THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.7704 Coverages; liability of association; limitations.

Sec. 7704. (1) This chapter shall provide coverage for the policies and contracts specified in subsection (2) to the following persons:

(a) To a person, other than nonresident certificate holders under group policies or contracts, who, regardless of where he or she resides, is the beneficiary, assignee, or payee of a person covered under subdivision (b).

(b) To a person who is an owner of, or certificate holder under, a policy or contract described in subsection (2), other than an unallocated annuity contract or structured settlement contract, and which owner or certificate holder is 1 of the following:

(*i*) A resident.

(*ii*) Not a resident, if all of the following conditions are met:

(A) The insurer that issued the policy or contract is domiciled in this state.

(B) The state in which the person resides has an association similar to the association created by this chapter.

(C) The person is not eligible for coverage by an association in any other state because the insurer was not licensed in that state at the time specified in the state's guaranty association law.

(*iii*) Not a resident, if both of the following conditions are met:

(A) The person would have been considered a resident at the time the contract was obtained by the person.

(B) The person is not eligible for coverage by another guaranty association.

(c) For an unallocated annuity contract, except as provided in subsection (3), to either of the following:

(*i*) To a person who is the owner of an unallocated annuity contract if the contract is issued to or in connection with a specific plan whose sponsor has its principal place of business in this state.

(*ii*) To a person who is the owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident of this state.

(d) For a structured settlement annuity, except as provided in subsection (3), to a person who is a payee under a structured settlement annuity, or a beneficiary of a payee if the payee is deceased, and the payee is either of the following:

(*i*) A resident, regardless of where the contract owner resides.

(*ii*) Not a resident, if either of the following conditions is met:

(A) The contract owner of the structured settlement annuity is a resident, and the payee or beneficiary is not eligible for coverage from the association where the payee or beneficiary resides.

(B) The contract owner of the structured settlement annuity is not a resident, and both of the following conditions are met:

(I) The insurer that issued the structured settlement annuity is domiciled in this state, and the state in which the contract owner resides has an association similar to the association created by this chapter.

(II) Neither the payee or beneficiary nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(2) Except as provided in subsections (3), (4), and (5), this chapter provides coverage to a person specified in subsection (1) for direct, nongroup life, health, annuity, and supplemental policies or contracts, for certificates under direct group life, health, annuity, and supplemental policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this chapter.

(3) This chapter does not provide coverage to a person who is a payee or beneficiary of a contract owner that is a resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state or to a person otherwise covered under subsection (1)(c), if any coverage is provided by the association of another state to that person.

(4) This chapter is intended to provide coverage to a person who is a resident of this state and, in special circumstances, to a nonresident. To avoid duplicate coverage, if a person who would otherwise receive coverage under this chapter is provided coverage under the laws of any other state, the person shall not be provided coverage under this chapter. In determining the application of the provisions of this chapter in situations where a person could be covered by the association of more than 1 state, whether as an owner, payee, beneficiary, or assignee, this chapter shall be construed in conjunction with other state laws to result in coverage by only 1 association.

(5) This chapter does not provide coverage for the following:

(a) A portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy or contract owner, including, but not limited to, the nonguaranteed portion of a variable or separate

account product.

(b) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract.

(c) A portion of a policy or contract to the extent that the rate of interest on which it is based or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value exceeds the following:

(*i*) Averaged over the period of 4 years prior to the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the rate of interest determined by subtracting 2 percentage points from Moody's corporate bond yield average averaged for that same 4-year period or for a lesser period if the policy or contract was issued less than 4 years before the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first.

(*ii*) On and after the date on which the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first, the rate of interest determined by subtracting 3 percentage points from Moody's corporate bond yield average as most recently available.

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

(*i*) A multiple employer welfare arrangement as defined in section 7001.

(*ii*) A minimum premium group insurance plan.

(*iii*) A stop-loss or excess-loss group insurance plan. This subparagraph does not apply to the insured portion of a stop-loss or excess-loss group insurance plan written pursuant to section 407a or 5208 or written by a member property casualty insurer if the premiums were identified as disability insurance premiums in its annual statement.

(*iv*) An administrative services only contract.

(e) A portion of a policy or contract to the extent that it provides dividends or experience rating credits, voting rights, or payment of any fees or allowances be paid to a person, including the policy or contract owner, in connection with the service to or administration of the policy or contract.

(f) A policy or contract issued in this state by an insurer at a time when it did not have a certificate of authority to issue the policy or contract in this state.

(g) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal pension benefit guaranty corporation regardless of whether the federal pension benefit guaranty corporation has become liable to make any payments with respect to the benefit plan.

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

(i) An obligation that does not arise under the express written terms of the policy or contract issued by the insurer to the contract owner or policy owner, including, but not limited to, any of the following:

(*i*) A claim based on marketing materials.

(*ii*) A claim based on side letters, riders, or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements.

(*iii*) A claim based on misrepresentations of or regarding policy benefits.

(*iv*) An award of exemplary or punitive damages or statutory interest and claims related to bad faith in the payment of claims, and attorney fees and costs.

(*v*) A claim for penalties or consequential or incidental damages.

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

(k) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired insurer or an insolvent insurer, whichever occurs first. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this subdivision, the interest or change in value determined by using the procedures defined in the policy or contract shall be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and is not subject to forfeiture.

(*l*) A portion of a policy or contract to the extent that the assessments required by section 7709 for the policy or contract are preempted by federal or state law.

(m) A policy or contract providing any hospital, medical, prescription drug, or other health care benefits under part C or part D of title XVIII of the social security act, 42 USC 1395w-21 to 1395w-29 and 42 USC 1395w-101 to 1395w-152, or under regulations issued under part C or part D of title XVIII of the social security act, 42 USC 1395w-21 to 1395w-29 and 42 USC 1395w-101 to 1395w-152.

(6) The benefits that the association may become obligated to cover shall not exceed the lesser of the following:

(a) The contractual obligations for which the insurer is liable or would have been liable if it were not an impaired insurer or an insolvent insurer.

(b) With respect to 1 life, regardless of the number of policies or contracts:

(*i*) $300,000.00 in life insurance death benefits, but not more than $100,000.00 in net cash surrender and net cash withdrawal values for life insurance.

(*ii*) Except as otherwise provided in subparagraphs (*iv*) and (*v*), $100,000.00 in health insurance benefits, including any net cash surrender and net cash withdrawal values.

(*iii*) $250,000.00 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.

(*iv*) $300,000.00 in disability income insurance benefits or long-term care benefits.

(*v*) $500,000.00 in basic hospital, medical, and surgical insurance benefits.

(c) With respect to each individual participating in a governmental retirement benefit plan established under section 401(k), 403(b), or 457 of the internal revenue code of 1986, 26 USC 401, 403, and 457, covered by an unallocated annuity contract or the beneficiaries of each such individual, if deceased, in the aggregate, $250,000.00 in present value annuity benefits, including net cash surrender and net cash withdrawal values.

(d) With respect to each payee of a structured settlement annuity, or the beneficiary or beneficiaries of a deceased payee, $250,000.00 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any.

(e) For either 1 contract owner provided coverage under subsection (1)(c)(*ii*) or 1 plan sponsor whose plans own directly or in trust 1 or more unallocated annuity contracts not included in subdivision (C), $5,000,000.00 in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, if 1 or more unallocated annuity contracts are covered contracts under this chapter and are owned by a trust or other entity for the benefit of 2 or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state, but in no event is the association obligated to cover more than $5,000,000.00 in benefits for all those unallocated contracts.

(7) In no event is the association obligated to cover more than the following:

(a) An aggregate of $300,000.00 in benefits for any 1 life under subsection (6)(b)(*i*), (*ii*), (*iii*), and (*iv*), (c), and (d).

(b) An aggregate of $500,000.00 in benefits for any 1 life under subsection (6)(b)(*v*).

(c) For 1 owner of multiple nongroup policies of life insurance, whether the policy owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, $5,000,000.00 in benefits, regardless of the number of policies and contracts held by the owner.

(8) The limitations under subsections (6) and (7) are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired insurer or insolvent insurer attributable to covered policies. The costs of the association's obligations under this act may be satisfied by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights.

(9) In performing its obligations to provide coverage under section 7708, the association is not required to guarantee, assume, reinsure, or perform, or cause to be guaranteed, assumed, reinsured, or performed, contractual obligations of the insolvent insurer or impaired insurer under a covered policy or contract that do not materially affect the economic benefits of the covered policy or contract.

History: Add. 1982, Act 194, Imd. Eff. June 28, 1982;—Am. 1982, Act 501, Imd. Eff. Dec. 31, 1982;—Am. 1989, Act 302, Imd. Eff. Jan. 3, 1990;—Am. 1996, Act 548, Imd. Eff. Jan. 15, 1997;—Am. 2006, Act 671, Imd. Eff. Jan. 10, 2007;—Am. 2010, Act 157, Imd. Eff. Sept. 2, 2010.

Compiler's note: Enacting section 1(1) of Act 671 of 2006 provides:

"Enacting section 1. (1) Sections 7702, 7704, 7705, 7706, 7707, 7708, 7709, 7711, 7712, 7714, and 7717 of the insurance code of 1956, 1956 PA 218, MCL 500.7702, 500.7704, 500.7705, 500.7706, 500.7707, 500.7708, 500.7709, 500.7711, 500.7712, 500.7714, and 500.7717, as amended by this amendatory act, apply to an insurer impairment or insurer insolvency proceeding commenced on or after the effective date of this amendatory act for which guaranty association coverage obligations are incurred."

Enacting section 1 of Act 157 of 2010 provides:

"Enacting section 1. This amendatory act's increase in the maximum benefits under section 7704(6)(b)(iii), (c), and (d) of the

insurance code of 1956, 1956 PA 218, MCL 500.7704, does not apply to a member insurer that is under either a rehabilitation or liquidation order on the effective date of this amendatory act."

Popular name: Act 218