CHAPTER 18
THE CONTRACT OF INSURANCE

ARTICLE 1
CLASSES OF INSURANCE

§ 18101. Limitations.

An insurer authorized to do business in Guam may only write classes of insurance authorized by this article and by the insurer's certificate of authority.

SOURCE: GC § 43300.

§ 18102. Fire Insurance.

Fire insurance includes insurance upon buildings and other property against loss or damage by fire, lightning, windstorms, cyclones, tornadoes, typhoons, hail or earthquakes, water from the breakage or leakage of sprinklers, pumps, or other apparatus erected for extinguishing fires, and water pipes; and against loss or damage arising from the prevention or suspension of rent or use and occupation of any building, plant or manufacturing establishment, due to the hazard or peril against which the insurance is carried.

SOURCE: GC § 43301.

§ 18103. Marine Insurance.

Marine insurance includes insurance upon ocean and inland risks, and transportation, but not including any other casualty insurance as hereinafter provided.

SOURCE: GC § 43302.

§ 18104. Life Insurance.

Life insurance includes insurance in all forms of life, endowments and annuities, but does not include health, accident or sickness insurance or any other casualty insurance as hereinafter provided.

SOURCE: GC § 43303.

§ 18105. Accident, Sickness, Health, Health Maintenance Organization, Property Damage and Liability Insurance.

(a) Accident insurance and sickness or health insurance includes insurance against injury, disablement resulting from sickness, and every insurance appertaining thereto. Property damage insurance includes all types of insurance against loss or damage to property and liability therefore. Liability insurance includes all insurance against loss or damage resulting from accident to, or injury, fatal or non-fatal, suffered by any person, and for which the insurer is liable.

(b) A Health Maintenance Organization (HMO) is an insurer that is licensed to engage in the business of insurance on Guam that provides individual or group health care plans; or

health care services which an enrolled population might reasonably require to maintain good health, including, as a minimum, emergency care, inpatient hospital and medical services, and outpatient medical services on a prepaid basis and regulated under Guam law for solvency. An HMO operating in such manner shall be issued by the Commissioner a Health Maintenance Organization Certificate of Authority.

SOURCE: GC § 43304. Amended by P.L. 28-168:2 (Jan. 10, 2007).

§ 18106. Fidelity and Surety Insurance.

Fidelity and surety insurance includes all guaranteeing of persons holding places of public trust, and of the performance of contracts other than insurance policies. It also includes the execution of all bonds, undertakings and contracts of suretyship.

SOURCE: GC § 43305.

§ 18107. Motor Vehicle Insurance.

Motor vehicle insurance includes all insurance on motor or power driven vehicles, except those operating on water or on rails, against loss or damage to or loss of use of the vehicle or its tools, appliances or equipment, against legal liability for loss or damage to persons or property resulting through the operation of the vehicle caused by fire, self-ignition, explosion, theft, collision or other insurance hazards, including hazards incident to transporting such vehicle by land or water.

SOURCE: GC § 43306.

§ 18108. Title Insurance.

Title insurance includes insurance or guaranty of title to real or personal property or any interest or encumbrance thereon, or of information relative to real property, against loss by reason of defective titles, encumbrances, or adverse claims of title, or otherwise.

SOURCE: GC § 43307.

§ 18109. Worker's Compensation Insurance.

Worker's compensation insurance includes insurance against loss from liability imposed by law upon employers to compensate employees and their dependents for injury sustained

by employees arising out of and in the course or scope of their employment.

SOURCE: GC § 43308.

§ 18110. Miscellaneous.

Miscellaneous insurance includes insurance upon any risk not included within or under any of the foregoing classes and which is a proper subject for insurance, not prohibited by law or contrary to sound public policy.

SOURCE: GC § 43309.

ARTICLE 2
PARTIES, EVENTS AND INTERESTS

§ 18201. Capacity to Insure.

Any person capable of making a contract may be an insurer, subject to the restrictions imposed by this Title.

SOURCE: GC § 43325.

§ 18202. Capacity to be Insured.

Any person except a public enemy may be insured or may be a beneficiary.

SOURCE: GC § 43326.

§ 18203. Events Subject to Insurance.

Except as provided in this article, any contingent or unknown event, whether past or future, which may damnify a person having an insurable interest, or create a liability against him, may be insured against, subject to the provisions of this Title.

SOURCE: GC § 43327.

§ 18204. Insurable Interest.

(a) Every interest in property, or any relation thereto, or any liability in respect thereto, of such a nature that a contemplated peril might directly damnify the insured, is an insurable interest. A mere contingent or expectant interest in anything, not founded upon an actual right to or in the thing, nor upon any valid contract for it, is not insurable.

(b) Every person has an insurable interest in the life and health of:

(1) Himself;

(2) Any person upon whom he depends wholly or in part for education or support;

(3) Any person under a legal obligation to him for the payment of money or respecting property or services, of which death or illness might delay or prevent performance;

(4) Any person upon whose life any estate or interest vested in him depends.

(c) If the insured has no insurable interest, the contract is void.

SOURCE: GC § 43328.

§ 18205. Insurable Interest: Measure.

Except in the case of property held by the insured as a carrier or depository, the measure of an insurable interest in property is the extent to which the insured might be damnified by loss of, or injury to, the property.

SOURCE: GC § 43329.

§ 18206. Insurable Interest: Carrier or Depository.

A carrier or depository of any kind has an insurable interest in a thing held by him as such to the extent of its value.

SOURCE: GC § 43330.

§ 18207. Insurable Interest: Type of Existence.

An interest in property insured must exist when the insurance takes effect and when the loss occurs but need not exist in the meantime; an interest in the life or health of a person insured must exist when the insurance takes effect but need not exist thereafter or when the loss occurs.

SOURCE: GC § 43331.

§ 18208. Insurable Interest: Change.

Except in the cases herein specified, and in the cases of life and disability insurance, a change of interest in any part of a subject insured, unaccompanied by a corresponding change of interest in the insurance, suspends the insurance to an equivalent extent until the interest in the subject and the interest in the insurance are vested in the same person.

(a) A change of interest in a subject insured after the occurrence of an injury which results in a loss does not affect the right of the insured to indemnity for the loss.

(b) A change of interest in one or more of several distinct subjects separately insured by one policy does not avoid the insurance as to the others.

(c) A change of interest by will or succession, on the death of the insured, does not avoid insurance; and his interest in the insurance passes to the person taking his interest in the subject matter insured.

(d) In the case of partners, joint owners, or owners in common, who are jointly insured, a transfer of interest by one to another thereof does not avoid insurance even though it has been agreed that the insurance shall cease upon an alienation of the subject insured.

SOURCE: GC § 43332.

§ 18209. Insurable Interest: Transfer.

The mere transfer of subject matter insured does not transfer the insurance, but suspends it until the same person become the owner of both the insurance and the subject matter insured.

SOURCE: GC § 43333.

ARTICLE 3
THE POLICY

§ 18301. Contents.

The written instrument in which a contract of insurance is set forth is the policy and it shall contain the information required herein:

(a) The parties between whom the contract is made;

(b) A description of the property, life or interest insured;

(c) The interest of the insured;

(d) The risk insured against;

(e) The period during which such insurance is to continue;

(f) Either the statement of the Premium or if the insurance is of a character where the exact premium is only determinable upon the termination of the contract, a statement of the basis and rates upon which the final premium is to be determined and paid. Such premium shall exclude as a basis, the appraised value of the land.

SOURCE: GC § 43350. Subsection (f) amended by P.L. 24-144:2.

§ 18302. Signature.

All policies issued on risks in Guam shall be signed and subscribed as provided in this section:

(a) If the insurer is an admitted domestic insurer, each policy shall be signed and subscribed by two (2) of the major officers of the insurer designated in its articles of incorporation or in its by-laws to do so.

(b) If the insurer is an admitted foreign insurer, it shall be signed and subscribed by two (2) of the major officers of the insurer authorized to do so and in all cases it shall be counter-signed by such insurer's authorized resident general agent, or shall have attached thereto an appropriate countersignature endorsement signed by such resident general agent.

(c) If the insurer is an admitted alien insurer, it shall be signed by its United States general manager or other person in charge of its United States business if it has such official, or if it does not, by two (2) of the major officers of the insurer authorized to do so, and in all cases it shall be countersigned by such insurer's authorized resident general agent, or shall have attached thereto an appropriate countersignature endorsement signed by such resident general agent.

(d) Countersignature, by an authorized resident general agent of the insurer originating a contract of insurance participated in by other insurers as co-sureties or co-indemnitors, shall satisfy all countersignature requirements in respect of such contract of insurance.

(e) The provisions of this section relating to countersignature by an insurer's authorized general agent shall not apply to:

(1) any contract of insurance covering the rolling stock of any railroad, or covering any vessel, aircraft, or motor carrier used in interstate or foreign commerce, or covering any liability or other risks incident to the ownership, maintenance or operation thereof;

(2) any contract of reinsurance between any insurance companies or other insurers;

(3) any contract of insurance covering any property in interstate or foreign commerce, or any liability or risks incident thereto.

SOURCE: GC § 43351.

§ 18303. Coverage.

When the name of the person intended to be insured is specified in a policy, it can be applied only to his own interest.

SOURCE: GC § 43352.

§ 18304. Subsequent Owner of Interest.

A policy may be so framed that it will inure to the benefit of whosoever, during the continuance of the risk, becomes the owner of the interest insured.

SOURCE: GC § 43353.

§ 18305. Liability Policy: Direct Action.

On any policy of liability insurance the injured person or his heirs or representatives shall have a right of direct action against the insurer within the terms and limits of the policy, whether or not the policy of insurance sued upon was written or delivered in Guam, and whether or not such policy contains a provision forbidding such direct action, provided that the cause of action arose in Guam. Such action may be brought against the insurer alone, or against both the insured and insurer.

SOURCE: GC § 43354.

§ 18306. Liability Policy: Insolvency or Bankruptcy.

No policy of liability insurance shall be issued or delivered in Guam, unless it contains provisions to the effect that the insolvency or bankruptcy of the insured shall not release the insurer from the payment of damages for injuries sustained or loss occasioned during the term of such policy, and that in case execution against the insured is returned unsatisfied in any action brought by the injured person or his heirs, because of such insolvency or bankruptcy, an action may be maintained by the injured person or his heirs or representatives against such insurer within the terms and limits of the policy for the amount of the judgment not exceeding the amount of the policy.

SOURCE: GC § 43355.

§ 18307. Open or Valued.

A policy is either:

(a) An open policy which is one wherein the value of the subject matter is not agreed upon but is left to be ascertained in case of loss. An open policy shall not be written on real property for fire insurance or miscellaneous insurance.

(b) A valued policy which is one containing on its face an expressed agreement that the thing insured shall be valued at a specified sum.

SOURCE: GC § 43356.

§ 18308. Form: Approval.

It shall be unlawful for an insurer to use a policy form in affecting insurance except health insurance as approved pursuant to § 18308.1 without first obtaining the Commissioner's approval thereof as provided herein:

(a) The Commissioner shall study each form for the purpose of guarding against any fraud, misrepresentations or other forms of unfairness to the writings of the insured; if he shall approve a form, he shall endorse his approval on the face of both duplicates and transmit one to the insured and keep one in his permanent files; if he shall disapprove a

form, he shall issue an order of disapproval stating therein his reasons and transmit a copy of the same to the insurer.

(b) All policies and provisions therein shall be printed in a type of which the face is not smaller than ten-point.

(c) Every policy form filed with the Commissioner for approval shall be accompanied by a filing fee of Twenty Dollars ($20.00).

SOURCE: GC § 43357. Subsection (c) added by P.L. 29-002:V:I:97 (May 18, 2007). Amended by P.L. 29-121:4 (Dec. 2, 2008).

NOTE: GC § 43357 contained subsections (b) and (c) without a subsection (a). GC § 43357 (b) and (c) changed to (a) and (b) respectively to reflect correct citation.

§ 18308.1 Form Approval: Health Insurance.

(a) No health insurance policy or endorsement shall be delivered or issued for delivery in Guam unless the policy or endorsement form is filed for approval with the Commissioner at least forty-five (45) days prior to its effective date.

(b) The Commissioner shall review each health insurance policy or endorsement filed for the purpose of determining the following about the policy or endorsement:

(1) Whether it is in violation of this Chapter;

(2) Whether it contains any title, heading, or provision that is misleading;

(3) Whether it contains provisions that are so unclear or deceptively worded that they encourage misrepresentation; or

(4) Whether it provides coverage of such a limited nature that it is contrary to the public interest of Guam.

(c) Within forty-five (45) days after the filing of any health insurance policy form or endorsement requiring approval pursuant to this Section, the Commissioner will indicate approval by signing or giving explanation for disapproval in writing. The Commissioner, for good cause, may extend, for up to an additional forty-five (45) days, the period within which he shall approve or disapprove the policy form or endorsement.

Good cause may include written notification to the insurer within the first forty-five (45) days that its submission is incomplete, and the items necessary to complete the submission. Any policy form or endorsement received but neither approved nor disapproved by the Commissioner shall be deemed approved at the end of the forty-five (45) days if the period is not extended, or at the end of the extended period, if any; however, no policy form or endorsement shall be deemed approved under the provisions of this Section unless written notice of the intent to use the policy form or endorsement has been filed with the Commissioner.

(d) If the Commissioner proposes to withdraw approval previously given or deemed given to the policy form or endorsement to which this Section applies, he shall notify the insurer in writing at least ninety (90) days prior to the proposed effective date of withdrawal giving his reasons for withdrawal.

(e) The policy and endorsement forms approved under this Section shall be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge for the copies.

(f) Every health insurance policy form filed with the Commissioner for approval shall be accompanied by a filing fee of Twenty Dollars ($20.00). An application for insurance and other collateral documents which are not incorporated by reference into a policy of insurance are not insurance policy forms for the purpose of determining the filing fee.

SOURCE: Added by P.L. 29-121:5 (Dec. 2, 2008)

§ 18309. Coinsurance Clause Explanation.

Where a policy contains a coinsurance clause, the insurer shall notify the policy-holder of its existence, such notification to include the following information:

(a) The name of the Insured;

(b) The policy number of the policy and the effective date thereof;

(c) The following notice in type of which the face is not smaller than six (6) points:

"Important, this policy contains a coinsurance clause. If the amount of insurance purchased is not equal to the cash or replacement cost of your insured property then the settlement you received arising from future losses will not be sufficient to replace the loss you have suffered. It is your responsibility as the insured to make certain the insured value, as stated below, is equal to cash value or full replacement cost of your insured property if you desire full protection."

(d) The coinsurance clause in its entirety is a type of which the face is not smaller than six (6) points;

(e) The insured value of the property.

SOURCE: GC § 43358. Repealed by P.L. 13-187:218; Added by P.L. 14-71:1.

§ 18310. Coinsurance Clause Explanation: Notification.

Notification of the coinsurance clause, as required by § 18309, shall be made in the manner and at such intervals in time as shall be prescribed by the Commissioner of Banking and Insurance.

SOURCE: GC § 43359. Added by P.L. 14-71:1.

2011 NOTE: Reference to the "Insurance Commissioner" changed to the "Commissioner of Banking and Insurance" pursuant to P.L. 27-088:10 (May 6, 2004).

§ 18311. Penalty.

Any person violating any of the provisions of this article shall be guilty of a misdemeanor, and shall, upon conviction, be subject to a fine of not more than one thousand dollars ($1,000.00) if the person convicted is not a natural person, or if the person convicted is a natural person, a fine of not more than five hundred dollars ($500.00) or imprisonment of not more than six (6) months, or both such fine and imprisonment.

SOURCE: GC § 43360. Renumbered by P.L. 14-71:1.

ARTICLE 4
THE PREMIUM

§ 18401. Accrual of Premium.

The insurer is entitled to payment of the premium as soon as the subject matter insured is exposed to the peril insured against.

SOURCE: GC § 43375.

§ 18402. Right to Return of Premium.

Unless the insurance contract otherwise provides, a person insured is entitled to a return of premium after a policy is cancelled or rescinded as provided herein:

(a) To the whole premium if no part of his interest in the thing insured is exposed to any of the perils insured against;

(b) Where the insurance is for a definite term, and the insured surrenders his policy, to such proportion of the premium as corresponds to the unexpired portion of the term after deducting from the whole premium any claim for loss or damage which has previously accrued;

(c) When the contract is void or voidable on account of the fraud or misrepresentation of the insurer;

(d) When the contract is void or voidable on account of facts of the existence of which the insured was ignorant without his fault;

(e) When, by any default of the insured other than actual fraud, the insurer did not incur any liability under the policy.

SOURCE: GC § 43376.

§ 18403. Acknowledgment of Receipt of Premium.

An acknowledgment in a policy of receipt of the premium is conclusive evidence of its payment, so far as to make the policy binding, notwithstanding any stipulation in the policy that it shall not be binding until the premium is actually paid.

SOURCE: GC § 43377.

ARTICLE 5
RATES

§ 18501. Approval.

(a) All rates, rate schedules, rate plans and methods of computing rates to be applied to any insurance transacted in Guam shall be filed with the office of the Commissioner, and before any rates may be charged, advertised, publicized, or otherwise represented, they shall have the approval of the Commissioner.

(b) It shall be unlawful for any insurer to use any rates in violation of the provisions of this section, or to alter, amend or otherwise change any rates without the approval of the Commissioner.

(c) It shall be unlawful for any insurer to charge any rate for any insurance transacted in Guam other than the rate approved by the Commissioner for such insurer for such risk and class of insurance.

(d) A filing fee of Two Hundred Dollars ($200.00) shall be paid for every rate plan or request for the Commissioner's approval that is filed with the Commissioner.

SOURCE: GC § 43385. Subsection (d) added by P.L. 29-002:V:I:98 (May 18, 2007). Subsection (a) amended by P.L. 29-121:6 (Dec. 2, 2008).

§ 18501.1 Rate Approval: Health Insurance.

(a) No insurance rate, rate schedule, rate plans or methods of computing rates to be applied to any insurance transacted in Guam shall be advertised, publicized, charged or otherwise represented in Guam unless the rate, rate schedule, rate plan or method of computing rates is filed for approval with the Commissioner at least forty-five (45) days prior to its effective date, whichever occurs first.

(b) The Commissioner shall review each rate, rate schedule, rate plan or method of computing rates for the purpose of determining the following about the rate, rate schedule, rate plan or method of computing rates:

(1) whether it is in violation of this Chapter;

(2) whether it is unreasonable in relation to the benefits provided; or

(3) whether it exceeds those amounts established by rule or regulation.

(c) Within forty-five (45) days after the filing of any insurance rate, rate schedule, rate plan or method of computing rates requiring approval pursuant to this Section, the Commissioner will indicate approval by signing or giving explanation for disapproval in writing. The Commissioner, for good cause, may extend, for up to an additional forty-five (45) days, the period within which he shall approve or disapprove the rate, rate schedule, rate plan or method of computing rates. Good cause may include written notification to the insurer within the first forty-five (45) days that its rate submission is incomplete, and the items necessary to complete the submission. Any rate, rate schedule, rate plan or method of computing rates received but neither approved nor disapproved by the Commissioner shall be deemed approved at the end of the forty-five (45) days if the period is not extended, or at the end of the extended period, if any; however, no rate, rate schedule, rate plan or method of computing rates policy form or endorsement shall

be deemed approved under the provisions of this Section unless written notice of the intent to use the rate, rate schedule, rate plan or method of computing rates has been filed with the Commissioner.

(d) It shall be unlawful for any insurer to use any rate in violation of the provisions of this Section, or to alter, amend or otherwise change any rate without the approval of the Commissioner.

(e) It shall be unlawful for any insurer to charge any rate for insurance transacted in Guam other than the rate approved by the Commissioner for such insurer for such risk and class of insurance.

(f) If the Commissioner proposes to withdraw approval of a rate, rate schedule, rate plan or method of computing rates previously given or deemed given to which this Section applies, he shall notify the insurer in writing at least ninety (90) days prior to the proposed effective date of withdrawal giving his reasons for withdrawal.

(g) The rate, rate schedule, rate plan or method of computing rates approved under this Section shall be open to public inspection. Copies may be obtained by any person on request and upon payment of a reasonable charge for the copies.

(h) A filing fee of Two Hundred Dollars ($200.00) shall be paid for every rate plan or request filed for the Commissioner's approval.

SOURCE: Added by P.L. 29-121:7 (Dec. 2, 2008).

§ 18502. Standards.

An insurer in making rates, and the Commissioner in approving them, shall apply the standards prescribed in this section:

(a) Rates shall not be excessive or inadequate, as herein provided, nor shall they be unfairly discriminatory.

(b) No rate shall be held excessive unless such rate is unreasonably high for the insurance provided and reasonable degree of competition does not exist in Guam

with respect to the classification to which such rate is applicable.

(c) No rate shall be held inadequate unless such rate is unreasonably low for the insurance provided and the continued use of such rate endangers the solvency of the insurer; or unless such rate is unreasonably low for the insurance provided and the use of such rate by the insurer will have the effect of destroying competition in Guam

(d) Consideration shall be given, to the extent applicable, to past and prospective loss experiences, to prevailing hazards, and to underwriting profits, contingencies, expenses and other normal business requirements and factors.

SOURCE: GC § 43386.

§ 18503. Rating Bureaus.

Insurers are authorized to become members or subscribers of rating bureaus, or advisory organizations of a like nature and may use the rates, rating systems, and underwriting rules and policy forms of such organizations, provided the same are not excessive, inadequate, nor unfairly discriminatory, conform to the provisions of this Title, and are approved by the Commissioner prior to their use as provided.

SOURCE: GC § 43357.

§ 18504. Penalty.

Any person who is found violating any provision of this Article shall pay a fine of not more than Five Thousand Dollars ($5,000.00).

SOURCE: GC § 43388. Repealed by P.L. 13-187:219. Added by P.L. 27-002:V:I:99 (May 18, 2007).

ARTICLE 6
LOSS

§ 18601. Peril not Insured Against: Rescue Efforts.

An insurer is liable:

(a) Where the thing insured is rescued from a peril insured against and which would otherwise have caused a loss if in the course of such rescue, the thing is exposed to a peril not insured against, and which permanently deprives the insured of its possession, in whole or in part.

(b) If a loss is caused by efforts to rescue the thing insured from a peril insured against.

SOURCE: GC § 43400.

§ 18602. Wilful Act of Insured: Negligence.

An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured or of the insured's agents or others.

SOURCE: GC § 43401.

§ 18603. Notice of Loss.

Failure to give notice of loss covered by marine or fire insurance within any period provided for by the policy or otherwise, shall not exonerate the insurer if the notice is given within a reasonable time after the insured loss has or should have

first knowledge of said loss. In all other classes of insurance, the insured shall have at least twenty (20) days after the event within which to give notice of loss. No requirement of notice within a lesser period is valid.

SOURCE: GC § 43402.

§ 18604. Preliminary Proof of Loss.

When preliminary proof of loss is required by a policy, the insured is not bound to give such proof as would be necessary in a court of justice, but it is sufficient for him to give the best evidence in his power at the time.

SOURCE: GC § 43403.

§ 18605. Waiver of Defects in Notice or Preliminary Proof.

All defects in a notice of loss, or in preliminary proof thereof, which the insured might remedy, and which the insurer omits to specify to him, without unnecessary delay, as grounds of objection, are waived.

SOURCE: GC § 43404.

§ 18606. Waiver of Delay.

Delay in the presentation to an insurer of notice, or preliminary proof of loss, is waived if caused by an act of the insurer, or if he omits to make objection promptly and specifically upon that ground.

SOURCE: GC § 43405.

§ 18607. Policy Requiring Proof by Third Person: Sufficiency of Compliance.

If a policy requires, by way of preliminary proof of loss, the certificate or testimony of a person other than the insured beneficiary, there is sufficient compliance with the requirement if the insured or the beneficiary (a) uses reasonable diligence to procure the certificate or testimony, and (b) in case of refusal to give it to him, furnishes reasonable evidence to the insurer that the refusal was not induced by just grounds of disbelief in the facts necessary to be certified or testified to.

SOURCE: GC § 43406.

§ 18608. Failure to Pay Loss, Recovery of Amount Due and Damages.

In all cases where loss occurs and the insurer liable therefor shall fail to pay the same within the time specified in the policy, after demand made therefor, such insurer shall be liable to pay the holder of such policy, in addition to the amount of such loss, twelve percent (12%) damages upon the amount of such loss, together with all reasonable attorney's fees for the prosecution and collection of said loss; said attorney's fees to be taxed by the court where the same is heard on original action, by appeal or otherwise, and to be taxed as a part of the costs therein, and collected as other cost are or may be by law collected; and writs of attachment or garnishment filed or issued after proof of loss or death has been received by the insurer shall not defeat the provisions of this section, provided the insurer desiring to pay the amount of the claim as shown in the proof of loss or death may pay said amount into the registry of the court after issuance of writs of attachment and garnishment, in which event there shall be no further liability on the part of said insurer. [U.S. for use of *Getz Bros. & Co. v. Markowitz Bros.* (1967), 383 F.2d. 595.]

SOURCE: GC § 43407.

§ 18609. Total Loss by Fire or Miscellaneous Insurance: Recovery of Full Amount.

A fire or miscellaneous insurance policy, in case of a total loss of any risk insured under the classes specified in this Title as fire or miscellaneous insurance shall be held and considered to be a liquidated demand against the insurer taking such risk for the full amount stated in such policy, or the full amount upon which the insurer charges, collects or receives a premium; provided the provisions of this article shall not apply to personal property. In the event of a total loss or destruction of any personal property on which the amount of the appraisal or agreed loss is less than the total amount insured thereon, the insurer shall return to the insured the unearned premium for the excess of insurance over the appraised or agreed loss, to be paid at the same time and in the same manner as the loss shall be paid; and the unearned premium shall be a just and legal claim against the

insurer. [*National Union Fire Ins. Co. v. Santos* (1962), 303 F.2d. 309.]

SOURCE: GC § 43408.

ARTICLE 7
DOUBLE INSURANCE

§ 18701. Double Insurance.

Double insurance exists when the same person is insured by several insurers separately in respect to the same subject, interest and risk.

SOURCE: GC § 43425.

§ 18702. Double Insurance: Contribution.

In case of double insurance, the several insurers are liable to pay losses thereon as follows:

(a) Fire insurance. In fire and miscellaneous insurance, each insurer shall contribute ratably without regard to the dates of the several policies.

(b) Marine insurance. In marine insurance, the liability of the several insurers for a total loss, whether actual or constructive, where the policies are not simultaneous, is in the order of the dates of the several policies. No liability attaches to a second or other subsequent policy, except as to the excess of the loss over the amount of all previous policies on the same interest. If two (2) or more policies bear the same date, they are deemed to be simultaneous, and each insurer on simultaneous policies shall contribute ratably, the insolvency of any of the insurers does not affect the proportionate liability of the other insurers. All insurers on the same marine interest shall contribute ratably for a partial or average loss.

SOURCE: GC § 43426.

ARTICLE 8
REINSURANCE

§ 18801. Definitions.

A contract of reinsurance is one by which an insurer procures a third person to insure him against loss or liability by reason of such original insurance.

SOURCE: GC § 43450.

§ 18802. Authorization.

No admitted insurer shall reinsure with any other insurer who has not been previously admitted in Guam, or who has not been approved by the Commissioner as a reinsurer.

SOURCE: GC § 43451.

ARTICLE 9
HEALTH INSURANCE COVERAGE

SOURCE: Pursuant to P.L. 35-128:3 (Dec. 29, 2020), the title of this article was amended from "Health Insurance Coverage; Blood and Blood Derivatives."

§ 18901. Health Insurance Coverage; Blood and Blood Derivatives, Mandate Established.

(a) No health insurance company or health care provider contracted to provide health care to employees in a small group or large group plan may deny coverage to the employee or dependent on the basis of blood or blood derivatives. Blood and blood derivatives shall be covered and may be subject to

maximum limitations per annum.

(1) Guaranteed Availability.

(A) Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. As a condition of conducting health insurance coverage on Guam, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not impose any preexisting condition exclusion with respect to such plan or coverage, pursuant to Subsection 2 of this Section.

(B) Definition, for the purposes of this Part. The term "preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

(2) Prohibition on Rescissions. For the purposes of this Section, and in conformance with SEC. 2712 [42 U.S.C. 300gg–12] *Prohibition On Rescissions*, a group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Sections 2702(c), 2703(b) or 2742(b) of the Public Health Service Act.

SOURCE: Added by P.L. 32-235:2 (Jan. 2, 2015) as 11 GCA § 103121. Codified to this section by the Compiler pursuant to the authority granted by 1 GCA § 1606.

§ 18902. Coverage of Routine Costs of Care During Approved Clinical Trials.

(a) A health insurance company or healthcare plan shall continue coverage of routine costs for any insured during the approved clinical trial.

(b) For the purposes of this Section, routine costs of care include any treatments, procedures, and services the insured may need while participating in the clinical trial that would normally be covered if the insured were not participating in a trial.

(c) For the purposes of this Section, approved clinical trials are designed to study new methods to prevent, detect, or treat cancer or another life-threatening illness. An approved clinical trial must meet any of the following conditions:

(1) be federally approved or funded - this means that one (1) or more of the organizations listed below approved or funded the clinical trial:

(A) the National Institutes of Health (NIH), including organizations under the NIH such as the National Cancer Institute (NCI);

(B) organizations funded by the NIH or NCI, including academic institutions, designated cancer centers, and cooperative groups;

(C) the Centers for Disease Control and Prevention (CDC);

(D) the Agency for Health Care Research and Quality (ARHQ);

(E) the Center for Medicare and Medicaid Services (CMS);

(F) the Department of Defense, the Department of Veteran Affairs, or the Department of Energy, if the trial is subject to unbiased, scientific review that is similar to NIH requirements;

(2) have an investigational new drug application; or

(3) be excused from investigational new drug application requirements.

(d) Health insurance companies or healthcare plans are not required to cover the cost of any clinical trials.

SOURCE: Added by P.L. 35-128:2 (Dec. 29, 2021).

ARTICLE 10
HEALTH INSURANCE COVERAGE; SCREENINGS

§ 181001. Coverage for Prostate and Cervical Cancer Detection.

(a) Except for a fraternal benefit society, a health care insurer that offers, issues for delivery, delivers, or renews in Guam, a health care insurance plan, shall provide coverage for the costs of prostate cancer screening tests as required under the schedule described in Subsection (b) of this Section, and shall provide coverage for the costs of cervical cancer screening tests as required under the schedule described in Subsection (c) of this Section. The coverage required by this Section is subject to standard policy provisions applicable to other benefits, including deductible or copayment provisions.

(b) The minimum coverage required under Subsection (a) of this Section for prostate cancer screening includes an annual prostate cancer screening test, by digital rectal examination, for a person who is forty (40) or more years of age.

(c) The minimum coverage required under Subsection (a) of this Section for cervical cancer screening is an annual pap

smear cancer screening test for a person who is twenty-one (21) or more years of age.

(d) The coverage described by this Section shall be effective in the event that the United States Preventive Services Task Force, its recommendations, or the provisions of the Affordable Care Act or its successor acts, should cease to require such coverage.

SOURCE: Added by P.L. 34-002:2 (May 10, 2017).

§ 181002. Coverage Under Health Benefit Plan for Colorectal Cancer Examinations and Laboratory Tests.

(a) Except for a fraternal benefit society, a health benefit plan issued or renewed on or after January 1, 2018, shall provide coverage for all colorectal cancer examinations and laboratory tests specified in current American Cancer Society guidelines for complete colorectal cancer screening of asymptomatic individuals as follows:

(1) Coverage or benefits shall be provided for all colorectal screening examinations and tests that are administered at a frequency identified in the most recent version of the American Cancer Society guidelines for complete colorectal cancer screening; and

(2) The covered individual shall be:

(A) fifty (50) years of age or older; or

(B) less than fifty (50) years of age and at high risk for colorectal cancer according to the current colorectal cancer screening guidelines of the American Cancer Society.

(b) Coverage under this Section shall not be subject to a deductible or coinsurance for services received from participating providers under the health benefit plan in the event that the United States Preventive Services Task Force recommendations or the provisions of the Affordable Care Act or its successor acts should cease to require such coverage.

SOURCE: Added by P.L. 34-003:2 (May 10, 2017).

§ 181003. Breast Cancer Screening Benefit in Every Health Insurance Policy.

(a) (1) Every policy of health insurance issued or renewed to a resident of Guam on or after January 1, 2019, except a policy that provides coverage only for specified and limited benefits, *shall* provide coverage for screening by low-dose mammography for occult breast cancer as follows:

(A) for women thirty-five (35) to thirty-nine (39) years of age, one (1) baseline mammogram;

(B) for women forty (40) years of age and older, an annual mammogram; and

(C) for a woman of any age, and for men beginning at age forty (40) who have a first-degree consanguineous relative that was diagnosed to have developed breast cancer at forty (40) years of age or younger, mammogram screening may be performed as recommended by the patient's physician, but not more than once annually.

(2) The services provided in this Section are *not* subject to any coinsurance or deductible provisions which may be in force in such policies, contracts, plans or agreements for routine x-ray examinations.

(b) The term, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one (1) rad mid-breast, with two (2) views for each breast, or digital breast tomosynthesis (DBT), or full-field digital mammography (FFDM).

(1) Digital breast tomosynthesis (DBT) is a form of breast imaging, or mammography, that uses a low-dose x-ray system and computer reconstructions to create three-dimensional images of the breasts.

(2) Full-field digital mammography (FFDM) is a mammography system in which the x-ray film is replaced

by electronics that convert x-rays into mammographic pictures of the breast.

(c) To the extent permitted by federal law, rules, and regulations, the provisions of this Section, *supra, shall* apply to persons covered by Medicaid without the requirement for precertification. The provisions of this Section, *supra, shall* also apply to persons covered by the Medically Indigent Program (MIP) without the requirement for precertification.

SOURCE: Added by P.L. 34-109:2 (May 14, 2018).

2018 NOTE: Subsection/subitem designations added/altered pursuant to 1 GCA § 1606.

§ 181004. Diabetes Screening Coverage in Health Insurance Policies.

(a) This screening recommendation applies to adults aged forty (40) to seventy (70) years who are obese or overweight. Persons who have a family history of diabetes, have a history of gestational diabetes or polycystic ovarian syndrome, or are members of certain racial/ethnic groups (that is, African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders) may be at an increased risk for diabetes at a younger age or at a lower body mass index, and clinicians should consider screening earlier in persons with one (1) or more of these characteristics.

(b) The Director of the Department of Public Health and Social Services may adjust the screening recommendations in Subsection (a) of this Section in the event that the *U.S. Preventive Services Task Force* adopts new recommendations.

(c) Every policy of health insurance issued or renewed to a resident of Guam on or after January 1, 2021 and the Medically Indigent Program shall cover diabetes screening as defined in Subsection (a) of this Section. Coverage under this Section shall not be subject to a deductible or coinsurance for services.

SOURCE: Added by P.L. 35-104:2 (Oct. 29, 2020).

ARTICLE 11
HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDER

SOURCE: Added by P.L. 34-006:3 (May 10, 2017 as 22 GCA, Chapter 29A (§§ 29A101-29A103). Codified to this chapter and article by Compiler pursuant to 1 GCA § 1606.

2017 NOTE: Pursuant to P.L. 34-006:7 (May 10, 2017), insurance coverage requirements shall be in effect regardless of any repeal or change in provisions of the Affordable Care Act.

§ 181101. Definitions.

For the purposes of this Chapter:

(a) Autism spectrum disorder (ASD) means one (1) of the three (3) following disorders as defined in the most recent edition of the diagnostic and statistical manual of mental disorders of the American Psychiatric Association:

(1) Autistic disorder;

(2) Asperger's syndrome; or

(3) Pervasive developmental disorder—not otherwise specified.

(b) Behavioral therapy means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.

(c) Behavioral health treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism

spectrum disorder, and that meet all of the following criteria:

(1) The treatment is prescribed by a physician or surgeon duly licensed to practice on Guam, or is developed by a psychiatrist or psychologist, any of which shall be duly licensed to practice on Guam.

(2) The treatment is provided under a treatment plan prescribed by a qualified ASD service provider and is administered by one (1) of the following:

(A) a qualified ASD service provider;

(B) a qualified ASD service professional supervised and employed by the qualified autism spectrum disorder service provider; or

(C) an ASD service paraprofessional supervised and employed by a qualified ASD service provider.

(3) The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified ASD service provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the qualified autism spectrum disorder service provider and modified whenever appropriate, and shall be consistent with all of the following items performed by the qualified autism spectrum disorder service provider, who:

(A) describes the patient's behavioral health impairments to be treated;

(B) designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported;

(C) provides intervention plans that utilize evidence-based practices, with demonstrated

clinical efficacy in treating autism spectrum disorder; and

(D) discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(4) The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services, and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care insurance service plan upon request.

(d) Qualified autism spectrum disorder service provider means either of the following:

(1) a person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorder, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or

(2) a person licensed pursuant to Part 1 or Part 2 of Chapter 12, 10 GCA as a physician or surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist who designs, supervises, or provides treatment or services for autism spectrum disorder, provided the services are within the experience and competence of the licensee.

(e) Small employer shall mean a business with less than ten (10) employees.

(f) Bundling means combining various limited benefit insurance policies, and advertising or indicating in any manner that these policies are major medical expense

coverage policies or could be substituted for major medical expense coverage.

(g) Limited benefit coverage means an insurance policy that is designed, advertised, and marketed to supplement major medical insurance; and that includes accident only, dental only, vision only, disability income only, fixed or hospital indemnity, specified disease insurance, credit insurance, or Taft-Hartley trusts.

SOURCE: Added by P.L. 34-006:3 (May 10, 2017 as 22 GCA § 29A101-29A103). Codified to this section by the Compiler pursuant to 1 GCA § 1606.

§ 181102. Mandate.

(a) Except for those offered by a fraternal benefit society, every health care insurance service or health maintenance organization plan contract that provides hospital, medical, or surgical coverage shall also provide coverage for behavioral health treatment for autism spectrum disorder no later than October 1, 2017. The coverage shall be provided in the same manner and shall be subject to the same requirements as provided in 22 GCA Chapter 29.

(b) Except for a fraternal benefit society, every insurer, which shall include all insurance companies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in Guam Medicare supplement policies or certificates licensed to do business on Guam, shall be subject to the provisions of this Chapter.

SOURCE: Added by P.L. 34-006:3 (May 10, 2017 as 22 GCA § 29A102. Codified to this section by the Compiler pursuant to 1 GCA § 1606.

§ 181103. Subscription Contracts for Healthcare Insurance; Autism Spectrum Disorder; Coverage; Exceptions.

(a) Except for those offered by a fraternal benefit society, health care insurance service plans issued by a health insurance carrier, hospital service corporation, medical service corporation, insurance company, health maintenance organization, and any other entity delivering or issuing for delivery in Guam Medicare

supplement policies or certificates issued pursuant to 22 GCA Chapter 29 shall not:

(1) exclude or deny coverage for a treatment or impose dollar limits, deductibles and coinsurance provisions based solely on the diagnosis of autism spectrum disorder. For the purposes of this Subsection, "treatment" includes diagnosis, assessment, and services; or

(2) exclude or deny coverage for medically necessary behavioral therapy services. To be eligible for coverage, behavioral therapy services shall be provided or supervised by a licensed or certified autism spectrum disorder provider.

(b) This Chapter does not:

(1) apply to a health insurance subscription contract that is issued to an individual or through a small employer; or

(2) apply to bundled or limited benefit coverage as defined in § 181101(f) of this Chapter.

(c) The coverage required by this Chapter is subject to all the terms and conditions of the subscription contract. Nothing in this Chapter prevents a corporation from imposing deductibles, coinsurance or other cost sharing in relation to the coverage required by this Chapter.

(d) Coverage for diagnosis, treatment and behavioral therapy is subject to:

(1) a Seventy-five Thousand Dollars ($75,000) maximum benefit per year for an eligible person up to the age of fifteen (15); or

(2) a Twenty-five Thousand Dollars ($25,000) maximum benefit per year for an eligible person who is between the ages of sixteen (16) and twenty-one (21).

SOURCE: Added by P.L. 34-006:3 (May 10, 2017 as 22 GCA § 29A103. Subsection (d) amended by P.L. 35-019:3 (May 9, 2019).

NOTE: Codified to this section by the Compiler pursuant to 1 GCA § 1606. Internal reference altered to reflect change.
