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STATE OF CALIFORNIA
CALIFORNIA DEPARTMENT OF INSURANCE
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ADOPT: TEXT OF REGULATION

California Code of Regulations, Title 10, Chapter 5, Subchapter 2: Policy Forms and Other Documents

Article 11. Standards for Health History Questionnaires in Health Insurance Applications, Pre-Issuance Medical Underwriting and Rescission of Health Insurance Policies

Section 2274.70 Purpose

The purpose of this article is to:

(a) Clarify and make specific the application of the following statutes to the medical underwriting process and the permissibility of rescission by insurers: Insurance Code sections 10113, 10119.3, 10380, 10381.5 and 10384 and related insurance policy provisions;

(b) Set forth standards for determining whether questions used to ascertain the health condition or history of an applicant for health insurance coverage are clear and unambiguous pursuant to Insurance Code section 10291.5(c)(1);

(c) Identify bases on which the Commissioner may find that provisions in a health insurance policy containing a health history questionnaire which the insurer makes part of the contract between the insurer and the insured are unintelligible, uncertain, ambiguous, abstruse or likely to mislead an applicant pursuant to Insurance Code section 10291.5(b)(1);

(d) Set forth standards for determining whether questions on a health history questionnaire, supplemental questionnaire or script used during pre-issuance underwriting are reasonable and necessary for medical underwriting purposes as required by Insurance Code section 10291.5(c)(2);

(e) Set forth requirements for the pre-issuance medical underwriting process pursuant to Insurance Code section 10384;

(f) Set forth attestation requirements for agents assisting insureds in the submission of health insurance applications; and

(g) Set forth requirements for the conduct of post-issuance rescission investigations where a claim has been submitted or the insurer has received notice of a claim.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.71 Scope

(a) This article shall apply to all health insurance policies as defined in Insurance Code section 106(b) and all certificates issued under such policies where the insurer applies medical underwriting guidelines and where guaranteed issue requirements do not apply.

(b) This article is not intended to set forth an exhaustive list of all rights and responsibilities of insureds or insurers with respect to applicable statutes governing medical underwriting and rescissions of health insurance policies and related issues. This article also is not intended to set forth an exhaustive list of acts or practices necessary to comply with applicable laws.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04, 10113, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.72 Definitions

For purposes of this article,

(a) “Policy” or “policies” refers to the written instrument, which is a contract of insurance that puts insurance coverage into effect and includes group certificates and fraternal benefit society certificates.

(b) “Reasonable layperson standard” means a method of evaluating health history information that recognizes and takes into account the level of understanding and appreciation of words and terms in a health history questionnaire by the average individual who lacks professional training and experience in medicine.

(c) “Questions” means questions and all requests for information, including statements or disclosures requested of the applicant in a health history questionnaire that is part of an application for health insurance coverage.

(d) “Personal Health Record” (“PHR”) means a dynamic set of personal health history information derived from a private, secure database maintained by a health insurer or health plan and that contains medical claims and other information. A PHR may be “auto-populated” with medical and related information, including claims records reflecting diagnoses and procedure codes, dates of treatments, prescription records, medical testing and other allowed clinical

information. A PHR is distinct from an electronic medical record, which is primarily intended for use by medical professionals. A PHR is designed primarily for use by the insured.

(e) "Material," when used to describe information relied on by an insurer, indicates specific information that would be a determining factor to the insurer in deciding whether to accept or reject a proposed insurance risk associated with a health insurance policy or in determining the rate that will be offered.

(f) "Medical Underwriting" means the process of determining the relative risks of providing health insurance coverage to an individual by examining medical and other information and applying medical underwriting guidelines. The purpose of medical underwriting is to reject or accept the proposed insurance risk and, if accepted, to set the level of coverage and the rate that will be offered.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04, 10113, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co.*, 160 Cal.App.4th 528 (2008).

Section 2274.73 Standards for Health History Questions on an Application for Health Insurance Coverage

(a) Inquiries into an applicant's health history shall hold applicants to the reasonable layperson standard. Whenever possible, information from a PHR shall be requested and, if available, relied upon during medical underwriting in addition to or, if sufficient, instead of health history questionnaires.

(b) All questions designed to ascertain the health condition or history of an applicant shall be limited to eliciting only medical information that is reasonable and necessary for medical underwriting.

(c) Medical information that is reasonable and necessary for medical underwriting means only such information that is essential to an insurer's calculation of prospective risk of the coverage being requested.

(d) Questions on an application for health insurance coverage shall:

(1) Be clear, specific, unambiguous and written to be understood by a reasonable layperson.

(2) Clearly state the period of time covered by the question. Specified time periods for each question shall be as short as possible to make a reasonable underwriting determination and must be limited to time periods required by sound actuarial underwriting standards used by the insurer.

(3) Be phrased to elicit information about diagnoses, treatments and recent consultations with health care providers known to the applicant.

(4) Provide each applicant with the opportunity to indicate whether he or she is unsure of the answer, does not know how to respond to any individual health history question, or does not understand the question. Health history questions that offer response choices in addition to YES or NO, such as Not Sure, on a health history questionnaire may, as appropriate, satisfy this requirement.

(5) Offer the applicant an opportunity to indicate the applicant's inability to recall or remember the information requested. To the extent that such response choices impede the insurer's ability to apply its medical underwriting guidelines, the insurer shall pursue alternative methods of obtaining such information, including but not limited to telephone interviews, medical records or other sources of information.

(e) To avoid unclear, ambiguous and abstruse questions which may be likely to mislead, an application for health insurance coverage shall not:

(1) Include compound questions requiring a single answer or questions containing double negatives.

(2) Include questions that are unlimited in time and scope unless the insurer's medical underwriting guidelines based on sound actuarial principles reasonably require an unlimited time and scope.

(3) Include questions requiring the applicant to evaluate or understand the significance of a physical symptom or the cause of physical symptoms.

(4) Include questions requiring the applicant to guess or speculate regarding the kinds of symptoms that may be significant to the health insurer.

(5) Include questions phrased to require an applicant to guess or speculate about the significance of symptoms, conditions, disorders or impairments.

(6) Ask the applicant to make an overall appraisal of the applicant's general health or draw general conclusions about the applicant's medical or health status.

(7) Include any question which solicits or is reasonably calculated to solicit information regarding an HIV test result. Nor may any request for or use of objective, independently received information violate the statutory prohibition against an HIV test being used or required as a condition of obtaining health insurance coverage.

(f) Insurers shall use either a separate health history questionnaire for each individual applicant or a questionnaire in which each question calls for a separate, identifiable response from each applicant.

(g) An application for health insurance shall not ask any question that requires the applicant to make a determination as to whether an agent has or has not provided assistance as defined in Subdivision (c) of Section 2274.76.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.74 Standards for Avoiding Prohibited Postclaims Underwriting

(a) In order to complete medical underwriting prior to issuing a policy, the insurer shall obtain the necessary information to evaluate eligibility for coverage in accordance with the insurer's medical underwriting guidelines and determine the appropriate rate for the policy offered. This process shall include but not be limited to the following activities by the insurer:

(1) Obtaining the applicant's PHR, if available, and health history information from external verifiable sources other than the information provided by the applicant on the health history questionnaire and evaluating that information by applying the insurer's underwriting guidelines;

(2) Obtaining and evaluating commercially available medical underwriting information for each applicant, such as commercially available claims data, claims data from prior insurers if available and commercially available pharmaceutical information;

(3) Reviewing and evaluating each individual applicant's health status and health history using PHR data and/or self-reported information from each individual's application in conjunction with other reasonably available sources of health history information for each individual applicant, including but not limited to the applicant's medical records or current or prior claims history with the insurer or its affiliates;

(4) Checking reasonably available health history information obtained from all sources for accuracy, completeness and consistency, taking into account that self-reported health information must be evaluated in light of the applicant's status as a layperson not schooled in medicine unless the insurer has documentable grounds to believe the applicant has formal medical training;

(5) Verifying that the information submitted by the applicant is accurate and complete, including checking with the assisting agent when applicable;

(6) Assessing the prospective risk to the insurer of providing insurance coverage to the applicant using its rating criteria and underwriting guidelines, which must be based on sound actuarial principles, and resolving all reasonable questions arising from this process; and

(7) Determining whether to accept the identified risk presented by an application for health insurance coverage before offering a health insurance policy to the applicant.

(b) In order to resolve all reasonable questions arising from written information submitted on or with an application prior to issuing a policy, the insurer shall obtain and use any necessary additional information external to the health insurance application to resolve inconsistencies or conflicts in the application. This process shall include but not be limited to the follow activities:

(1) Insurers shall apply their medical underwriting guidelines to any material information obtained from or through an assisting agent. If an assisting agent indicates awareness of any information not disclosed on the health insurance application which may bear on the risks presented by the health insurance application, then, in order to complete its medical underwriting, the insurer shall promptly contact the agent, obtain such information and determine if the information is material to medical underwriting. Insurers shall maintain documentation of material information received from assisting agents that is used in medical underwriting of the application for health insurance.

(2) The insurer shall review the applicant's responses in, or submitted with, the application for health insurance and identify all responses contained within the application or information submitted with the application that appear to be (i) inconsistent, ambiguous, doubtful or incomplete, (ii) in conflict with information reported elsewhere on the application, (iii) in conflict with any other information the insurer is aware of or in the insurer's possession, including but not limited to medical records, PHR data, prior claims history or an application submitted for coverage provided by the insurer on an earlier date or information provided by an assisting agent;

(3) The insurer shall conduct reasonable and appropriate follow-up of any inadequate, unclear, incomplete, doubtful or otherwise questionable or inconsistent material information on the application prior to issuing a policy;

(4) The insurer shall obtain clarification from the applicant, as reasonable and necessary, and resolve all inconsistencies, doubts and questions prior to issuing a health insurance policy and document such resolution and explanation of such inconsistencies, doubts and questions;

(5) The insurer shall review the applicant's responses in, or submitted with, the application for health insurance and identify responses which indicate that the applicant did not understand the question or partially answered the question, or had doubts about the answer to the question, or omitted or provided answers that conflict with other information that the insurer has gathered during underwriting. The insurer shall resolve any such identified uncertainties, questions, conflicts or doubts; and

(6) The insurer shall obtain and evaluate additional information necessary to resolve every response that is identified as required in (5) above. The additional information necessary to resolve all reasonable questions or omissions may include, but is not limited to, information obtained through (a) the insurer's further communication with the applicant, (b) a review of medical records and other sources of health history or health status information, such as a PHR,

for each individual who has applied for insurance coverage or (c) a commercial pharmaceutical or medical information database.

(c) Unless the insurer has complied fully with Subdivisions (a) and (b) of this Section 2274.74, the insurer is prohibited from rescinding, canceling, limiting a policy or certificate, or increasing the rate charged, subsequent to receiving: (1) a request for authorization of service or verification of eligibility for benefits; (2) notice of a claim; (3) a claim or a request for a change in coverage; or (4) any other communication that puts the insurer on notice of a claim.

Note: Authority cited: Sections 790.10, 10119.3, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10119.3, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co.*, 160 Cal.App.4th 528 (2008).

Section 2274.75 Documentation Requirements and Examination by Commissioner

(a) In order to complete medical underwriting and resolve all reasonable questions arising from written information submitted on or with an application pursuant to Insurance Code section 10384, the insurer shall document the following in writing and such documentation shall be subject to examination by the Commissioner pursuant to Sections 730, 733, 734, 790.04, 790.14, 12921.1, 12924 and 12926 of the Insurance Code and Title 10, Chapter 5, Section 2695.3 California Code of Regulations:

(1) The insurer's completion of medical underwriting;

(2) The insurer's identification and resolution of all reasonable questions arising from written information submitted on or with the application for health insurance coverage;

(3) The insurer's attempts to verify the accuracy and completeness of the application;

(4) All communications relating to the processes described in this article, including communications to and from the insured;

(5) All communications with the agent assisting the applicant regarding any aspect of (1) the application, (2) the submission of the application or any supplemental information to the insurer, or (3) the underwriting of the policy based on information in the application;

(6) All communications referred to in these regulations shall include electronic records as defined in Civil Code Section 1633.2(g).

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10291.5,

10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.76 Agent Attestation and Notification Requirements When Health Insurance Applications Are Submitted to Insurers

(a) Any agent, as defined in Section 1622 or 1626 of the Insurance Code assisting an applicant in submitting an application for health insurance as that phrase is defined in Subdivision (c) of this Section 2274.76 shall notify the insurer that the agent has provided such assistance.

(b) For purposes of Insurance Code Section 10119.3, an application includes an application for health insurance submitted electronically using an Internet web site provided by the insurer or any other Internet web site, such as an agent's or broker's web site, which is intended to be used for submission of health insurance applications to insurers.

(c) For purposes of Insurance Code section 10119.3, assisting an applicant in submitting an application for health insurance to a health insurer includes: (1) providing information or advice or answering the applicant's questions about any aspect of the application or its submission (2) providing information or advice or answering the applicant's questions about the medical underwriting of the application (3) providing information or advice or answering any of the applicant's questions about the health insurance coverage sought by the applicant or (4) entering information directly into or onto the application.

(d) If the agent provides assistance to the applicant as described in Subdivision (c) of this Section 2274.76 at any time prior to the date of issuance of the policy sought by the applicant, the agent is required to comply with all provisions of Insurance Code section 10119.3 and any regulation promulgated thereunder, including but not limited to Subdivision (a) of this Section 2274.76.

(e) In order to complete medical underwriting, insurers are required to obtain the written attestation of any agent who assists an applicant in submitting an application for health insurance. If the agent provided no assistance to an applicant in submitting an application for health insurance as defined in Subdivision (c), the insurer must obtain and maintain written notification from the agent of this fact, unless no agent has been involved in completing or submitting the application. Insurers may not complete medical underwriting and issue a health insurance policy without receiving an agent attestation as required by Section 10119.3 of the Insurance Code unless the insurer is processing the application without the involvement of any agent.

(f) When an insurer receives an electronically submitted application for health insurance through an agent's web site, the insurer is required to promptly provide to the agent (1) a copy of the application and (2) notification of its receipt.

(g) When an agent is notified by either the insurer or by the agent's web site that an application for health insurance has been electronically submitted to the insurer through the agent's Web Site, the agent must promptly deliver to the insurer a notification stating whether or not the agent

provided assistance to the applicant. If the agent did not assist the applicant in submitting an application for health insurance within the meaning of Subdivision (c)of Section 2274.76 prior to the receipt of the application by the insurance company, but provides such assistance to the applicant thereafter and prior to the issuance of the policy, the agent must provide an attestation in order to comply with all provisions of Insurance Code section 10119.3 and any regulation promulgated thereunder, including but not limited to Subdivision (a) of this Section 2274.76.

Note: Authority cited: Sections 790.10, 10119.3, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10119.3, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.77 Return of Completed Application for Health Insurance Coverage at Time of Policy Transmission; Notice and Communication Requirements

(a) At the time of issuance and delivery of the policy, the insurer shall return to the insured a complete copy of the application for health insurance coverage attached to the health insurance policy with an express instruction to the applicant to review the copy of the application.

(b) Applicants shall be asked immediately to contact the insurer if there are any discrepancies on the application compared with the information submitted by the applicant or if a response to a health history question does not reflect a correct or complete answer based on the applicant's knowledge of the facts sought and appreciation of the significance of the question.

(c) An insurer shall not use information on the application for health insurance to assert material misrepresentation or omission as the basis for rescission or cancellation of the policy unless the application was attached to the policy at the time it was delivered to the insured

(d) For purposes of Insurance Code section 10381.5, the phrase "attached to or endorsed on the policy" means that a complete copy of the applicant's application for health insurance coverage was included in the same mailing, or other delivery mechanism used, at the same time that the health insurance policy was delivered.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian*, 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04, 10113,10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.78 Post-Contract Issuance Rescission or Cancellation Investigations

(a) This Section, 2274.78, applies only to claims investigations intended to produce facts or other information that could be used as the basis for an evaluation by the insurer of whether to rescind or cancel the policy where the insurer has either received a claim from a claimant as defined in Subdivision (c) of Section 2695.2 or a notice of a claim as defined in Section 2695.2(n).

(b) The provisions of this Section 2274.78 that follow this Subdivision (b) do not apply to claims investigations not intended to produce information that could serve as the basis for an evaluation by the insurer of whether to rescind or cancel the policy. Accordingly, claims investigations not subject to the provisions of this section include, but are not limited to, (1) investigations interpreting policy provisions such as exclusion of pre-existing conditions, exclusion of investigational or experimental treatment, exclusion of care not medically necessary and coordination of benefits provisions or (2) investigations of member or provider appeals.

(c) If an insurer receives medical or health history information about an insured after having issued health insurance coverage to the insured and such information reasonably raises a question of whether the insured misrepresented or omitted material information prior to issuance of the policy, any review or investigation conducted by the insurer shall commence immediately but in no event later than fifteen (15) calendar days from receipt of the information. The dates relevant to the conduct of the investigation and any decisions regarding the investigation shall be clearly documented in the insurer's claim file. As used herein, an applicant's misrepresentation or omission of material health information on the application for health insurance must be of facts known to the applicant and the insurer must ascertain that the applicant appreciated the significance of the information requested.

(d) Immediately but in no event later than seven (7) days after an insurer's decision to commence an investigation or review as described in subdivision (c), the insurer shall send a written notice to the insured that it is conducting an investigation as described in subdivision (c).

(e) In the required written notice to the insured described in subdivision (d), the insurer shall clearly describe, in lay terms, the reason for the investigation and the substantive information on which the investigation is based. The insurer shall include with the notice copies of any applicable documents, such as claims, medical records, or any other information in the insurer's possession at the time of the notice and that is included in the insurer's review and investigation. The insurer shall provide to the insured all documents the insurer uses in its investigation that provided the basis for initiating the investigation except that an insurer is not required to provide documents that are otherwise protected by law.

(f) The insurer shall conduct and diligently pursue an investigation as described in subdivision (c) of this Section 2274.78, but shall not seek information that is not reasonably required for or material to the resolution of the investigation. The insurer shall only request information from the insured that is material to its investigation and such request shall be clear and timely. The insurer shall not request information from the insured that it can obtain directly, including but not limited to medical records.

(g) The insurer's investigation as described in subdivision (c) of this Section 2274.78 shall be completed promptly, but in no event later than ninety (90) calendar days after delivery of the

notice described in Subdivision (d) of this Section 2274.78, unless the insurer can demonstrate good cause for delay. The insurer shall send a written notice of the status of its investigation to the insured every thirty (30) calendar days providing the insured with detailed information and an opportunity to provide further information to the insurer regarding its investigation.

(h) Immediately, but in no event later than seven (7) calendar days after concluding its investigation, the insurer shall send a written notice to the insured, which shall include detailed findings and the insurer's final determination regarding the insured's health insurance coverage.

(i)The notice of determination pursuant to Subdivision (h) of this Section 2274.78 shall indicate that if the insured believes the decision is incorrect and wishes to dispute it, he or she may have the matter reviewed by the Department of Insurance. This notice shall include the address and telephone number of the unit of the Department of Insurance that reviews claims and underwriting practices. The insurer shall not require the rescinded former insured to file an appeal with the insurer prior to seeking assistance from the Department of Insurance.

(j) The insurer must comply at all times with applicable insurance statutes, regulations and other laws governing claims payment, claims handling, benefits, and coverage determinations including during the investigation described in Subdivision (c) of this Section 2274.78.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian,* 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04,10113, 10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).

Section 2274.79 Severability

If any provision or clause of this Article or the application thereof to any person or situation is held invalid, such invalidity shall not affect any other provision or application of this Article which can be given effect without the invalid provision or application. To this end, the provisions of this Article are declared to be severable.

Note: Authority cited: Sections 790.10, 10291.5, 10384, 12921, 12926, Insurance Code; *CalFarm Ins. Co. v. Deukmejian,* 48 Cal.3d 805 (1989); *20th Century Ins. Co. v. Garamendi*, 8 Cal. 4th 216 (1994). Reference: Sections 106, 380, 730, 733, 734, 796.04, 10113,10291.5, 10380, 10381.5, 10384, Insurance Code; *Thompson v. Occidental Life Ins. Co.*, 9 Cal.3d 904 (1973), *Ticconi v. Blue Shield of California Life & Health Ins. Co*., 160 Cal.App.4th 528 (2008).