paid by the ceding insurer, but not yet recovered from the assuming insurer, under the terms and provisions of the policies reinsured under the reinsurance agreement.

(b) To pay the assuming insurer amounts held in the trust account in excess of the amount necessary to secure the credit or reduction from liability for reinsurance taken by the ceding insurer.

(c) Where the ceding insurer has received notification of termination of the trust and the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days before the termination date, to withdraw amounts equal to the assuming insurer's share of liabilities, to the extent that the liabilities have not yet been funded by the assuming insurer, and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for the uses and purposes specified in

subdivisions (a) and (b) of this subrule as may remain executory after withdrawal and for any period after the termination date.

(14) Either the reinsurance agreement or the trust agreement must stipulate that assets deposited in the trust account must be valued according to their current fair market value and consist only of cash (United States legal tender), certificates of deposit issued by a United States bank and payable in United States legal tender, and investments permitted by chapter 9 of the code, MCL 500.901 to 500.947, or any combination of cash, certificates of deposit, or investments, as long as investments in or issued by an entity controlling, controlled by or under common control with either the grantor or the beneficiary of the trust must not exceed 5% of total investments. The agreement may further specify the types of investments to be deposited. If the reinsurance agreement covers life, annuities, or accident and health risks, then the provisions required by this subrule must be included in the reinsurance agreement.

(15) The trust agreement may provide that the trustee may resign upon the delivery of a written notice of resignation that is effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by the delivery, to the trustee and the beneficiary, of a written notice of removal that is effective not less than 90 days after receipt by the trustee and the beneficiary of the notice. However, a resignation or removal is not effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(16) The grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive payments of any dividends or interest upon any shares of stock or obligations included in the trust account. The interest or dividends must be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name.

(17) The trustee may be given authority to invest and accept substitutions of any funds in the account only if the investment or substitution is made with the prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions that the trustee determines are at least equal in current fair market value to the assets withdrawn and are consistent with the restrictions in R 500.1123(1)(c).

(18) The trust agreement may provide that the beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. The transfer may be conditioned upon the trustee's receipt, either before the transfer or simultaneous with the transfer, of other specified assets.

(19) The trust agreement may provide that, upon termination of the trust account, all assets not previously withdrawn by the beneficiary must, with the written approval by the beneficiary, be delivered over to the grantor.

History: 2019 AACS; 2021 MR 10, Eff. May 18, 2021.

R 500.1134 Credit for reinsurance; reciprocal jurisdictions.

Rule 14. (1) Pursuant to section 1103(7) to (18) of the code, MCL 500.1103, the director shall allow credit for reinsurance ceded by a domestic insurer to an assuming insurer that is licensed to write reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction, and that meets the other applicable requirements of these rules.

(2) Credit is allowed pursuant to this rule if the reinsurance is ceded from an insurer domiciled in this state to an assuming insurer meeting all of the following conditions:

(a) The assuming insurer is licensed to transact reinsurance by, and has its head office or is domiciled in, a reciprocal jurisdiction.

(b) The assuming insurer has and maintains on an ongoing basis minimum capital and surplus, or its equivalent, calculated on at least an annual basis as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, and confirmed as set forth in subdivision (g) of this subrule according to the methodology of its domiciliary jurisdiction, in the following amounts, as applicable:

(i) No less than $250,000,000.

(ii) For an assuming insurer that is an association, including incorporated and individual unincorporated underwriters, both of the following amounts:

(A) Minimum capital and surplus equivalents (net of liabilities) or own funds of the equivalent of at least $250,000,000.

(B) A central fund containing a balance of the equivalent of at least $250,000,000.

(c) The assuming insurer has and maintains on an ongoing basis a minimum solvency or capital ratio, as applicable, as follows:

(i) For an assuming insurer that has its head office or is domiciled in a reciprocal jurisdiction described in subrule (9)(b)(i) of this rule, the ratio specified in the applicable covered agreement.

(ii) For an assuming insurer that is domiciled in a reciprocal jurisdiction described in subrule (9)(b)(ii) of this rule, a risk-based capital (RBC) ratio of 300% of the authorized control level, calculated pursuant to the formula developed by the NAIC.

(iii) For an assuming insurer that is domiciled in a reciprocal jurisdiction described in subrule (9)(b)(iii) of this rule, after

consultation with the reciprocal jurisdiction and considering any recommendations published through the NAIC committee process, including, but not limited to, solvency or capital ratio as the director determines to be an effective measure of solvency.

(d) The assuming insurer agrees to and provides adequate assurance of its agreement to all the following by submitting a properly executed form approved by the director:

(i) The assuming insurer must agree to provide prompt written notice and explanation to the director if it falls below the minimum requirements set forth in subdivisions (b) or (c) of this subrule, or if any regulatory action is taken against it for serious noncompliance with applicable law.

(ii) The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the director as agent for service of process. The director may also require that the consent be provided and included in each reinsurance agreement under the director's jurisdiction. This paragraph does not limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent the reinsurance agreement is unenforceable under applicable insolvency or delinquency laws.

(iii) The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer, that have been declared enforceable in the territory where the judgment was obtained.

(iv) Each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its estate, if applicable.

(v) The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement that involves this state's ceding insurers and agree to notify the ceding insurer and the director and to provide 100% security to the ceding insurer consistent with the terms of the scheme if the assuming insurer enters into a solvent scheme of arrangement. That security must be in a form consistent with the provisions of sections 1103(6) and 1105 of the code, MCL 500.1103 and 500.1105, and the requirements, as applicable, under R 500.1123, R 500.1124, R 500.1125, R 500.1126, and R 500.1133.

(vi) The assuming insurer must agree in writing to meet the applicable information filing requirements as set forth in subdivision (e) of this subrule.

(e) The assuming insurer or its legal successor must provide, if requested by the director, on behalf of itself and any legal predecessors, the following documentation to the director:

(i) For the 2 years preceding entry into the reinsurance agreement and on an annual basis after those years, the assuming insurer's annual audited financial statements, in accordance with the applicable law of the jurisdiction of its head office or domiciliary jurisdiction, as applicable, including the external audit report.

(ii) For the 2 years preceding entry into the reinsurance agreement, the solvency and financial condition report or actuarial opinion if filed with the assuming insurer's supervisor.

(iii) Before entry into the reinsurance agreement and not more than semi-annually afterward, an updated list of all disputed and overdue reinsurance claims outstanding for 90 days or more, regarding reinsurance assumed from ceding insurers domiciled in the United States.

(iv) Before entry into the reinsurance agreement and not more than semi-annually afterward, information regarding the assuming insurer's assumed reinsurance by ceding insurer, ceded reinsurance by the assuming insurer, and reinsurance recoverable on paid and unpaid losses by the assuming insurer to allow for the evaluation of the criteria set forth in subdivision (f) of this subrule.

(f) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements. There is evidence of a lack of prompt payment if any of the following criteria is met:

(i) More than 15% of the reinsurance recoverables from the assuming insurer are overdue and in dispute as reported to the director.

(ii) More than 15% of the assuming insurer's ceding insurers or reinsurers have overdue reinsurance recoverables on paid losses of 90 days or more that are not in dispute and that exceed for each ceding insurer $100,000, or as otherwise specified in a covered agreement.

(iii) The aggregate amount of reinsurance recoverables on paid losses that are not in dispute, but are overdue by 90 days or more, exceeds $50,000,000, or as otherwise specified in a covered agreement.

(g) The assuming insurer's supervisory authority must confirm to the director on an annual basis that the assuming insurer complies with the requirements set forth in subdivisions (b) and (c) of this subrule.

(3) Subrule (2) of this rule does not preclude an assuming insurer from providing the director with information on a voluntary basis.

(4) The director shall timely create and publish a list of reciprocal jurisdictions. The list must include any reciprocal

jurisdiction described in subrule (9)(b)(i) and (ii) of this rule and consider any other reciprocal jurisdiction included on the list published through the NAIC committee process. The director may approve a jurisdiction that does not appear the NAIC list, as provided by applicable law or regulation or pursuant to criteria published through the NAIC committee process. The director may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets 1 or more of the requirements of a reciprocal jurisdiction, as provided by applicable law or regulation or pursuant to a process published through the NAIC committee process, except that the director shall not remove from the list a reciprocal jurisdiction as described under subrule (9)(b)(i) or (ii). Upon removal of a reciprocal jurisdiction from the list, credit for reinsurance ceded to an assuming insurer domiciled in that jurisdiction must be allowed if otherwise allowed pursuant to sections 1103, 1105, and 1106 of the code, MCL 500.1103, 500.1105, and 500.1106, and these rules.

(5) The director shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this rule and to which cessions must be granted credit under this rule. Both of the following apply to the list of assuming insurers:

(a) If an NAIC accredited jurisdiction has determined that the conditions set forth in subrule (2) of this rule have been met, the director has the discretion to defer to that jurisdiction's determination and add that assuming insurer to the list of assuming insurers to which cessions must granted credit under this subrule. The director may accept financial documentation filed with another NAIC accredited jurisdiction or with the NAIC in satisfaction of the requirements of subrule (2) of this rule.

(b) When requesting that the director defer to another NAIC accredited jurisdiction's determination, an assuming insurer must submit a properly executed form approved by the director and additional information as the director may require. If the director receives a request under this subdivision, the director shall notify other states through the NAIC committee process and provide relevant information with respect to the determination of eligibility.

(6) If the director determines that an assuming insurer no longer meets 1 or more of the requirements under this rule, the director may revoke or suspend the eligibility of the assuming insurer for recognition under this rule. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured pursuant to section 1105 of the code, MCL 500.1105. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into before the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the director and are consistent with the provisions of section 1105 of the code, MCL 500.1105.

(7) Before denying statement credit or imposing a requirement to post security under subrule (6) of this rule or adopting any similar requirement that has substantially the same regulatory impact as security, the director shall do all of the following:

(a) Communicate with the ceding insurer, the assuming insurer, and the assuming insurer's supervisory authority that the assuming insurer no longer satisfies 1 of the conditions listed in subrule (2) of this rule.

(b) Provide the assuming insurer with 30 days from the initial communication to submit a plan to remedy the defect and 90 days from the initial communication to remedy the defect, except in exceptional circumstances in which a shorter period is necessary for policyholder and other consumer protection. After the expiration of 90 days or less, as set out in this subdivision, if the director determines that no or insufficient action was taken by the assuming insurer, the director may impose any of the requirements as set out in this subrule.

(c) Provide a written explanation to the assuming insurer of any of the requirements set out in this subrule.

(8) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding liabilities.

(9) As used in this rule:

(a) "Covered agreement" means that term as defined in section 1103(27)(b)(*i*) of the code, MCL 500.1103.

(b) "Reciprocal jurisdiction" means a jurisdiction, as designated by the director pursuant to subrule (4) of this rule, that meets 1 of the following:

(i) A jurisdiction that meets the conditions under section 1103(27)(b)(*i*) of the code, MCL 500.1103.

(ii) A jurisdiction that meets the conditions under section 1103(27)(b)(*ii*) of the code, MCL 500.1103.

(iii) A qualified jurisdiction, as determined by the director pursuant to section 1103(6)(c) of the code, MCL 500.1103, and R 500.1131(15), that is not otherwise described in paragraphs (i) or (ii) of this subdivision, and that the director determines meets all of the following additional requirements:

(A) Provides that an insurer that has its head office or is domiciled in the qualified jurisdiction shall receive credit for reinsurance ceded to a United States-domiciled assuming insurer in the same manner as credit for reinsurance is received for reinsurance assumed by insurers domiciled in the qualified jurisdiction.

(B) Does not require a United States-domiciled assuming insurer to establish or maintain a local presence as a condition for entering into a reinsurance agreement with any ceding insurer subject to regulation by the non-United States jurisdiction or as

a condition to allow the ceding insurer to recognize credit for such reinsurance.

(C) Recognizes the United States state regulatory approach to group supervision and group capital, by providing written confirmation by a competent regulatory authority, in the qualified jurisdiction, that insurers and insurance groups that are domiciled or maintain their headquarters in this state or another jurisdiction accredited by the NAIC shall be subject only to worldwide prudential insurance group supervision including worldwide group governance, solvency and capital, and reporting, as applicable, by the director or the commissioner of the domiciliary state and will not be subject to group supervision at the level of the worldwide parent undertaking of the insurance or reinsurance group by the qualified jurisdiction.

(D) Provides written confirmation by a competent regulatory authority in the qualified jurisdiction that information regarding insurers and their parent, subsidiary, or affiliated entities, if applicable, must be provided to the director pursuant to a memorandum of understanding or similar document between the director and the qualified jurisdiction, including, but not limited to, the International Association of Insurance Supervisors Multilateral Memorandum of Understanding or other multilateral memoranda of understanding coordinated by the NAIC.

History: 2021 MR 10, Eff. May 18, 2021.

CASUALTY INSURANCE RATES

R 500.1201
Source: 1980 AACS.

R 500.1202
Source: 1980 AACS.

R 500.1203
Source: 1980 AACS.

R 500.1204
Source: 1980 AACS.

R 500.1205
Source: 1980 AACS.

R 500.1206
Source: 1980 AACS.

R 500.1207
Source: 1980 AACS.

R 500.1208
Source: 1980 AACS.

R 500.1209
Source: 1980 AACS.

R 500.1210
Source: 1980 AACS.

1980 CSO AND 1980 CET UNISEX MORTALITY TABLES

R 500.1221
Source: 1984 AACS.

R 500.1222
Source: 1984 AACS.

R 500.1223
Source: 1984 AACS.

R 500.1224
Source: 1984 AACS.

R 500.1225
Source: 1984 AACS.

PROPERTY AND CASUALTY INSURANCE COMPANY RESERVES

R 500.1231
Source: 1982 AACS.

R 500.1232
Source: 1982 AACS.

R 500.1233
Source: 1982 AACS.

R 500.1234
Source: 1982 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

MORTALITY TABLE FOR INDIVIDUAL ANNUITY VALUATION

R 500.1241
Source: 2019 AACS.

SURPLUS LINES INSURANCE FEES

R 500.1251
Source: 2015 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE BUREAU

FIRE INSURANCE--WITHHOLDING

R 500.1261
Source: 2018 AACS.

R 500.1262
Source: 2018 AACS.

R 500.1263
Source: 2018 AACS.

R 500.1264
Source: 2018 AACS.

R 500.1265
Source: 2018 AACS.

R 500.1266

Source: 2018 AACS.

R 500.1267
Source: 2018 AACS.

R 500.1268
Source: 2018 AACS.

R 500.1269
Source: 2018 AACS.

R 500.1270
Source: 2018 AACS.

R 500.1271
Source: 2018 AACS.

SMOKER AND NONSMOKER MORTALITY TABLES

R 500.1281
Source: 1986 AACS.

R 500.1282
Source: 1986 AACS.

R 500.1283
Source: 1986 AACS.

R 500.1284
Source: 1986 AACS.

R 500.1285
Source: 1986 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

MORTALITY TABLE FOR GROUP ANNUITY VALUATION

R 500.1291
Source: 2019 AACS.

FIRE AND INLAND MARINE INSURANCE RATES

R 500.1301
Source: 1980 AACS.

R 500.1302
Source: 1980 AACS.

R 500.1303
Source: 1980 AACS.

R 500.1304
Source: 1980 AACS.

R 500.1305
Source: 1980 AACS.

R 500.1306
Source: 1980 AACS.

R 500.1307
Source: 1980 AACS.

R 500.1308
Source: 1980 AACS.

R 500.1309
Source: 1980 AACS.

R 500.1310
Source: 1980 AACS.

WORKERS' COMPENSATION INSURANCE

R 500.1351
Source: 1983 AACS.

R 500.1352
Source: 1983 AACS.

R 500.1353
Source: 1983 AACS.

R 500.1354
Source: 1983 AACS.

R 500.1355
Source: 1983 AACS.

R 500.1357
Source: 1983 AACS.

R 500.1358
Source: 1983 AACS.

R 500.1359
Source: 1983 AACS.

ADVERTISEMENT OF LIFE INSURANCE AND ANNUITIES

R 500.1371
Source: 1983 AACS.

R 500.1375
Source: 1983 AACS.

R 500.1377
Source: 1997 AACS.

R 500.1379
Source: 1983 AACS.

R 500.1381
Source: 1983 AACS.

R 500.1383
Source: 1983 AACS.

R 500.1385
Source: 1997 AACS.

R 500.1387
Source: 1983 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE BUREAU

ESSENTIAL INSURANCE

R 500.1501 Definitions.
Rule 1. (1) As used in these rules:
(a) "Classification" means a grouping of individuals or risks on the basis of 1 or more characteristics for purposes of measuring and rating differences in anticipated losses or expenses, or both. A classification does not include a grouping of individuals or risks solely for statistical data gathering purposes.
(b) "Code" means the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302.
(c) "Complaint" means a written statement by a person to an insurer, a producer, or the director claiming that an insurer or producer has improperly denied him or her automobile insurance or home insurance or has charged an incorrect premium for automobile insurance or home insurance.
(d) "Denial" or "denied" means both declination and termination.
(e) "Incorrect premium" means a premium charged for automobile insurance or home insurance that is not consistent with a rate or rating plan or classification approved by the department.
(f) "Loss portion" means the portion of a rate that is attributable to provisions for incurred losses and allocated loss adjustment expenses.
(g) "Loss ratio" means any of the following ratios for a specified time period, as appropriate for the context of evaluation:
(i) The ratio of actual incurred losses to total earned premiums at collected rate levels.
(ii) The ratio of actual incurred losses to total earned premiums at current rate levels.
(iii) The ratio of reasonably anticipated incurred losses to total estimated earned premiums at proposed rate levels.
(h) "Rating cell" means a group of individuals or risks for which a single rate is determined when 2 or more rating classifications are combined to define a population of individuals or risks for rating purposes.
(i) "Relativity" means either the ratio of rates for any 2 rating classifications or the absolute difference in rates for any 2 rating classifications, whichever is applicable for a particular rating system.
(j) "Uncertainty of loss" means a measure of the nature and the extent of the variability of actual losses for a group of individuals or risks from the mean anticipated loss for the group and includes other similar measures of risk.
(k) "Underwriting" means the offer or refusal to insure, the offer or refusal to continue to insure, or the limitation of the amount of coverage available to, an individual, risk, or class of individuals or risks.
(2) A term defined in the code has the same meaning when used in these rules.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1502 Other insurance coverages to be considered to be automobile insurance.
Rule 2. In addition to the insurance coverages described in section 2102(2)(a), (b), and (c) of the code, MCL 500.2102, all of the following insurance coverages are considered to be automobile insurance under section 2102(2)(d) of the code, MCL 500.2102:
(a) Insurance coverage commonly known as "uninsured motorist insurance," for both bodily injury and property damage claims.
(b) Insurance coverage for the liability existing under section 3135(3)(e) of the code, MCL 500.3135.
(c) Insurance coverage commonly known as "underinsured motorist insurance."
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1503 Excessive rates.
Rule 3. For the purposes of section 2109(1)(a) of the code, MCL 500.2109, both of the following apply in determining

whether a rate for automobile insurance or home insurance is excessive:

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

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

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

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

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

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

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

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

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

R 500.1504 Inadequate rates.

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

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

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

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

R 500.1505 Unfairly discriminatory rates.

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

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

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

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

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

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

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

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

(e) That with regard to private passenger automobile insurance and private residential property insurance, rates for an insurance coverage provided are established in a manner that can reasonably be anticipated to produce loss ratios that are

substantially uniform among the classifications, kinds, or types of individuals or risks to which the rates apply. Evaluation of loss ratios must make appropriate adjustments for differences in deductibles and limits of liability among insureds, for expense provisions that are not allocated to premiums on a percentage-of-premium basis, and for differences in contingency factors among classifications and must give due consideration to the credibility of experience for groupings of individuals or risks, to trends in past and prospective loss experience, and to historical patterns between projected and realized loss ratios. For purposes of this subdivision, "substantially uniform" means the absence of significant variations among loss ratios. This subdivision does not prohibit the use of appropriate pure premium relativities to estimate or evaluate rate relativities.

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

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

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

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

R 500.1506 Expense provisions.

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

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

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

R 500.1507 Expense allocation.

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

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

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

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

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

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

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

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

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

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

(c) The person's right to a private informal managerial-level conference addressing the complaint with the insurer, the procedure the person shall follow if he or she wishes to request a private informal managerial-level conference, and the

process applicable to a private informal managerial-level conference. All of the following apply to that process:
(i) If a private informal managerial-level conference is requested, the conference and proposed resolution must be provided by the insurer within 30 days after the date of the person's request.
(ii) The private informal managerial-level conference may be held by telephone, video teleconference or other substantially similar electronic means, or in-person, as long as the following requirements are met:
(A) If the conference is held by telephone or video teleconference or other substantially similar electronic means, the insurer shall state at the beginning of the conference that it is a private informal managerial-level conference and identify all persons by name and title who are listening to, or otherwise participating in, the conference. In addition, the insurer shall either provide a toll-free telephone service or other service at no cost to the person making the complaint, or pay all charges associated with the conference. As applicable, the written notice must indicate the telephone number that must be called and state that the telephone number may be called collect if a toll-free number is not provided or explain in sufficient detail other instructions for participating in a conference held by video teleconference or other substantially similar electronic means.
(B) If the conference is held in-person, the conference must be held within a reasonably accessible distance from the Michigan residence of the person or persons named on the policy as insured or the location of the risk and be held at a time reasonably convenient to the person making the complaint or the person's designated representative.
(iii) The private informal managerial-level conference must include the participation of the person making the complaint, or the person's designated representative, and a supervisory or higher level representative of the insurer who is authorized to decide the dispute on behalf of the insurer.
(d) The person's right to submit a complaint to the director and for a review and determination if the private informal managerial-level conference fails to resolve the dispute. The written notice must explain this right as described in R 500.1510.
(e) The person's right to appoint another person as his or her designee to act on his or her behalf throughout the complaint-resolution process set forth in this rule and R 500.1509 to R 500.1514.
(4) A compliant, request for information pertinent to the denial or premium charge, and request for a private informal managerial-level conference submitted pursuant to subrule (3) of this rule must be made not later than 30 days after the date of the written notice required under subrule (1) or (2) of this rule unless an exception is made by the insurer to extend that 30-day period. An exception extending the 30-day period under this subrule must be in writing and provided to the person making the complaint or request for information or private informal managerial-level conference.
(5) An insurer or producer shall send the written notices required under subrules (1) and (2) of this rule, or if applicable, a written extension of the 30-day period under subrule (4) of this rule, by mail, unless the insurer or producer and the person entitled to the notice or extension have previously agreed to another means of communication and that agreement includes within its scope the notice or extension contemplated under this rule and is consistent with applicable law.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1509 Complaint-resolution process; information provided following private informal managerial-level conference.
Rule 9. (1) Upon the conclusion of a private informal managerial-level conference, the insurer shall provide the person making the complaint the following information in writing and in language understandable to a person of ordinary intelligence:
(a) The action taken by the insurer to resolve the dispute.
(b) The facts and documentation supporting the action.
(c) The specific section or sections of the law supporting the action.
(d) A statement explaining the person's right to submit a complaint to the director and for a review and determination within 120 days after the date that the information under this rule is mailed or provided if the person disagrees with the proposed resolution included in the information. The statement must also provide instructions regarding how to submit a complaint to the director and request a review and determination, provide the department's toll-free number and mailing address, and clearly indicate the date that the information under this rule is mailed or provided.
(e) A statement describing the status of the automobile or home insurance coverage or coverages involved.
(2) The insurer shall mail the information under subrule (1) of this rule to the person making the complaint, unless the insurer and the person have previously agreed to another means of communication and that agreement includes within its scope providing the information contemplated under this rule and is consistent with applicable law.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1510 Complaint-resolution process; right to director's review and determination; review of written materials; meeting.
Rule 10. (1) If a person has reason to believe an insurer or producer has improperly denied him or her automobile insurance

or home insurance or has charged an incorrect premium for that insurance and a private informal managerial-level conference fails to resolve the dispute because the person disagrees with the insurer's proposed resolution following the conference or the insurer did not provide a private informal managerial-level conference and proposed resolution within 30 days after the date of the person's request, the person has a right to submit a complaint to the director and for a review and determination to resolve the dispute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

R 500.1515 Collection and reporting of data by insurers.

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

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

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

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

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

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

R 500.1516 Exchange of claim information.

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

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

R 500.1517 Exchange of automobile insurance claim information.

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

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

(a) The name and address of the insured.

(b) The policy number of such insured.

(c) The name of the driver of the insured vehicle, if known.
(d) The period of time insured, if available, but in all cases, the expiration date.
(e) Whether the claim is open or closed at the time of the report.
(f) Date or dates of loss.
(g) Amount of loss paid under each coverage.
(3) The requesting insurer shall specify in its request for claim information the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1518 Exchange of home insurance claim information.
Rule 18. (1) Every insurer subject to chapter 21 of the code, MCL 500.2101 to 500.2131, underwriting home insurance shall respond, on a form similar to figure 1 under R 500.1521, within 30 calendar days, to a request by another insurer for information concerning the claim history of a specified person. The claim information requested or reported must be information as described in section 2111(7)(f) of the code, MCL 500.2111.
(2) The reporting insurer shall report home insurance information as follows:
(a) Name and address of the insured.
(b) Policy number of such insured.
(c) Location of insured premises.
(d) Date of loss or losses.
(e) Amount paid.
(f) Coverage involved.
(g) Whether or not a fire loss was investigated by civil authorities.
(3) The requesting insurer shall specify in its request the name, address, and responding company's policy number of the insured who is the subject of the request. The requesting insurer shall also provide with the request a stamped, addressed envelope for the return of the completed claim information form.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1519 Exchange of claim information; reporting period.
Rule 19. An insurer is responsible for reporting, upon request, automobile insurance and home insurance claim information only for current policies or those that expired 90 days immediately preceding the date of receipt of a request for claim information. The claim information reported must cover the 3 years last preceding the expiration date, including claim information originally reported by another carrier.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1520 Fee for providing claim data prohibited.
Rule 20. A fee must not be charged by an insurer for providing the claim information required by these rules for the first 12 calendar months immediately following October 30, 1981.
History: 1981 AACS; 2021 MR 6, Eff. Mar 24, 2021.

R 500.1521 Figure 1.
Rule 21. Figure 1 reads as follows:
Date Submitted: _____
Named Insured _____
Address _____

Responding Company
Policy Number _____ Period Insured: From _____ to _____

We recently received an application for auto property (circle one) insurance from the above individual. As provided for in Section 2130 of the Insurance Code of 1956, 1956 PA 218, MCL 500.2130, please supply the claim experience for the past 3 years as available. If additional space is needed, please complete on the back of this form.

FOR AUTOMOBILE CLAIMS

Claim Status (Check One)			Amount of Loss Paid				Name of Driver of Insured
Open	Closed	Loss Date	BI	PIP	PD	Coll	Vehicle if Available

1._____ _____ _____ _____ _____ _____ _____ _____
2._____ _____ _____ _____ _____ _____ _____ _____
3._____ _____ _____ _____ _____ _____ _____ _____

FOR HOME INSURANCE CLAIMS

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

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

_____
Name of Company

_____
Address

_____
Date Completed

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

CREDIT INSURANCE AGE UNDERWRITING

R 500.2031
Source: 1983 AACS.

R 500.2032
Source: 1983 AACS.

HEARING PROCEDURES

R 500.2101

R 500.2102
Source: 1983 AACS.

R 500.2103
Source: 1983 AACS.

R 500.2104
Source: 1983 AACS.

R 500.2105
Source: 2015 AACS.

R 500.2106
Source: 2015 AACS.

R 500.2107
Source: 2015 AACS.

R 500.2108
Source: 1983 AACS.

R 500.2109
Source: 2015 AACS.

R 500.2110
Source: 2015 AACS.

R 500.2111
Source: 2015 AACS.

R 500.2112
Source: 2015 AACS.

R 500.2113
Source: 2015 AACS.

R 500.2114
Source: 2015 AACS.

R 500.2115
Source: 2015 AACS.

R 500.2116
Source: 2015 AACS.

R 500.2117
Source: 2015 AACS.

R 500.2118
Source: 2015 AACS.

R 500.2119
Source: 2015 AACS.

R 500.2120
Source: 2015 AACS.

R 500.2121
Source: 2015 AACS.

R 500.2122
Source: 2015 AACS.

R 500.2123
Source: 2015 AACS.

R 500.2124
Source: 2015 AACS.

R 500.2125
Source: 2015 AACS.

R 500.2126
Source: 2015 AACS.

R 500.2127
Source: 2015 AACS.

R 500.2128
Source: 2015 AACS.

R 500.2129
Source: 2015 AACS.

R 500.2130
Source: 2015 AACS.

R 500.2131
Source: 2015 AACS.

R 500.2132
Source: 1983 AACS.

R 500.2133
Source: 1983 AACS.

R 500.2134
Source: 2015 AACS.

R 500.2136
Source: 2015 AACS.

R 500.2137
Source: 2015 AACS.

R 500.2138
Source: 2015 AACS.

R 500.2139
Source: 1983 AACS.

R 500.2140
Source: 1983 AACS.

R 500.2141
Source: 1983 AACS.

R 500.2142
Source: 1983 AACS.

CLARIFICATION OF REASONABLE CLASSIFICATION SYSTEM UNDER INSURANCE CODE

R 500.2151
Source: 2012 AACS.

R 500.2152
Source: 2012 AACS.

R 500.2153
Source: 2012 AACS.

R 500.2154
Source: 2012 AACS.

R 500.2155
Source: 2012 AACS.

INSURANCE POLICY FORMS - DISCRETIONARY CLAUSES

R 500.2201
Source: 2007 AACS.

R 500.2202
Source: 2007 AACS.

INSURANCE POLICY FORMS - SHORTENED LIMITATION OF ACTION CLAUSES

R 500.2211
Source: 2007 AACS.

R 500.2212
Source: 2007 AACS.

INSURANCE POLICY FORMS - NONCONFORMING CLAUSES

R 500.2231
Source: 2010 AACS.

R 500.2232
Source: 2010 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE BUREAU

GENERAL RULES

R 501.1
Source: 1979 AC.

R 501.2
Source: 1979 AC.

R 501.3
Source: 2018 AACS.

R 501.4
Source: 1997 AACS.

R 501.5
Source: 1997 AACS.

R 501.6
Source: 1997 AACS.

R 501.7
Source: 1997 AACS.

R 501.9
Source: 1997 AACS.

R 501.10
Source: 1997 AACS.

R 501.11
Source: 1979 AC.

R 501.12
Source: 1979 AC.

R 501.13
Source: 1979 AC.

R 501.14
Source: 1997 AACS.

R 501.15
Source: 1997 AACS.

WRITTEN EXAMINATION FOR HEALTH AND ACCIDENT AGENTS

R 501.151
Source: 1997 AACS.

R 501.152
Source: 1997 AACS.

R 501.153
Source: 1997 AACS.

R 501.154—R 501.156
Source: 1997 AACS.

R 501.157
Source: 1983 AACS.

R 501.158
Source: 1997 AACS.

FARMERS' MUTUAL FIRE INSURANCE COMPANIES

R 501.201
Source: 1979 AC.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

PETITION REQUESTING PROMULGATION, AMENDMENT, OR RESCISSION OF RULES

R 501.351
Source: 2018 AACS.

R 501.352
Source: 2018 AACS.

R 501.353
Source: 2018 AACS.

R 501.354
Source: 2018 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

PROCEDURES FOR INFORMAL MANAGERIAL-LEVEL CONFERENCES AND REVIEW BY COMMISSIONER OF INSURANCE

R 550.101
Source: 2018 AACS.
R 550.102
Source: 2018 AACS.

R 550.103
Source: 2018 AACS.

R 550.104
Source: 2018 AACS.

R 550.105
Source: 2018 AACS.

R 550.106
Source: 2018 AACS.

R 550.107
Source: 2018 AACS.

R 550.108
Source: 2018 AACS.

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

INSURANCE

CERTIFICATES - DISCRETIONARY CLAUSES

R 550.111
Source: 2018 AACS.

R 550.112
Source: 2018 AACS.

CREDIT INSURANCE RATES, FORMS, AND STANDARDS

R 550.201
Source: 1995 AACS.

R 550.202
Source: 1995 AACS.

R 550.203
Source: 1987 AACS.

R 550.204
Source: 1987 AACS.

R 550.205
Source: 1987 AACS.

R 550.206
Source: 1987 AACS.

R 550.207
Source: 1987 AACS.

R 550.208
Source: 1987 AACS.

R 550.209
Source: 1987 AACS.

R 550.210
Source: 1987 AACS.

R 550.211
Source: 1995 AACS.

R 550.212
Source: 1995 AACS.

R 550.213
Source: 1987 AACS.

R 550.214
Source: 1987 AACS.

R 550.215
Source: 1987 AACS.

R 550.216
Source: 1987 AACS.

R 550.217
Source: 1987 AACS.

R 550.218
Source: 1987 AACS.

R 550.219
Source: 1987 AACS.

R 550.220
Source: 1987 AACS.

R 550.221
Source: 1987 AACS.

CREDIT INSURANCE POLICY FORMS – DISCRETIONARY CLAUSES

R 550.301
Source: 2007 AACS.

R 550.302

Source: 2007 AACS.

DEPARTMENT OF TREASURY

HEALTH INSURANCE CLAIMS ASSESSMENT ACT

GENERAL RULES

R 550.402
Source: 2013 AACS.

R 550.403
Source: 2013 AACS.

R 550.404
Source: 2013 AACS.

DEPARTMENT OF COMMUNITY HEALTH

BUREAU OF FINANCIAL MANAGEMENT AND ADMINISTRATIVE SERVICES

SHARING HEALTH CARE INFORMATION

R 550.501
Source: 2010 AACS.

R 550.502
Source: 2010 AACS.

R 550.503
Source: 2010 AACS.

R 550.504
Source: 2010 AACS.

R 550.505
Source: 2010 AACS.

CORPORATION AND SECURITIES BUREAU

LIVING CARE

PART 1. GENERAL PROVISIONS

R 554.1
Source: 2015 AACS.

R 554.2
Source: 2015 AACS.

R 554.3
Source: 2015 AACS.

R 554.4
Source: 2015 AACS.

R 554.5
Source: 2015 AACS.

R 554.6
Source: 2015 AACS.

R 554.21
Source: 2015 AACS.

R 554.22
Source: 2015 AACS.

R 554.23
Source: 2015 AACS.

R 554.24
Source: 2015 AACS.

R 554.25
Source: 2015 AACS.

R 554.26
Source: 2015 AACS.

R 554.27
Source: 2015 AACS.

R 554.28
Source: 2015 AACS.

R 554.29
Source: 2015 AACS.

R 554.31
Source: 2015 AACS.

R 554.32
Source: 2015 AACS.

R 554.33
Source: 2015 AACS.

R 554.34
Source: 2015 AACS.

R 554.35
Source: 2015 AACS.

R 554.41
Source: 2015 AACS.

R 554.42
Source: 2015 AACS.

R 554.51
Source: 2015 AACS.

R 554.52
Source: 2015 AACS.

R 554.53
Source: 2015 AACS.

R 554.61
Source: 2015 AACS.

R 554.62
Source: 2015 AACS.

R 554.63
Source: 2015 AACS.

R 554.64
Source: 2015 AACS.

R 554.65
Source: 2015 AACS.

R 554.66
Source: 2015 AACS.

R 554.67
Source: 2015 AACS.

R 554.68
Source: 2015 AACS.

R 554.69
Source: 2015 AACS.

R 554.70
Source: 2015 AACS.

R 554.71
Source: 2015 AACS.

FARMLAND AND OPEN SPACE PRESERVATION

R 554.701
Source: 2013 AACS.

PART 2. ELIGIBLE LANDS

R 554.721
Source: 2013 AACS.

R 554.722
Source: 2013 AACS.

R 554.723
Source: 2013 AACS.

PART 3. APPLICATION FOR DEVELOPMENT RIGHTS AGREEMENT OR EASEMENT

R 554.731
Source: 2013 AACS.

R 554.732
Source: 1979 AC.

R 554.733
Source: 2013 AACS.

R 554.734
Source: 2013 AACS.

R 554.735
Source: 1979 AC.

R 554.736
Source: 2013 AACS.

R 554.737
Source: 2013 AACS.

PART 4. TERMINATION OF A DEVELOPMENT RIGHTS AGREEMENT OR EASEMENT

R 554.741
Source: 2013 AACS.

R 554.742
Source: 2013 AACS.

R 554.743
Source: 2013 AACS.

R 554.744
Source: 2013 AACS.

R 554.745
Source: 1979 AC.

R 554.746
Source: 2013 AACS.

R 554.747
Source: 2013 AACS.

R 554.748
Source: 1979 AC.

R 554.749
Source: 1979 AC.

R 554.750
Source: 2013 AACS.

R 554.751
Source: 2013 AACS.

CONDOMINIUMS

PART 1. GENERAL PROVISIONS

R 559.101
Source: 1985 AACS.

R 559.102
Source: 1985 AACS.

R 559.103
Source: 1997 AACS.

R 559.104
Source: 1997 AACS.

R 559.105
Source: 1997 AACS.

R 559.106
Source: 1985 AACS.

R 559.107
Source: 1979 AC.

R 559.108
Source: 2014 AACS.

R 559.109
Source: 1985 AACS.

R 559.110
Source: 2014 AACS.

R 559.111
Source: 1985 AACS.

R 559.112
Source: 1985 AACS.

PART 2. PERMIT TO TAKE RESERVATIONS

R 559.201
Source: 1997 AACS.

PART 3. CONTENTS OF A MASTER DEED

R 559.301
Source: 1985 AACS.

PART 4. CONDOMINIUM SUBDIVISION PLAN

R 559.401
Source: 1985 AACS.

R 559.42
Source: 1979 AC.

R 559.403
Source: 1985 AACS.

R 559.404
Source: 1979 AC.

R 559.405
Source: 1985 AACS.

R 559.406
Source: 1985 AACS.

R 559.407
Source: 1985 AACS.

R 559.408
Source: 1979 AC.

R 559.409
Source: 1985 AACS.

R 559.410
Source: 1985 AACS.

R 559.411
Source: 1985 AACS.

R 559.412
Source: 1997 AACS.

R 559.413
Source: 1985 AACS.

R 559.414
Source: 1997 AACS.

R 559.415
Source: 1979 AC.

PART 5. BYLAWS IN A MASTER DEED

R 559.501
Source: 1985 AACS.

R 559.502
Source: 1985 AACS.

R 559.503
Source: 1997 AACS.

R 559.504
Source: 1979 AC.

R 559.505
Source: 1985 AACS.

R 559.506
Source: 1979 AC.

R 559.507
Source: 1979 AC.

R 559.508
Source: 1979 AC.

R 559.509
Source: 1979 AC.

R 559.510
Source: 1979 AC.

R 559.511
Source: 1985 AACS.

R 559.512
Source: 1979 AC.

R 559.513
Source: 1979 AC.

R 559.514
Source: 1979 AC.

R 559.515
Source: 1985 AACS.

PART 6. APPROVAL OF A MASTER DEED

R 559.601
Source: 1997 AACS.

R 559.602
Source: 1997 AACS.

R 559.603
Source: 1997 AACS.

R 559.604
Source: 1997 AACS.

R 559.605
Source: 1997 AACS.

R 559.606
Source: 1997 AACS.

R 559.607
Source: 1997 AACS.

PART 7. PERMIT TO SELL AND SALES

R 559.701
Source: 1997 AACS.

R 559.702
Source: 1997 AACS.

R 559.703
Source: 1997 AACS.

R 559.704
Source: 1997 AACS.

PART 8. ESCROW

R 559.801
Source: 1997 AACS.

R 559.802
Source: 1997 AACS.

R 559.803
Source: 1997 AACS.

PART 9. DISCLOSURE STATEMENT

R 559.901
Source: 1985 AACS.

R 559.902
Source: 1985 AACS.

R 559.903
Source: 1985 AACS.

DEPARTMENT OF LABOR & ECONOMIC GROWTH

BUREAU OF CONSTRUCTION CODES

OFFICE OF LAND SURVEY AND REMONUMENTATION

SUBDIVISIONS OF LAND

PART 1. DEPARTMENT OF LABOR AND ECONOMIC GROWTH

R 560.101
Source: 2008 AACS.

R 560.103
Source: 2008 AACS.

R 560.104
Source: 2008 AACS.

R 560.105
Source: 2008 AACS.

R 560.106
Source: 2008 AACS.

R 560.107
Source: 2008 AACS.

R 560.108
Source: 2008 AACS.

R 560.109
Source: 2008 AACS.

R 560.110
Source: 2008 AACS.

R 560.111
Source: 2008 AACS.

R 560.112
Source: 2008 AACS.

R 560.113
Source: 2008 AACS.

R560.114
Source: 2008 AACS.

R 560.115
Source: 2008 AACS.

R 560.116
Source: 2008 AACS.

R 560.117
Source: 2008 AACS.

R 560.118
Source: 2008 AACS.

R 560.119
Source: 2008 AACS.

R560.120
Source: 2008 AACS.

R 560.121
Source: 2008 AACS.

R 560.122
Source: 2008 AACS.

R 560.126
Source: 2008 AACS.

R 560.127
Source: 2008 AACS.

R 560.128
Source: 2008 AACS.

R 560.129
Source: 2008 AACS.

R 560.130
Source: 2008 AACS.

R 560.131

Source: 2008 AACS.

R 560.132
Source: 2008 AACS.

R 560.133
Source: 2008 AACS.

R 560.134
Source: 2008 AACS.

R 560.135
Source: 2008 AACS.

PART 2. DEPARTMENT OF TRANSPORTATION

R 560.201
Source: 1979 AC.

R 560.202
Source: 1979 AC.

R 560.203
Source: 1979 AC.

R 560.204
Source: 1979 AC.

R 560.205
Source: 1979 AC.

DEPARTMENTS OF TREASURY, TRANSPORTATION, NATURAL RESOURCES, AND COMMUNITY HEALTH

SUBDIVISIONS OF LAND

PART 3. DEPARTMENT OF NATURAL RESOURCES

R 560.301
Source: 1988 AACS.

R 560.302
Source: 1988 AACS.

R 560.303
Source: 1998-2000 AACS.

R 560.304
Source: 1998-2000 AACS.

PART 4. DEPARTMENT OF ENVIRONMENTAL QUALITY ON-SITE WATER SUPPLY AND SEWAGE DISPOSAL FOR LAND DIVISIONS AND SUBDIVISIONS

R 560.401
Source: 2001 AACS.

R 560.402

Source: 2001 AACS.

R 560.403
Source: 2001 AACS.

R 560.404
Source: 2001 AACS.

R 560.405
Source: 2001 AACS.

R 560.406
Source: 2001 AACS.

R 560.407
Source: 2001 AACS.

R 560.408
Source: 2001 AACS.

R 560.409
Source: 2001 AACS.

R 560.410
Source: 2001 AACS.

R 560.411
Source: 2001 AACS.

R 560.412
Source: 2001 AACS.

R 560.413
Source: 2001 AACS.

R 560.414
Source: 2001 AACS.

R 560.415
Source: 2001 AACS.

R 560.416
Source: 2001 AACS.

R 560.417
Source: 2001 AACS.

R 560.418
Source: 2001 AACS.

R 560.419
Source: 2001 AACS.

R 560.420
Source: 2001 AACS.

R 560.421
Source: 2001 AACS.

R 560.422
Source: 2001 AACS.

R 560.423
Source: 2001 AACS.

R 560.424
Source: 2001 AACS.

R 560.425
Source: 2001 AACS.

R 560.426
Source: 2001 AACS.

R 560.427
Source: 2001 AACS.

R 560.428
Source: 2001 AACS.

DEPARTMENT OF TREASURY

STATE TREASURER

AUDIT STANDARDS FOR EXAMINATIONS UNDER

THE UNIFORM UNCLAIMED PROPERTY ACT

R 567.1
Source: 2017 AACS.

R 567.2
Source: 2017 AACS.

R 567.3
Source: 2017 AACS.

R 567.4
Source: 2017 AACS.

R 567.5
Source: 2017 AACS.

R 567.6
Source: 2017 AACS.

R 567.7
Source: 2017 AACS.

R 567.8
Source: 2017 AACS.

R 567.9
Source: 2017 AACS.

R 567.10

Source: 2017 AACS.

R 567.11
Source: 2017 AACS.

R 567.12
Source: 2017 AACS.

R 567.13
Source: 2017 AACS.

R 567.14
Source: 2017 AACS.

R 567.15
Source: 2017 AACS.

FAMILY INDEPENDENCE AGENCY

STATE CHILD ABUSE AND NEGLECT PREVENTION BOARD

CHILDREN'S TRUST FUND GRANT PROGRAM

R 722.751
Source: 1986 AACS.

R 722.752
Source: 1986 AACS.

R 722.753
Source: 1986 AACS.

R 722.754
Source: 1986 AACS.

R 722.755
Source: 1986 AACS.

R 722.756
Source: 1986 AACS.

JAILS, LOCKUPS, AND SECURITY CAMPS

PART 1. GENERAL PROVISIONS

R 791.501 – R 791.655
Source: 1998-2000 AACS.

DEPARTMENT OF CORRECTIONS

BUREAU OF CORRECTIONAL FACILITIES

JAILS, LOCKUPS, AND SECURITY CAMPS

R 791.701
Source: 1998-2000 AACS.

R 791.702
Source: 1998-2000 AACS.

R 791.703
Source: 1998-2000 AACS.

R 791.704
Source: 1998-2000 AACS.

R 791.705
Source: 1998-2000 AACS.

R 791.706
Source: 1998-2000 AACS.

R 791.707
Source: 1998-2000 AACS.

R 791.708
Source: 1998-2000 AACS.

R 791.709
Source: 1998-2000 AACS.

R 791.710
Source: 1998-2000 AACS.

R 791.711
Source: 1998-2000 AACS.

R 791.712
Source: 1998-2000 AACS.

R 791.713
Source: 1998-2000 AACS.

R 791.714
Source: 1998-2000 AACS.

R 791.715
Source: 1998-2000 AACS.

R 791.716
Source: 1998-2000 AACS.

R 791.717
Source: 1998-2000 AACS.

R 791.718
Source: 1998-2000 AACS.

R 791.719
Source: 1998-2000 AACS.

R 791.720
Source: 1998-2000 AACS.

R 791.721
Source: 1998-2000 AACS.

R 791.722
Source: 1998-2000 AACS.

R 791.723
Source: 1998-2000 AACS.

R 791.724
Source: 1998-2000 AACS.

R 791.725
Source: 1998-2000 AACS.

R 791.726
Source: 1998-2000 AACS.

R 791.727
Source: 1998-2000 AACS.

R 791.728
Source: 1998-2000 AACS.

R 791.729
Source: 1998-2000 AACS.

R 791.730
Source: 1998-2000 AACS.

R 791.731
Source: 1998-2000 AACS.

R 791.732
Source: 1998-2000 AACS.

R 791.733
Source: 1998-2000 AACS.

R 791.734
Source: 1998-2000 AACS.

R 791.735
Source: 1998-2000 AACS.

R 791.736
Source: 1998-2000 AACS.

R 791.737
Source: 1998-2000 AACS.

R 791.738
Source: 1998-2000 AACS.

R 791.739
Source: 1998-2000 AACS.

R 791.749
Source: 1998-2000 AACS.

DEPARTMENT OF CORRECTIONS

GENERAL RULES

PART 1. GENERAL PROVISIONS

R 791.1101
Source: 2002 AACS.

R 791.1105
Source: 1997 AACS.

R 791.1115
Source: 1989 AACS.

PART 2. ORGANIZATION AND OPERATION OF DEPARTMENT

R 791.2201
Source: 1997 AACS.

R 791.2205
Source: 1993 AACS.

R 791.2210
Source: 1989 AACS.

R 791.2215
Source: 1997 AACS.

R 791.2220
Source: 1993 AACS.

R 791.2225
Source: 1997 AACS.

R 791.2230
Source: 1997 AACS.

R 791.2235
Source: 1997 AACS.

R 791.2240
Source: 1997 AACS.

R 791.2245
Source: 1997 AACS.

PART 3. PRISONER HEARING PROCEDURES

R 791.3301
Source: 2015 AACS.

R 791.3305
Source: 2015 AACS.

R 791.3310
Source: 2015 AACS.

R 791.3315
Source: 2015 AACS.

R 791.3320
Source: 2002 AACS.

R 791.3325
Source: 1997 AACS.

PART 4. PRISONER CLASSIFICATION AND TRANSFER

R 791.4401
Source: 2002 AACS.

R 791.4405
Source: 1997 AACS.

R 791.4410
Source: 2003 AACS.

R 791.4415
Source: 2002 AACS.

R 791.4420
Source: 1993 AACS.

R 791.4425
Source: 1993 AACS.

R 791.4430
Source: 1997 AACS.

R 791.4435
Source: 1997 AACS.

R 791.4440
Source: 1997 AACS.

PART 5. PRISONER MISCONDUCT

R 791.5501
Source: 2002 AACS.

R 791.5505
Source: 2002 AACS.

R 791.5510
Source: 2002 AACS.

R 791.5513
Source: 1998-2000 AACS.

R 791.5515
Source: 1998-2000 AACS.

PART 6. PRISONER RIGHTS AND PRIVILEGES

R 791.6601

Source: 1997 AACS.

EMERGENCY RULES

FINDING OF EMERGENCY

R 791.6603
Source: 2002 AACS.

R 791.6605
Source: 1998-2000 AACS.

R 791.6607
Source: 1995 AACS.

R 791.6609
Source: 1995 AACS.

R 791.6611
Source: 1995 AACS.

R 791.6613
Source: 1997 AACS.

R 791.6614
Source: 1995 AACS.

R 791.6615
Source: 1997 AACS.

R 791.6617
Source: 1997 AACS.

R 791.6619
Source: 1997 AACS.

R 791.6621
Source: 1997 AACS.

R 791.6623
Source: 1997 AACS.

R 791.6625
Source: 1997 AACS.

R 791.6627
Source: 1997 AACS.

R 791.6629
Source: 1997 AACS.

R 791.6631
Source: 1997 AACS.

R 791.6633
Source: 1997 AACS.

R 791.6635
Source: 1997 AACS.

R 791.6637
Source: 1997 AACS.

R 791.6638
Source: 1995 AACS.

R 791.6639
Source: 1993 AACS.

R 791.6641
Source: 1997 AACS.

R 791.6643
Source: 1997 AACS.

R 791.6645
Source: 1997 AACS.

PART 7. PAROLE, REPRIEVE, AND COMMUTATION OF SENTENCE

R 791.7701
Source: 1997 AACS.

R 791.7705
Source: 1997 AACS.

R 791.7710
Source: 1997 AACS.

R 791.7715
Source: 1996 AACS.

R 791.7716
Source: 1996 AACS.

R 791.7720
Source: 1997 AACS.

R 791.7725
Source: 1997 AACS.

R 791.7730
Source: 1996 AACS.

R 791.7735
Source: 1988 AACS.

R 791.7740
Source: 1988 AACS.

R 791.7745
Source: 1988 AACS.

R 791.7750
Source: 1988 AACS.

R 791.7755
Source: 1997 AACS.

R 791.7760
Source: 1996 AACS.

R 791.7765
Source: 1996 AACS.

R 791.7770
Source: 1997 AACS.

PART 8. YOUTHFUL TRAINEES

R 791.8801
Source: 1997 AACS.

R 791.8810
Source: 1997 AACS.

R 791.8820
Source: 1997 AACS.

PART 9. PROBATION

R 791.9910
Source: 1993 AACS.

R 791.9930
Source: 1993 AACS.

PART 10. INTERSTATE COMPACT ON PAROLE AND PROBATION

R 791.10001
Source: 1997 AACS.

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

MICHIGAN OFFICE OF ADMINISTRATIVE HEARINGS AND RULES

ADMINISTRATIVE HEARING RULES

PART 1: GENERAL

R 792.10101
Source: 2016 AACS.

R 792.10102
Source: 2015 AACS.

R 792.10103
Source: 2015 AACS.

R 792.10104
Source: 2015 AACS.

R792.10105
Source: 2015 AACS.

R 792.10106

Source: 2015 AACS.

R 792.10107
Source: 2015 AACS.

R 792.10108
Source: 2015 AACS.

R 792.10109
Source: 2015 AACS.

R 792.10110
Source: 2015 AACS.

R 792.10111
Source: 2015 AACS.

R 792.10112
Source: 2015 AACS.

R 792.10113
Source: 2015 AACS.

R 792.10114
Source: 2015 AACS.

R 792.10115
Source: 2015 AACS.

R 792.10116
Source: 2015 AACS.

R 792.10117
Source: 2015 AACS.
R 792.10118
Source: 2015 AACS.

R 792.10119
Source: 2015 AACS.

R 792.10120
Source: 2015 AACS.

R 792.10121
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R 792.10122
Source: 2015 AACS.

R 792.10123
Source: 2015 AACS.

R 792.10124
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Source: 2015 AACS.

R 792.10126
Source: 2015 AACS.

R 792.10127
Source: 2015 AACS.

R 792.10128
Source: 2015 AACS.

R 792.10129
Source: 2015 AACS.

R 792.10130
Source: 2015 AACS.

R 792.10131
Source: 2015 AACS.

R792.10132
Source: 2015 AACS.

R 792.10133
Source: 2015 AACS.

R 792.10134
Source: 2015 AACS.

R 792.10135
Source: 2015 AACS.

R 792.10136
Source: 2015 AACS.

R 792.10137
Source: 2015 AACS.

PART 2. TAX TRIBUNAL

SUBPART A. GENERAL PROVISIONS.

R 792.10201
Source: 2015 AACS.

R 792.10203
Source: 2015 AACS.

R 792.10205
Source: 2015 AACS.

R 792.10207
Source: 2015 AACS.

R 792.10209
Source: 2015 AACS.

R 792.10211
Source: 2015 AACS.

R 792.10213
Source: 2015 AACS.

SUBPART B. MATTERS BEFORE ENTIRE TRIBUNAL.

R 792.10215
Source: 2015 AACS.

R 792.10217
Source: 2013 AACS.

R 792.10219
Source: 2015 AACS.

R 792.10221
Source: 2015 AACS.

R 792.10223
Source: 2015 AACS.

R 792.10225
Source: 2015 AACS.

R 792.10227
Source: 2015 AACS.

R 792.10229
Source: 2015 AACS.

R 792.10231
Source: 2015 AACS.

R 792.10233
Source: 2015 AACS.

R 792.10237
Source: 2015 AACS.

R 792.10239
Source: 2015 AACS.

R 792.10241
Source: 2015 AACS.

R 792.10243
Source: 2015 AACS.

R 792.10247
Source: 2015 AACS.

R 792.10249

Source: 2013 AACS.

R 792.10251
Source: 2015 AACS.

R 792.10253
Source: 2015 AACS.

R 792.10255
Source: 2015 AACS.

R 792.10257
Source: 2015 AACS.

R 792.10259
Source: 2015 AACS.

SUBPART C. MATTERS BEFORE SMALL CLAIMS DIVISION.

R 792.10261
Source: 2015 AACS.

R 792.10263
Source: 2015 AACS.

R 792.10265
Source: 2015 AACS.

R 792.10267
Source: 2015 AACS.

R 792.10269
Source: 2015 AACS.

R 792.10271
Source: 2015 AACS.

R 792.10273
Source: 2015 AACS.

R 792.10275
Source: 2015 AACS.

R 792.10277
Source: 2015 AACS.

R 792.10279

R 792.10281
Source: 2013 AACS.

R 792.10283
Source: 2015 AACS.

R 792.10285

Source: 2013 AACS.

R 792.10287
Source: 2015 AACS.

R 792.10289
Source: 2015 AACS.

PART 3: DEPARTMENT OF ENVIRONMENTAL QUALITY AND DEPARTMENT OF NATURAL RESOURCES

R 792.10301 Scope of rules; statutory procedures; absence of procedures.
Rule 301. (1) These rules govern all contested case proceedings before the department of environment, Great Lakes, and energy and the department of natural resources and requests for declaratory rulings.
(2) These rules do not apply to proceedings under parts 615 and 617 of the natural resources and environmental protection act, 1994 PA 451, MCL 324.61501 to 324.61527 and MCL 324.61701 to 324.61738.
(3) If a rule does not address an issue of procedure, then chapter 4 of the act applies.
History: 2015 AACS.; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10302 Definitions.
Rule 302. As used in this part:
(a) "Department" means the department of environment, Great Lakes, and energy or the department of natural resources.
(b) "Director" means the director of the department of environment, Great Lakes, and energy or the department of natural resources.
(c) "Final decision maker" means the director or any other person to whom the director has delegated final decision making authority in contested cases.
History: 2015 AACS.; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10303
Source: 2015 AACS.

R 792.10304
Source: 2015 AACS.

R 792.10305
Source: 2015 AACS.

R 792.10306
Source: 2015 AACS.

PART 4: PUBLIC SERVICE COMMISSION.
PRACTICE AND PROCEDURE BEFORE THE COMMISSION

SUBPART A. GENERAL PROVISIONS

R 792.10401
Source: 2015 AACS.

R 792.10402
Source: 2015 AACS.

R 792.10403
Source: 2015 AACS.

R 792.10404
Source: 2015 AACS.

R 792.10405
Source: 2015 AACS.

R 792.10406
Source: 2015 AACS.

R 792.1407
Source: 2015 AACS.

R 792.10408
Source: 2015 AACS.

R 792.10409
Source: 2015 AACS.

SUBPART B. INTERVENTIONS

R 792.10410
Source: 2015 AACS.

R 792.10411
Source: 2015 AACS.

R 792.10412
Source: 2015 AACS.

R 792.10413
Source: 2015 AACS.

R 792.10414
Source: 2015 AACS.

SUBPART C. HEARINGS

R 792.10415
Source: 2015 AACS.

R 792.10416
Source: 2015 AACS.

R 792.10417
Source: 2015 AACS.

R 792.10418
Source: 2015 AACS.

R 792.10419
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R 792.10420
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R 792.10421
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R 792.10422
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R 792.10423
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R 792.10424
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R 792.10425
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R 792.10426
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R 792.10427
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R 792.10428
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R 792.10429
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R 792.10430
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R 792.10431
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R 792.10432
Source: 2015 AACS.

R 792.10433
Source: 2015 AACS.

R 792.10434
Source: 2015 AACS.
R 792.10435
Source: 2015 AACS.

SUBPART D. REOPENINGS AND REHEARINGS

R 792.10436
Source: 2015 AACS.

R 792.10437
Source: 2015 AACS.

R 792.10438

Source: 2015 AACS.

SUBPART E. COMPLAINTS

R 792.10439
Source: 2015 AACS.

R 792.10440
Source: 2015 AACS.

R 792.10441
Source: 2015 AACS.

R 792.10442
Source: 2015 AACS.

R 792.10443
Source: 2015 AACS.

R 792.10444
Source: 2015 AACS.

R 792.10445
Source: 2015 AACS.

R 792.10446
Source: 2015 AACS.

SUBPART F. SPECIFIC PROCEEDINGS

R 792.10447
Source: 2015 AACS.

SUBPART G. DECLARATORY RULINGS

R 792.10448
Source: 2015 AACS.

PART 5: DEPARTMENT OF TRANSPORTATION

SUBPART A. BUREAU OF HIGHWAY TECHNICAL SERVICES – HEARINGS ON TRAFFIC CONTROL ORDERS

R 792.10501 General rules.
Rule 1501. The general rules of the employment relations commission, R 423.101 to R
423.484, govern practice and procedure in administrative hearings conducted by the hearing system in cases arising under 1939 PA 176, MCL 423.1 to 423.30, and 1947 PA 336, MCL 423.201 to 423.217, with the exclusion of parts 2 and 3 of those rules.
History: 2015 AACS; 2015 MR 5, Eff. March 11, 2016; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10502
Source: 2015 AACS.

R 792.10503
Source: 2015 AACS.

R 792.10504
Source: 2015 AACS.

R 792.10505
Source: 2015 AACS.

R 792.10506
Source: 2015 AACS.

SUBPART B. BUREAU OF HIGHWAY TECHNICAL SERVICES DRIVEWAYS, BANNERS, AND PARADES ON AND OVER HIGHWAYS HEARINGS AND APPEALS

R 792.10507
Source: 2015 AACS.

SUBPART C. OFFICE OF HIGHWAY SAFETY RELOCATION ASSISTANCE

R 792.10508
Source: 2015 AACS.

R 792.10509
Source: 2015 AACS.

R 792.10510
Source: 2015 AACS.

R 792.10511
Source: 2015 AACS.

SUBPART D. BUREAU OF HIGHWAY TECHNICAL SERVICES ADVERTISING ADJACENT TO HIGHWAYS – HEARINGS AND APPEALS

R 792.10512
Source: 2015 AACS.

PART 6: DEPARTMENT INSURANCE AND FINANACIAL SERVICES

R 792.10601 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10602 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10603 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10604 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10605 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10606 Rescinded.

History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10607 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10608 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.10609 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

PART 7: LICENSING AND REGULATORY AFFAIRS HEALTH CODE BOARDS. DISCIPLINARY PROCEEDINGS

R 792.10701
Source: 2015 AACS.

R 792.10702
Source: 2015 AACS.

R 792.10703
Source: 2015 AACS.

R 792.10704
Source: 2015 AACS.

R 792.10705
Source: 2015 AACS.

R 792.10706
Source: 2015 AACS.

R 792.10707
Source: 2015 AACS.

R 792.10708
Source: 2015 AACS.

R 792.10709
Source: 2015 AACS.

R 792.10710
Source: 2015 AACS.

R 792.10711
Source: 2015 AACS.

R 792.10712
Source: 2015 AACS.

R 792.10713
Source: 2015 AACS.

R 792.10714
Source: 2015 AACS.

R792.10715
Source: 2015 AACS.

PART 8: DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS CORPORATIONS, SECURITIES & COMMERCIAL LICENSING BUREAU

R 792.10801
Source: 2015 AACS.

R 792.10802
Source: 2015 AACS.

R 792.10803
Source: 2015 AACS.

R 792.10804
Source: 2015 AACS.

R 792.10805
Source: 2015 AACS.

R 792.10806
Source: 2015 AACS.

R 792.10807
Source: 2015 AACS.

R 792.10808
Source: 2015 AACS.

R 792.10809
Source: 2015 AACS.

PART 9: DEPARTMENT OF COMMUNITY HEALTH PROVIDERS HEARING PROCEDURES SUBPART A. EMERGENCY MEDICAL SERVICES PERSONNEL LICENSING

R 792.10901
Source: 2015 AACS.

R 792.10902
Source: 2015 AACS.

R 792.10903
Source: 2015 AACS.

SUBPART B.MEDICAL SERVICES ADMINISTRATION MSA PROVIDER HEARINGS

R 792.10904
Source: 2015 AACS.

R 792.10905
Source: 2015 AACS.

R 792.10906
Source: 2015 AACS.

SUBPART C. LEGISLATION AND POLICY CERTIFICATE OF NEED

R 792.10907
Source: 2015 AACS.

R 792.10908
Source: 2015 AACS.

R 792.10909
Source: 2015 AACS.

R 792.10910
Source: 2015 AACS.

R 792.10911
Source: 2015 AACS.

R 792.10912
Source: 2015 AACS.

PART 10: DEPARTMENT OF HUMAN SERVICES & DEPARTMENT OF COMMUNITY HEALTH

SUBPART A. PUBLIC BENEFITS

R 792.11001
Source: 2015 AACS.

R 792.11002
Source: 2015 AACS.

R 792.11003 **Source:** 2015 AACS.

R 792.11004
Source: 2015 AACS.

R 792.11005
Source: 2015 AACS.
R 792.11006
Source: 2015 AACS.

R 792.11007
Source: 2015 AACS.

R 792.11008
Source: 2015 AACS.

R 792.11009
Source: 2015 AACS.

R 792.11010
Source: 2015 AACS.

R 792.11011
Source: 2015 AACS.

R 792.11012

Source: 2015 AACS.

R 792.11013
Source: 2015 AACS.

R 792.11014
Source: 2015 AACS.

R 792.11015
Source: 2015 AACS.

R 792.11016
Source: 2015 AACS.

R 792.11017
Source: 2015 AACS.

R 792.11018
Source: 2015 AACS.

SUBPART B. DEBT ESTABLISHMENT

R 792.11019
Source: 2015 AACS.

R 792.11020
Source: 2015 AACS.

SUBPART C. ADOPTION SUBSIDY

R 792.11021
Source: 2015 AACS.

R 792.11022
Source: 2015 AACS.

R 792.11023
Source: 2015 AACS.

R 792.11024
Source: 2015 AACS.

SUBPART D. ADULT FOSTER CARE FACILITY LICENSING AND CHILD CARE ORGANIZATION

R 792.11025
Source: 2015 AACS.

R 792.11026
Source: 2015 AACS.

SUBPART E. EXPUNCTION HEARINGS

R 792.11027
Source: 2015 AACS.

PART 11. OCCUPATIONAL SAFETY AND HEALTH

SUBPART A. GENERAL PROVISIONS

R 792.11101
Source: 2015 AACS.

R 792.11102 Definitions.
Rule 1102. (1) "Act" as used in this part means the Michigan occupational safety and health act, 1974 PA 154, MCL 408.1001 to 408.1094.
(2) "Board" means the board of health and safety compliance and appeals within the department.
(3) "Citation" means a written communication issued by the department to an employer under section 33 of the act, MCL 408.1033.
(4) "Day" means a calendar day.
(5) "Department" means the department of labor and economic opportunity.
(6) "Director" means the director of the department or the director's authorized representative.
(7) "Executive secretary" means secretary to the board.
(8) "Party" means an applicant for relief, an employer cited or seeking a variance, an affected employee or employees, or their authorized representative, a person allowed to intervene, or the department.
(9) "Permanent variance" means a written order issued by the department authorizing an employer to deviate from the requirements of an occupational safety or health standard when protection is provided to employees equal to that which would be provided by compliance with the requirements of the standard.
(10) "Temporary variance" means a written order issued by the department authorizing an employer to deviate from the requirements of an occupational safety or health standard before the effective date of the standard for the specific period of time necessary for the employer to achieve compliance with the standard.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11103
Source: 2015 AACS.

R 792.11104
Source: 2015 AACS.

R 792.11105
Source: 2015 AACS.

R 792.11106
Source: 2015 AACS.

SUBPART B. CITATION & MODIFICATION OF ABATEMENT HEARINGS

R 792.11107
Source: 2015 AACS.

R 792.11108
Source: 2015 AACS.

R 792.11109

Source: 2015 AACS.

R 792.11110
Source: 2015 AACS.

R 792.11111
Source: 2015 AACS.

R 792.11112
Source: 2015 AACS.

R 792.11113
Source: 2015 AACS.

R 792.11114
Source: 2015 AACS.

R 792.11115
Source: 2015 AACS.

SUBPART C. VARIANCE HEARINGS

R 792.11116
Source: 2015 AACS.

R 792.11117
Source: 2015 AACS.

R 792.11118
Source: 2015 AACS.

PART 12: WAGE AND FRINGE BENEFIT HEARINGS

R 792.11201
Source: 2015 AACS.

R 792.11202
Source: 2015 AACS.

R 792.11203
Source: 2015 AACS.

R 792.11204
Source: 2015 AACS.

R 792.11205
Source: 2015 AACS.

R 792.11206
Source: 2015 AACS.

R 792.11207
Source: 2015 AACS.
R 792.11208
Source: 2015 AACS.

PART 13: WORKERS' COMPENSATION HEARINGS AND APPEALS

SUBPART A. WORKERS' COMPENSATION BOARD OF MAGISTRATES

R 792.11301 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11302 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11303 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11304 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11305 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11306 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11307 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11309 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11310 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11311 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11312 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11313 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

SUBPART B. MICHIGAN COMPENSATION APPELLATE COMMISSION

R 792.11314 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11315 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11316 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11317 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11318 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11319 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11320 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11321 Rescinded.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

PART 14: EMPLOYMENT SECURITY HEARINGS AND APPEALS

SUBPART A. GENERAL PROVISIONS

R 792.11401
Source: 2015 AACS.

R 792.11402
Source: 2015 AACS.

R 792.11403
Source: 2015 AACS.

R 792.11404
Source: 2015 AACS.

SUBPART B. APPEALS TO ADMINISTRATIVE LAW JUDGES

R 792.11405
Source: 2015 AACS.

R 792.11406
Source: 2015 AACS.

R 792.11407
Source: 2015 AACS.

R 792.11408
Source: 2015 AACS.

R 792.11409
Source: 2015 AACS.

R 792.11410
Source: 2015 AACS.

R 792.11411
Source: 2015 AACS.

R 792.11412

Source: 2015 AACS.

R 792.11413
Source: 2015 AACS.

R 792.11414
Source: 2015 AACS.

R 792.11415
Source: 2015 AACS.

R 792.11416
Source: 2015 AACS.

SUBPART C. MICHIGAN COMPENSATION APPELLATE COMMISSION APPEALS UNEMPLOYMENT CASES

R 792.11417
Source: 2015 AACS.

R 792.11418
Source: 2015 AACS.

R 792.11419
Source: 2015 AACS.

R 792.11420
Source: 2015 AACS.

R 792.11421
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R 792.11422
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R 792.11423
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R 792.11424
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R 792.11425
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R 792.11426
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R 792.11427
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R 792.11428
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R 792.11429
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R 792.11430

Source: 2015 AACS.

R 792.11431
Source: 2015 AACS.

R 792.11432
Source: 2015 AACS.

R 792.11433
Source: 2015 AACS.

PART 15. EMPLOYMENT RELATIONS COMMISSION

R 792.11501 General rules.
Rule 1501. The general rules of the employment relations commission, R 423.101 to R 423.484, govern practice and procedure in administrative hearings conducted by the hearing system in cases arising under 1939 PA 176, MCL 423.1 to 423.30, and 1947 PA 336, MCL 423.201 to 423.217, with the exclusion of parts 2 and 3 of those rules.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11503
Source: 2016 AACS.

R 792.11504
Source: 2016 AACS.

R 792.11505
Source: 2016 AACS.

R 792.11506
Source: 2016 AACS.

R 792.11507
Source: 2016 AACS.

R 792.11508
Source: 2016 AACS.

R 792.11509
Source: 2016 AACS.

R 792.11510
Source: 2016 AACS.

R 792.11511
Source: 2016 AACS.

R 792.11512
Source: 2016 AACS.

R 792.11513
Source: 2016 AACS.

R 792.11514
Source: 2016 AACS.

R 792.11515
Source: 2016 AACS.

R 792.11516
Source: 2016 AACS.

R 792.11517
Source: 2016 AACS.

PART 16: OFFICE OF RETIREMENT SERVICES

SUBPART A. GENERAL HEARING RULES

R 792.11601 Scope; definitions.
Rule 1601. (1) These rules apply to hearings held under the jurisdiction of the state employees' retirement board, the judges' retirement board, the state police retirement board, and the public school employees' retirement board.
(2) As used in these rules:
(a) " Retirement act" means the state employees' retirement act, 1943 PA 240, MCL 38.1 to 38.69; the judges retirement act of 1992, 1992 PA 234, MCL 38.2101 to 38.2670; the state police retirement act of 1986, 1986 PA 182, MCL 38.1601 to 38.1674; or the public school employees retirement act of 1979, 1980 PA 300, MCL 38.1301 to 38.1437, as applicable.
(b) "Application" means a request for a benefit provided by an applicable retirement act, including a request to reopen a closed application and a reapplication.
(c) "Board" means the retirement board as defined in the applicable retirement act.
(d) "Closed application" means a request by an individual for a benefit provided by the act that was withdrawn by the individual or otherwise never decided by the retirement system or the board.
(e) "Good cause," as used in this part, means the legitimate failure to file a document or a witness list in a timely manner and does not include a person's own careless neglect or inattention to the requirements of these rules.
(f) "Reapplication" means a request by an individual for a benefit provided by the applicable retirement act, that was previously decided by the staff of the retirement system or the board.
(3) The terms defined in the retirement act have the same meaning when used in these rules.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11602
Source: 2015 AACS.

R 792.11603
Source: 2015 AACS.

R 792.11604
Source: 2015 AACS.

R 792.11605
Source: 2015 AACS.

R 792.11606
Source: 2015 AACS.

R 792.11607
Source: 2015 AACS.

R 792.11608
Source: 2015 AACS.

R 792.11609 Medical examination.

Rule 1609. (1) For purposes of deciding eligibility for disability retirement under sections 21 and 24 of the state employees' retirement act, 1943 PA 240, MCL 38.21 and 38.24, a medical examination conducted by 1 or more medical advisors means either a personal medical examination of the retirement system member or a review of the application and medical records of the member.
(2) If an applicant for a disability retirement under section 21 or 24 of the state employees' retirement act, 1943 PA 240, MCL 38.21 and 38.24, fails to submit to a reasonable medical examination requested by the system, the application shall be denied.
History: 2015 AACS; 2021 MR 21, Eff. Nov. 12, 2021.

R 792.11610
Source: 2015 AACS.

R 792.11611
Source: 2015 AACS.

PART 17: TEACHER CERTIFICATION

R 792.11701
Source: 2015 AACS.

R 792.11702
Source: 2015 AACS.

R 792.11703
Source: 2015 AACS.

R 792.11704
Source: 2015 AACS.

R 792.11705
Source: 2015 AACS.

R 792.11706
Source: 2015 AACS.

R 792.11707
Source: 2015 AACS.

R 792.11708
Source: 2015 AACS.

R 792.11709
Source: 2015 AACS.

PART 18: SPECIAL EDUCATION HEARINGS

R 792.11801
Source: 2015 AACS.

R 792.11802
Source: 2015 AACS.

R 792.11803
Source: 2015 AACS.

PART 19: CORRECTIONS

R 792.11901
Source: 2015 AACS.

R 792.11902
Source: 2015 AACS.

R 792.11903
Source: 2015 AACS.