(3) ATTEMPT TO SETTLE A CLAIM BASED ON AN APPLICATION THAT IS ALTERED WITHOUT NOTICE TO, OR THE KNOWLEDGE OR CONSENT OF, THE INSURED;

(4) FAIL TO INCLUDE WITH EACH CLAIM PAID TO AN INSURED OR BENEFICIARY A STATEMENT OF THE COVERAGE UNDER WHICH PAYMENT IS BEING MADE;

(5) FAIL TO SETTLE A CLAIM PROMPTLY WHENEVER LIABILITY IS REASONABLY CLEAR UNDER ONE PART OF A POLICY, IN ORDER TO INFLUENCE SETTLEMENTS UNDER OTHER PARTS OF THE POLICY;

(6) FAIL TO PROVIDE PROMPTLY ON REQUEST A REASONABLE EXPLANATION OF THE BASIS FOR A DENIAL OF A CLAIM; OR

(7) FAIL TO MEET THE REQUIREMENTS OF TITLE 19, SUBTITLE 13 OF THE HEALTH – GENERAL ARTICLE FOR PREAUTHORIZATION FOR A HEALTH CARE SERVICE.

REVISOR'S NOTE: This section is new language derived without substantive change from former Art. 48A, § 230A(c).

In item (1) of this section, the reference to the "coverage" at issue is added to conform to § 27–304(1) of this subtitle.

Defined terms: "Insurer" § 1–101
"Policy" § 1–101

27–304. SAME — GENERAL BUSINESS PRACTICE.

IT IS AN UNFAIR CLAIM SETTLEMENT PRACTICE AND A VIOLATION OF THIS SUBTITLE FOR AN INSURER OR NONPROFIT HEALTH SERVICE PLAN, WHEN COMMITTED WITH THE FREQUENCY TO INDICATE A GENERAL BUSINESS PRACTICE, TO:

(1) MISREPRESENT PERTINENT FACTS OR POLICY PROVISIONS THAT RELATE TO THE CLAIM OR COVERAGE AT ISSUE;

(2) FAIL TO ACKNOWLEDGE AND ACT WITH REASONABLE PROMPTNESS ON COMMUNICATIONS ABOUT CLAIMS THAT ARISE UNDER POLICIES;

(3) FAIL TO ADOPT AND IMPLEMENT REASONABLE STANDARDS FOR THE PROMPT INVESTIGATION OF CLAIMS THAT ARISE UNDER POLICIES;

(4) REFUSE TO PAY A CLAIM WITHOUT CONDUCTING A REASONABLE INVESTIGATION BASED ON ALL AVAILABLE INFORMATION;

(5) FAIL TO AFFIRM OR DENY COVERAGE OF CLAIMS WITHIN A REASONABLE TIME AFTER PROOF OF LOSS STATEMENTS HAVE BEEN COMPLETED;

(6) FAIL TO MAKE A PROMPT, FAIR, AND EQUITABLE GOOD FAITH ATTEMPT, TO SETTLE CLAIMS FOR WHICH LIABILITY HAS BECOME REASONABLY CLEAR;