

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW
YORK

TITLE 11. INSURANCE DEPARTMENT
CHAPTER III. POLICY AND CERTIFICATE PROVISIONS [FN1]
SUBCHAPTER B. PROPERTY AND CASUALTY INSURANCE
PART 73. CLAIMS-MADE POLICIES; SCOPE OF APPLICATION; MINIMUM STANDARDS

Text is current through February 15, 2002, and annotations are current through August 1, 2001.

Section 73.0 Preamble.

(a) Traditionally, most liability insurance policies protect against injury or damage that occurs during the policy period. Such "occurrence" policies generally provide coverage, even though an actual claim is made or suit is filed, arising from that occurrence, subsequent to the policy period. In contrast, "claims-made" policies generally provide coverage only when a claim is made during the policy period with regard to injury or damage that has taken place during that time.

(b) Following a public hearing on the Commercial General Liability (CGL) claims-made policy form proposed for general application by the Insurance Services Office, Inc. (ISO), and after evaluation of information received as a result of numerous meetings and communications with all interested parties, the Insurance Department issued an opinion and decision dated October 11, 1985 disapproving the proposed policy form and related endorsements for use in this State. Additional modifications thereafter submitted by ISO have been carefully analyzed by the department, which, however, reaffirmed its disapproval of the claims-made policy form approach for CGL purposes.

(c) The Insurance Department finds that claims-made coverage tends to provide less protection than occurrence coverage, that claims-made coverage compared to occurrence coverage is a more complicated and confusing method of coverage that can create potential coverage gaps and that, on balance, across-the-board application of the claims-made policy form for all types of liability coverages would be an unwarranted and inappropriate change in the traditional insurance system and, therefore, not in the public interest.

(d) As indicated in the October 11, 1985 opinion, however, the department has approved, and will continue to approve, claims-made policy forms for specific types of commercial liability coverages, as authorized by this Part, where substantial availability problems have been experienced, where there is sufficient size and sophistication, or where risks embody exposures with long-tail or latent injury characteristics. The department, taking into consideration the range of existing and potential problems with the claims-made policy form, sets forth in this Part governing definitions and minimum standards required for department approval of a claims-made policy form in such areas.

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(e) The fourth amendment adds employment practices liability to the list of coverages eligible to be written on a claims-made basis; lowers the financial threshold requirements for large commercial insureds; and eliminates a disclosure requirement. These actions recognize marketplace developments over the last decade that have resulted in the widespread use of claims-made policies and the increased knowledge and sophistication of insureds, insurance agents and brokers with respect to this coverage.

Section 73.1 Definitions.

For purposes of this Part, the following definitions shall apply:

(a) Claims-made policy means an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay (including injury or damage occurring prior to the effective date of the policy, but subsequent to the retroactive date, if any), arising out of incidents, acts or omissions, as long as the claim is first made during the policy period or any extended reporting period.

(b) Retroactive date means a date concurrent with the effective date of the policy or a particular date prior to the effective date of the policy upon which the insurer and insured agree in the policy that policy coverage will be applicable.

(c) Prior acts coverage, nose or nose coverage means coverage under the policy for injury or damage that occurs on or after the retroactive date and prior to the effective date of the policy.

(d) Extended reporting period coverage, tail or tail coverage means coverage for that period of time specified in the policy wherein claims first made after termination of coverage under the policy, for injury or damage that occurs during the policy term, or that occurs on or after the retroactive date, if any, will be considered made during the policy term.

(e) Medical malpractice insurance means insurance as defined in section 5501(b) of the Insurance Law.

(f) Public entity insurance means insurance as defined in section 107(a)(50) of the Insurance Law.

(g) Large commercial insured means a commercial risk policy insured that:

(1) has a net worth of at least \$7,500,000, as determined by an independent certified public accountant, as of the insured's fiscal year end immediately preceding the policy's effective date;

(2) has gross assets exceeding \$25,000,000 and a net worth of at least \$1,500,000, as determined by an independent certified public accountant, as of the insured's fiscal year end immediately preceding the policy's effective date;

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(3) is a for-profit business entity that generates annual gross revenues exceeding \$25,000,000, and has a net worth of at least \$1,500,000, as determined by an independent certified public accountant, as of the insured's fiscal year end immediately preceding the policy's effective date;

(4) is a for-profit business entity that has gross assets exceeding \$25,000,000 and generates annual gross revenues exceeding \$25,000,000, as determined by an independent certified public accountant, as of the insured's fiscal year end immediately preceding the policy's effective date; or

(5) is a not-for-profit organization or public entity with an annual budget exceeding \$25,000,000 for each of its three fiscal years immediately preceding the policy's effective date.

(h) Excess liability policy means any commercial liability policy, other than an excess motor vehicle liability policy, written over one or more underlying liability policies that in the aggregate provide primary coverage of at least \$1,000,000.

(i) Commercial umbrella policy means any such policy as provided for in Part 150 of this Title (Regulation 51).

(j) Occurrence policy means an insurance policy that covers liability for injury or damage that the insured is legally obligated to pay arising out of incidents, acts or omissions that occurred during the policy period, and where a claim may be made during or subsequent to the policy period.

(k) Insurer shall include the Medical Malpractice Insurance Association (MMIA) and the New York Property Insurance Underwriting Association.

(l) Circumstance or incident means any accident, happening or event, including continuous or repeated exposure to the same general harmful conditions (and shall include any intentional act by or at the discretion of the insured which results in personal injury or property damage if such injury or damage arises solely from the use of reasonable force for the purpose of protecting persons or property), which although it has not yet resulted in a claim or claims being made, in writing, against the insured for personal injury or property damage, it is likely to result in a claim or claims being made against the insured at some future date.

(m) Notice of circumstance, circumstance reporting, notice of incident or incident reporting means whenever the insured has information relating to a circumstance or incident and gives notice of such circumstance or incident, in writing, during the period of the policy, or within 60 days (90 days in the case of public entity liability insurance) following expiration of the policy, to the insurer, then any claim, as respects such circumstance or incident, which is made, in writing, against the insured shall be deemed to have been first made on the date upon which the notice of such circumstance or incident was first sent to the insurer.

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(n) Termination of coverage means, whether made by the insurer or the insured at any time:

(1) cancellation or nonrenewal of a policy; or

(2) decrease in limits, reduction of coverage, increased deductible or self-insured retention, new exclusion, or any other change in coverage less favorable to the insured.

(o) Professional liability insurance means insurance as defined in section 107(a)(49) of the Insurance Law.

(p) Claims-made relationship means that period of time between the effective date of the first claims-made policy between the insurer and the insured and the cancellation or nonrenewal of the last consecutive claims-made policy between such parties, where there has been no gap in coverage, but does not include any period covered by extended reporting period coverage.

(q) Physician claims-made relationship means that period of time between the effective date of the first claims-made policy between any insurer and the insured and the cancellation or nonrenewal of the last consecutive claims-made policy between such insurer, or another insurer, and the insured, where there has been no gap in coverage, but does not include any period covered by extended reporting period coverage.

(r) Issue shall include issue for delivery.

(s) Not-for-profit organization means a corporation, association, organization or trust described in section 501(c)(3) of the United States Internal Revenue Code.

Section 73.2 Types of coverages and risks.

Claims-made coverage any not be provided in any policy issued or renewed in this State, except that:

(a) The following coverages or risks may be written on a claims-made basis:

(1) completed operations liability;

- (2) directors and officers liability;
- (3) employee benefits liability;
- (4) errors and omissions liability;
- (5) excess liability;
- (6) fiduciary liability;
- (7) pollution and environmental impairment liability;
- (8) public entity liability;
- (9) products liability;
- (10) professional liability (including medical malpractice liability);
- (11) ski resort liability, subject to subdivision (f) of this section;
- (12) employment practices liability; and
- (13) risks specified in paragraph (d)(1) of this section.

(b) A commercial umbrella policy may be issued or renewed on a claims-made basis over underlying coverages which are written on a claims-made basis pursuant to this section. The umbrella policy must provide coverage on an occurrence basis over underlying coverages written on an occurrence basis, as well as for any coverages not subject to an underlying coverage requirement.

(c)

(1) Any commercial liability policy may be issued or renewed on a claims-made basis if at least 90 percent of the liability insurance premium for the policy is attributable to product liability, completed operations liability or medical malpractice liability exposure.

(2) Legal services insurance may be provided on a claims-made basis when written as part of a policy of liability insurance covering related risks of a type specified in subdivision (a) of this section.

(d)

(1) A liability policy may be issued or renewed in this State on a claims-made basis if the policy:

- (i) insures a large commercial insured;
- (ii) provides primary coverage of at least \$5,000,000 per occurrence;

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(iii) provides umbrella or excess coverage of at least \$1,000,000 per occurrence, where the underlying limits are at least \$2,000,000 per occurrence; or

(iv) is written with a deductible, or over a self-insured retention, of at least \$100,000 per occurrence.

(2) Any policy issued or renewed pursuant to this subdivision must comply with all the provisions of this Part, except:

(i) subdivisions (e)(1), (e)(3)(ii), (f), (h)(1), (2) and (4), and (n) of section 73.3 of this Part;

(ii) subdivisions (a)(5), (b) and (c) of section 73.7 of this Part; and

(iii) section 73.8 of this Part.

(e) Notwithstanding any other provision of this Part, claims-made coverage shall not be permitted for:

(1) motor vehicle liability; or

(2) any liability risk or coverage subject to section 3425 of the Insurance Law.

(f) In light of substantial liability insurance availability problems experienced by ski resorts, ski resort liability insurance may be written on a claims-made basis, provided that any such policy also:

(1) is written with notice of circumstance, circumstance reporting, notice of incident or incident reporting;

(2) offers general liability limits of at least \$5,000,000 per occurrence;

(3) has no annual aggregate limits on general liability losses;

(4) in the event of sale, retirement or dissolution on the part of the insured, offers unlimited extended reporting period coverage for an additional premium of not more than 100 percent of the expiring policy's earned premium; and

(5) otherwise complies with the requirements of this Part.

Because it is based upon current availability problems, this permission in regard to claims-made policies for ski resort liability will be reviewed by the department on a periodic basis.

Section 73.3 Terms and conditions of claims-made policies.

Except as provided in section 73.2(d) of this Part, no claims-made liability insurance policy shall be issued or renewed in this State, unless the policy and the issuing insurer comply with the following minimum standards:

(a) A claim will be deemed first made when the insurer receives written notice of a claim or suit from the insured or a third party, but this shall not preclude an insurer from utilizing written notice of incident as the trigger of coverage under the policy.

(b) A retroactive date may not be changed during the term of the claims-made relationship and any extended reporting period.

(c)

(1) Upon termination of coverage, extended reporting period coverage required by this Part must be available for any claims-made liability coverage provided under the policy.

(2) Upon termination of coverage pursuant to section 73.1(n)(2) of this Part, extended reporting period coverage when required shall apply only in regard to that coverage terminated.

(3) For policies issued or renewed pursuant to section 73.2(d)(1) of this Part, extended reporting period coverage need not be offered upon termination of coverage pursuant to section 73.1(n)(2) of this Part.

(4) Except as otherwise permitted by this Part, endorsements restricting extended reporting period coverage are prohibited.

(d) Upon termination of coverage, a 60-day automatic extended reporting period, or 90 days in case of public entity liability insurance policies, must be provided by the insurer.

(e)

(1) Within 30 days after termination of coverage, the insurer must advise the insured in writing of the automatic extended reporting period coverage and the availability of, the premium for, and the importance of purchasing additional extended reporting period coverage. For policies subject to audit, retrospective rating or experience rating, the premium for extended reporting period coverage included in the above notices may be quoted on an estimated basis.

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(2) Upon cancellation due to nonpayment of premium or fraud on the part of the insured, an insurer shall not be required to provide a premium quotation for extended reporting period coverage unless requested by the insured.

(3) The insured shall have the greater of the following in which to submit written acceptance of extended reporting period coverage:

(i) 60 days from the effective date of termination of coverage; or

(ii) 30 days from the date of mailing or delivery of the advice required by paragraph (1) of this subdivision.

(4) For the purpose of determining the length of the extended reporting period, the coverage required by subdivision (d) of this section shall be included.

(f) Except as provided in subdivision (g) of this section, and sections 73.4 and 73.5 of this Part, upon termination of coverage, an insurer must offer the insured a three-year extended reporting period.

(g) Upon termination of coverage for the following types of coverages or risks, the insurer must offer a one-year extended reporting period:

(1) directors and officers liability, except not-for-profit organizations;

(2) employee benefits liability;

(3) fiduciary liability;

(4) public entity liability;

(5) pollution and environmental impairment liability;

(6) ski resort liability subject to section 73.2(f) of this Part;

(7) employment practices liability; and

(8) policies issued or renewed pursuant to section 73.2(d) of this Part.

(h) Upon termination of coverage:

(1) Except for the coverages delineated in subdivision (g) of this section, where a claims- made relationship has continued for at least three years and the policy contains an annual aggregate liability limit, the aggregate liability limit, if any, for the extended reporting period coverage shall be at least equal to 100 percent of such policy's annual aggregate limit.

(2) Except for the coverages delineated in subdivision (g) of this section, where a claims- made relationship has continued for less than three years and the policy contains an annual aggregate liability limit, the aggregate liability limit, if any, for the extended reporting period coverage shall be at least equal to the greater of:

(i) the amount of coverage remaining in such policy's annual aggregate liability limit; or

(ii) 50 percent of such policy's annual aggregate liability limit.

(3) Where a policy as specified in subdivision (g) of this section contains an annual aggregate liability limit, the aggregate liability limit, if any, for the extended reporting period coverage shall be at least equal to the amount of coverage remaining in such policy's annual aggregate liability limit.

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(4) Where termination of coverage is due only to a decrease in the policy's annual aggregate liability limit, the aggregate liability limit, if any, required by this subdivision for the extended reporting period coverage shall be no greater than the amount of such decrease.

(5) Where a policy has no annual aggregate liability limit, the insurer shall provide extended reporting period coverage without an aggregate liability limit.

(i) Upon termination of coverage, the aggregate liability limit, if any, for the automatic extended reporting period coverage required by subdivision (d) of this section shall be at least equal to the amount of coverage remaining in the policy's annual aggregate liability limit.

(j)

(1) Except as provided in paragraph (2) of this subdivision, the premium charged for extended reporting period coverage shall be based upon the rates for such coverage in effect on the date the policy was issued or last renewed, and the insurer shall not charge a different premium for such coverage due to any change in its rates, rating plans or rating rules subsequent to issuance or last renewal of the policy.

(2) The premium charged for extended reporting period coverage may be based upon the rates, rating plan or rating rules in effect upon termination of coverage, if the claims-made policy:

(i) provides for extended reporting period coverage of at least five years; and

(ii) if the claims-made policy contained an annual aggregate limit, provides extended reporting period coverage having a separate aggregate liability limit, if any, equal to at least 100 percent of such policy's annual aggregate liability limit.

(3) The premium for extended reporting period coverage shall be commensurate with the coverage provided. Upon termination of coverage on a date other than the policy's anniversary date, the cost of extended reporting period coverage shall be appropriately reduced.

(k) Where a claims-made relationship has continued for less than one year, subdivisions (e) through (h) and (j) of this section shall not apply upon termination of coverage for nonpayment of premium or fraud.

(l) Upon termination of coverage, other than for a policy rated on a retrospective basis:

(1) Any return premium due the insured shall be credited toward the premium for additional extended reporting period coverage if the insured elects such coverage.

(2) Where premium is due to the insurer for coverage during the claims-made relationship, any monies received by the insurer from the insured as payment for the extended reporting period coverage shall first be applied to such premium owing for the policy.

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(m) During a claims-made relationship and any extended reporting period, a person employed or otherwise affiliated with the insured and covered by the insured's claims-made policy during such affiliation, shall continue to be covered under such policy and any extended reporting period after such affiliation has ceased for such person's covered acts or omissions during such affiliation.

(n)

(1) A claims-made policy issued to a corporation, partnership or other entity shall provide extended reporting period coverage upon termination of coverage to any person covered under the policy, if:

(i) such entity has been placed in liquidation or bankruptcy or permanently ceases operations;

(ii) the entity or its designated trustee does not purchase extended reporting period coverage;

(iii) such person requests the extended reporting period coverage within 120 days of the termination of coverage; and

(iv) the coverage or risk is of the type enumerated in paragraph (2), (3), (4), (6) or (10) of section 73.2(a) of this Part.

(2) The insurer shall have no obligation to provide any notice to any such person of the availability of the extended reporting period coverage required by paragraph (1) of this subdivision.

(3) The insurer may charge the person for whom extended reporting period coverage is provided a premium commensurate with such coverage.

(o) An insurer may issue a claims-made policy with more liberal policy provisions than required by this Part, subject to policy form approval by the superintendent.

Section 73.4 Terms and conditions of medical malpractice policies other than for physicians.

In addition to the requirements contained in section 73.3 of this Part, except subdivisions (f) through (g) of such section, all claims-made medical malpractice policies, other than for physicians, issued or renewed in this State, shall meet the following minimum requirements:

(a) Upon termination of coverage, an insurer must offer the insured an extended reporting period providing coverage for an unlimited time period.

(b) Upon termination of coverage, an insurer shall provide the extended reporting period coverage required by subdivision (a) of this section, without charging an additional premium, if, while covered by the policy, the insured:

(1) dies;

(2) becomes permanently disabled and is unable to carry out his or her practice; or

(3) retires permanently and totally from practice after attaining the age of 65 or older and has been insured on a claims-made basis with the same insurer for a period of five or more consecutive years.

(c) Upon termination of coverage, a policy issued to a person must provide, to a hospital whose facilities are used by such person, extended reporting period coverage, as required by subdivision (a) of this section, to protect the interests of such hospital, if such person does not purchase extended reporting period coverage. The insurer shall not charge the hospital a premium for such coverage.

Section 73.5 Terms and conditions of medical malpractice policies for physicians.

In addition to the requirements contained in section 73.3 of this Part, except subdivisions (b) and (f) through (h) of such section, all claims-made medical malpractice policies for physicians licensed in this State, which are issued or renewed in this State, shall comply with the following minimum requirements:

(a) A retroactive date may not be changed during the term of the physician claims-made relationship and any extended reporting period.

(b) Upon termination of coverage:

(1) An insurer shall offer the insured an extended reporting period providing coverage for an unlimited time period.

(2) The extended reporting period coverage shall provide an annually renewed aggregate liability limit equal to at least 100 percent of the policy's annual aggregate liability limit, except that the annually renewed aggregate liability limit need not be provided where a simultaneous extended reporting period is issued, pursuant to section 70.8(g)(2) of this Title.

(3) The insured shall have the option of purchasing such extended reporting period coverage either in a single payment or in three annual installments with an additional finance charge.

(c) Upon termination of coverage, an insurer shall provide the extended reporting period coverage required by subdivision (b) of this section, without charging an additional premium, if, while covered by the policy, the insured:

(1) dies;

(2) becomes permanently disabled and is unable to carry out the practice of medicine; or

(3) retires permanently and totally from the practice of medicine after (i) attaining the age of 65 or older and has been insured with an authorized insurer on a claims-made basis for a period of five or more consecutive years, or (ii) attaining the age of 55 or older and has been insured with an authorized insurer on a claims-made basis for a period of 10 or more consecutive years.

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(d) Upon termination of coverage, a policy issued to a person must provide, to a hospital whose facilities are used by such, person extended reporting period coverage as required by subdivision (b) of this

section, to protect the interests of such hospital, if such person does not purchase extended reporting period coverage. The insurer shall not charge the hospital a premium for such coverage.

(e) During a physicians claims-made relationship and any extended reporting period, a person employed or otherwise affiliated with the insured and covered by the insured's claims-made policy during such affiliation, shall continue to be covered under such policy and any extended reporting period after such affiliation has ceased for such person's covered acts or omissions during such affiliation.

Section 73.6 Intercompany transfer mechanism for medical malpractice policies for physicians.

(a) If claims-made coverage of an insured physician who continues to practice in this State is transferred from an authorized insurer to another authorized insurer without any gap in coverage, the former entity shall pay over to the successor an actuarially appropriate dollar amount to provide for the requirements of section 73.5 of this Part, and the insured shall be entitled to the benefits of such section as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

(b) If claims-made coverage of an insured physician is transferred from an insurer in liquidation to an authorized insurer not in liquidation without any gap in coverage, then the successor entity shall accept the amounts payable from the property/casualty insurance security fund as provided in Insurance Law, section 7603(a)(1)(G), to provide for the requirements of section 73.5 of this Part and subdivision (a) of this section, and the insured shall be entitled to such benefits as if such insured had been continuously covered by the successor entity during the entire period of consecutive years of coverage.

Section 73.7 Disclosure and notice requirements.

Every claims-made liability insurance policy issued or renewed in this State shall contain the following minimum disclosure and notice requirements:

(a) The policy application and the declaration page, or addenda thereto, shall contain a notice, conspicuously displayed, stating:

(1) that the policy is, or identifying those portions of the policy that are, written on a claims-made basis;

(2) that the policy provides no coverage for claims arising out of incidents, occurrences or alleged wrongful acts which took place prior to the retroactive date stated in the policy;

(3) that the policy covers only claims actually made against the insured while the policy remains in effect (or incidents reported if the insurer utilizes written notice of incident as the trigger of coverage under the policy) and all coverage under the policy ceases upon the termination of the policy, except for the automatic extended reporting period coverage (required by section 73.3[d] of this Part), unless the insured purchases additional extended reporting period coverage;

(4) the length of any automatic or additional extended reporting period coverage and, unless such coverage is for an unlimited time period, there shall also be a statement advising the insured specifically of potential coverage gaps that may arise upon expiration of such extended reporting period coverage; and

(5) that, during the first several years of the claims-made relationship, claims-made rates are comparatively lower than occurrence rates, and that the insured can expect substantial annual premium increases, independent of overall rate level increases, until the claims-made relationship reaches maturity.

(b) Except as provided in subdivision (c) of this section:

(1) The declarations page, or an addendum thereto, shall state the premium that will be charged for each extended reporting period coverage option if the policy is terminated on the next anniversary date.

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(2) For a policy subject to audit, retrospective rating or experience rating, the premium stated on the declarations page, or an addendum thereto, for the extended reporting period coverage may be the estimated premium.

(3) If there is a change in the policy premium as a result of any change in the nature or extent of the risk during the policy period, the insurer at the time of such change shall specify a revised premium for the extended reporting period coverage.

(4) Alternatively, the insurer may specify the percentage of the current policy's premium, using rates in effect on the effective date of the policy, that will be charged for the extended reporting period coverage in the event that the policy is terminated on the next anniversary date.

(5) In the event that extended reporting period coverage is issued pursuant to section 73.3(f) or (g) of this Part, and the extended reporting period premium cannot be determined at the time of issuance or renewal of the policy due to potential reduction of the aggregate limit of liability by the time the policy terminates under section 73.3(h)(2) or (3) of this Part, an insurer may provide the insured with a reasonable estimate of the actual extended reporting period coverage premium to be charged. The actual premium charged for the extended reporting period coverage shall not exceed 115 percent of the estimated amount.

(c) For policies meeting the requirements of paragraph (j)(2) of section 73.3 of this Part, and where the premium for the extended reporting period coverage will be determined pursuant to such paragraph, the declarations page, or an addendum thereto, shall state that:

(1) the rates for extended reporting period coverage will be based on the rates in effect at the time of termination of coverage;

(2) such rates may be subject to substantial increase over the rates currently in effect;

(3) the average statewide percentage changes, and the effective dates, of each rate revision for the particular type of insurance which the insurer has implemented in this State during the five-year period immediately preceding the effective date of the policy shall be provided upon the written request of the insured; and

(4) such changes may or may not be indicative of future rate changes.

Section 73.8 Exemptions.

This Part shall not apply to aircraft liability policies, fidelity and surety policies, nuclear liability policies, or marine indemnity and protection policies.

Section 73.9 Applicability.

(a) The minimum standards set forth in this Part shall apply to every new claims-made policy issued on or after August 1, 1986 and to every existing claims-made policy renewed on or after October 1, 1986.

(b) The first amendment to this Part shall be applicable to every claims-made policy issued or renewed on or after the effective date of this amendment, except that this entire Part, as amended, shall be applicable to medical malpractice policies for physicians issued or renewed on or after July 1, 1986 and to medical malpractice policies for certified nurse midwives issued or renewed on or after October 1, 1986.

(c) The second amendment to this Part shall be applicable to new policies issued on or after October 1, 1987 and existing policies renewed on or after December 1, 1987.

(d) The third amendment to this Part shall apply to policies issued or renewed on or after July 1, 1993.

(e) The fourth amendment to this Part shall be applicable to policies issued or renewed on or after August 1, 1997.

Section 73.10 [Renumbered]