Second Regular Session of the 124th General Assembly (2026)

HOUSE ENROLLED ACT No. 1260

AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-1-3-22 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 22. (a) As used in this section, "fraudulent insurance act" means:

(1) the preparation or presentation of a written statement as part of, or in support of:

(A) a fraudulent application for the issuance or rating of a policy of commercial insurance; or

(B) a fraudulent claim under a policy of commercial or personal insurance; or

(2) the concealment, for the purpose of misleading, of information concerning any fact material to an application or claim described in subdivision (1).

(b) As used in this section, "fraudulent insurance act" includes the act or omission of a person who, knowingly and with intent to defraud, does any of the following:

(1) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, a reinsurer, a purported insurer or reinsurer, a broker, or an agent of an insurer, reinsurer, purported insurer or reinsurer, or broker, an oral or written statement that the person knows to contain materially false information as part of, in support of, or concerning any fact that is material to:

(A) an application for the issuance of an insurance policy;

(B) the rating of an insurance policy;

(C) a claim for payment or benefit under an insurance policy;

(D) premiums paid on an insurance policy;

(E) payments made in accordance with the terms of an insurance policy;

(F) an application for a certificate of authority;

(G) the financial condition of an insurer, a reinsurer, or a purported insurer or reinsurer; or

(H) the acquisition of an insurer or a reinsurer;

or conceals any information concerning a subject set forth in clauses (A) through (H).

(2) Solicits or accepts new or renewal insurance risks by or for an insolvent insurer, reinsurer, or other entity regulated under this title.

(3) Removes or attempts to remove:

(A) the assets;

(B) the record of assets, transactions, and affairs; or

(C) a material part of the assets or the record of assets, transactions, and affairs;

of an insurer, a reinsurer, or another entity regulated under this title, from the home office, other place of business, or place of safekeeping of the insurer, reinsurer, or other regulated entity, or conceals or attempts to conceal from the department assets or records referred to in clauses (A) through (C).

(4) Diverts, attempts to divert, or conspires to divert funds of an insurer, a reinsurer, another entity regulated under the Indiana Code, or other persons, in connection with any of the following:

(A) The transaction of insurance or reinsurance.

(B) The conduct of business activities by an insurer, a reinsurer, or another entity regulated under this title.

(C) The formation, acquisition, or dissolution of an insurer, a reinsurer, or another entity regulated under this title.

(c) A person or entity regulated under this title that has knowledge or a reasonable belief that a fraudulent insurance act is being or has been committed shall furnish the information to:

(1) the department; or

(2) the National Insurance Crime Bureau;

not later than sixty (60) days after the person receives notice of the fraudulent insurance act. If the National Insurance Crime Bureau receives information under this subsection, the National Insurance Crime Bureau shall disclose the information to the department.

~~(c)~~ **(d)** A person **or entity** who acts without malice, fraudulent

intent, or bad faith is not subject to civil **or criminal** liability for filing a report or furnishing, orally or in writing, other information concerning a suspected, anticipated, or completed fraudulent insurance act if the report or other information is provided to or received from any of the following:

(1) The department or an agent, an employee, or a designee of the department.

(2) Law enforcement officials or an agent or employee of a law enforcement official.

(3) The National Association of Insurance Commissioners.

(4) Any agency or bureau of federal or state government established to detect and prevent fraudulent insurance acts.

(5) Any other organization established to detect and prevent fraudulent insurance acts.

(6) The National Insurance Crime Bureau.

(7) Any person or entity regulated under this title.

~~(6)~~ **(8)** An agent, an employee, or a designee of an entity referred to in subdivisions (3) through ~~(5).~~ **(7).**

~~(d)~~ **(e)** This section does not abrogate or modify in any way any common law or statutory privilege or immunity.

SECTION 2. IC 27-1-3-23 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 23. (a) For the purposes of this section, a party is "substantially justified" in initiating a civil action if the action had a reasonable basis in law or fact at the time the action was initiated.

(b) If:

(1) a person or entity referred to in section ~~22(c)~~ **22(d)** of this chapter, or an employee or agent of a person or entity referred to in section ~~22(c),~~ **22(d),** is the prevailing party in a civil action for libel, slander, or any other relevant tort arising out of the filing of a report or the furnishing of information under section ~~22(c)~~ **22(d)** of this chapter; and

(2) the party who initiated the action was not substantially justified in initiating the action;

the person, entity, employee, or agent referred to in subdivision (1) is entitled to an award of attorney's fees and costs.

SECTION 3. IC 27-1-44.5-12 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 12. (a) Except as provided in subsections (b), (c), and (e), the fee schedule for each type of unrestricted data request is as follows:**

Non-program Affiliated Individual

Data Set	Per Quarter	Per Year
Member Eligibility	$1,000	$4,000
Medical Claims	$1,500	$6,000
Pharmacy Claims	$ 500	$2,000
Hospital Encounters		
Inpatient	$1,500	$6,000
Outpatient	$1,250	$5,000
Emergency Dept.	$1,250	$5,000

Commercial Entity (Non-redistribution)

Data Set	Per Quarter	Per Year
Member Eligibility	$1,500	$6,000
Medical Claims	$2,250	$9,000
Pharmacy Claims	$ 750	$3,000
Hospital Encounters		
Inpatient	$2,250	$9,000
Outpatient	$1,875	$7,500
Emergency Dept.	$1,875	$7,500

Nonprofit/Educational Entity

Data Set	Per Quarter	Per Year
Member Eligibility	$ 250	$1,000
Medical Claims	$ 375	$1,500
Pharmacy Claims	$ 125	$ 500
Hospital Encounters		
Inpatient	$ 375	$1,500
Outpatient	$ 312.50	$1,250
Emergency Dept.	$ 312.50	$1,250

Commercial Redistributor (Resellers)

Data Set	Per Quarter	Per Year
Member Eligibility	$2,500	$10,000
Medical Claims	$3,750	$15,000
Pharmacy Claims	$1,250	$5,000
Hospital Encounters		
Inpatient	$3,750	$15,000
Outpatient	$3,125	$12,500
Emergency Dept.	$3,125	$12,500

(b) Data files, reports, or tables not otherwise listed in subsection (a) or custom data sets must be generated at a base rate of eighty dollars ($80) per hour with a minimum one (1) hour charge applied. An additional fee of three cents ($0.03) must be charged per individual life generated in the data, report, or table. A written estimate of the total cost must be provided to an entity that requests data or information under this subsection before the

request is fulfilled.

(c) State or local agencies within the geographical boundaries of Indiana that request data for public distribution or non-redistribution purposes may not be charged a fee under this section.

(d) If it is determined by the data base that access to the analytic environment is necessary based on the quantity and type of data requested, the requesting entity will incur an additional licensing fee of one thousand dollars ($1,000) per month per user.

(e) Member eligibility data sets for the requested time period must be provided at no charge if requested along with at least one (1) other data set.

(f) A requesting entity may submit to the department a request for a waiver of any applicable fees if the entirety of the entity's research findings will be released to the public at no cost to the reader.

(g) A fee collected under this section must be deposited in the department of insurance fund created by IC 27-1-3-28.

(h) Before November 1, 2026, and before November 1 of each year thereafter, the department shall submit a report to the budget committee that contains the following information for the most recently preceding state fiscal year:

(1) The total amount of fees collected in total and for each fee type of unrestricted data.

(2) The number of individuals subject to fees in total and for each fee type of unrestricted data.

(3) Additional fee amounts charted in subsection (b) and the total amount collected.

(4) Additional licensing fee amounts charted in subsection (c) and the total amount collected.

(5) The total fund balance in the department of insurance fund under IC 27-1-3-28 as of June 30 of the most recently preceding state fiscal year.

SECTION 4. IC 27-2-28-1, AS AMENDED BY P.L.236-2025, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) This chapter applies to a personal automobile or homeowner's policy that is issued, delivered, amended, or renewed **on or** after ~~June 30, 2026.~~ **January 1, 2027.**

(b) This chapter does not apply to:

(1) notices required by the federal Fair Credit Reporting Act (15 U.S.C. 1681 et seq.); **or**

(2) declinations of coverage.

SECTION 5. IC 27-2-28-2, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. **(a)** As used in this chapter, "automobile policy" means a policy providing one (1) or more of the types of insurance described in Class 2(f) of IC 27-1-5-1.

(b) The term includes an automobile policy under which the insured vehicle designated in the policy is rated as private passenger.

(c) The term does not include personal insurance policies for the coverage of:

(1) boats;

(2) inland marine;

(3) motorcycles;

(4) off-road vehicles;

(5) recreational vehicles;

(6) trailers;

(7) fleets;

(8) antique or collector vehicles;

(9) classic vehicles;

(10) specialty vehicles; or

(11) any other personal insurance policy not listed in subdivisions (1) through (10).

SECTION 6. IC 27-2-28-3, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. **(a)** As used in this chapter, "homeowner's policy" means a policy that provides:

(1) coverage for:

(A) damage to or the destruction of:

(i) a structure; or

(ii) a unit within a structure;

that is used as a residence by one (1) or more individuals; and

(B) damage to or the loss of personal property that is present in the structure or unit described in clause (A);

caused by perils such as fire, hail, and lightning; and

(2) coverage against the civil liability of the policyholder arising from bodily injury or property damage incurred by others.

(b) The term includes a mobile homeowner's policy, manufactured homeowner's policy, condominium homeowner's policy, and renter's coverage.

(c) The term does not include farm policies, nonowner occupied dwellings, other residential policies that are not written on a homeowner's policy form or other landlord policies.

SECTION 7. IC 27-2-28-6, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 6. (a) As used in this chapter, "material change" means

~~(1) an~~ **a premium** increase of more than ten percent (10%) over ~~the expiring premium for;~~ ~~or~~ **and above the increases in the insurer's filed rate plan, including base rate increases and any other changes to the insurer's filed rate plan.**

~~(2) another adverse or unfavorable change in the terms of coverage or amount of;~~

~~insurance in connection with a personal automobile or homeowner's policy.~~

(b) The term does not include the following:

(1) An increase in the insurer's filed rate plan and automatic inflationary increases.

(2) An additional premium due to a change initiated by the insured, such as:

(A) adding or removing vehicles or drivers;

(B) adding an endorsement;

(C) adding additional coverages;

(D) adding covered premises; or

(E) increasing coverage limits or deductibles.

(3) An additional premium due to a change in risk exposure as a result of the insured's participation in a usage based or telematics insurance program.

(4) Changes resulting from a property inspection.

(5) For purposes of the second or subsequent renewals, rate increases that are implemented over more than one (1) policy period if:

(A) the implementation plan is included in the insurer's filed rate plan; or

(B) the increase for any one (1) policy period is not more than ten percent (10%) over the expiring policy period's premium.

SECTION 8. IC 27-2-28-8, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 8. (a) An insurer that makes a material change to an insured's personal automobile or homeowner's policy shall provide a written notice to the insured that:

(1) explains the principal factors for the material change; or

(2) states that the insured has a right to request and obtain an explanation of the principal factors for the material change.

(b) **Not later than thirty (30) days after** an insured ~~who~~ receives a notice of a material change described in subsection (a)(2), **the insured** may submit to the insurer a written request for an explanation of the principal factors for the material change.

(c) ~~Upon~~ **Not later than forty-five (45) days after** receiving a request for an explanation under subsection (b), the insurer shall provide written notice to the insured explaining the principal factors for the material change.

(d) An insurer shall provide a copy of a written notice provided under subsection (a)(1) or (c):

(1) to the insurance producer, if any, who:

(A) represented:

(i) the insured in obtaining coverage from the insurer; or

(ii) the insurer in regard to the providing of coverage to the insured; and

(B) is not an employee, an exclusive agent, or a captive agent of the insurer; and

(2) to the insurer's reporting portal for agent communications.

(e) A written notice provided under subsection (a) or (c), or a written request submitted under subsection (b), must be provided by:

(1) first class mail; or

(2) electronic delivery as set forth in IC 27-1-43.

SECTION 9. IC 27-2-28-12, AS ADDED BY P.L.226-2023, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 12. (a) The commissioner shall adopt rules under IC 4-22-2 to implement ~~this chapter.~~

~~(b) The rules adopted under subsection (a) must include~~ monetary penalties for a violation of this chapter that are consistent with other penalties assessed for similar violations under this title.

~~(c)~~ **(b)** The commissioner is solely responsible for the enforcement of this chapter.

SECTION 10. IC 27-5.1-2-24.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 24.5. (a) The commissioner may waive the requirements of this chapter or IC 27-1-9, whichever is applicable, for a merger or consolidation of a farm mutual insurance company with any other company (as defined in IC 27-1-2-3) if:**

(1) the farm mutual insurance company is notified that it will lose reinsurance coverage within one hundred twenty (120) days; or

(2) another emergency event occurs that places the farm

mutual insurance company in imminent danger of insolvency.

(b) A farm mutual insurance company that decides to merge or consolidate as a result of an emergency event described in subsection (a) shall provide notice of the emergency event to the commissioner not later than ten (10) days after the emergency event occurs.

(c) The commissioner shall issue a decision on the proposed merger or consolidation not more than ninety (90) days after receiving notice from a farm mutual insurance company under subsection (b).

SECTION 11. IC 27-6-8-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 3. This chapter applies to all kinds of direct insurance except:

(1) life, annuity, health, or disability insurance;

(2) mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks;

(3) fidelity or surety bonds, or any other bonding obligations;

(4) credit insurance, vendors' single interest insurance, or collateral protection insurance or similar insurance with the primary purpose of protecting the interests of a creditor arising out of a creditor-debtor transaction;

(5) **other than coverages that may be set forth in a cybersecurity insurance policy,** warranty or service contract insurance, **including insurance that provides:**

(A) for the repair, replacement, or service of goods or property;

(B) indemnification for repair, replacement, or service for the operational or structural failure of the goods or property due to a defect in materials, workmanship, or normal wear and tear; or

(C) reimbursement for the liability incurred by the issuer of agreements or service contracts that provide the benefits described in clauses (A) and (B);

(6) title insurance;

(7) ocean marine insurance;

(8) a transaction between a person or an affiliate of a person and an insurer or an affiliate of an insurer that involves the transfer of investment or credit risk without a transfer of insurance risk;

(9) insurance provided by or guaranteed by a government entity; and

(10) insurance written on a retroactive basis to cover known losses for which a claim has already been made and the claim is

known to the insurer at the time the insurance is bound.

SECTION 12. IC 27-6-8-4, AS AMENDED BY P.L.158-2024, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 4. (a) As used in this chapter, unless otherwise provided:

(1) The term "account" means any one (1) of the three (3) accounts created by section 5 of this chapter.

(2) The term "association" means the Indiana Insurance Guaranty Association created by section 5 of this chapter.

(3) The term "commissioner" means the commissioner of insurance of this state.

(4) The term "covered claim" means an unpaid claim which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this chapter applies issued by an insurer, if the insurer becomes an insolvent insurer after the effective date (January 1, 1972) of this chapter and (a) the claimant or insured is a resident of this state at the time of the insured event or (b) the property from which the claim arises is permanently located in this state. "Covered claim" shall be limited as provided in section 7 of this chapter, and shall not include the following:

(A) Any amount due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise. However, a claim for any such amount, asserted against a person insured under a policy issued by an insurer which has become an insolvent insurer, which if it were not a claim by or for the benefit of a reinsurer, insurer, insurance pool or underwriting association, would be a "covered claim" may be filed directly with the receiver or liquidator of the insolvent insurer, but in no event may any such claim be asserted in any legal action against the insured of such insolvent insurer.

(B) Any supplementary obligation including but not limited to adjustment fees and expenses, attorney fees and expenses, court costs, interest and bond premiums, whether arising as a policy benefit or otherwise, prior to the appointment of a liquidator.

(C) Any unpaid claim that is filed with the association after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer. For the purpose of filing a claim under this clause, notice of a claim to the liquidator of the insolvent insurer is considered to be notice to

the association or the agent of the association and a list of claims must be periodically submitted to the association (or another state's association that is similar to the association) by the liquidator.

(D) A claim that is excluded under section 11.5 of this chapter due to the high net worth of an insured.

(E) Any claim by a person who directly or indirectly controls, is controlled, or is under common control with an insolvent insurer on December 31 of the year before the order of liquidation.

(F) Any amount awarded as punitive or exemplary damages.

(G) Any amount sought as a return of premium under any retrospective rating plan.

(H) Any claim filed with the association or a liquidator for protection afforded under the insured's policy for incurred but not reported losses.

All covered claims filed in the liquidation proceedings shall be referred immediately to the association by the liquidator for processing as provided in this chapter.

(5) "Cybersecurity insurance" means first and third party coverage in a policy or endorsement written on a direct, admitted basis for losses and loss mitigation arising out of or relating to:

(A) data privacy breaches;

(B) unauthorized information network security intrusions;

(C) computer viruses;

(D) ransomware;

(E) cyber extortion;

(F) identity theft; and

(G) similar exposures.

~~(5)~~ **(6)** The term "high net worth insured" means the following:

(A) For purposes of section 11.5(a) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured, calculated on a consolidated basis) that exceeds twenty-five million dollars ($25,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

(B) For purposes of section 11.5(b) of this chapter, an insured that has a net worth (including the aggregate net worth of the insured and all subsidiaries and affiliates of the insured,

calculated on a consolidated basis) that exceeds fifty million dollars ($50,000,000) on December 31 of the year immediately preceding the year in which the insurer becomes an insolvent insurer.

~~(6)~~ **(7)** The term "insolvent insurer" means (a) a member insurer holding a valid certificate of authority to transact insurance in this state either at the time the policy was issued or when the insured event occurred and (b) against whom a final order of liquidation, with a finding of insolvency, to which there is no further right of appeal, has been entered by a court of competent jurisdiction in the company's state of domicile. "Insolvent insurer" shall not be construed to mean an insurer with respect to which an order, decree, judgment or finding of insolvency whether preliminary or temporary in nature or order to rehabilitation or conservation has been issued by any court of competent jurisdiction prior to January 1, 1972 or which is adjudicated to have been insolvent prior to that date.

(8) The term "insured" means any named insured, any additional insured, any vendor, lessor, or any other party identified as an insured under the policy.

~~(7)~~ **(9)** The term "member insurer" means any person who is licensed or holds a certificate of authority under IC 27-1-6-18 or IC 27-1-17-1 to transact in Indiana any kind of insurance for which coverage is provided under section 3 of this chapter, including the exchange of reciprocal or inter-insurance contracts. The term includes any insurer whose license or certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily surrendered. A "member insurer" does not include farm mutual insurance companies organized and operating pursuant to IC 27-5.1 other than a company to which IC 27-5.1-2-6 applies.

~~(8)~~ **(10)** The term "net direct written premiums" means direct gross premiums written in this state on insurance policies to which this chapter applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct premiums written" does not include premiums on contracts between insurers or reinsurers.

~~(9)~~ **(11)** The term "person" means an individual, an aggregation of individuals, a corporation, a partnership, or another entity.

(12) The term "receiver" means liquidator, rehabilitator, conservator, or ancillary receiver, as the context requires.

(13) The term "self-insurer" means a person who covers the

person's liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

(b) Notwithstanding any other provision in this chapter, an insurance policy that is issued by a member insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity, shall be considered to have been issued by a member insurer which is an insolvent insurer for the purposes of this chapter in the event that the insurer to which the policy has been allocated, transferred, assumed by, or otherwise made the sole responsibility of is placed in liquidation.

(c) An insurance policy that was issued by a nonmember insurer and later allocated, transferred, assumed by, or otherwise made the sole responsibility of a member insurer under a state statute shall not be considered to have been issued by a member insurer for the purposes of this chapter.

SECTION 13. IC 27-6-8-5, AS AMENDED BY P.L.158-2024, SECTION 21, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 5. There is created a nonprofit unincorporated legal entity to be known as the Indiana Insurance Guaranty Association (referred to in this chapter as the "association"). All insurers defined as member insurers in section ~~4(a)(7)~~ **4(a)(9)** of this chapter shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under section 8 of this chapter and shall exercise its powers through a board of directors established under section 6 of this chapter. For purposes of administration and assessment, the association shall be divided into three (3) separate accounts:

(1) The worker's compensation insurance account.

(2) The automobile insurance account.

(3) The account for all other insurance to which this chapter applies.

SECTION 14. IC 27-6-8-7, AS AMENDED BY P.L.52-2013, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 7. (a) The association shall do all of the following:

(1) Be obligated to pay covered claims existing before the order of liquidation, or arising within thirty (30) days after the order of

liquidation, or before the policy expiration date if less than thirty (30) days after the order of liquidation, or before the insured replaces the policy or causes its cancellation, if the insured does so within thirty (30) days of the order of liquidation. The obligation shall be satisfied by paying to the claimant an amount as follows:

(A) The full amount of a covered claim for benefits under worker's compensation insurance.

(B) With respect to a claim for the return of unearned premium, ~~the lesser of:~~ **an amount not exceeding ten thousand dollars ($10,000) per policy for a covered claim for the return of unearned premium, but the obligation shall include only the amount of each covered claim that is in excess of fifty dollars ($50).**

~~(i) eighty percent (80%) of the paid but unearned premium; or~~

~~(ii) six hundred fifty dollars ($650) multiplied by the number of months or partial months remaining in the policy term; not to exceed twelve (12) months.~~

(C) An amount not to exceed three hundred thousand dollars ($300,000) per covered claim. For purposes of this clause, all claims of any kind that arise out of or are related to the bodily injury to or death of one (1) person constitute a single claim, regardless of the number of claims made or the number of claimants.

(D) In no event shall the association be obligated to pay an amount in excess of three hundred thousand dollars ($300,000) for all first and third party claims under a policy or endorsement providing, or that is found to provide, cybersecurity insurance coverage and arising out of or related to a single insured event, regardless of the number of claims made or the number of claimants.

The association is not, in any event, obligated to pay a claimant any amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. **Notwithstanding any other provision in this chapter, a covered claim may not include a claim filed with the guaranty fund after the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.**

In the case of a claim for wrongful death, the foregoing obligation of the association shall, in addition to the limits set forth above,

be subject to the limitations provided by the wrongful death statutes of the state. Such amounts which are legally payable because of the death of a claimant shall be paid to the claimant's estate, to the claimant's father or mother or guardian, to the surviving spouse or children, or to the next of kin as set out in IC 34-23-1 and IC 34-23-2.

The amount for which the association shall be obligated may also include payments in fact made to others, not members of claimant's household, which were reasonably incurred to obtain from such other persons ordinary and necessary services for the production of income in lieu of those services the claimant would have performed for the claimant had the claimant not been injured.

In the case of claims arising from bodily injury, sickness, or disease, including those in which death results, under IC 22-3 or similar state or federal laws providing benefits for occupational injury or disease, the association is obligated only to the extent provided under IC 22-3.

A third party having a covered claim against any insured of an insolvent member insurer may file such claim in the liquidation proceeding under IC 27-9-3 if such insolvent member insurer is a domestic insurer and pursuant to the applicable provisions of law of the state of domicile if such insolvent member insurer is not a domestic insurer. The liquidator shall immediately refer said claim to the association to process as provided in this chapter unless the claimant shall within thirty (30) days from the date of filing said claim in the liquidation proceeding, file with the commissioner as liquidator a written demand that said claim be processed in liquidation proceedings as a claim not covered by this chapter.

(2) Be deemed the insurer to the extent of its obligation on the covered claims as limited by this chapter and to this extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent, including those relating to reinsurance contracts and treaties entered into by the insolvent insurer. However, the association's obligation to defend any insured of the insolvent insurer or to ~~indemnity~~ **indemnify** against the costs of such defense terminates as soon as the claimant or claimants have been paid all benefits that they are entitled to under this chapter.

(3) Allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for

each account amounts necessary to pay the obligation of the association under subdivision (1) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, the cost of examination under IC 27-6-8-12 and other expenses authorized by this chapter. **There are two (2) classes of assessments as follows:**

(A) Class A assessments are assessments that are authorized and called by the board for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired insurer or insolvent insurer.

(B) Class B assessments are assessments that are authorized and called by the board to the extent necessary to carry out the powers and duties of the association under this chapter with regard to an impaired insurer or insolvent insurer.

The amount of a Class A assessment must be determined by the board and may be authorized and called on a pro rata or non-pro rata basis. If pro rata, the board may provide that the assessment be credited against future Class B assessments. The **amount of a Class B assessment** ~~assessments~~ of each member insurer shall be on a uniform percentage basis in the proportion that the net direct written premiums in this state of the member insurer for the preceding calendar year on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the preceding calendar year on the kinds of insurance in the account. ~~However, in addition to the pro rata assessments already described, an assessment may be made against each member insurer in a stated amount up to fifty dollars ($50) per year for the purpose of paying the administrative expenses of the association.~~ There shall be no **Class B** assessment for any account so long as assets held in such account are sufficient to cover all estimated payments for liquidation in process under such account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year on any account an amount greater than one percent (1%) of that member insurer's net direct written premiums in this state for the preceding calendar year on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the association in any account, does not provide in any one (1) year

in any account an amount sufficient to make all necessary payments from that account, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. However, during the period of deferment no dividends shall be paid to shareholders or policyholders by a company whose assessment has been deferred. A deferred assessment shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies whose assessments were increased as the result of such deferment, or at the option of any such company, shall be credited to future assessments against such company.

(4) Investigate, adjust, compromise, settle, and pay covered claims to the extent of the association's obligation and deny all other claims and may review settlements, releases, and judgments to which the insolvent insurer or its insured were parties to determine the extent to which such settlements, releases, and judgments may be properly contested, and as appropriate to contest them. **The association shall pay claims in any order that it may deem reasonable, including the payment of claims as they are received from the claimants or in groups or categories of claims. The association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims and to appoint and direct other service providers for covered services.**

(5) Notify such persons as the commissioner directs under IC 27-6-8-9(b)(i).

(6) Handle claims through its employees or through one (1) or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(7) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association and shall pay the other expenses of the association authorized by this

chapter. Any unreimbursed obligation of the association to a member insurer designated a servicing facility shall constitute an admitted asset of such member insurer.

(8) Be entitled to and permitted to examine all claims, files, and records of an insolvent insurer at such times and to such extent as necessary or appropriate to obtain information regarding covered claims individually and in the aggregate, and to establish such procedures as appropriate to obtain prompt notice of all covered claims and information pertaining thereto during the course of liquidation.

(9) Have the right to review and contest, as set forth in this subsection, settlements, releases, compromises, waivers, and judgments to which the insolvent insurer or its insureds were parties before the entry of the order of liquidation. In an action to enforce settlements, releases, and judgments to which the insolvent insurer or its insureds were parties before the entry of the order of liquidation, the association shall have the right to assert the following defenses, in addition to the defenses available to the insurer:

(A) The association is not bound by a settlement, release, compromise, or waiver executed by an insured or the insurer or any judgment entered against an insured or the insurer by consent or through a failure to exhaust all appeals, if the settlement, release, compromise, waiver, or judgment was:

(i) executed or entered within one hundred twenty (120) days before the entry of an order of liquidation and the insured or insurer did not use reasonable care in entering into the settlement, release, compromise, waiver, or judgment or did not pursue all reasonable appeals of an adverse judgment; or

(ii) executed by or taken against an insured or the insurer based on default, fraud, collusion, or the insurer's failure to defend.

(B) If a court of competent jurisdiction finds that the association is not bound by a settlement, release, compromise, waiver, or judgment for the reasons described in clause (A), the settlement, release, compromise, waiver, or judgment shall be set aside and the association shall be permitted to defend any covered claim on the merits. The settlement, release, compromise, waiver, or judgment may not be considered as evidence of liability

or damages in connection with any claim brought against the association or any other party under this chapter.

(C) The association shall have the right to assert any statutory defenses or rights of offset against any settlement, release, compromise, or waiver executed by an insured or the insurer or any judgment taken against the insured or the insurer.

(10) As to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend, the association, either on its own behalf or on behalf of an insured, may apply to have the judgment, order, decision, verdict, or finding set aside by the same court or administrator that entered the judgment, order, decision, verdict, or finding and shall be permitted to defend the claim on the merits.

(b) The association may do the following:

(1) Appear in, defend, and appeal any action on a covered claim, but the association shall have no obligation to pay any amount in excess of the provisions of IC 27-6-8-7.

(2) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(3) Borrow funds necessary to effect the purposes of this chapter in accord with the plan of operation.

(4) Sue or be sued.

(5) Negotiate and become a party to any contracts as are necessary to carry out the purpose of this chapter.

(6) Perform such other acts as are necessary or proper to effectuate the purpose of this chapter.

(7) Refund to the then member insurers in proportion to the contribution of each such member insurer to that account that amount by which the assets of the account exceed the liabilities if, at the end of the calendar year, the board of directors finds that the assets of the association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year, provided that the association may retain as a reserve fund from the excess of the assets over liabilities at the end of any calendar year an amount not to exceed ten percent (10%) of such excess assets of such account. Any such reserve fund or earnings from its investment shall be used only for the payment of covered claims and authorized association expenses. Upon appropriate action by the board of directors such reserve fund shall be refunded to the then member insurers in proportion to the total

contribution of each such member insurer to such account.

(c) The following apply with respect to an action involving the association:

(1) Except for an action by the receiver, an action related to or arising out of this chapter against the association must be brought in an Indiana court.

(2) Indiana courts have exclusive jurisdiction over all actions against the association related to or arising out of this chapter.

(3) The exclusive venue for an action by or against the association is in the Marion County Circuit Court, Marion County, Indiana. However, the association may waive this venue for a particular action.

SECTION 15. IC 27-6-8-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 9. (a) The commissioner shall:

(i) Notify the association of the existence of an insolvent insurer not later than three (3) working days after the commissioner receives an order of liquidation.

(ii) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(b) The commissioner may:

(i) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the order of liquidation and of their rights under this chapter. This notification shall be by mail at their last known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation in all counties in which the insolvent insurer transacted insurance business shall be sufficient.

(ii) Require each insurance producer of the insolvent insurer to give prompt written notice by first class mail of such insolvency and the rights of the insured under this chapter to each insured of the insolvent insurer for whom the insurance producer is insurance producer of record, at such insured's last known address.

(iii) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. The fine shall not exceed five percent (5%)

of the unpaid assessment per month, except that no fine shall be less than one hundred dollars ($100) per month.

(iv) Revoke the designation of any servicing facility if the commissioner finds claims are being handled unsatisfactorily.

(v) Any final action or order of the commissioner under this chapter shall be subject to judicial review in a court of competent jurisdiction.

(c) If the commissioner determines that any member insurer may be subject to a future delinquency proceeding under IC 27-9, the commissioner may do the following to assist in the performance of the commissioner's duties:

(1) Share confidential and privileged documents, material, or information reported under an enterprise risk filing with the association regarding the member insurer.

(2) Share confidential and privileged documents, material, the contents of an examination report, a preliminary examination report or its results, or any matter relating thereto, including working papers, recorded information, documents, and copies thereof produced by, obtained by, or disclosed to the commissioner or to any other person in the course of any examination with the association regarding the member insurer.

(3) Disclose the information described in this subsection to the association so long as the association agrees in writing to hold the information confidential in a manner consistent with this chapter and uses the information to prepare for the possible liquidation of the member insurer. Access to the information disclosed by the commissioner to the association under this subsection shall be limited to the association's staff and its counsel. The board of directors of the association may have access to the information disclosed by the commissioner to the association once the member insurer is subject to a delinquency proceeding under IC 27-9, subject to any terms and conditions established by the commissioner.

(4) Disclose the information described in this subsection with associations in other states and with any organization of one (1) or more state associations of similar purposes so long as the recipient of the information agrees in writing to hold the information confidential in a manner consistent with this chapter and uses the information to prepare for the possible liquidation of the member insurer. Access to the information disclosed by the commissioner under this subsection shall be

limited to the association's staff and its counsel. The board of directors of the association may have access to the information disclosed by the commissioner to the association once the member insurer is subject to a delinquency proceeding under IC 27-9, subject to any terms and conditions established by the commissioner.

(5) If the commissioner determines that a liquidation is likely, the commissioner may cooperate with the association and with any organization of one (1) or more state associations of similar purposes to provide for an orderly transition to liquidation to minimize any delay in the handling and payment of claims.

SECTION 16. IC 27-6-8-11.5, AS AMENDED BY P.L.158-2024, SECTION 22, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 11.5. (a) The association is not obligated to pay a first party claim by a high net worth insured described in section ~~4(a)(5)(A)~~ **4(a)(6)(A)** of this chapter.

(b) The association has the right to recover from a high net worth insured described in section ~~4(a)(5)(B)~~ **4(a)(6)(B)** of this chapter all amounts paid by the association to or on behalf of the high net worth insured, regardless of whether the amounts were paid for indemnity, defense, or otherwise.

(c) The association is not obligated to pay a claim that:

(1) would otherwise be a covered claim;

(2) is an obligation to or on behalf of a person who has a net worth greater than the net worth allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by the applicable law of the state of residence of the claimant; and

(3) has been denied by the association of the state of residence of the claimant on the basis described in subdivision (2).

(d) The association may also, at its sole discretion and without assumption of any ongoing duty to do so, pay any third party claims or cybersecurity insurance obligations covered by a policy or endorsement of an insolvent company on behalf of a high net worth insured. In that case, the association shall recover from the high net worth insured under this section all amounts paid on its behalf, all allocated claim adjusted expenses relating to the claims, the association's attorney's fees, and all court costs in any action necessary to collect the full amount to the association's reimbursement under this section.

~~(d)~~ **(e)** The association shall establish reasonable procedures,

subject to the approval of the commissioner, for requesting financial information from insureds:

(1) on a confidential basis; and

(2) in the application of this section.

~~(c)~~ **(f)** The procedures established under subsection ~~(d)~~ **(e)** must provide for sharing of the financial information obtained from insureds with:

(1) any other association that is similar to the association; and

(2) the liquidator for an insolvent insurer;

on the same confidential basis.

~~(f)~~ **(g)** If an insured refuses to provide financial information that is:

(1) requested under the procedures established under subsection ~~(d);~~ **(e);** and

(2) available;

the association may, until the time that the financial information is provided to the association, consider the insured to be a high net worth insured for purposes of subsections (a) and (b).

~~(g)~~ **(h)** In an action contesting the applicability of this section to an insured that refuses to provide financial information under the procedures established under subsection ~~(d),~~ **(e),** the insured bears the burden of proof concerning the insured's net worth at the relevant time. If the insured fails to prove that the insured's net worth at the relevant time was less than the applicable amount set forth in section ~~4(a)(5)(A)~~ **4(a)(6)(A)** or ~~4(a)(5)(B)~~ **4(a)(6)(B)** of this chapter, the court shall award to the association the association's full costs, expenses, and reasonable attorney's fees incurred in contesting the claim.

SECTION 17. IC 27-6-8-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 20. (a) The association may join one (1) or more organizations of other state associations of similar purposes to further the purposes and administer the powers and duties of the association. The association may designate one (1) or more of these organizations to:**

(1) act as a liaison for the association; and

(2) to the extent the association authorizes, bind the association in agreements or settlements with receivers of insolvent insurance companies or their designated representatives.

(b) The association, in cooperation with other obligated or potentially obligated guaranty associations or their designated representatives, shall make all reasonable efforts to coordinate and cooperate with receivers or their designated representatives in the

most efficient and uniform manner, including the use of Uniform Data Standards as promulgated or approved by the National Association of Insurance Commissioners.

SECTION 18. IC 27-7-5-2, AS AMENDED BY P.L.130-2020, SECTION 13, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. (a) Except as provided in subsections (d), (f), and (h), the insurer shall make available, in each automobile liability or motor vehicle liability policy of insurance which is delivered or issued for delivery in this state with respect to any motor vehicle registered or principally garaged in this state, insuring against loss resulting from liability imposed by law for bodily injury or death suffered by any person and for injury to or destruction of property to others arising from the ownership, maintenance, or use of a motor vehicle, or in a supplement to such a policy, the following types of coverage:

(1) in limits for bodily injury or death and for injury to or destruction of property not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death, and for the protection of persons insured under the policy who are legally entitled to recover damages from owners or operators of uninsured motor vehicles for injury to or destruction of property resulting therefrom; or

(2) in limits for bodily injury or death not less than those set forth in IC 9-25-4-5 under policy provisions approved by the commissioner of insurance, for the protection of persons insured under the policy provisions who are legally entitled to recover damages from owners or operators of uninsured or underinsured motor vehicles because of bodily injury, sickness or disease, including death resulting therefrom.

The uninsured and underinsured motorist coverages must be provided by insurers for either a single premium or for separate premiums, in limits at least equal to the limits of liability specified in the bodily injury liability provisions of an insured's policy, unless such coverages have been rejected in writing by the insured. However, underinsured motorist coverage must be made available in limits of not less than fifty thousand dollars ($50,000). At the insurer's option, the bodily injury liability provisions of the insured's policy may be required to be equal to the insured's underinsured motorist coverage. Insurers may not sell

or provide underinsured motorist coverage in an amount less than fifty thousand dollars ($50,000). Insurers must make underinsured motorist coverage available to all existing policyholders on the date of the first renewal of existing policies that occurs on or after January 1, 1995, and on any policies newly issued or delivered on or after January 1, 1995. Uninsured motorist coverage or underinsured motorist coverage may be offered by an insurer in an amount exceeding the limits of liability specified in the bodily injury and property damage liability provisions of the insured's policy.

(b) A named insured of an automobile or motor vehicle liability policy has the right, in writing, to:

(1) reject both the uninsured motorist coverage and the underinsured motorist coverage provided for in this section; or

(2) reject either the uninsured motorist coverage alone or the underinsured motorist coverage alone, if the insurer provides the coverage not rejected separately from the coverage rejected.

A rejection of coverage under this subsection by a named insured is a rejection on behalf of all other named insureds, all other insureds, and all other persons entitled to coverage under the policy. No insured may have uninsured motorist property damage liability insurance coverage under this section unless the insured also has uninsured motorist bodily injury liability insurance coverage under this section. Following rejection of either or both uninsured motorist coverage or underinsured motorist coverage, unless later requested in writing, the insurer need not offer uninsured motorist coverage or underinsured motorist coverage in or supplemental to a renewal or replacement policy issued to the same insured by the same insurer or a subsidiary or an affiliate of the originally issuing insurer. Renewals of policies issued or delivered in this state which have undergone interim policy endorsement or amendment do not constitute newly issued or delivered policies for which the insurer is required to provide the coverages described in this section.

(c) A rejection under subsection (b) must specify:

(1) that the named insured is rejecting:

(A) the uninsured motorist coverage;

(B) the underinsured motorist coverage; or

(C) both the uninsured motorist coverage and the underinsured motorist coverage;

that would otherwise be provided under the policy; and

(2) the date on which the rejection is effective.

(d) The following apply to the coverage described in subsection (a) in connection with a commercial umbrella or excess liability policy,

including a commercial umbrella or excess liability policy that is issued or delivered to a motor carrier (as defined in IC 8-2.1-17-10) that is in compliance with the minimum levels of financial responsibility set forth in 49 CFR Part 387:

(1) An insurer is not required to make available in a commercial umbrella or excess liability policy the coverage described in subsection (a).

(2) An insurer that, through a rider or an endorsement, reduces or removes from a commercial umbrella or excess liability policy the coverage described in subsection (a) shall:

(A) through the United States mail; or

(B) by electronic means;

provide to the named insured written notice of the reduction or removal.

(3) An insurer that makes available in a commercial umbrella or excess liability policy the coverage described in subsection (a):

(A) may make available the coverage in limits determined by the insurer; and

(B) is not required to make available the coverage in limits equal to the limits specified in the commercial umbrella or excess liability policy.

(e) A rejection under subsection (b) of uninsured motorist coverage or underinsured motorist coverage in an underlying commercial policy of insurance is also a rejection of uninsured motorist coverage or underinsured motorist coverage in a commercial umbrella or excess liability policy.

(f) An insurer is not required to make available the coverage described in subsection (a) in connection with coverage that:

(1) is related to or included in a commercial policy of property and casualty insurance described in Class 2 or Class 3 of IC 27-1-5-1; and

(2) covers a loss related to a motor vehicle:

(A) of which the insured is not the owner; and

(B) that is used:

(i) by the insured or an agent of the insured; and

(ii) for purposes authorized by the insured.

(g) For purposes of subsection (f), "owner" means:

(1) a person who holds the legal title to a motor vehicle;

(2) a person who rents or leases a motor vehicle and has exclusive use of the motor vehicle for more than thirty (30) days;

(3) the conditional vendee or lessee under an agreement for the conditional sale or lease of a motor vehicle; or

(4) the mortgagor under an agreement for the conditional sale or lease of a motor vehicle under which the mortgagor has:

(A) the right to purchase; and

(B) an immediate right of possession of;

the motor vehicle upon the performance of the conditions stated in the agreement.

(h) The following apply to the coverage described in subsection (a) in relation to a personal umbrella or excess liability policy:

(1) An insurer is not required to make available the coverage described in subsection (a) under a personal umbrella or excess liability policy.

(2) An insurer that reduces or removes, through a rider or an endorsement, coverage described in subsection (a) under a personal umbrella or excess liability policy shall:

(A) through the United States mail; or

(B) by electronic means;

provide to the named insured written notice of the reduction or removal.

(3) An insurer that makes available the coverage described in subsection (a) under a personal umbrella or excess liability policy:

(A) may make available the coverage in limits determined by the insurer; and

(B) is not required to make available the coverage in limits equal to the limits specified in the personal umbrella or excess liability policy.

(4) A rejection under subsection (b) of uninsured motorist coverage or underinsured motorist coverage in an underlying personal policy of insurance is also a rejection of uninsured motorist coverage or underinsured motorist coverage in a personal umbrella or excess liability policy.

(i) A policy of insurance that provides coverage in excess of any liability relating to a self-insured retention amount shall be considered a commercial umbrella or excess liability policy under subsection (d).

SECTION 19. IC 27-7-6-0.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 0.5. Section 6 of this chapter, as amended in the 2026 session of the general assembly, applies to automobile insurance policies that are issued, delivered, amended, or renewed on or after January 1, 2027.**

SECTION 20. IC 27-7-6-6, AS AMENDED BY P.L.196-2021,

SECTION 36, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 6. (a) An insurer shall not fail to renew a policy unless it mails to the named insured, at the address shown in the policy, at least ~~twenty (20)~~ **thirty (30)** days advance notice of its intention not to renew the policy.

(b) If a policy was procured by an independent insurance producer duly licensed by the state of Indiana, a notice of intent not to renew the policy shall be mailed to the independent insurance producer at least ten (10) days prior to the mailing of the notice of intention not to renew to the named insured under subsection (a), unless such notice of intent is or has been waived in writing by the independent insurance producer.

(c) This section does not apply:

(1) if the insurer has manifested its willingness to renew; or

(2) in case of nonpayment of premium.

However, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

(d) A notice of intention not to renew is not required under this section if:

(1) the insured is transferred from an insurer to an affiliate of the insurer for future coverage; and

(2) the transfer results in the same or broader coverage.

(e) Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal.

SECTION 21. IC 27-7-12-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 1. (a) **Except as provided in subsection (b),** this chapter applies to policies of insurance covering risks to property located in Indiana that take effect or are renewed after June 30, 2001, and that insure loss of or damage to:

(1) real property consisting of not more than four (4) residential units, one (1) of which is the principal place of residence of the named insured; or

(2) personal property:

(A) in which the named insured has an insurable interest; and

(B) that is used within a residential dwelling for personal, family, or household purposes.

(b) Section 4 of this chapter, as amended in the 2026 session of the general assembly, and section 6.5 of this chapter, as added in

the 2026 session of the general assembly, apply to policies of insurance described in subsection (a) that are issued, delivered, amended, or renewed on or after January 1, 2027.

~~(b)~~ **(c)** This chapter does not apply to the following:

(1) A policy of inland marine insurance.

(2) The cancellation or nonrenewal of an automobile insurance policy under IC 27-7-6.

(3) The cancellation or nonrenewal of a commercial property and casualty insurance policy under IC 27-1-31-2.5.

SECTION 22. IC 27-7-12-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 2. **(a) As used in this chapter, "aerial image" means an image of a named insured's property captured from an airborne platform.**

~~(a)~~ **(b)** As used in this chapter, "cancellation" refers to a termination of property insurance coverage that occurs during the policy term.

~~(b)~~ **(c)** As used in this chapter, "nonpayment of premium" means the failure of the named insured to discharge any obligation in connection with the payment of premiums on policies of insurance subject to this chapter, regardless of whether the payments are directly payable to the insurer or its agent or indirectly payable under a premium finance plan or extension of credit. The term includes the failure to pay dues or fees where payment of the dues or fees is a prerequisite to obtaining or continuing property insurance coverage.

~~(c)~~ **(d)** As used in this chapter, "nonrenewal" or "nonrenewed" refers to a termination of property insurance coverage that occurs at the end of the policy term.

~~(d)~~ **(e)** As used in this chapter, "renewal" or "to renew" refers to:

(1) the issuance and delivery by an insurer at the end of a policy period of a policy superseding a policy previously issued and delivered by the same insurer; or

(2) the issuance and delivery of a certificate or notice extending the term of an existing policy beyond its policy period or term.

~~(e)~~ **(f)** As used in this chapter, "termination" means a cancellation or nonrenewal. The term does not include:

(1) the requirement of a reasonable deductible;

(2) reasonable changes in the amount of insurance; or

(3) reasonable reductions in policy limits or coverage;

if the requirements or changes are directly related to the hazard involved and are made on the renewal date for the policy. The term does not include a transfer of a policy to another insurer.

SECTION 23. IC 27-7-12-4, AS AMENDED BY P.L.196-2021, SECTION 38, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2026]: Sec. 4. (a) Notice of nonrenewal by an insurer must:

(1) be in writing;

(2) be mailed to the named insured at the last known address of the named insured;

(3) state the insurer's intention not to renew the policy upon expiration of the current policy period;

(4) upon request of the named insured, be accompanied by a written explanation of the specific reasons for the nonrenewal; ~~and~~

(5) be mailed to the named insured at least ~~twenty (20)~~ **sixty (60)** days before the expiration of the current policy period; **and**

(6) comply with section 6.5(a)(1) of this chapter if the insurer used aerial images as the sole reason for nonrenewing a policy.

(b) If the policy was procured by an independent insurance producer licensed in Indiana, the insurer shall mail notice of nonrenewal to the insurance producer not less than ten (10) days before the insurer mails the notice to the named insured under subsection (a), unless the obligation to notify the insurance producer is waived in writing by the insurance producer.

(c) Notice of nonrenewal under this section is not required if:

(1) the named insured is transferred from an insurer to an affiliate of the insurer for future coverage; and

(2) the transfer results in the same or broader coverage.

(d) If an insurer mails to an insured a renewal notice, bill, certificate, or policy indicating the insurer's willingness to renew a policy and the insured does not respond, the insurer is not required to mail to the insured notice of intention not to renew.

SECTION 24. IC 27-7-12-6.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 6.5. (a) When utilizing aerial images as the sole reason for nonrenewing a policy, an insurer shall do the following:**

(1) Ensure that the nonrenewal notice sent to the named insured under section 4 of this chapter includes information about how the named insured can request to review copies of the images of the property that were used to make the decision. Photos must have been taken within the past twenty-four (24) months.

(2) Establish a point of contact and a process for a named insured to use to provide documentation of completion of the required work that the insurer communicates to the named

insured under subdivision (1). The documentation must be used by the insurer in considering whether to uphold or reverse the nonrenewal.

(3) Establish an appeal process that allows the named insured to correct any errors or misunderstandings related to the nonrenewal.

(4) Provide the named insured at least sixty (60) days to cure the defects or conditions underlying a nonrenewal after the date the insurer identifies the specific conditions under subdivision (1). An insurer shall have the right to assess the work used to cure the defects or conditions to ensure they have been corrected in a manner that meets the standards originally communicated by the insurer under subdivision (1).

(5) Offer a renewal policy to a named insured who submits proof that they have cured the defects or conditions identified under subdivision (1). However, an insurer may nonrenew the policy only for a reason unrelated to the defects or conditions identified under subdivision (1).

(b) The department shall adopt rules under IC 4-22-2 to effectuate the provisions of this section.

SECTION 25. IC 27-7-18.7 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]:

Chapter 18.7. Property and Casualty Insurance for Condominium Units

Sec. 1. As used in this chapter, "condominium" has the meaning set forth in IC 32-25-2-7.

Sec. 2. As used in this chapter, "condominium unit" has the meaning set forth in IC 32-25-2-9.

Sec. 3. As used in this chapter, "co-owner" has the meaning set forth in IC 32-25-2-11.

Sec. 4. As used in this chapter, "property and casualty insurance" means one (1) or more of the types of insurance described in IC 27-1-5-1, Class 2 and Class 3.

Sec. 5. (a) This section applies to a condominium in which all of the condominium units:

(1) were designed and built for occupancy by not more than two (2) separate families; and

(2) contain not more than two (2) separate living quarters.

(b) Notwithstanding IC 32-25-8-9, the co-owners of a condominium described in subsection (a) may obtain property and casualty insurance coverage for the condominium units through

one (1) of the following methods:

(1) By purchasing a master policy for property and casualty insurance.

(2) By allowing each co-owner to purchase property and casualty insurance on an individual basis.

(c) This section may not be construed to relieve the co-owners from any obligation under IC 32-25-8-9 to provide insurance coverage under a master policy for:

(1) the land on which the condominium is located;

(2) swimming pools and other recreational facilities; or

(3) any other parts of the condominium existing for common use.

SECTION 26. IC 27-8-11-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 8.5. (a) As used in this section, "insurance producer" has the meaning set forth in IC 27-1-15.6-2.**

(b) An insurer shall provide any insurance producer who has contracted with the insurer with access to a complete list of every provider that has entered into an agreement with an insurer under section 3 of this chapter.

(c) An insurer shall make the information described in subsection (b) available on the insurer's portal for insurance producer communications.

SECTION 27. IC 27-8-13-9.3, AS ADDED BY P.L.56-2025, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 9.3. (a) **Except as provided in subsection (b),** this section applies to a Medicare supplement policy or certificate delivered, issued, or renewed on or after January 1, 2026.

(b) The amendments made to this section in the 2026 session of the general assembly apply to a Medicare supplement policy or certificate delivered, issued, or renewed on or after March 15, 2026.

~~(b)~~ **(c)** This section applies to:

(1) an applicant who submits an application for a Medicare supplement policy or certificate before or during the six (6) month period beginning on the first day of the first month during which the applicant is:

(A) at least sixty-five (65) years of age; and

(B) timely enrolled for benefits under Medicare Part B without penalty under federal law; and

(2) an applicant who:

(A) is at least sixty-five (65) years of age;

(B) is insured under a Medicare supplement policy or certificate;

(C) submits an application for a Medicare supplement policy or certificate:

(i) to an issuer that is different than the issuer of the applicant's current Medicare supplement policy or certificate; and

(ii) ~~within sixty (60) days of~~ **during the period beginning one (1) month before** the applicant's birthday **and ending one (1) month after the applicant's birthday;** and

(D) seeks to maintain the same type of lettered Medicare supplement plan, including any variation of the lettered plan.

~~(c)~~ **(d)** An issuer of a Medicare supplement policy or certificate shall not deny, condition the issuance or effectiveness of, or discriminate in the pricing of a Medicare supplement policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant to which subsection ~~(b)~~ **(c)** applies.

~~(d)~~ **(e)** A new Medicare supplement policy or certificate issued to an applicant under subsection ~~(b)(2)~~ **(c)(2)** must go into effect on the first day of the **next** month ~~that is at least thirty (30) days~~ after the signature date on the application for the Medicare supplement policy or certificate.

SECTION 28. IC 27-13-9-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.5. (a) A health maintenance organization shall provide any insurance producer who has contracted with the health maintenance organization with access to a complete list of every participating provider that provides health care services through the health maintenance organization.**

(b) A health maintenance organization shall make the information described in subsection (a) available on the health maintenance organization's portal for insurance producer communications.

SECTION 29. IC 27-19-3-1.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: **Sec. 1.5. The commissioner shall have the authority to do the following:**

(1) Establish any program, promulgate any rule, policy, guideline, or plan, or change any program, rule, policy, or guideline to:

(A) implement;

(B) establish;

(C) create;

(D) administer; or

(E) otherwise operate;

a health benefit exchange.

(2) Apply for, accept, or expend federal money related to the creation, implementation, or operation of a health benefit exchange.

(3) Establish any advisory board or committee that the commissioner deems necessary to provide recommendations on the creation, implementation, or operation of a health benefit exchange.

SECTION 30. IC 34-30-2.1-402, AS ADDED BY P.L.105-2022, SECTION 12, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2026]: Sec. 402. IC 27-1-3-22 (Concerning persons **or entities** reporting fraudulent insurance acts).

SECTION 31. **An emergency is declared for this act.**

Speaker of the House of Representatives

President of the Senate

President Pro Tempore

Governor of the State of Indiana

Date: _____ Time: _____