§ * 65.15 Claims for personal injury protection benefits--accidents on and after December 1, 1977

The following are rules for the settlement of claims for first-party and additional first-party benefits on account of injuries arising out of the use or operation of a motor vehicle or a motorcycle on and after December 1, 1977. These rules shall apply to Insurers and self-insurers, and the term insurer, as used in this section, shall include both insurers and self-insurers as those terms are defined in this Part and article 51 of the Insurance Law, the Motor Vehicle Accident Indemnification Corporation (MVAIC), pursuant to section 5221(b) of the Insurance Law and any company or corporation providing insurance pursuant to section 5103(g) of the Insurance Law for the items of basic economic loss specified in section 5102(a) of the Insurance Law. These rules and procedures are subject to the special provisions, contained in section 65.18 of this Part, which are applicable to claims for loss of earnings from work resulting from accidents which occurred prior to February 20, 1980.

(a) Claim practice principles to be followed by all insurers.

(1) Have as your basic goal the prompt and fair payment to all automobile accident victims.

(2) Assist the applicant in the processing of a claim. Do not treat the applicant as an adversary.

(3) Do not demand verification of facts unless there are good reasons to do so. When verification of facts is necessary, it should be done as expeditiously as possible.

(4) Hasten the processing of a claim through the use of a telephone whenever it is possible to do so.

(5) Clearly inform the applicant of the insurer's position regarding any disputed matter.

(6) Respond promptly, when a response is indicated, to all communications from insureds, applicants, attorneys and any other interested persons.

(7) Every insurer shall distribute copies of this regulation to every person directly responsible to it for the handling and settlement of claims for first-party benefits, and every insurer shall satisfy itself that all such personnel are thoroughly conversant with this regulation.

(b) Notice.

(1) If the applicant's written notice of a claim, required by section 65.11 of this Part and the mandatory and additional personal injury protection endorsements, is given to a designated agent of an insurer or to a person authorized to receive service of summons, the insurer is deemed to have received the notice; provided, however, that unless otherwise provided by law or contract, notice to the agent shall not be notice to the insurer if the agent promptly notifies the applicant that the agent is not authorized to receive notice of a claim.

(2) If the agent is permitted to receive a notice of a claim, the agent may acknowledge receipt of such notice in the manner set forth in this section.

(3) Receipt of a Department of Motor Vehicles Accident Report 104 (MV 104), or other accident report indicating injuries to eligible injured persons, Shall be deemed written notice of a claim.

(4) The written notice required by section 65.11 of this Part and the mandatory and additional personal injury protection endorsement(s) shall be deemed to be satisfied by the insurer's receipt of a completed prescribed application for motor vehicle no-fault benefits (NYS Form N-F 2) forwarded to the applicant pursuant to paragraph (c)(2) of this section or by the insurer's receipt of a completed hospital facility form (NYS Form N-F 5).

(c) Acknowledgment of claim.

(1) Whenever the insurer receives notice of claim by telephone, the party receiving such notice on behalf of the insurer shall be identified to the caller by name and title and shall request the name, address and telephone number of the applicant and the name of the policyholder or the policy number or both, if available, along with reasonably obtainable information regarding the time, place and circumstances of the accident which will enable the insurer to begin processing the claim.

(2) Unless the insurer will pay the claim as submitted within 30 calendar days, then, within five business days after notice is received by the insurer at the address of its proper claim processing office, either orally pursuant to paragraph (1) of this subdivision or in any other manner, the insurer shall forward to the applicant the prescribed application for motor vehicle no-fault benefits (NYS Form N-F 2) accompanied by the prescribed cover letter (NYS Form N-F 1). If notice is initially received by the insurer at an address other than the proper claims processing office, the five-day period for forwarding of the prescribed forms

shall commence on the day such notice is received at the proper claims processing office, but in no event shall the prescribed forms be forwarded later than 15 business days after receipt of the original notice.

(3) Attached as an appendix (Appendix 13-A, infra) are the following prescribed claim forms that must be used by all insurers, and shall not be altered:

(i) Cover Letter (NYS Form N-F 1);

(ii) Application for Motor Vehicle No-Fault Benefits (NYS Form N-F 2);

(iii) Verification of Treatment by Attending Physician or Other Provider of Health Service (NYS Form N-F 3);

(iv) Verification of Hospital Treatment (NYS Form N-F 4);

(v) Hospital Facility Form (NYS Form N-F 5);

(vi) Employer's Wage Verification Report (NYS Form N-F 6);

(vii) Verification of Self-Employment Income (NYS Form N-F 7);

(viii) Agreement to Pursue Social Security Disability Benefits (NYS Form N-F 8);

(ix) Agreement to Pursue Workers' Compensation or New York State Disability Benefits (NYS Form N-F 9);

(x) Denial of Claim Form (NYS Form N-F 10);

(xi) Subrogation Agreement (NYS Form N-F 11);

(xii) Lump-Sum Settlement Agreement (NYS Form N-F 12);

(xiii) Election-Optional Basic Economic Loss (NYS Form N-F 13);

(d) Claim procedure.

(1) Within 10 business days after receipt of the completed application for motor vehicle no-fault benefits, the insurer shall forward, to the parties required to complete them, those prescribed verification forms it will require prior to payment of the initial claim. The insurer is entitled to receive all items necessary to verify the claim directly from the parties from whom such verification was requested.

(2) Subsequent to the receipt of one or more of the completed prescribed verification forms, any additional verification required by the insurer shall be requested within 10 business days of receipt of the prescribed verification forms.

(3) If the additional verification required by the insurer is a medical examination, the insurer shall schedule the examination to be held within 30 calendar days from the date of receipt of the prescribed verification forms.

(4) All medical examinations requested by the insurer shall be held at a place and time reasonably convenient to the applicant and in a facility properly equipped for the performance of the medical examination. The insurer shall inform the applicant at the time the examination is scheduled that the applicant will be reimbursed for any loss of earnings and reasonable transportation expenses incurred in complying with the request.

(5) An insurer must accept proof of claim submitted on a form other than a prescribed form if it contains substantially the same information as the prescribed form. An insurer, however, may require the submission of the prescribed application for motor vehicle no-fault benefits and the prescribed hospital facility form.

(6) In lieu of a prescribed application for motor vehicle no-fault benefits submitted by an applicant and a verification of hospital treatment (NYS Form N-F 4), an insurer shall accept a completed hospital facility form (NYS Form N-F 5) (or an N-F 5 and Uniform Billing Form (UBF-1) which together supply all the information requested by the N-F 5) submitted by a provider of health services with respect to the claim of such provider.

(7) When benefits are claimed under an additional personal injury protection endorsement, the insurer may require that the applicant execute a prescribed subrogation agreement (NYS Form N-F 11) prior to the payment of any benefits. If the insurer shall impose the above requirement, it shall deliver the prescribed agreement to the applicant as soon as it is known that the claim is payable under an additional personal injury protection endorsement.

(8) If the insurer has knowledge that the applicant for benefits under a mandatory or additional personal injury protection endorsement is entitled to benefits under any other mandatory or optional first-party automobile or no-fault automobile insurance for the same elements of loss, the insurer should give written notice of claim to all other such sources of benefits in order to protect its right under the endorsement to recover from such other sources their proportionate share of the costs of the claim and the allocated expenses of processing the claim.

(9) Every insurer who does not staff and maintain a claims office in this State shall establish a communications system, by means of a direct toll-free telephone line, to conveniently process all claims made pursuant to article 51 of the Insurance Law. Such toll-free number shall appear on all correspondence relating to claims.

(e) Follow-up requirements.

(1) Application for motor vehicle no-fault benefits. At a minimum, the insurer shall, within 10 calendar days, mail a second application for motor vehicle no-fault benefits, with the prescribed cover letter, to the eligible injured person or such person's attorney if, 30 calendar days after the original mailing, a prescribed application has not been completed and returned to the insurer. If the follow-up is sent to the applicant's attorney, a copy of the prescribed cover letter, marked "second notice," shall be forwarded to the applicant.

(2) Verification requests. At a minimum, if any requested verification has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was originally requested, either by a telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

(f) Election.

(1) If an insured has purchased optional basic economic loss (OBEL) coverage pursuant to section 5102(a)(5) of the Insurance Law, the insurer shall notify each eligible injured person (or that person's legal representative) making a claim under such policy that such person may elect how OBEL coverage will be applied.

(2) The insurer shall mail form NYS N-F 13 to the eligible injured person or that person's legal representative as soon as, and in no event later than 15 calendar days after, the insurer has received claims aggregating $ 30,000 in basic economic loss.

(3) If the eligible injured person or that person's legal representative does not return the election form (NYS N-F 13) within 15 calendar days after the initial mailing, then within five calendar days after such time has elapsed the insurer shall mail to the eligible injured person or that person's legal representative a second election notice, clearly marked "SECOND NOTICE".

(4) Failure of the eligible injured person or that person's legal representative to respond to the second notice within 15 calendar days after its mailing shall be considered an election by the eligible injured person to apply OBEL coverage to all elements of basic economic loss.

(5) Once made by the eligible injured person or that person's legal representative, an OBEL election cannot be changed, except that, if claims payable under OBEL coverage have not yet been received by the Company, an eligible injured person who has failed to respond to the second notice in a timely manner may make an election.

(g) Payment or denial of claim (30-day rule).

(1)

(i) No-fault benefits are overdue if not paid within 30 calendar days after the insurer receives verification of all of the relevant information requested pursuant to subdivision (d) of this section. In the case of a medical examination, the verification is deemed to have been received by the insurer on the day the examination was performed.

(ii) An insurer shall defer payment of OBEL benefits for claims submitted by or on behalf of the eligible injured person until an OBEL option has been elected in accordance with subdivision (f) of this section. An insurer shall pay or deny such claims under OBEL coverage within 30 calendar days of the date that an election has been made.

(2)

(i) An insurer may not interrupt the payment of benefits for any element of basic or extended economic loss pending the administering of a medical examination, unless the applicant or the applicant's attorney is responsible for the delay or inability to schedule the examination, in which case any denial of payment shall be made only in accordance with policy provisions on a prescribed denial of claim form (NYS Form N-F 10).

(ii) Notwithstanding subparagraph (i) of this paragraph, if the insurer has information which clearly demonstrates that the applicant is no longer disabled, the insurer may discontinue the payment of benefits by forwarding to the applicant a prescribed denial of claim form.

(iii) Except as provided in paragraph (5) of this subdivision, an insurer shall not issue a denial of claim form (NYS Form N-F 10) prior to its receipt of verification of all of the relevant information requested pursuant to subdivision (d) of this section (e.g., medical reports, wage verification, etc.). An insurer shall follow the procedures described in paragraph (e) (2) of this section to keep the applicant and such person's attorney informed of the status of the claim.

(iv) If the specific reason for a denial of a no-fault claim, or any element thereof, is a medical examination report requested by the insurer, the insurer shall release a copy of that report to the applicant for benefits, the applicant's attorney, or the applicant's treating physician, upon the written request of any of these parties.

(3) Within 30 calendar days after proof of claim is received, the insurer shall either pay or deny the claim in whole or in part.

(i) If the insurer denies a claim in whole or in part involving elements of basic economic loss, or for accidents occurring on and after January 1, 1982 involving elements of extended economic loss, the insurer shall notify the applicant or the authorized representative on the prescribed denial of claim form, in duplicate, and shall furnish, if requested by the applicant, one copy of all prescribed claim forms submitted by or on behalf of the applicant thereto. However, where a denial involves a portion of a health provider's bill, the insurer may make such a denial on a form or letter approved by the department which is issued in duplicate. No form or letter shall be approved unless it contains substantially the same information as the prescribed form which is relevant to the claim denied.

(ii) Notwithstanding subparagraph (i) of this paragraph, where there is a denial in part of a medical bill as a result of charges not conforming to section 5108 of the Insurance Law, an insurer may effect compliance with subparagraph (i) for those overcharges of $ 50 or less by telephone agreement with the provider or provider's representative, with proper documentation of such agreement in the claim file. The provider must have been entitled to direct payment pursuant to subdivision (i) of this section.

(iii) If the insurer denies a claim in whole or in part, solely involving elements of loss arising under an additional personal injury protection endorsement for an accident which occurred prior to January 1, 1982, the insurer shall notify the applicant or the authorized representative on the prescribed denial of claim form and shall attach one copy of all prescribed claim forms submitted by or on behalf of the applicant thereto, but shall delete from the denial of claim form paragraph (2) (arbitration), which is not available for the resolution of such disputes unless agreed to by the parties. However, where a denial involves a portion of a health provider's bill, the insurer may make such a denial on a form or letter approved by the department which is issued in duplicate. No form or letter shall be approved unless it contains substantially the same information as the prescribed form which is relevant to the claim denied.

(4) Where an insurer denies part of a claim, it shall pay benefits for the undisputed elements of the claim. Such payments shall be made without prejudice to either party.

(5) If an insurer has determined that benefits are not payable for any of the following reasons:

(i) no coverage on the date of accident;

(ii) circumstances of the accident not covered by no-fault; or

(iii) statutory exclusions pursuant to section 5103(b) of the Insurance Law;

it shall notify the applicant within 10 business days after such determination on a prescribed denial of claim form, specifying the reasons for the denial. Failure by an insurer to notify the applicant of its denial of the claim within the 10-business-day period after its determination shall not preclude the insurer from asserting a defense to the claim which is based upon the reasons for such denial.

(6) A failure to observe any of the time frames specified in this section shall not prevent an insurer from requiring proper proof of claim.

(7) Notwithstanding paragraph (5) of this subdivision, if an insurer has reason to believe that the applicant was operating a motor vehicle while intoxicated or impaired by the use of a drug, and such intoxication or impairment was a contributing cause of the automobile accident, the insurer shall be entitled to all available information relating to the applicant's condition at the time of the accident. Proof of a claim shall not be complete until the information which has been requested, pursuant to paragraph (d) (1) or (2) of this section, has been furnished to the insurer by the applicant or the authorized representative.

(8) Where the insurer has determined that a self-employed applicant's disability arose from the claimed accident, the insurer shall be deemed to have proof of claim for loss of earnings or substitute services, subject to receipt of medical proof of disability for the period claimed, when it has received a completed prescribed verification of self-employment income form (NYS N-F 7) and the proof requested thereon. The insurer shall determine therefrom the amount of loss of earnings benefits, if any, due the applicant. Notwithstanding the above, if an insurer requires verification in addition to the proof supplied, it may request such additional verification pursuant to paragraph (d) (2) of this section.

(9) A death benefit claim will be deemed to have been proven when the insurer receives a copy of the decedent's death certificate and proof that the personal representative of the decedent's estate was duly appointed in this State or any other jurisdiction.

(10) For the purposes of counting the 30 calendar days after proof of claim, wherein the claim becomes overdue pursuant to section 5106 of the Insurance Law, with the exception of subdivision (e) of this section, any deviation from the rules set out in this section shall reduce the 30 calendar days allowed.

Example: Where an insurer sends an application for motor vehicle no-fault benefits 15 business days after notice is received at the address of the insurer's proper claim processing office instead of five business days, the 30 calendar days permitted by paragraph (1) of this subdivision are reduced to 20 calendar days.

(h) Interest on overdue payments.

(1) All overdue mandatory personal injury protection benefits due an applicant or assignee shall bear interest at a rate of two percent per month, compounded and calculated on a pro rata basis using a 30-day month. The aforementioned two-percent per-month interest shall also be payable on all overdue additional personal injury protection benefits due an applicant or assignee as a result of an accident occurring on or after January 1, 1982. When payment is made on an overdue claim, any interest calculated to be due in an amount exceeding $ 5 shall be paid to the applicant or the applicant's assignee without demand therefor.

(2) The insurer shall not suggest that the interest due be waived.

(3) If an applicant does not request arbitration or institute a lawsuit within 30 days after the receipt of a denial of claim form or payment of benefits calculated pursuant to Insurance Department regulations, interest shall not accumulate on the disputed claim or element of claim until such action is taken. If any applicant is a member of a class in a class action brought for payment of benefits, but is not a named party, interest shall not accumulate on the disputed claim or element of claim until a class which includes such applicant is certified by court order, or such benefits are authorized in that action by Appellate Court decision, whichever is earlier.

(4) If an applicant has submitted a dispute to arbitration or the courts, interest shall accumulate, unless the applicant unreasonably delays the arbitration or court proceeding.

(5) The insurer shall separately identify any interest payment on an overdue claim from benefit payments. This may be done by issuing separate drafts for each amount or by an accompanying statement that clearly and separately identifies the components of the draft.

(6) An insurer may not include in its ratemaking calculations any interest paid on an overdue claim.

(i) Attorneys.

(1) An applicant or an assignee shall be entitled to recover their attorney's fees, for services necessarily performed in connection with securing payment, if a valid claim or portion thereof was denied or overdue. If such a claim was initially denied and subsequently paid by the insurer, the attorney's fee shall be $ 60. If such a claim was overdue but not denied, the attorney's fee shall be equal to the amount of interest payable pursuant to subdivision (h) of this section, subject to a maximum fee of $ 60.

(2) If a dispute is resolved in accordance with any of the optional arbitration procedures contained in this Part, either during the initial review by the Insurance Department or by an arbitration award, and if payment is not made by the insurer in

accordance with the terms specified in the conciliation letter or arbitration award within 30 days following such resolution, an additional attorney's fee shall be paid by the insurer. The additional attorney's fee shall be $ 60 and shall become payable only after written days request from the attorney to the department, received more than 30 after mailing of the conciliation letter or arbitration award and upon the department's confirmation of nonpayment within the 30-day period. Such fee shall not be payable if an arbitration award is appealed in accordance with the provisions of this Part.

(3) The insurer shall segregate any attorney's fee on an overdue claim from the loss and interest payments, either through issuance of separate drafts or through an accompanying statement which clearly and separately identifies the components of the draft.

(4) No attorney's fee payable by an insurer on account of an overdue claim may be included by the insurer in any ratemaking calculations.

(j) Direct payments.

(1) An insurer shall pay benefits for any element of loss, other than death benefits, directly to the applicant or, when appropriate, to the applicant's parent or legal guardian or to any person legally responsible for necessities, or, upon assignment by the applicant or any of the aforementioned persons, shall pay the providers of services or the applicant's employer directly. Death benefits shall be paid to the estate of the eligible injured person.

(2) In order for a health care provider to receive direct payment from the insurer, the health care provider must submit to the insurer either:

(i) a properly executed assignment on either the prescribed Verification of Treatment by Attending Physician or Other Provider of Service (NYS Form N-F 3) or the prescribed No-Fault Assignment of Benefits form (Form N-F - AOB) contained in Appendix 13-A; or

(ii) a properly executed Authorization to Pay Benefits contained on NYS Form N-F 3. Execution of an authorization to pay benefits shall not constitute or operate as a transfer of all rights from the eligible injured person to the provider. The use of these prescribed forms shall be required and applicable to all claims arising from motor vehicle accidents, which occur on and after March 1, 2002.
**NB Effective until June 24, 2002

(3) The insurer may request, in writing, the original assignment or authorization to pay benefits form to establish proof of claim in accordance with the procedures contained in subdivision (d) of this section. The insurer must maintain the original form in its claim file.
**NB Effective until June 24, 2002

(4) If an assignment has been furnished an insurer, the assignor or legal representative of the assignor shall not unilaterally revoke the assignment after the services for which the assignment was originally executed were rendered. If the assignment is revoked for services not yet rendered, the assignor or legal representative shall provide written notification to the insurer that the assignee has been notified of the revocation.
**NB Renumbering effective until June 24, 2002 then becomes (2)

(5) The draft or check in payment of benefits shall include information sufficient to identify the element(s) of covered expense(s) being reimbursed, or must be accompanied by an explanation containing such identifying information.
**NB Renumbering effective until June 24, 2002 then becomes (3)

Example: Payment of loss of earnings shall indicate that the payment is for loss of earnings, and shall identify the period of lost time from work being reimbursed and the rate at which reimbursement is being made.

(k) Sources of mandatory personal injury protection benefits.

(1) Institution of claims for first-party benefits--priority.

(i) Subject to subparagraph (vi) of this paragraph, an applicant who is an operator or occupant of an insured motor vehicle, or any other person, not occupying another motor vehicle or a motorcycle, who sustains a personal injury arising out of the use or operation in New York State of such motor vehicle, shall institute the claim against the insurer of such motor vehicle.

(ii) An applicant who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation in New York State of more than one insured motor vehicle or insured motorcycle shall institute the claim against the insurer of any one of such motor vehicles or motorcycles unless the insurers agree among themselves that one of them will accept and pay the claim initially.

(iii) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motorcycle, and who sustains a personal injury arising out of the use or operation of a motor vehicle outside of New York State, shall institute the claim against the insurer of the named insured or the insurer of the relative. The first such insurer applied to shall process the claim. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially (see paragraph (4) of this subdivision).

(iv) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motorcycle, and

who sustains a personal injury arising out of the use or operation of an uninsured motor vehicle in New York State, shall institute the claim against the insurer of the named insured or the insurer of the relative. If there is no such insurer and the accident occurs in New York State, then an applicant who is a qualified person as defined in article 52 of the Insurance Law shall institute the claim against the MVAIC (see paragraph (4) of this subdivision).

(v) An applicant who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury arising out of the use or operation in New York State of an insured motorcycle, shall institute the claim against the insurer of the motorcycle.

(vi) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motor vehicle or a motorcycle, and who sustains a personal injury on or after July 22, 1982 arising out of the use or operation of an uninsured motorcycle in New York State shall institute the claim against the insurer of the named insured or the insurer of the relative. If there is no such insurer and the accident occurs in New York State, then an applicant who is a qualified person as defined in article 52 of the Insurance Law shall institute the claim against the MVAIC (see paragraph (4) of this subdivision).

(vii) An applicant who is a named insured or a relative of a named insured, other than the occupant of a motor vehicle or a motorcycle, and who sustains a personal injury on or after July 22, 1982 arising out of the use or operation of a motorcycle outside of New York State shall institute the claim against the insurer of the named insured or relative. The first such insurer applied to shall process the claim. Where there is more than one insurer which would be the source of benefits, the insurers may agree among themselves, if there is a valid basis therefor, that one of them will accept and pay the claim initially (see paragraph (4) of this subdivision).

(viii) An applicant who is a New York State resident and who is neither a named insured or relative under any mandatory personal injury protection endorsement nor the owner of an uninsured motor vehicle and who sustains a personal injury arising out of the use or operation of a New York insured motor vehicle outside of New York State shall institute the claim against the insurer of such motor vehicle provided the policy insuring the vehicle was issued or renewed on or after January 1, 1983.

(ix) An applicant, other than an operator, owner, or employee of the owner or operator of a bus or school bus, who, while an occupant of such bus or school bus, sustains a personal injury arising out of the use or operation in New York State of such bus or school bus, shall institute the

claim against the applicant's own insurer. If the applicant does not have an insurer, the applicant shall institute the claim against the insurer of the bus or school bus.

(x) An applicant who is an operator, owner, or employee of the operator or owner of a bus or school bus, and who, while an occupant of such bus or school bus, sustains a personal injury arising out of the use or operation of such bus or school bus, shall institute the claim against the insurer of such bus or school bus.

(2) If a dispute regarding priority of payment arises among insurers who otherwise are liable for the payment of first-party benefits, then the first insurer to whom notice of claim is given pursuant to subdivision (b) or paragraph (c) (1) of this section, by or on behalf of an eligible injured person, shall be responsible for payment to such person. Any such dispute shall be resolved in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law (section 65.10 of this Part).

(3) If the source of first-party benefits is at issue because the status of the injured person as a pedestrian or an occupant of a motor vehicle is in dispute, the insurer to whom notice of claim was given or if such notice was given to more than one insurer, the first insurer to whom notice was given shall, within 15 calendar days after receipt of notice, obtain an agreement with the other insurer or insurers as to which insurer will furnish no-fault benefits. If such an agreement is not reached within the aforementioned 15 days, then the insurer to whom such notice was first given shall process the claim and pay first-party benefits and resolve the dispute in accordance with the arbitration procedures established pursuant to section 5105 of the Insurance Law (section 65.10 of this Part).

(4) The insurer of the named insured or relative shall be responsible for the payment of first-party benefits to such person when he/she is injured through the use or operation of another motor vehicle, the alleged insurer of which has denied coverage claiming it did not have a policy in force on such vehicle on the accident date; provided, however, that the named insured or relative injured in the accident was not the owner of the alleged uninsured motor vehicle. Payment by the insurer of the named insured or relative shall not affect any legal right of such insurer to challenge the validity of the denial by the other insurer.

(5) Any insurer paying first-party benefits shall be reimbursed by other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the provisions entitled "Other sources of first-party benefits" contained in section 65.11 of this Part and provisions entitled "Other coverage" contained in section 65.12 of this Part.

(l) Sources of additional personal injury protection benefits.

(1) Institution of claims--priority. Generally, an applicant's initial source of additional personal injury protection benefits will be the same source which provides the mandatory personal injury protection benefits, until the total available limits under that source's mandatory and additional personal injury protection coverages are exhausted. Specifically:

(i) An applicant who is an operator or occupant of an insured motor vehicle covered for additional personal injury protection benefits, and who sustains a personal injury arising out of the use or operation in New York State of such motor vehicle, shall institute the claim against the insurer of such motor vehicle.

(ii) An applicant who is a named insured or a relative of a named insured covered by additional personal injury protection benefits, and who, while an operator or occupant of a motor vehicle, sustains a personal injury arising out of the use or operation of such motor vehicle outside of New York State, shall institute the claim against the insurer of the named insured or the relative. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process the claim, unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See paragraph (2) of this subdivision.)

(iii) An applicant who is a named insured or a relative of a named insured covered for additional personal injury protection benefits, and who is neither an operator nor an occupant of a motor vehicle or a motorcycle, and who sustains a personal injury through the use or operation of a motor vehicle (on or after July 22, 1982), a motorcycle shall institute the claim against the insurer of the named insured or the relative. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process the claim, unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See paragraph (2) of this subdivision.)

(iv) An applicant who is not a named insured or a relative of a named insured covered for additional personal injury protection benefits, and who is an occupant of an insured motor vehicle covered for additional personal injury protection benefits or a motor vehicle operated by a person covered for additional personal injury protection benefits, and who sustains a personal injury through the use or operation of the insured motor vehicle outside of New York State, shall institute the claim against the insurer of the owner or operator of the insured motor vehicle. Where there is more than one insurer which would be the source of benefits, the first such insurer applied to shall process

the claim unless the insurers agree among themselves that another such insurer will accept and pay the claim initially. (See paragraph (2) of this subdivision.)

(v) An applicant who has exhausted the additional personal injury protection benefits available under the initial sources as set forth in this subdivision, shall then apply for benefits from the next available source providing a higher level of additional personal injury protection benefits. This latter source shall provide benefits to the extent that the total limit available under such latter source exceeds the amount available under the initial sources as set forth in this subdivision. This process will repeat until all available additional personal injury protection benefit sources have been exhausted.

(2) Any insurer paying additional personal injury protection benefits as provided in this subdivision shall be reimbursed by the other insurers for their proportionate share of the costs of the claim and the allocated expenses of processing the claim, in accordance with the other coverage; nonduplication paragraph of the additional personal injury protection endorsement contained in section 65.13 of this Part.

(m) Scope of coverage.

(1) An insurer shall be liable only for the payment of benefits for losses caused by the accident, including those caused by the aggravation of preexisting conditions.

(2) An Insurer shall pay benefits to an applicant for losses arising out of an accident in the following situations:

(i) where coverage has been excluded for an applicant operating a vehicle while in an intoxicated condition or while the applicant's ability is impaired by the use of a drug, if such intoxicated or drugged condition was not a contributing cause of the accident causing the injuries;

(ii) where coverage has been excluded for an applicant operating or occupying a motor vehicle known to the applicant to be stolen, and the applicant is an involuntary operator or occupant of said vehicle;

(iii) where there is no physical contact between the applicant and a motor vehicle or motorcycle which is the proximate cause of the injury;

(iv) where the motor vehicle or motorcycle is used without the specific permission of the owner, but is not a stolen vehicle; or

(v) where the accident arises out of repairing, servicing or otherwise maintaining a motor vehicle or a motorcycle, other than in the course of a business, and for which no charge or fee is contemplated.

(n) Computation of basic economic loss. When claims aggregate to more than $50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefor were made to the insurer prior to the exhaustion of the $50,000. If the insurer pays the $50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services.

(o) Measurement of no-fault benefits.

(1) Medical expenses.

(i) Payment for medical expenses shall be in accordance with fee schedules promulgated under section 5108 of the Insurance Law and contained in Part 68 of this Title (Regulation 83).

(ii) Where an applicant receives treatment from a health maintenance organization, an Insurance Law article 43 corporation, a Veterans Administration hospital or provider, or any other provider which does not render specific charges for services, or where any such charges are indeterminate, the applicant shall be entitled to payment of benefits equal to the value for equivalent services rendered by a provider as limited by section 5108 of the Insurance Law and Part 68 of this Title (Regulation 83).

(iii) Pursuant to section 5102(a)(1) of the Insurance Law, an insurer shall not be liable for the payment of medical and other benefits enumerated in section 5102(a)(1) if, during a period of one year from the date of the accident, no such expenses have been incurred by the applicant.

(iv) The term nursing, as used in section 5102(a)(1)(i) of the Insurance Law, shall include but not be limited to all necessary services rendered to the eligible injured person by a licensed practical nurse.

(v) If the applicant's injuries warrant occupational therapy or rehabilitation based on an attending physician's recommendation, or if the injuries have rendered the applicant unable to resume the applicant's occupation, the insurer shall inform the applicant of the coverage for occupational therapy or rehabilitation required by section 5102(a)(1)(ii) of the Insurance Law, and the insurer shall assist the applicant in obtaining such occupational therapy and rehabilitation.

(vi) The term any other professional health services, as used in section 5102(a)(1)(iv) of the Insurance Law, this Part and approved endorsements, shall be limited to those services that are required or would be required to be

licensed by the State of New York if performed within the State of New York. Such professional health services should be necessary for the treatment of the injuries sustained and within the lawful scope of the licensee's practice. Charges for the services shall be covered pursuant to schedules promulgated under section 5108 of the Insurance Law and Part 68 of this Title (Regulation 83). The services need not be initiated through referral by a treating or practicing physician.

(vii) The scope of the term religious methods of healing recognized by the laws of this State, as used in section 5102(a)(1)(iii) of the Insurance Law, this Part and approved endorsements, is a method recognized under article 131 of the Education Law. Charges for such services shall be covered pursuant to schedules promulgated under section 5108 of the Insurance Law.

(viii) Services rendered to the eligible injured person by a certified or licensed home health care agency shall be considered a medical expense payable under section 5102(a)(1) of the Insurance Law.

(ix) Pursuant to section 5102(b)(2) of the Insurance Law, when the applicant is entitled to workers' compensation benefits due to the same accident, the workers' compensation carrier shall be the sole source of reimbursement for medical expenses.

(x) If a provider of health service requires proof of the applicant's ability to pay for the services to be rendered as a result of the accident, the insurer shall provide the applicant or the provider (if the applicant is entitled to benefits) with a letter stating that the applicant has coverage under its policy and that the necessary medical expenses incurred as a result of the accident are covered expenses subject to the policy limits and conditions and applicable fee schedules.

(xi) Within 30 calendar days of a submission by a dentist or plastic surgeon of a proposal for a course of treatment and charges, an insurer shall review such proposal and notify the provider as to whether or not payment will be made in accordance with the proposal. The foregoing shall apply to non-emergency situations and when the course of treatment is expected to involve covered expenses of $ 250 or more.

(2) Loss of earnings. In determining loss of earnings from work:

(i) Benefits from other sources shall not be considered as an offset against or a deduction from loss of earnings, unless article 51 of the Insurance Law expressly provides for such offset or deduction.

(a) Within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall not take a deduction for

statutory or contractual wage continuation plans which are diminished or exhausted as payments are made or when accumulated sick leave time is used. In order for an insurer to be entitled to offset or deduct payments received by a claimant under a particular wage continuation plan, the plan must meet all of the following conditions:

(1) the applicant must be entitled to receive the same level of wage continuation benefits for a subsequent unrelated accident or illness when he or she returns to work after recovering from the injuries sustained in the motor vehicle accident;

(2) benefits for a subsequent unrelated accident or illness must be equal in both time and amount to the wage continuation benefits to which the applicant was entitled as a result of the injuries suffered in the motor vehicle accident; and

(3) wage continuation benefits for a subsequent disability must be immediately available, without any requirement that the applicant work a stated period of time before full benefits are restored.

(b) Within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall take a deduction for any payments made by an employer on a voluntary basis.

(c) Within the meaning of section 5102(a)(2) of the Insurance Law, insurers shall not take a deduction for contractual or voluntary long-term disability plans, which generally become effective six months after the date disability begins.

(ii) Insureds covered by wage continuation plans which meet the criteria for deduction set forth in clause (i)(a) of this paragraph, are entitled to a premium reduction to reflect the insurer's reduced exposure to loss, pursuant to section 2330 of the Insurance Law. Insurers shall grant the premium reduction upon receipt of information that indicates the insured is covered by such wage continuation plan.

(iii) Loss of earnings from work shall not necessarily be limited to the applicant's actual level of earnings at the time of the accident, but may also include demonstrated future earnings reasonably projected.

(iv) An applicant, whose unemployment was the result of the seasonal nature of the work which the applicant usually performed, shall be entitled to receive payments for loss of earnings from work during the claimed period of disability

arising from the accident which coincides with the seasonal period of employment.

(v) Where the injury renders an unemployed applicant ineligible to receive unemployment benefits, the applicant shall be entitled to receive payments for loss of earnings from work equivalent in value to the unemployment benefits which the applicant would otherwise have received. If an unemployed applicant is eligible for disability benefits pursuant to Workers' Compensation Law, section 207 (sick unemployed fund), the no-fault insurer shall supplement such benefits to bring them up to the level of the lost unemployment benefits. If the unemployed applicant is not eligible for such disability benefits, the insurer shall pay an amount equal to the lost unemployment benefits. Such loss of earnings is eligible basic economic loss, but is not subject to the 20-percent offset from loss of earnings provided for in section 5102(b)(1) of the Insurance Law.

(vi) If the applicant, while disabled, is discharged from employment solely because of inability to work due to the injury, benefits for basic economic loss shall continue at the same level while the disability continues.

(vii) If an applicant, while disabled, is discharged from employment, benefits shall cease if the position would have been lost had the accident not occurred (e.g., plant shutdown, strike, etc.). However, the insurer shall reimburse the applicant for benefits lost which would have been received had the applicant not been disabled (e.g., union strike benefits, unemployment, etc.).

(viii) During the continuance of a disability arising from a covered accident, loss of earnings benefits due and payable must be paid periodically, at least once in every 30 calendar days.

(ix) Refusal by an eligible injured person to accept reasonable rehabilitative treatment may be the basis for denial of future payment of benefits for loss of earnings from work and may be used as evidence to dispute the reasonableness or necessity of any further expense or loss.

(x) Substitute services.

(a) Where an applicant sustains expenses in obtaining services in lieu of those such person would have performed for income, but still suffers a net loss of earnings from work which the applicant would have performed, such loss of earnings is eligible basic economic loss and shall be subject to the offsets provided for in section 5102(b) of the Insurance Law; and the cost of substitute services reasonably sustained is also eligible basic economic loss, but shall not be subject to such offsets.

(b) Where an applicant has a claim for both substitute services and loss of earnings from work, the claim for substitute services shall be primary in computing the loss of earnings benefit payable.

(xi) Monthly work loss limit. The monthly limitation on the aggregate of work loss and substitute services shall not be prorated in the event that one is unable to work or is required to obtain substitute services for a period less than one month. A month shall be each consecutive period of 30 days beginning with the date of the accident unless the injury extends for more than one year, in which case there shall be 12 monthly payment periods for the period from the date of accident to each annual anniversary of the accident date.

(xii) The maximum first-party benefit payable for loss of earnings from work under the mandatory coverage is $ 1,000 per month for claims arising from accidents occurring prior to November 12, 1991 and $ 2,000 per month for claims arising from accidents occurring on and after November 12, 1991.

(xiii) Lump-sum settlement for loss of earnings.

(a) An Insurer may at its option enter into a lump-sum settlement agreement for the payment of first-party benefits, provided that competent medical testimony establishes that:

(1) the period of disability will extend for at least three years beyond the date of the accident; and

(2) the settlement would be of material benefit to the applicant, occupationally and from a rehabilitative standpoint.

(b) Lump-sum settlements shall be permitted only for the payment of loss of earnings from work and may be reduced to the present value of net benefit payments computed on the basis of a six-percent annual interest factor and any other applicable offsets.

(c) No lump-sum settlement shall be permitted unless the form for lump-sum settlement agreement, Appendix 13-A, infra, is executed by the parties specified thereon and approved by an arbitrator or a court of competent jurisdiction in accordance with the provisions of this section.

(3) Other reasonable and necessary expenses sustained. Where the applicant sustains other reasonable and necessary expenses, such services must be actually performed for a charge by a person who

is not legally obligated to render them and would not ordinarily perform such services as part of a family relationship; provided, however, that if a member of a family or relative suffers pecuniary loss in order to render such services, such person shall be reimbursed to the extent of the reasonable value of such services.

(p) Releases. Except as provided in subparagraph (o)(2)(xiii) of this section (lump-sum settlements), there shall be no settlement nor any release, express or implied, for (mandatory or optional personal injury protection benefits) mandatory PIP or additional PIP benefits.

(q) Offsets.

(1) State or Federal Workers' Compensation Law benefits that are to be deducted from first-party benefits or additional first party benefits in accordance with this Part shall not include payments made under any workers' compensation law of the Dominion of Canada or any of its provinces.

(2) Federal social security disability benefits that are to be deducted from first-party or additional first-party benefits shall include, but not be limited to, disability benefits provided for under the Railroad Retirement Act.

(3)

(i) If any source of workers' compensation benefits, or disability benefits under article 9 of the Workers' Compensation Law, denies liability for payment of benefits, in whole or in part, the insurer responsible for the payment of first-party or additional first-party benefits shall pay benefits without deducting the withheld workers' compensation or disability benefits; provided, however, that the applicant executes a prescribed agreement to pursue workers' compensation or New York State disability benefits (NYS Form N-F 9), which shall obligate the applicant to diligently pursue the claim and to repay first party benefits equal to the withheld amounts in the event such amounts are eventually paid to the applicant. The insurer is entitled to independent verification of the claim in accordance with this section. If the applicant paid an attorney's fee out of the proceeds of the award, pursuant thereto, the amount of the attorney's fee shall be deducted from the repayment.

(ii) The insurer should send a copy of the completed agreement to the local district office of the Workers' Compensation Board nearest the applicant's residence. Thereafter, the Workers' Compensation Board will give the insurer notice of the applicant's hearing, so that the insurer may be present. Although the insurer may not be a party to such hearing, it may submit evidence to the referee and may request that the referee put specific questions to the parties.

(iii) If the applicant will not execute the agreement and the automobile insurer is held ultimately liable, such insurer shall not on that account be responsible for the payment of an attorney's fee or interest on the late payment. To the extent that any reimbursement due the insurer is not made by the applicant, the insurer may thereafter deduct such amounts from any future first-party benefits due on the claim.

(4) When it becomes apparent that an applicant, who is receiving no-fault first-party benefits, will be disabled for more than one year, the insurer shall proceed as follows:

(i) Forward to the applicant, in triplicate, the prescribed agreement to pursue social security disability benefits (NYS Form N-F-8) and a self-addressed, stamped return envelope. The applicant shall bring this form to the Social Security Administration (SSA) and, when completed, one copy will be retained by the SSA, one will be retained by the applicant and one will be returned by the applicant to the insurer in the self-addressed, return envelope.

(ii) Pursuant to the agreement, the insurer shall continue to pay first-party benefits until the applicant begins receiving social security disability benefits.

(iii) The insurer, when notified by the Social Security Administration of the amount of the award and the effective date thereof, shall, as of the effective date, reduce the applicant's first-party benefits in an amount equal to the monthly social security disability benefits awarded on account of the applicant's injury, inclusive of awards made to the applicant's spouse and dependents on account of the injury. However, if the applicant paid an attorney's fee out of the proceeds of the award, pursuant thereto, the insurer shall not take credit for that portion of the award in computing the amount of the reduction.

(iv) In the event that the applicant fails to execute the agreement, the insurer may, beginning the 27th week after the accident, or 35 calendar days after the agreement was forwarded to the applicant (the extra five calendar days allowed are for mailing) in the event the 27th week has passed, estimate the social security disability benefit it believes the applicant is entitled to on account of the automobile accident and begin reducing the applicant's first-party benefits accordingly. If it is later determined that no such social security disability benefits were due the applicant or that the estimate made by the automobile insurer was too high, the insurer shall pay the applicant for benefits due but shall not on that account be responsible for an attorney's fee or interest on the late payment.

(v) To the extent that any reimbursement due the insurer pursuant to the agreement is not made by the applicant, the insurer may thereafter deduct such amounts from any future no-fault benefits due on the claim.

(5) Workers' compensation or disability benefits liens reimbursement of section 5102(b)(2) offset.

(i) For automobile accidents occurring between December 1, 1977 and June 30, 1978, inclusive, both workers' compensation providers and disability benefits providers who paid benefits to claimants are entitled to satisfy statutory liens against the proceeds of any tort recovery arising out of an automobile accident, including actions brought pursuant to section 5104(a) of the Insurance Law. This paragraph is intended to effect the same result as is accomplished in section 65.6(p)(5) of this Part, namely, that the claimant be made whole, since the rationale of the cases cited therein as applied to workers' compensation liens is equally applicable to disability benefits liens.

(ii) The offset provided for in section 5102(b)(2) of the Insurance Law for amounts recovered or recoverable in accidents occurring on and after December 1, 1977 and through June 30, 1978, inclusive, under State or Federal laws providing workers' compensation or disability benefits under article 9 of the Workers' Compensation Law shall cease to be applicable when the lien of the provider of workers' compensation or disability benefits has been satisfied out of the proceeds of any recovery obtained by or on behalf of a claimant against a third-party tortfeasor pursuant to section 5104(a) of the Insurance Law or when a workers' compensation or disability benefits provider, as assignee, has effected such a recovery. On or before July 1, 1980 or within two years after the satisfaction of such lien or the obtaining of such recovery by a provider of workers' compensation or disability benefits, whichever is later, such claimant shall notify the no-fault insurer liable for the payment of first-party benefits of such satisfaction of lien or recovery. Upon submission of proof of such satisfaction or recovery, the no-fault insurer shall make the claimant whole with respect to first arty benefits for items of basic economic loss not recoverable in an action brought pursuant to section 5104(a) for which the no-fault insurer has taken an offset. The maximum amount payable by a no-fault insurer pursuant to this subparagraph shall be the amount of the offset taken by such no-fault insurer pursuant to section 5102(b)(2). Examples of the application of the foregoing are:

(a) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of $15,000 from first-party benefits due claimant. Claimant recovers $ 25,000 in an action brought pursuant to section 5104(a). Workers' compensation lien of $15,000, less the workers' compensation provider's share of expenses and

attorney's fees payable under section 29(1) of the Workers' Compensation Law, in the amount of $ 5,000 is satisfied out of the $25,000 recovery. In order to make the claimant whole, the no-fault insurer shall pay the claimant $10,000 in first-party benefits. The amount owed to the claimant is the net amount of the satisfied lien.

(b) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of $15,000 from first-party benefits due claimant. Claimant recovers $10,000 in an action brought pursuant to section 5104(a), which is the total amount available to satisfy the judgment or settlement. Workers' compensation lien of $15,000 is compromised to $5,000, less the provider's share of expenses and attorney's fees, in the amount of $ 2,000 and is satisfied out of the $10,000 recovery. In order to make the claimant whole, the no-fault insurer shall pay the claimant $3,000 in first-party benefits. The amount owed to the claimant by the no-fault insurer is the net amount of the compromised lien, not the full amount of the no-fault insurer's offset.

(c) Pursuant to section 5102(b)(2), the no-fault insurer takes an offset of $40,000 from first-party benefits due claimant. The workers' compensation provider pays an additional $20,000 in benefits pursuant to the Workers' Compensation Law. Claimant recovers $200,000 in an action brought pursuant to section 5104(a). The workers' compensation lien of $60,000 less the provider's share of expenses and attorney's fees is satisfied out of the $200,000 recovery. In order to make the claimant whole, the automobile insurer shall pay the claimant $40,000 in first party benefits. The amount owed the claimant by the no-fault insurer can never exceed the amount of the section 5102(b)(2) offset taken by the no-fault insurer.

(iii) In lieu of the procedure set forth in subparagraph (ii) of this paragraph, subject to acceptance by the workers' compensation or disability benefits provider, the claimant may assign the payment right to the workers' compensation or disability benefits provider having the lien, as an alternative to the workers' compensation or disability benefits provider obtaining satisfaction of its lien directly from claimant's recovery. The assignment shall be effective only if there has been a recovery made pursuant to section 5104(a) of the Insurance Law. The maximum obligation of satisfied out of the recovery, but for the assignment and shall, in no event, exceed the amount of the offset taken by the no-fault insurer under section 5102(b)(2) of the Insurance Law. The no fault insurer shall honor such assignment by paying first-party benefits

directly to the workers' compensation or disability benefits provider for appropriate credit toward satisfaction of its lien.

(iv) Under subparagraph (ii) of this paragraph, the no-fault insurer shall either pay or deny in whole or in part on the prescribed denial of claim form (NYS Form N-F-10) within 30 days after submission of proof that the workers' compensation or disability benefits lien has been satisfied or that the provider, as assignee, has effected such recovery.

(v) Under subparagraph (iii) of this paragraph, the no-fault insurer shall, provided proof of assignment has been received, either pay the workers' compensation or disability benefits provider or deny payment in whole or in part on the prescribed denial of claim form (NYS Form N-F10) within 30 days after receipt of proof of recovery by the claimant in an action brought pursuant to section 5104(a) of the Insurance Law.

(vi) Failure to make timely payment, as provided for in subparagraph (iv) or (v) of this paragraph, shall subject the no-fault insurer to the interest, attorney's fees and arbitration provisions of sections 65.15(h)-(i) and 65.16 of this Part.

(vii) Whenever a lien is asserted against the proceeds of any tort recovery made pursuant to section 5104(a) of the Insurance Law for workers' compensation benefits paid pursuant to any other State or Federal law, the no-fault insurer shall make the claimant whole in a manner consistent with the objectives set out in subparagraph (i) of this paragraph.

(6)

(i) Whenever an eligible injured person is entitled to disability benefits under article 9 of the Workers' Compensation Law, the insurer shall be entitled to an offset equal to the lesser of (a) 50 percent of the applicant's average weekly wage loss not to exceed $145 per week, or(b) the actual dollar amount of the disability benefits being received where the employer's plan provides a maximum payment of less than $145 per week. The $145 per week previously referred to shall be adjusted whenever section 204 of the Workers' Compensation Law is amended to provide a higher statutory dollar maximum. The offset shall be applicable during the statutory 26-week benefit period beginning seven days after the accident date except in the case where lower benefits are paid in exchange for a longer benefit period. In no event shall the offset for New York State disability benefits exceed the weekly statutory dollar maximum multiplied by the maximum statutory benefit period (currently $145 x 26 weeks = $3,770).

(ii) The insurer shall provide the applicant with a notice and proof of claim for disability benefits (DB 450), which has been printed on buff-colored paper and, in addition, shall notify the applicant's employer that such employer is required to process the applicant's disability benefits claim if its employees are covered for such benefits by the Workers' Compensation Law. The notification to the employer should be sent along with the Employer's Wage Verification Report (NYS Form N-F-6). Unless the insurer has complied with the above, it shall not take an offset for New York State disability benefits until it verifies that the applicant is actually receiving statutory disability benefits.

(iii) For all qualified wage continuation plans, (referred to in clause (o)(2)(i)(a) of this section) which provide benefits equal to less than 100 percent of the employee's salary, the insurer should reduce the amount paid under the plan by the amount required to be paid in satisfaction of the New York State Disability Law. Only the excess over the New York State Disability Benefits is a qualified wage continuation plan benefit.

Example:		A	B
Gross Monthly Earnings		$ 2,500	$ 2,000
Monthly Qualified Wage Continuation Plan Benefit	$ 1,500		
NYS Disability Offset	- 580		
Insurer's Qualified Wage Continuation Plan Offset		-$ 920	-$ 920
Gross Lost Earnings		$ 1,580	$ 1,080
Less 20%		316	216
		$ 1,264	$ 864
First-Party Benefit For Loss of Earnings Limited to Maximum of $ 1,000		$ 1,000	
Less NYS Disability Offset*		$ 580	$ 580
Net Loss of Earnings Benefit		$ 420	$ 284

(iv) The insurer, when making its first payment for loss of earnings, shall include a written explanation of the computation of the New York State disability offset taken.

(r) Reimbursement and trust agreement. An insurer may request that an applicant assign to the insurer such applicant's right to commence an action, pursuant to section 5104(b) of the Insurance Law, before two years after the accrual thereof; provided, however, that such request

must be accompanied by a clear, detailed explanation that the applicant has the right to refuse such request and that such refusal will not prejudice the applicant's eligibility for the payment of any first-party benefits to which the applicant is entitled. If, as a result of such assignment, the insurer recovers an amount in excess of the amount paid or payable to the applicant in first-party benefits, such excess amount shall be remitted to the applicant less a pro rata share of collection costs.

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* FOOTNOTE: If N.Y.S. disability benefits are taxable, the offset should be deducted from the lesser of gross lost earnings or $1,250, prior to the 20% offset.

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* NB Reinstated effective February 1, 2000 per Medical Society of New York v. Neil D. Levin as Superintendent of Insurance, 712 NY2d 745 (Supreme Court, New York County).

Section statutory authority: Insurance Law, §A43, §A51, §A52, §2330, §5102, §5103, §5104, §5105, §5106, §5108, §5221; Education Law, §T8A131; Workers' Compensation Law, §A29, §29, §204, §207

Added 65.15 on 11/28/77; amended 65.15 on 4/25/78; amended 65.15 on 8/10/78; amended 65.15 on 4/29/80; amended 65.15 on 6/30/80; amended 65.15 on 1/05/81; amended 65.15 on 12/29/81; amended 65.15 on 5/03/82; amended 65.15 on 12/20/82; amended 65.15 on 8/30/85; amended 65.15 on 6/08/88; amended 65.15 on 7/30/91; amended 65.15 on 5/15/92; added 65.15(c)(3)(xiii) on 11/25/92; added 65.15(f)-(m) relettered (g)-(n) on 11/25/92; added 65.15(f) added on 11/25/92; amended 65.15(g)(1) on 11/25/92; amended 65.15(g)(10) on 11/25/92; amended 65.15(i) on 11/25/92; amended 65.15(o)(2)(xii) on 11/25/92; amended 65.15(p) on 11/25/92; amended 65.15(q)(5)(vi) on 11/25/92; amended 65.15(q)(6)(iii) on 11/25/92; repealed 65.15 on 11/03/99; amended 65.15(j) on 12/31/01, expired 90 days after filing; amended 65.15(j) on 3/27/02, expired 90 days after filing.