

Insurance Underwriting Online Study Book

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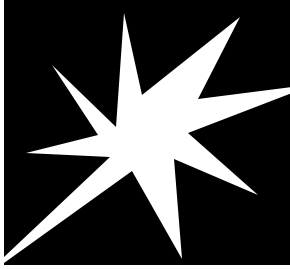
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Introduction To Insurance Underwriting

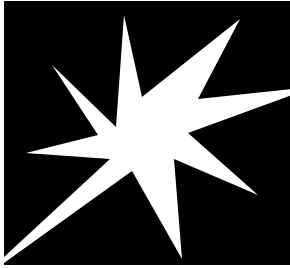
Underwriting is a critically important function and is performed each time an insurance application is taken. Its purpose is to determine if applications represent risks acceptable to the insurer to determine whether or not the insurer will issue a policy to an applicant. Underwriting is based on a variety of criteria, established by each insurer and regulated by state and federal law. Each underwriting decision involves balancing the insurer's desire to earn premium with the insurer's ability to cover claims and remain in compliance with regulatory financial requirements while making a profit.

This course discusses each important facet of underwriting. It begins by answering the question "What is Underwriting?". Factors in underwriting, including key components used in underwriting when the application insures people, property, a business or business operations, are delineated. Then, the various types of underwriters are discussed and how their responsibilities differ depending upon the line of insurance they underwrite. The four basic underwriting decisions, whether to reject an application, issue the application as substandard, issue the application as standard, or issued the application as preferred, are taken up next. Finally, the monitoring of underwriting decisions is explained.

Later, the Underwriting Process is examined. First, the objective of the underwriting task is described and a close look is taken at the components that must exist for a risk to be acceptable to the insurer. Then, each underwriting resource is reviewed, starting with the application for various lines of insurance and including consumer reports, Medical Information Bureau information, site inspections, insurance maps, insurance company files and industry statistics. The key elements underwriters take into consideration when accepting an insured and the role of the agent in the underwriting process conclude this chapter.

The next chapter provides information concerning legislation and its impact on underwriting. State and federal regulations dealing with the setting of adequate rates, privacy laws, unfair trade practices, discrimination and required coverages are all examined. The final chapter of the course discusses reinsurance and its roll in underwriting. The reinsurance industry, treaty reinsurance and facultative reinsurance are included in this discussion.

Upon completion of this course, the agent will have a solid understanding of the importance, function process and purpose of underwriting. The agent will also know his or her important role in this process.



What is Underwriting?

Underwriting is the function of evaluating the subject of insurance, whether a person, property, profession, business, or other entity, and determining whether to insure it. The underwriter must apply company standards to each applicant, and, based on these standards, ascertain whether the application represents an acceptable risk. Underwriting is the foundation of the insurance transaction process.

The term *underwriter* arose out of marine insurance. In the 17th Century, merchants who were willing to take on a portion of the risk for voyages would list the amount of the voyage they were willing to insure and sign their names underneath a contract that detailed the terms of the risk. These merchants became known as underwriters because they wrote their names under the contract terms. Since that time, the insurance business has evolved and policies are no longer underwritten by individuals who insure risks, but the term *underwriter* continues to be applied to those who review and select risks to insure.

Factors In Underwriting

The factors used during the underwriting process varies somewhat based upon the type of insurance being underwritten. If people are being insured, such as under life, health and disability insurance, key factors used in the underwriting process may include:

- Age;
- Sex;
- Health and health history;
- Occupation and occupation history;
- Financial condition;
- Personal habits such as smoking or drinking alcohol;
- Size of the policy; and
- Current insurance in force.

If property is insured, as in homeowners, automobile, and commercial property insurance, underwriters may review factors such as:

- Type of the property;
- Value of the property;
- Condition of the property;
- Construction materials used in the property;
- Potential hazards surrounding or within the property;
- Age of the property;
- Use of the property;
- Security measures and other loss control measures associated with the property;
- Upkeep of the property;
- Location of the property;
- Current insurance in force on the property; and
- Prior losses associated with the property.

If a business or business operations are being underwritten under insurance such as general liability and professional liability insurance, factors that underwriters will weigh include:

- Type of business;

- Size of business;
- Financial condition of the business;
- Financial condition of owners;
- Business cycles affecting the business;
- Liability exposures;
- Experience of key employees and owners; and
- Past losses experienced by the business.

Functions of Underwriting

Underwriting involves examining application forms, supporting documents such as appraisals or bills that verify the value of property, or medical reports that verify the health condition of an individual, looking at insurance maps that provide information relevant to the statistical possibility of certain types of loss, reviewing statistical data applicable to the risk to be insured, reviewing company records regarding the application and evaluating site inspection reports. Upon a thorough examination of all the data, underwriters then assign rates to the application, or decline to issue a policy if it does not meet underwriting standards. During the entire process, the underwriting department frequently communicates with agents, inspectors, adjusters and other field personnel.

Types of Underwriters

An insurance company may issue policies for many different types of insurance. However, most underwriters perform their responsibilities as specialists. An underwriter may underwrite just property policies, just casualty policies, just personal property policies, just professional liability policies, and so on.

Property and Casualty Underwriters

Within the property and casualty field, underwriters often specialize in a particular type of property or casualty coverage. Within this field there may be fire underwriters, homeowners underwriters, automobile insurance underwriters, inland marine underwriters, commercial property underwriters, personal property underwriters, commercial general liability underwriters, professional liability underwriters and Workers Compensation underwriters, for example.

These underwriters, whether they perform underwriting tasks for one line of insurance or for many lines, must understand the risks involved with each line of insurance for which they underwrite and the available and practical methods of dealing with these risks. They must also be able to gather and understand the various resources used to evaluate each application and determine whether the applicant meets company underwriting standards. Such resources may include site inspection reports, business or personal financial statements and reports, and if a business is being insured, statistical reports generated by the industry in which the business falls, as well as statistical reports from the property and casualty insurance industry that are applicable to the risk.

Personal Line and Commercial Lines

A further distinction among property and casualty underwriters is whether they underwrite personal lines or commercial lines. Although both individuals and businesses need property and liability coverages, the insurance needs of an individual are very different from the needs of a business. In addition, there are many, many types of businesses and therefore many different sorts of risks associated with these varying business types. Therefore, within the commercial lines area, there may be many specialized underwriting functions.

If an underwriter works with commercial lines applicants, the underwriter is generally familiar with risk management principles and methods as they apply to the type of business being insured. Such underwriters also are knowledgeable regarding the type and scope of risks associated with various business occupancies. They understand that the risks related to running a supermarket are different from those that exist when operating a manufacturing plant. Depending on the insurer, a commercial property and casualty underwriter may even specialize in underwriting specific types of businesses. For example, if an insurer markets to those needing boilers and machinery insurance and also to those with extensive data processing facilities, one set of underwriters may work with the boilers and machinery applicants and another set work with those with data processing protection needs.

If a property and casualty underwriter works with personal lines applicants, the underwriter will have a deep understanding of the specific risks facing individuals, such as homeowners or drivers. A homeowners insurance underwriter will understand differences in home construction materials, the safety impact of various security systems, and other factors that determine the rates and insurability of a homeowners applicant. A personal automobile insurance underwriter will be an expert in understanding the various safety features in all makes of cars, what types of drivers are statistically found to be safe drivers, and so on. An underwriter working with highly valuable personal property owned by an individual will be familiar with appraisal reports and appropriate security measures that should be taken to protect the property.

Life and Health Underwriters

Another area of specialty for underwriters is life and health insurance. A life and health insurance underwriter is familiar with things such as the impact of medical history and other health issues on insurability. The health or life underwriter is able to read and understand medical reports such as the attending physician statement and data gathered from the Medical Information Bureau. Due to the extensive regulatory environment surrounding health insurance, health insurance underwriters are also very familiar with state and federal regulations regarding health coverage.

Liability Underwriters

Liability insurance underwriters must be familiar with the liability risks found inherently in commercial businesses, professionals or individuals. They must also be able to evaluate past losses, judgments and settlements in terms of the likelihood of reoccurrence in order to determine relative future risk. They must also be familiar with current trends in court judgments and with liability laws in order to properly evaluate high-risk applicants.

Group Underwriters

Many types of insurance are written on a group basis, and health insurance is often written in this manner. Group insurance is handled somewhat differently than individual policies for underwriting purposes. Generally in life and health insurance group programs, a rate is established that applies to the entire group to be insured. This rate is established by analyzing the characteristics of the group as a whole, as well as individuals within the group. This rate is generally reviewed and revised on an annual basis.

Under some types of group underwriting, individual rates are assigned to individuals within the group, but a discounted rate is applied because the individual is part of the group, so the insurer's marketing costs are reduced on a per coverage basis. A group offering automobile coverage to its members may have rates assigned in this way.

Some forms of group insurance, especially when offered as part of an employer's benefit package, are subject to special federal and state regulations. Because group underwriting

differs in operations and regulation from individual underwriting, an insurer may use specialized underwriters for group insurance.

Underwriting Decisions

When evaluating applicants, underwriters determine whether insurance on the applicant will be:

- rejected;
- issued on a substandard basis;
- issued on a standard basis; or
- issued on a preferred basis.

Rejecting Applicants

Insurers reject applications for insurance when they find that the applicant represents a risk that falls outside of the underwriting standards established by the insurance company. These underwriting standards take into consideration many items, such as regulations that require the insurer to establish adequate rates, laws that mandate that certain factors cannot be used to reject an application, insurance principles such as insurability and indemnity, the marketplace in which the insurer sells its products and the profit the insurer hopes to make on its business.

Issuing Policies on a Substandard Basis

The decision to issue a policy on a substandard basis occurs when a risk is not deemed to be outside underwriting standards, but is considered to be of high risk within those standards. The insurer generally has three basic options when it offers a substandard policy issue to an applicant. It may:

- a. issue the policy with a higher premium than would be required for a standard policy
- b. issue the policy with limited benefits
- c. issue the policy with certain exclusions

Higher Premium

The insurer may charge a higher premium to applicants deemed to be of higher risk than those who would be considered a standard risk as long as those higher rates fall within certain parameters. First, if the insurance policy is one that requires that rates be filed with the state in which the policy is issued, the rate must be approved by the state. Secondly, the rate may not be discriminatory. The insurer must charge every insured with the same characteristics the same rate. Thirdly, in some states higher premium may not be charged based on certain items as defined in state statutes. The insurer must of course comply with such statutes in determining whether to charge higher premium rates.

Limit Policy Benefits

Insurers may also respond to substandard applicants by offering a policy with limited policy benefits. Again, whether the insurer may limit benefits is regulated by state law. For example, under long-term care policies, some states require that policies offer a minimum home health care benefit limit as a certain ratio of the nursing home benefit limit. Therefore, a long-term care insurer could not limit the home health benefit on a policy in a manner that would not comply with such a law. Assuming state regulations are followed, an insurer could offer lower policy limits on certain coverages to a substandard applicant, or could offer lower policy limits for all coverages to such an applicant. Dealing with substandard applicants by limiting policy benefits is most common in commercial coverages.

Excluding Certain Provisions From Coverage

Another option an insurer may have is to offer an substandard applicant a policy that excludes coverage for certain property, insureds or operations that are deemed too high a risk for the

insurer to cover. As with the other options discussed, such exclusions must be allowable under state regulations. This type of exclusion is most common in commercial property and liability coverages. For example, an insurer may cover all the property owned by a business, except that within a building whose operations have been discontinued. Or, an insurer may offer to provide liability coverage for all business operations except for that portion that has potential pollution liability that is too high for the insurer to cover.

Issuing Policies on a Standard Basis

Underwriters base their determination that a policy should be issued on a standard basis on an analysis of the characteristics of the risk represented by the applicant. Applicants who are issued policies with standard rates fall within the normal boundaries of underwriting standards for that type of policy.

Issuing Policies on a Preferred Basis

If an application falls within the lowest risk boundaries of the underwriting standards, the policy is issued on a preferred basis. Preferred rates represent the lowest rates offered by an insurer for its coverage. Rates offered on a preferred basis must adhere to the insurance regulations applicable to them, just as rates offered on a substandard and standard basis must. Insurance regulators do not want insurers to offer rates that are so low that the insurer cannot meet its contractual obligations to pay covered claims.

Monitoring Underwriting Decisions

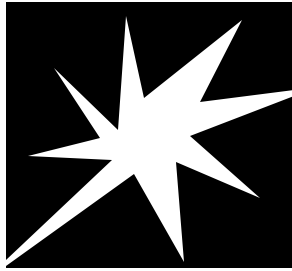
Once a policy is issued, underwriters continue to monitor the policy from an underwriting perspective. Such monitoring is done at policy renewal, commonly every six or twelve months, and as claims occur. Depending upon the type of policy and its provisions regarding rate increases, rates may be increased at renewal, or the insurer may make the decision not to renew the policy. Changes in rates or the decision to non-renew are only made if allowed by policy provisions and applicable regulation. Decisions to modify rates may be based on the actual claims experience over the last policy period for a specific insured, as may occur with Workers Compensation insurance and various commercial property policies, or may be based on a rate change for an entire class of policyholders or category of insurance. State regulations often limit factors that may be used to increase rates. For example, a state may not allow an increase in automobile rates until three claims have been paid under the policy. The decision for non-renewal, if allowed by regulation and policy terms, is typically done only if the insured has excessive claims or the insurer has decided to discontinue offering the type of insurance the policy represents.

The agent also has a role in the monitoring of underwriting decisions. The agent should meet with each client on an annual basis to review coverages and ensure all information on file with the insurer is accurate and up-to-date. This review of coverage also serves the purpose of making sure the client's insurance needs are properly met. Contact between the agent and client outside of the annual review may also result in the receipt by the agent of updated policy information. Updating policy information is an important part of the ongoing underwriting process. The agent must promptly and accurately submit such information to the insurer's home office.

Summary

- The factors used during the underwriting process vary based upon the type of insurance being underwritten.
- Underwriting involves the examination and evaluation of application forms and supporting documents, assigning rates to a policy or declining to issue a policy.

- Generally, underwriters work as specialists for a particular line or lines of insurance.
- Underwriters have four options when underwriting an application. These include determining whether the insurance on the applicant will be rejected, issued on a substandard basis, issued on a standard basis, or issued on a preferred basis.
- Once underwriting is complete and a policy issued, the underwriting decision is monitored as claims are received and upon renewal. The agent also is responsible to assist in monitoring insureds through each contact with that insured, and must forward appropriate updates to policy information promptly and accurately to the insurance company.



The Underwriting Process

Underwriting is the process of determining whether an insured is an acceptable risk, and if so, at what rate the insured will be accepted. Insurers cannot accept every applicant. An insurer has a responsibility to its current policyholders to make sure that it will be able to meet all the contractual obligations of its existing policies. If the insurance company issues policies on applicants that represent risks that are uninsurable or risks that require premiums higher than the insurer may charge can cover, the insurer's ability to meet its contractual obligations is jeopardized. On the other hand, a for-profit insurer wants to make money and to increase its number of policyholders. No insurer wants to reject applicants unnecessarily. All these factors must be taken into consideration in the underwriting process.

An insurer is also regulated by the states in which it does business. The states expect the insurer to establish reasonable, non-discriminatory standards for accepting insureds. Rates for many types of insurance must be approved by the states in which the insurer does business. Regulation is another important factor in the underwriting process.

Establishing An Application File

When an application is received in underwriting, the insurer's underwriting process begins. The application is reviewed to make sure it is complete, and that the application, on its face, meets underwriting standards. At this point it is also determined whether or not additional documentation will be required. If additional documentation is required, the underwriting department will request the documentation, reports or inspections, or will notify the agent or agency that these items are needed. Because the length of the underwriting process and policy issue is often governed by state regulations and company standards, the request for information, reports and inspections generally include a specified period of time in which the request must be fulfilled. If the information is not received within the specified time, the application file is generally closed, and any premium received is returned.

Often the first review of the application includes the determination of whether the risk demonstrates appropriate insurable interest. Insurable interest must exist in order for the application to continue through the underwriting process.

Insurable Interest

Often, the first characteristic of an acceptable insurance risk reviewed is whether it includes insurable interest. Requiring insurable interest helps to reduce the likelihood that the person or persons benefiting from the insurance will try, in some way, to cause or allow a loss. The definition of insurable interest varies depending upon the type of coverage being issued.

Under property insurance, the person who benefits from a property insurance policy must generally meet three requirements. He or she must:

1. be in a position to suffer a loss related to the insured or the insured property,
2. must not be in a position to profit or gain from a loss pertaining to the insured or the insured property, and
3. must have a financial interest in protecting the insured from a loss.

Under life insurance, for insurable interest to exist, the death of the insured must have a clear and definite financial impact on the policy owner. Insurable interest in life insurance is considered to exist if the policy owner and insured are the same person. It is also considered to exist if the spouse of the insured is the policy owner, if a parent is the policy owner and the parent's child is the insured, if a grandparent is the insured and policy owner is a grandchild, if a business is the policy owner and the insured is a key employee or an officer or director of the business, and if business partners own policies on the lives of one another. If a creditor is the policy owner and the debtor is the insured, there is insurable interest up to the extent of the debt only. Other relationships may include an insurable interest, but an underwriter is likely to ask for proof of such interest before accepting an application with an unusual insurable interest relationship.

Elements Of A Valid Contract

Another important factor an underwriter will look for in any insurance application is verifying that it complies with rules surrounding legal and valid contracts. Insurance contracts, like all contracts, must include four elements in order to be legal and valid:

1. Consideration
2. Agreement or assent of the parties
3. Competent Parties
4. Legal purpose or legal subject matter

Consideration

Consideration is something of value that induces the parties involved into making a contractual agreement. Consideration may be monetary, or can be in the form of a promise or an act. Under an insurance contract, premium is the consideration.

Assent of Both Parties

Under contract law, parties involved in a contract must agree to contract terms as they exist. This legal concept is known as *mutual assent*. In order for a contract to be valid, agreement cannot be made under any kind of duress, by mistake, or by any fraudulent means.

Competent Parties

A competent party is one having the legal capacity to enter into a contract. A minor does not have legal capacity to enter into a contract, nor does a person who has been declared legally insane, or those who are under the influence of intoxicants.

Legal Purpose

Every contract must be entered into with a legal purpose. If a contract has an illegal purpose, it is void. Examples of illegal purposes that might be found in life insurance are policies opened with the intent to commit murder or to falsify the death certificate of an insured in order to collect the death benefit. In property insurance, a contract with an illegal purpose may be one entered into in conjunction with a contract with an arson to burn the property insured.

Property-Casualty Contracts

In property-casualty insurance, most states prohibit policy forms that include provisions, exceptions or conditions that are misleading ambiguous, deceptive, overstate the coverage or misrepresent the coverage in the policy. States may also require that the policy contract include notices regarding the policy's cancellation or nonrenewal. If the policy is a personal lines policy such as a homeowner's or personal automobile policy, it will generally have cancellation and renewal provisions that are more lenient for the consumer than a policy written for a business.

For example, the insurer may have to return premium to a non-business insured more rapidly than the insurer must return premium to the named insured on a business policy.

States may also require that a declaration or information page be included in the policy form that identifies the individual insured, the property to which the insurance applies, any of minimum liability, and the effective date and time of policy inception. The policy form may also be required to include a clear insuring agreement, conditions under which the coverage applies, exclusions from policy coverage, definitions of important words in the policy, a statement that bankruptcy does not relieve the insurer of its obligations, an arbitration clause, an appraisal clause and a statement that the policy form and endorsements constitute the entire contract.

Exempt Commercial Policyholders

Under some state insurance regulations, certain commercial policyholders are exempt from rate and form requirements that would normally be applicable. An *exempt commercial policyholder* under these regulations is one who is a sophisticated business purchaser. Such a purchaser is likely to study and understand insurance coverages exclusions and the risks to which their business is subject. An exempt commercial policyholder may be one requiring customized insurance coverage rather than coverage through a filed form from the insurer.

To qualify as an exempt commercial policyholder, a state may require that the policyholder be of a certain size, for example, requiring that the business have a net worth of over a certain amount or requiring that net revenues or sales be over a certain amount. Other requirements may include that the policyholder employ a risk manager or pay annual insurance premiums of a certain minimum amount, such as at least \$500,000.

Insurable Risk

Another key aspect of each application reviewed by an underwriter is the determination if the risk the application represents is an insurable risk. Not all risks are insurable. As each risk is evaluated, it is important to note whether or not it can be insured. If not, insurance may not be purchased on the risk.

In order to be insurable, a loss must:

- arise from a *pure risk*,
- be definable,
- be calculable,
- not occur to many people simultaneously, and
- not be intentional.

Pure Risk

A pure risk is one which cannot result in the possibility of gain. In order to be insurable, a risk must have the potential of only two possible results: loss or no loss. If a risk includes the possibility of gain, it is called a *speculative risk*. Launching a marketing campaign is an example of a speculative risk. It may result in a loss in sales if people are turned off by the advertising, it may result in neither an increase nor a decrease in business if the advertising makes no impact, or it may result in increased sales. Insurance policies do not provide insurance for speculative risks. Insurers protect against pure risks such as fire. If no fire occurs, no loss occurs. If fire occurs, loss occurs. Liability claims or suits are pure risks. If a liability claim does not occur, no loss occurs. If a liability claim occurs, loss occurs, ranging from defense expenses to the payment of a damage award.

Definable Loss

Insurance covers losses that can be defined in terms of cause, time, place and amount. Cause must be definable in order to make sure that the coverage applies to losses arising from the cause. Time must be definable in order to make sure the loss occurred during the policy period or whatever terms the policy provides regarding the period of time in which claims may be made. Place must be definable to ensure that the loss occurred within the coverage territory stated in the policy. Amount must be definable so that the insurer pays the benefit due under the benefit limits of the policy.

Calculable Loss

Insurers must be able to calculate both actual and expected losses. Expected losses are the basis of premiums charged. Actual losses may result in an adjustment of premium in the preceding period and for ongoing coverage. Actual losses also are the basis for paying benefits from the policy.

Not Occur to Many People Simultaneously

In order to provide insurance, premiums must be collected from a large number of people exposed to the same type or types of loss. Even though the insureds are exposed to the same type of loss, the exposure for each insured must be independent. If all the insureds were exposed to loss by the same fire; for example if they all operated businesses in connecting wood buildings on the same street the insurer would not have sufficient premium to pay for their losses should a fire break out. In order for the insurer to pay all claims, losses must occur to a certain expected percentage of the insureds at a certain expected frequency. If a large number of the insureds are all affected by the same loss exposure, the insurer will either have to charge premiums of an amount that would make the insurance unaffordable or no more affordable than if the business were self-insured, or the insurer will not have sufficient premium collected to pay for losses suffered.

Unintentional Losses

Intentional losses are never insurable. First of all, intentional losses do not fit the models of probability used to determine premium amounts. Premium amounts are based on the frequency and severity of unintentional losses. Secondly, intentional losses may be criminal or fraudulent. Contracts must have a legal purpose. Insurance may not pay for losses which arise from illegal activity.

Applicable Factors for Underwriting

Once it is established that insurable interest exists, the application would result in a valid contract and the risk the application represents is insurable, the underwriters evaluate the basic characteristics of the risk. Each line of insurance is underwritten using pieces of information unique to that type of coverage. Most of the information is found on the application for the insurance, and additional data is provided through supporting reports, documents and inspections.

Under life and health insurance, information related to the medical history of the insured is weighed, as are the occupation and hobbies of the insured. Under property insurance, the property may be inspected or documents may have to be submitted that verify the value and condition of the property described in the application. In liability insurance covering a business, site inspections and contracts used by the business, as well as other documents related to the business and its operations, may be required. Liability coverage for a home or auto insurance policy may also require an inspection of the property.

Many forms of insurance require financial information to be submitted for the underwriting process. When individuals are covered, personal financial records may be needed. When a business is covered, the business' financial statements are generally submitted. If a professional is covered, both personal and business financials may be requested.

Determining Rates

Once all the information pertaining to the application and supporting documentation is evaluated, the underwriters determine whether a policy should be issued, and if so, what premium should be charged. As was discussed in the last chapter, policies may generally be issued with standard rates, substandard rates or preferred rates.

Rate Determination Methods

In many cases, state insurance law directly impacts rate determination. Some states promulgate rates for certain lines of insurance, and the insurer must use these rates for the insurance they issue in such lines. States may allow insurers to file rates for various lines of insurance. A range or band of rates are filed with the insurance department and the insurance company may use these rates and issue insurance once the insurance department of the state has approved the rate band. Another method states may allow is to require the insurer to file rates and then use these rates unless the insurance department in the state notifies the insurer that the rates are not allowable. Rate systems used in the various states are discussed in more detail in the next chapter.

Insurers are required to give due consideration to past and prospective loss experience, to the type and scope of hazards, to a reasonable profit margin, to dividends and return of premium, to past and prospective expenses and to any special assessments when setting rates.

Judgment Rating

Within the parameters of state law, underwriters may use one of three methods to assign rates. One method is known as the *judgment method*. Judgment rating refers to the underwriter using his or her own knowledge and experience to determine the rate that should be assigned to the applicant. No specified rates are applied. This sort of rating is normally done for special lines of insurance or for lines of insurance that do not require rates to be approved by the state.

Manual Rating

A second method used to determine rates is more and more commonly used, especially in heavily regulated lines of insurance. This method is known as *manual rating*. Under manual rating, pre-determined rates found in manuals are used to set rates for each policy. Manual rates may be promulgated by the state insurance department, or may be developed within the insurance company or by a rating bureau.

Merit Rating

The third method of setting rates is known as *merit rating*. Under merit rating, manual rates are used and then modified based on specific characteristics of the risks. Modifications to rates may be based on the experience of the insured over a specified period prior to and sometimes including the policy period or on the experience of the specific insured during the policy period, or on a schedule that quantifies applicable risk characteristics.

Experience Merit Rating

When the experience of the insured over a specified period is used, the applicant is generally asked about relevant behavior or occurrences applicable to the insurance coverage. This type of merit rating is known as *experience rating*. For example, a driver may be asked about traffic

violations that occurred during the last three years. Rates are based in part on the number of such violations over this period.

Retrospective Merit Rating

Another type of merit rating involves the underwriter reviewing the loss experience during the policy period and setting a rate based on that loss experience. This type of merit rating is known as *retrospective rating*. This sort of rate setting is often done in commercial lines of insurance and in Workers Compensation insurance.

Scheduled Merit Rating

A third type of merit rating, *scheduled rating*, is a sophisticated form of manual rating. Manual rates are used as the base rate, and rates are added or subtracted from this base rate based on amounts determined for various risk characteristics. For example, the use of certain fireproof construction materials may result in a reduction of the standard rate under this type of rating system.

Regardless of the type of method used to assign rates, rates are determined by evaluating the relative *frequency* and *severity* of a risk. Severity refers to the amount of financial loss that is likely should a risk occur. Frequency refers to the number of times a loss is likely to occur. A loss likely to be infrequent and small is less expensive to the insurer than one that may be infrequent and large, or one that is both frequent and large.

Competitive Markets and Rate Setting

Another component of rate setting regulations of many states is the determination of whether a competitive market exists. Some states require the insurance commissioner to evaluate the amount of competition offering various lines of insurance. The methods the insurance commissioner may take in determining the presence of a competitive market may include conducting hearings and tests pertaining to market structure, market performance and market conduct.

In a competitive market, consumers are able to easily compare insurance products and obtain insurance from competing insurers. Non-competitive markets may exist for high-risk insureds, such as those living in the path of severe windstorms, or insureds who have, or are statistically likely to have, a high number of claims. If a competitive market does not exist, the commissioner may be required under state insurance law to take steps to provide consumers within the non-competitive market with the ability to purchase insurance. Actions a commissioner may take include requiring insurers doing business in the state to provide insurance products for people unable to purchase them in the normal marketplace. The commissioner may set rates for these products or mandate that rates be kept within a certain level. Another action that may be taken in states where it is determined noncompetitive market exists, is that the state will form an insurance pool to cover the needs within this noncompetitive market.

In insurance rate regulations, the definition of an excess rate may include the presence of or lack of a competitive market. For example, a regulation may state that insurance rates in a competitive market are automatically presumed not to be excessive. Also in some states, if a competitive market exists, insurers may not have to file rates to keep doing business in the state. Such insurers may still have to file rates for information purposes and for use by the commissioner in determining that a competitive market still exists, but insurers within a competitive market may be exempt from the rate renewal filing requirements of insurers within a noncompetitive market.

Terms at Policy Issue

Besides setting specified rates, the applicant may be required to meet underwriting requirements in order for insurance to be issued or remain in force. For example, a business may be required to install a sprinkler system, a homeowner may be required to add railing to a deck, and an individual with a valuable coin collection may be required to place it in a safety deposit box in order for the insurance to apply.

Underwriting Resources

Many resources are used during the underwriting process. The most important of these resources is the application. In this section, we will review the basic components of applications for various lines of insurance, along with the other resources used in underwriting, including reports, site inspections, insurance maps, insurance company files and industry statistical reports and data.

Insurance Applications

The insurance application is a critical underwriting resource. From it, the underwriter finds most of the basic information needed to determine whether to issue a policy, and if so, at what premium and terms.

Life Insurance Applications

Each life application generally requires the following type of information:

- Applicant and insured name, address and other general information
- Medical information
- Agent's statement
- Selection of riders or optional features
- Signatures

General Information

The general information section of life insurance applications generally asks for the name, address, birth date, social security number and gender of the insured and owner. The relationship of the owner to the insured is also needed. The name or names of beneficiaries is also requested, along with the percentage for each beneficiary or other beneficiary designation, and the relationship of each beneficiary to the owner. Some applications also require the beneficiary's social security number. This is to aid the insurer in identifying the proper beneficiary, if necessary.

Medical Information

Medical questions include asking whether tobacco or nicotine products have been used, and if the insured had been diagnosed, treated or hospitalized for:

- cancer;
- heart attack;
- stroke;
- diabetes;
- kidney disorders;
- Alzheimer's disease;
- liver disorder;
- organ transplant;
- alcohol or drug use treatments;
- AIDS or HIV;
- irregular heart beat;

- high blood pressure;
- fainting spells;
- emphysema or other chronic lung or respiratory disorder;
- inability to work for more than a week in the past six months or year; and
- other similar questions.

If there is a “yes” response to the medical questions asked, the application will generally ask for more details. Once the application reaches the home office, medical reports or an attending physician statement may also be requested. Or, the insurer may have issued underwriting guidelines to the agent, who requests such reports through his or her agency office. These reports will be discussed later in this chapter.

Replacement

Each application also asks whether this proposed insurance will replace or change any existing or pending insurance. If the applicant answers “yes” to this question, the agent may be required by state regulations to complete state replacement forms with the applicant. State replacement forms generally include comparative information for the applicant to read regarding the proposed insurance and the policy to be replaced. They may also include disclosure statements for the applicant to sign indicating that the applicant understands that there may be surrender charges involved in canceling the existing policy, that the new policy generally includes commission loads and that a new surrender charge period may apply to the new policy. An insurance company required “1035 Exchange” or “Absolute Assignment” form must also be completed in a replacement situation.

Duties of Agents Regarding Replacement

The National Association of Insurance Commissioners, or NAIC, drafts Model Regulations regarding many insurance practices. The various states adopt these model regulations and may also amend them as their legislators find appropriate.

Included in the NAIC’s Model Regulation for Life Insurance and Annuities Replacement, are “Duties of Producers.” Under this Model Regulation, an agent who initiates an application is to submit to the insurer a statement signed by both the applicant and the agent stating whether the applicant has existing policies or contracts. This statement may be part of the application form or a separate document. If the signed statement indicates that replacement is not involved, the agent has no further duties.

However, if the applicant answered “yes” to the question regarding replacement under the Model Regulation, the agent must give and read to the applicant a notice regarding replacement in a form recommended by the NAIC, or a similar one approved by the insurance commissioner of the state in which the agent is doing business. The NAIC recommended disclosure form includes the following items:

- A place for the agent and applicant to sign for the receipt of the form.
- Definition of a replacement in consumer-friendly terms.
- A statement to the effect that the new policy may include acquisition costs and that surrender charges may apply to the existing policy.
- A place for the applicant to indicate the policy number and insurance company of the policy or policies which are to be replaced.
- A statement recommending that the applicant contact their existing insurance company or his or her agent for information about the old policy.
- A space where the applicant can indicate why the old contract is being replaced.
- Suggested questions for the applicant to discuss with both the new and old agent regarding: premium amounts and the length of time premiums must be paid; the

surrender charges, expense and sales charges applicable to both policies; whether suicide limitations apply to the new policy; whether a medical exam must be undergone for the new policy and the current insurability of the applicant; how the interest rate guarantees and current crediting rate compare; and the tax ramifications of the transaction.

Under the Model Regulations, besides the notice, the agent is required to leave a copy of all sales material at the time an application for a new policy is completed, or if electronic material is used, no later than the time of policy issue.

Violations and Penalties

Also included in this Model Regulation are the ramifications of violating the Regulation. Examples of violations to the Regulation include:

- deceptive or misleading information in the sales material;
- a failure to ask the applicant the questions regarding replacement;
- intentionally recording an incorrect answer;
- advising an applicant to give a negative answer regarding questions about replacement in order to keep from having to notify an existing insurance company; or
- advising an applicant to contact the existing insurer directly so that the replacing agent or company is obscured.

If an agent has a regular pattern of having customers who say they are not replacing insurance contracts on an application, and then afterward replace the insurance contracts, the Model Regulation states that such action is considered “prima facie” (a legal term meaning an obvious or plain fact) evidence of the agent’s intent to violate the regulation.

Under the Model Regulation, violators of the Regulation are subject to penalties that may include the revocation or suspension of an agent’s or company’s license, monetary fines and the forfeiture of any commissions or compensation paid to a producer related to the transaction in which the violations occurred. In addition, the insurance company may be required to make restitution, restore policy or contract values and pay interest at a specified rate on the amount.

Agent Statement

The agent has a responsibility to the insurer to report to the insurer on the application to provide information the insurer requests, such as how long the agent has known the applicant, whether the agent has knowledge that the proposed insurance is being purchased to replace existing insurance and to supply basic information the agent has knowledge of regarding the applicant’s health, financial situation and general character.

Selection of Features and Options

Depending on the type of policy applied for, the applicant will make several choices regarding the insurance coverage. All policies, other than single premium policies, generally provide a choice of payment frequency, including monthly, quarterly, semi-annual or annual payments. Many insurers offer the option of pre-authorized checks so the premium amount may be withdrawn directly from the applicant’s bank account.

If the policy is to include any riders, the applicant must indicate his or her selection. If the policy has an option of death benefits, the applicant must also select the death benefit option desired. If the policy includes variable sub-accounts, the applicant must select the initial sub-accounts into which cash values will be placed and the percentage to be placed into each one. Variable policies may also offer the ability to make telephone transfers among sub-accounts and other similar features the applicant must authorize.

Occupation/Hobbies

If the applicant is involved in certain occupations or hobbies, or is surrounded by certain sets of circumstances, a completion of a questionnaire designed for that occupation, hobby or circumstance may be required by the insurance company. Examples of items that may require the completion of a questionnaire include involvement in aviation, skydiving, military service, having foreign residency, and being in certain finance-related occupations.

Disclosures

Applications or accompanying documents also include disclosures regarding the Medical Information Bureau and the Fair Credit Reporting Act. The applicant must sign indicating receipt of these notices. The applicant must also give the insurer written permission to obtain consumer and investigative consumer reports.

Another important responsibility of insurance agents is to supply buyer's guides in accordance with state regulations. The agent must also be prepared to answer the consumer questions included in buyer's guides.

Dividend Options

If a life insurance policy is a *participating policy*, the application will include a section regarding the owner's dividend options. A participating life insurance policy participates in the earned surplus of the insurance company. Dividends may be paid to policy owners from such policies. Dividends may result from the insurer paying out claims in amounts that are lower than expected. This condition is known as *positive experience*. Dividends may also be paid because investment earnings are higher than expected or expenses are lower than expected. However, dividends do not have to be paid under such circumstances. They are paid at the discretion of the insurer

Options for dividend payments generally include:

- payment in cash
- reduction of premium due
- leaving on deposit
- purchase of paid-up additions
- purchase of term insurance

Receipt

Once the applicant has completed and signed the application, in some cases, the applicant gives the first premium check, made out to the insurance company, to the agent. The agent then gives a receipt to the applicant. In other cases, the first premium is not collected until policy delivery.

Submission to Underwriting

The agent is then responsible to submit the application and any premium received to the insurance company.

Health Insurance Applications

Health insurance is often issued under a group policy through an employer. An application for coverage under a group policy is often simpler than an application for individual coverage, but both types of applications ask similar information. A group application from an employer will normally include the following elements:

- Employer name
- Employer plan group number
- Employee name

- Employee address and phone number
- Date of hire
- Employee position or title
- Sex of the employee
- Birth date of the employee
- Marital Status
- Whether the employee uses tobacco
- Whether the application for coverage is based on COBRA (this is a federal law requiring the ability of terminated employees to continue health coverage under certain circumstances)
- Deductible amount, if any
- Coverage options, such as whether dental coverage or prescription drug coverage is to be included
- Dependent coverage information for spouse and children
- Prior coverage information (this information is necessary to comply with federal health coverage rules for group policies)
- Medical information:
 - Height and weight of adults covered
 - Whether any insured has had medical treatment for his or her back, colon, liver, kidney, diabetes, intestinal tract, muscular system, respiratory system, heart or circulatory system, or for any cancer, convulsions, a stroke or mental or emotional issues
 - Whether treatment had been received for alcohol or drug use
 - Whether the applicant had been diagnosed or treated for HIV, AIDs or ARC
 - Whether the applicant or any insured is pregnant
 - Whether there has been treatment or diagnosis related to any insured's ear, eye, joint, ulcer, rectal, hernia, allergy, asthma, arthritis, breast, thyroid, prostate, headache, gallbladder, urinary tract, digestive system, reproductive organs, or high blood pressure
 - Whether any insured has any other medical condition not included elsewhere in the application
 - Request for additional explanation on any medical condition indicated on the application

The information on the health insurance application is necessary for the underwriters to properly underwrite the coverage. In the case of group insurance, the items related to the employer and the employer plan group number is used for the basic purpose of placing the employee within the proper group plan. Date of hire and position in the firm is used to make sure the employee is identified correctly, and because under some benefits programs, the amount the employer pays for health benefits varies based on the length of time an employee is on the job and the position of the employee.

Applications include a question regarding whether the coverage is based on COBRA because COBRA coverage is governed by federal laws. The insurer must make sure that all these laws are complied with if the health coverage does fall under COBRA. Prior coverage information is also important because both federal and state law requires that certain waiting periods and exclusions may be reduced through the application of prior coverage periods. Optional coverages such as dental and prescription drug impact rates and terms of the coverage applicable to the insured.

The age, sex, marital status and use of tobacco all relate to characteristics of the risk that are used to determine rates for the health coverage. The more detailed health questions also are used to determine the type of health risk the applicant represents. Depending upon the

answers given, the underwriter may need additional information, such as attending physician statements and other medical reports.

Disability Income Applications

Disability income insurance is a form of health insurance, but includes important factors not relevant in other forms of health insurance such as medical expense coverage. Disability income insurance provides payment if the insured becomes disabled as defined under the policy. Underwriting in disability income insurance does not just look at the current health and health history of an insured, but also attempts to determine less easily documented risk characteristics related to the motivation of an insured to return to work should a disability occur.

Disability income insurance applications generally include the following items:

- Age of the insured
- Sex of the insured
- Occupation of the insured, including details regarding the insured's position Medical history
- An explanation of medical conditions, including their frequency, severity and likelihood of recurrence
- Height and weight of the insured
- Blood pressure and other health indicators
- Financial information such as the applicant's income, unearned income and net worth
- Mental health history
- Treatment for drug or alcohol use
- Prior coverage history
- Claims history

Disability income insurance applications include information regarding the medical history and current health conditions of an applicant that is similar to that found on other health insurance applications. However, disability underwriters are more concerned about whether or not a medical condition will lead to disability than are underwriters of other forms of health insurance.

Disability income insurance applications also include information regarding the financial status of an applicant that is not found in other forms of health insurance. This is because disability underwriters attempt to issue policies with benefit levels that do not encourage an insured to submit claims in order to better their financial position. Even the most generous disability income benefits are generally designed to meet basic income needs of the insured, not to give an insured a higher income than he or she would have had if the insured had been able to keep working.

Disability income policies also include information regarding the position of the insured within a business. Individual disability income policies are often marketed to owners of businesses, professionals or key executives. One reason that disability insurers look for such individuals to purchase their policies is that such individuals are generally highly motivated to return to work, meaning that disability income payments may not continue as long as they would for someone with less motivation to return to work.

Long-Term Care Insurance

The common underwriting factors included on a long-term care insurance application are the following:

- Age
- Sex
- Medical History, including

- Heart attack
- Diabetes
- Cancer
- High Blood Pressure
- Arthritis
- Renal disease (kidney failure)
- Respiratory distress that requires oxygen use
- Schizophrenia
- Dementia
- Spinal cord disorders
- Multiple strokes
- Systemic lupus
- Most recipients of transplants
- Tuberculosis
- Multiple episodes of fainting
- Severe growths or tumors
- Current medical condition
- Whether the insured has undergone drug or alcohol abuse treatment
- Family medical history
- Occupation

Long-term care insurance underwriting, as a form of health insurance, involves reviewing medical and health factors. Statistics related directly to long-term care are used to evaluate each risk and establish rates. For example, the sex of the applicant is important because women, due to having a longer life expectancy than men, are more likely to need some type of long-term care services.

Each type of medical condition an applicant may have is thoroughly scrutinized in long-term care insurance underwriting. The frequency and severity of the individual's condition is evaluated to determine insurability and applicable rates. For example, if an applicant has diabetes, yet does not have to take insulin or is on low doses of insulin, the underwriter may still deem the applicant as insurable. However, more advanced cases of diabetes may render an applicant uninsurable.

Certain types of medical conditions or behaviors may cause a long-term care application to be rejected. Drug abuse, alcoholism, kidney failure, schizophrenia, dementia, spinal cord disorders, multiple strokes, systemic lupus, tuberculosis and severe growths or tumors may cause an applicant to be deemed uninsurable.

Homeowners Application

Homeowners applications generally include the following information:

- Applicant's name
- Applicant's address
- Type of coverage requested (actual cash value, replacement cost, or other)
- Location of home
- Details regarding the home, including
 - Year built
 - Square footage of dwelling
 - Square footage of adjacent structures
 - Number of families
 - Number of stories
 - Type of roof
 - Value of personal property

- Whether the home includes a wood stove
 - Construction type (masonry, wood, other)
- Location of fire station, hydrant and fire district
- Mortgagee/Loss Payee information
- Additional coverage information (e.g. earthquake coverage)
- Discounts for which the homeowner qualifies
- Prior/Current Insurance Carrier and policy information
- Whether the homeowner has filed or is filing for bankruptcy
- Whether the homeowner is delinquent on house payments or taxes
- Whether anyone with a financial interest in the property has been convicted of fraud, arson or any other crime on property over the past five (or other specified time) years
- Whether there is a pool, and if so, if it is fenced
- Whether there is a pond, lake or dock on the premises
- Whether there is a hot tub on the premises
- Whether there is a trampoline on the premises
- Whether there are animals on the premises, and if so, what breed and if there has been a history of biting
- Whether there is a business on the premises, and if so, what type
- Description of other structures on the premises
- Whether the electric service is on circuit breakers
- Whether the home is the primary residence of the insured
- Whether there is existing structural damage
- Whether there are smoke detectors on the premises
- Whether there is brush or landslide exposure
- Type of wiring and plumbing and roofing
- Whether the property has been inspected by the agent
- Space for additional documentation, including photos of the property

The information on homeowners applications is used to determine insurability and rates under both the property coverage and liability coverage provided under homeowners policies. Items such as the location of the home, the construction materials used, and the age of the home most directly affect the property coverage. Insurance maps used by the underwriters help to determine the risk of fire and theft the homeowner may experience due to its location and are used for property insurance underwriting. The physical condition of the home, whether a pool, hot tub or trampoline are on the premises are more important factors for the liability insurance underwriting aspects of the policy.

Personal Automobile Application

Applications for personal automobile insurance generally include the following:

- Name and address of the named insured
- The year, make and model of autos to be covered
- Current automobile policy information
- Whether the autos are used for business or pleasure
- Whether the autos are used to drive to and from work and if so, how many miles to work
- The annual mileage of the autos to be covered
- Information on the drivers of the autos, including:
 - Driver's name
 - Driver's marital status
 - Length of time as drivers
 - Whether the drivers had any at fault claims, traffic violations or a loss of license in the last three years

- Amount of liability, collision and comprehensive coverage desired

Factors used in automobile insurance underwriting include the age of the driver, the sex and marital status of the driver and the driver's record. Statistically, single persons tend to have more accidents than married persons and younger people, particularly younger males, tend to have more accidents than do older adults. The amount of miles the auto is driven also has been statistically determined to impact the likelihood of an accident involving the automobile.

The type of automobile or automobiles covered impacts the amount of damage the automobile is likely to cause to another auto, and the safety of the driver and passenger. Likelihood of theft is also based on the make and model of the automobile insured and where it is garaged.

Commercial Automobile Application

Commercial automobile applications are completed by a named insured on behalf of the business owning the covered automobiles. These applications generally include the following factors:

- Name and address of named insured
- Garaging address of vehicles
- Type of business (individual, partnership, corporation, or other)
- Length of time business has been in operation
- Description of business operations
- Business' gross receipts for the current and past year
- Type of commodity transported
- Whether there is any exposure to flammables, explosives, chemicals or hazardous materials
- Area of business operations
- States in which vehicles are operated
- Large cities in which vehicles are operated
- Whether or not the business hauls cargo for others, and if so, details of such
- Whether vehicles are parked at a jobsite most of the day
- Whether vehicles are loaned, rented or leased to others, if so, under what terms
- Whether vehicles are loaned, rented or leased from others, if so, under what terms
- Whether vehicle owner/operators are used, and if so, under what terms
- Whether sub-contractors are used, and if so, under what terms
- Whether any employees use their own vehicles for the business
- Whether any family members use company-owned vehicles
- Whether passengers are allowed to ride in vehicles
- Whether all drivers are covered by Workers Compensation coverage
- Driver information, including:
 - Whether drivers are employees
 - Whether drivers are paid by the hour, by the load, or some other way
 - Whether there is a formal driver safety program
 - The maintenance program in place
 - Whether drivers are screened upon hire
 - Specific driver information, including name, driver's license number and other specifics
- Vehicle information, including:
 - Type and number of vehicles owned
 - Type and number of vehicles leased
 - Specific vehicle information, including model, type of vehicle, seating capacity, driving radius and garaging location
- Information regarding federal and state vehicle permits

- Prior loss information
- Policy limit and coverage information

Many of the items included in a commercial automobile policy are the same as those found in personal auto policies. The make and model of vehicle, where it is garaged and the drivers' records are all important underwriting factors. In addition, the territory in which the auto is used, and the cities in which it is driven are taken into consideration because more accidents occur in some places than in others.

Some of the questions on the application are used to determine if endorsements should be utilized in the coverage. For example the liability coverage of commercial auto policies exclude autos owned by employees. If employee-owned autos are used in the business, the business owner may want to add liability coverage for such autos through an endorsement.

State and federal permit information is requested to make sure the business is in compliance with state and federal laws regulating the use of the vehicles, and to provide underwriters with information regarding the use of the vehicles.

Commercial Property Application

Applications for commercial property coverage generally include:

- The name of the named insured
- The address of the named insured and the business owning the property to be covered
- Location of all property to be covered
- Description of property to be covered
- Value of property covered
- Security devices and other loss control measures related to the property
- Current amount of insurance in force on the property
- Whether the insurance currently applied for is to be in addition to the current insurance, or will replace the current insurance
- Loss history in the prior three years
- Date of site inspection and place to attach site inspection report

The information on the commercial property application is used to determine the exposure to property risks of the property. Property coverage generally protects against the perils of fire, lightning, explosion, theft, windstorm, hurricane, hail, riot, civil commotion, smoke, aircraft, and land vehicles, as well as other perils as defined by the policy. The location of the property is evaluated to determine its statistical risk of fire, windstorm, and other weather related perils. Location is also important in determining the risk of theft and vandalism. The type and value of personal property is also evaluated for the level of applicable risk exposures.

Site inspections are an important part of commercial property coverage and reports of site inspections may be submitted as part of the application. Site inspections are used to verify the type, condition and value of the property. Also from site inspections may come various underwriting requirements, such as requiring the installation of safety or security equipment.

Commercial General Liability Application

General liability and businessowners liability forms cover certain types of liability, but exclude liability that arises out of professional acts (errors) or failure to act (omissions) while conducting professional services. The types of liability protection offered by a general liability or businessowners liability form include bodily injury and property damage liability and personal and advertising injury liability. These liability forms also cover medical expenses arising out of

bodily injury on the insured's premises, or on the ways next to the insured's premises, or arising from the insured's operations.

A general liability application generally includes the following:

- Description of the business premises and operations to be insured
- Type of business to be insured (individual, partnership, corporation, joint venture, limited liability company, non-profit or other)
- The name and phone number of person to contact for an inspection and audit of accounting records
- Description of management experience
- Number of employees
- Whether there is:
 - Exposure to flammables, explosives, chemicals?
 - Exposure to asbestos?
 - Exposure to radioactive materials?
- Whether operations involve storing, treating, discharging, applying, disposing or transporting of hazardous material (e.g., landfills, wastes, fuel tanks, etc.)?
- Whether sporting or social events are sponsored?
- Whether the business owns, hires or leases watercraft, docks, or floats
- Whether any operations have been sold, acquired, or discontinued in last five years
- Whether the applicant a subsidiary of another entity or does applicant have any subsidiaries
- Whether any machinery and equipment is loaned and rented to others
- Whether there is a swimming pool on the premises
- Whether parking facilities and owned or rented
- Whether a fee is charged for parking
- Whether the applicant has in force Workers Compensation coverage
- Whether subcontractors are used and if so, if certificates of insurance are required from all subcontractors
- Whether the applicant leases employees
- Whether the applicant plans any structural alterations to the property
- Whether recreational facilities are provided for employees
- Coverage and loss history
- Schedule of hazards and whether they are products/completed operations or premises/operations hazards

The application for commercial liability insurance is used to help determine the type and nature of liability risks to which the business is exposed. The rates to be applied to the application will vary based on the type of liability risks that exist. For example, a business that deals with hazardous materials will be charged higher rates than a business dealing with cardboard boxes or other non-hazardous materials.

The insurer may also need to amend or endorse their basic policy coverage based on the specific liability attributes of the business. They may need to add a pollution liability endorsement or a builders risk endorsement, for example.

Professional Liability and Errors and Omissions Application

Applications for professional liability and errors and omissions insurance can require very detailed, complete information. They may require specific descriptions of functions performed and the amount of time dedicated to each function. Past employment may have to be documented carefully. The reason for the thoroughness of the applications, especially for certain occupations, is the high amount of risk the insurer may be underwriting. The insurer

wants to fully understand the scope of the risk being insured in order to charge appropriate premium, or in some cases, in order to refuse certain cases.

Name and Address

Each application includes the name and address of the applicant for the policy.

Type of Business Entity

The application also asks for the type of business entity - sole proprietorship, partnership, corporation and so on.

Limit of Liability

The amount of coverage requested is listed. The applicant may be able to choose from a wide range of coverage amounts, from \$100,000 or \$500,000 in coverage to \$1,000,000 or \$5,000,000 or more.

Deductible

Deductibles may range from zero for lower limit policies to as much as \$100,000 or more. Generally, the higher the deductible, the lower the premium charges will be. It is not uncommon for professionals who must carry high levels of expensive insurance, such as surgeons, to have a deductible of \$100,000.

Professional Services Description

Each application will ask for some form of description related to the professional services involved. The application may include several possible functions involved in the occupation and ask the applicant to indicate which functions apply and what percentage of time is spent in or percentage of income results from each function. For some occupations this portion of the application can be quite lengthy. An application for a lawyer may include fifty or more different types of law practices to which the applicant must assign a percentage.

Other Business Activity

If the applicant is involved in functions or activities not listed, these activities must also be disclosed and a percentage of time or income assigned.

Controlling Interest

The application may ask if the insured or other party has a controlling interest in the business.

Gross Revenue/ Projected Revenue

The application may ask for the amount of gross revenue which the professional or practice has earned. This helps the insurer and the agent to determine the appropriate amount of coverage. The insurer does not want the applicant to be covered by either too little or too much insurance.

Special Risks

If there are special areas of risk involved in an occupation, the application will include questions related to them. For example, computer professionals liability coverage may include questions regarding Y2K compliance and the work the computer specialist is doing with clients related to this issue. An application for a lawyer may ask about work related to securities transactions and whether the lawyer has any outside director or officer responsibilities. A physician's malpractice form may ask about certain types of surgeries or medical procedures.

Questions related to special risks and about important procedures in the firm or practice may also be included in the application. For example, record keeping is essential in many professions. The application may ask for details of the record keeping process within the

business. If fees are collected and money disbursed, the internal controls surrounding collection and disbursement may be inquired about. If a computer software risk is being underwritten, backup and other data safeguarding procedures may have to be explained on the application. The applicant should be as complete and accurate as possible when answering these items.

Years in Business

The insurer is interested in the stability of a business. The application asks for the number of years the business has existed. If the business is a new business, it may qualify for premium discounts. If it has been in existence for some time, the insurer is interested in knowing whether there has been continuous liability coverage in force.

Professional Qualifications

Another way in which the insurer assesses the risk of underwriting the professional or firm is by asking about the qualifications of the professionals being insured. Education, continuing education and any special credentials may be asked about.

Professional Associations

The insurer may be interested in knowing whether the insured belongs to any professional associations. Professional associations generally provide education and may require special standards of conduct in order to belong.

Use of Written Contract

If the applicant uses contracts to transact business, the insurer may ask questions related to limiting liability through contract language. As has been mentioned, some insurers reduce premium if liability is limited contractually.

Employees

The application will ask for information regarding the type and number of employees to be covered. This information may be used to determine the risk and related premium for employers liability and employment practices liability.

Contractors or Subcontractors

Certain forms may ask for information regarding the use of contractors and subcontractors. Forms for engineering firms, for example, may include questions related to subcontractors. The insurer may want to know whether contractors and subcontractors are required to carry their own liability policies.

Other Insurance

Other insurance currently in force which covers the liability of the professional is of interest to the insurer. Remember that the insurer wants to reduce the risk of moral hazard. The applicant should not have more insurance than is necessary for the risk to be appropriately covered.

Prior Insurance

Types and amounts of prior insurance are important information for the insurer. The insurer is interested in knowing if the insurance was occurrence based or claims based and if any extended reporting periods are in force.

Prior Claims

The insurer also wants details on prior claims. The insurer needs to be aware of any known exposures. If there is still exposure related to a prior occurrence, the insurer may attach an endorsement to the policy, specifically excluding claims related to that occurrence. The insurer

will also ask whether the insured has knowledge of any act, omission or error that could result in a professional liability claim.

Legal or Disciplinary Action Against Applicant

If any applicant has had any legal or disciplinary action made against him or her the details of the action must generally be disclosed to the insurer. If there are documents, such as copies of court orders or of a complaint, these are normally sent to the insurer along with the application.

Notice to the Applicant

Finally, the application will generally include a notice to the applicant. The notice requires the applicant to read the information and sign the application only if the applicant agrees to the representations made. The representations generally include that:

- the applicant declares that the answers in the application are true and that no material fact has been omitted;
- the applicant has disclosed any matters which could result in a claim; and
- the form is an application and not a guarantee of insurance.

The notice also generally includes the important statement that any person who knowingly and with intent to defraud any insurance company files an application with false information or conceals information regarding a material fact commits a fraudulent insurance act.

Special Coverages

If any additional coverages or endorsements are to be included, questions related to these coverages must also be completed on the application.

Inland Marine Personal Property Applications

Inland Marine Personal Property insurance, or personal property floater insurance, is often used to cover personal property in amounts greater than such property is covered through a homeowners policy. Such applications include the following information:

- Applicant name
- Applicant address
- Location of property (dwelling, apartment, condominium, mobile home, other)
- Occupation of members of the household
- Marital status of applicant
- Whether the location includes burglar alarms
- Whether the location includes any safes
- Security surrounding location if an apartment or condominium
- Whether property is located within one mile of a coast
- Whether the property is exhibited
- Whether the property is used in a business or commercially
- Where property is stored
- Loss history
- Coverage history
- Schedule of property to be insured, including:
 - Jewelry
 - Jewelry in Vault
 - Furs
 - Fine Arts
 - Cameras
 - Musical Instruments
 - Silverware
 - Stamps
 - Coins

- Golfer's Equipment
- Direction to attach appraisals and bills that verify the value of the property to be insured
- Description of any property in mini-storage and description of storage facilities

Personal property floater applications generally deal with valuable property. Often such applications must be accompanied by appraisal documents, bills and receipts that verify the property's value. Because the property is valuable, information regarding the safekeeping of the property is very important as well.

Ocean Marine Application

Ocean marine insurance is used to cover goods transported over the ocean and protects against *perils of the sea*. It is one of the oldest forms of insurance coverage. The application for such insurance may include the following:

- Name of the insured (often called assured in this form of insurance, and often a business)
- Address of the insured
- Type of business
- Type of cargo shipped and the percentage of each type as part of annual shipments. Type of cargo the insurer may ask may include:
 - General Merchandise
 - Branded Goods
 - Precision Instruments
 - Machinery
 - Bottled products, excluding beverages
 - Non-Perishable Food Items / Pharmaceutical Products
 - Bottled Beverages
 - Automobiles and other Motor Vehicles
 - Household Goods and Personal Property
 - Frozen Food (other than Frozen Meat)
 - Frozen Meats
 - Chemicals
 - Fine Arts, Antiques and Similar Items
 - Steel Sheets, Coils, Bars, Billets and Similar Items
 - Yachts
 - Computers, Mobile Phones and Similar Items
- Prior premium and loss history
- Primary shipment departure and arrival points
- Maximum value of any shipment
- Percentage of shipments representing full container loads, partial container loads and by breakbulk
- Percentage of shipments shipped by sea, air and by land
- Further explanation of any item on the application

Ocean marine coverage may be issued on a per shipment basis, or may be issued to cover all shipments from the insured. The latter method is used when an insured's shipments do not vary dramatically. If insurance is provided on a case-by-case basis, the details of the shipment must be scheduled, or listed, in the policy.

Workers Compensation Application

Workers Compensation applications are completed by the business that will provide the coverage for employees and generally include the following information:

- Name of the insured

- Address of the insured
- Type of business
- Years in business
- Total number of employees
- Number of full-time employees
- Number of part-time employees
- Number of employees under 18
- Number of employees over 65
- Number of employees who work from home
- Number of employees who drive employer-owned vehicles
- Whether the employer provide group transportation by employer-owned vehicles
- Whether the employer uses sub-contractors, and if so, the number of them
- Payroll information by class and payroll (typically based on regulating state statute)
- Excluded corporate executives (if state law allows the option for such people to be excluded from Workers Compensation coverage)
- Information related to workplace safety programs, such as:
 - Whether the business has a safety program
 - Whether safety meetings are held and if so, how often
 - Whether new employees participate in safety training
 - Whether injured employees are offered modified work
- Information related to the Workers Compensation claims process in place at the business

Workers Compensation rates are based on job classifications and set by the state in which the Workers Compensation policy applies. Each job is assigned a classification code, and each code has a rate, with higher risk jobs being assigned a higher rate. The premium is based on each \$100 of payroll multiplied by the applicable rate. Underwriters then often use a retrospective rating process to adjust rates each policy year. Also affecting rates is the utilization of rehabilitation. If an employer has a rehabilitation program which retrains employees or provides physical exercise and therapy, rates may be reduced by the insurer.

Medical Reports

Besides the application, the underwriters have other resources they may utilize during the underwriting process. For life and health insurance, the medical history of the insured must be examined. The application for the policy includes questions pertaining to basic medical information, including age, height, weight and health history of the applicant and the applicant's family.

Besides the application, if the coverage amount requested is above an insurance company's *non-medical* limit, additional medical information may be requested through a medical report. Generally, a *medical report* may be completed by a paramedic or a registered nurse. If there is information in the application or medical report that requires further explanation, an attending physician's statement, or APS, may be required. An APS must be completed by a physician who treated the medical condition under question.

Attending Physician Statement

An APS is a questionnaire sent to the applicant's doctor. The doctor must complete the questionnaire in order for the underwriters to complete the underwriting process. The proposed insured must give his or her permission on the application for the attending physician to provide this information.

An attending physician statement is a relatively simple document. It generally includes:

- Patient's (insured's) name
- Patient's address
- If related to an insured's employment, a statement for the physician to designate whether the patient is able to return to work, and if unable, when it is anticipated the patient will be able to return to work
- An area for the physician to indicate the physician's diagnosis and prognosis.
- An area for additional remarks for the physician
- The physician's name, license number, address, phone number and signature

The Medical Information Bureau

Besides medical reports and APS reports, insurers have access to medical information through the Medical Information Bureau, Inc. or MIB. The MIB is an association of most life and health insurers in the United States. The MIB contains information about the medical condition of applicants and insureds.

Applicants must currently authorize the release of information to the MIB. The information may only be used for underwriting and claims purposes, and medical information is released only to the applicant's physician, or directly to the applicant if the applicant requests.

The Medical Information Bureau is considered to be an important tool of the insurance industry because of its role in reducing fraud. By keeping track of important pieces of information used in the application and underwriting of life, health, disability and long-term care insurance, it is more difficult for applicants to falsify applications and claims. Reducing false applications and claims means that premiums do not have to be raised for everyone who purchases such insurance due to fraud that has been discovered through the use of the MIB. More information about the Medical Information Bureau can be found on its website at www.mib.com.

Inspection, Consumer and Credit Reports

If an applicant applies for amounts of insurance above certain levels, the insurer may conduct inspection reports and/or acquire credit reports on the applicant. An inspection report is created from interviews with an applicant's neighbors, associates and employees, and sometimes with the applicant as well. The inspection report and interviews are conducted by national investigative organizations hired by the insurer. Insurance companies request inspection reports in order to get a better understanding of an applicant's overall character, lifestyle, financial situation and risks to which an applicant may be exposed.

Consumer Reports

Credit reports provide information about the financial condition of an applicant. This is important to an insurer because insurance involves a financial commitment from the policy holder. If an insurer accepts policies from people with poor credit, or credit below a certain standard, policy lapses are likely to go up. Lapses cause an increase in expenses to the insurer who has incurred policy issue expenses associated with the policy.

Credit and consumer reports are regulated by the Fair Credit Reporting Act. This Act was originally enacted in 1970 and has been amended by other legislation since that time. It is important that agents understand the regulations applying to insurers from the Act so that agents are careful to follow the disclosure requirements that the insurer has put in place in accordance with these laws and so that agents can answer questions from customers asking to what use insurers are able to put these reports.

The Act regulates consumer reports and investigative consumer reports. Under the act a consumer report is defined as follows:

Consumer report.

(1) In general. The term “consumer report” means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer’s credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer’s eligibility for

(A) credit or insurance to be used primarily for personal, family, or household purposes;

(B) employment purposes; or

(C) any other purpose authorized under section 604 [§ 1681b].

(2) Exclusions. The term “consumer report” does not include

(A) any

(i) report containing information solely as to transactions or experiences between the consumer and the person making the report;

(ii) communication of that information among persons related by common ownership or affiliated by corporate control; or

(iii) communication of other information among persons related by common ownership or affiliated by corporate control, if it is clearly and conspicuously disclosed to the consumer that the information may be communicated among such persons and the consumer is given the opportunity, before the time that the information is initially communicated, to direct that such information not be communicated among such persons;

(B) any authorization or approval of a specific extension of credit directly or indirectly by the issuer of a credit card or similar device;

(C) any report in which a person who has been requested by a third party to make a specific extension of credit directly or indirectly to a consumer conveys his or her decision with respect to such request, if the third party advises the consumer of the name and address of the person to whom the request was made, and such person makes the disclosures to the consumer required under section 615 [§ 1681m]; or

(D) a communication described in subsection (o).

The Act also defines “investigative consumer reports,” which the insurance industry generally refers to as “inspection reports:”

The term “investigative consumer report” means a consumer report or portion thereof in which information on a consumer’s character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, or associates of the consumer reported on or with others with whom he is acquainted or who may have knowledge concerning any such items of information. However, such information shall not include specific factual information on a consumer’s credit record obtained directly from a creditor of the consumer or from a consumer reporting agency when such information was obtained directly from a creditor of the consumer or from the consumer.

Permissible Purposes of Consumer Reports

Under the Fair Credit Reporting Act, consumer reports may only be furnished for certain purposes by consumer reporting agencies. One of these permissible purposes is furnishing a report to a person the consumer reporting agency has reason to believe intends to use in connection with the underwriting of insurance.

Furnishing Consumer Reports

Under the Fair Credit Reporting Act, a consumer reporting agency may only issue a consumer report that is not initiated by a consumer request if the consumer authorizes the agency to provide the report or the transaction for which the consumer report is used is considered a “firm offer of insurance.” If a consumer report is issued because the transaction is a “firm offer of insurance” and is not authorized by the consumer, the report may only furnish the name and address of the consumer, an identifier used solely to verify the identify of the consumer and other information pertaining to the consumer that does not provide the relationship of experience of the consumer with a particular creditor or other entity.

Items That May Not Be Included In Consumer Reports

Consumer reports initiated by the consumer or authorized by the consumer may not generally include:

- bankruptcy that occurred more than ten years before the report;
- civil suits, civil judgments and records of arrest that were recorded by the greater of seven years before the report of the governing statute of limitations has expired;
- paid tax liens that were paid more than seven years before the report;
- accounts placed for collection or charged to profit or loss more than seven years before the report; and
- any adverse information, other than records of convictions of crimes, that occurred more than seven years before the report.

Disclosing Investigative Consumer Reports

In order to have an investigative report prepared, it must be clearly and accurately disclosed to the consumer that an investigative consumer report, that includes information about the consumer’s character, general reputation, personal characteristics, and mode of living, may be made. The disclosure to the consumer must:

- be in writing;
- be mailed or delivered to the consumer not more than three days after the date the report was requested; and
- include a statement that the consumer has the right to request information about the nature and scope of the investigation.

If the consumer requests information about the nature and scope of the investigation, the person who caused the report to be prepared must comply with the consumer’s request in writing not later than five days after the request was received.

Disclosures to Consumers

The Fair Credit Reporting Act and related legislation also requires that reporting agencies, upon request from the consumer, disclose:

- all information in the consumer’s file at the time of the request, other than credit scores or similar risk predictors;
- sources of information, other than information used solely for an investigative consumer report which must be available if needed for the discovery process in an applicable court case;
- the identity of each person who procured a consumer report generally in the last one year period only; and
- dates, original payees and amounts of any checks upon which is based any adverse characterization of the consumer.

A consumer reporting agency must also include a “Summary of Rights” with the disclosure to the consumer. A Summary of Rights includes:

- a brief description of the Fair Credit Reporting Act and all consumer rights within it;
- an explanation of how a consumer may exercise rights under the Fair Credit Reporting Act;
- a list of Federal agencies responsible for the enforcement of the provisions in the Act, including addresses and phone numbers;
- a statement that the consumer may have additional rights under State law; and
- a statement that a consumer reporting agency is not required to remove accurate derogatory information from a consumer's file that is in compliance with the Act.

Disputed Information

If a consumer disputes the information from a consumer reporting agency, the consumer reporting agency must reinvestigate the information free of charge. The consumer reporting agency must then record the current status of the disputed information or delete inaccurate information, generally within thirty days from the date the consumer reporting agency receives the notice of dispute from the consumer. In some cases, the consumer reporting agency can deny reinvestigation because it determines the request is frivolous or irrelevant.

If information in a consumer's file is found to be inaccurate or unverifiable, the consumer reporting agency must promptly delete the item or modify it as applicable.

Special Restrictions On Investigative Consumer Reports

If a consumer reporting agency prepares a subsequent investigative consumer report on the same consumer, it cannot include any adverse information in the report, other than matters of public record, unless the adverse information has been verified during the process of making the subsequent report, or the adverse information was received within three months prior to the date the subsequent report is furnished.

Requirements For Uses Of Consumer Reports

The insurance company is a user of consumer reports and is subject to certain rules found in the Fair Credit Reporting Agency and related legislation. Under these rules, if adverse actions are taken on the basis of information found in consumer reports, the insurer must:

- provide to the consumer oral, written, or electronic notice of the adverse action;
- provide to the consumer orally, in writing or electronically the name, address and phone number of the consumer reporting agency that furnished the report along with a statement that the consumer reporting agency is unable to provide the consumer with the specific reasons the adverse action was taken; and
- provide to the consumer oral, written or electronic notice of the consumer's rights to obtain a free copy of the report and to dispute the accuracy or completeness of information.

Duties of Users Making Insurance Solicitations On The Basis of Information Contained in Consumer Files

Anyone who uses a consumer report in connection with an insurance transaction not initiated by the consumer and that is a "firm offer of insurance" must include with the solicitation:

- a written statement that information in the consumer report was used in connection with the transaction, that the consumer received the offer of insurance because the consumer satisfies the criteria of insurability for the offer;
- a statement that, if applicable, the insurance may not be extended if the consumer does not meet the criteria of insurability; and
- a statement that the consumer has the right to prohibit information contained in the consumer's file with any consumer reporting agency from being used in any credit or insurance transaction not initiated by the consumer.

The person who makes an offer of insurance based on a consumer report must also maintain on file the criteria used to select the consumer to receive the offer, all criteria bearing on credit worthiness or insurability that are used to select consumers for the offer, and any requirement for the furnishing of collateral as a condition of insurability for three years after the offer was made.

Site Inspections

Another valuable tool in the underwriting process is a site inspection. Site inspections are often used in commercial insurance, and may also be used in homeowners insurance underwriting.

Site inspections involve inspecting buildings on the insured premises and noting what construction materials have been used, what safety devices, such as sprinkler systems or fire doors, are in place, the overall condition and upkeep of the property, whether there are any hazardous conditions present, what type of personal property exists, and so on.

Inspection of the premises may be done as part of a risk management process. Commercial property and casualty insurers often include loss control or risk management in the underwriting process. The agent or risk management personnel employed by the insurance company may be responsible to conduct a thorough review of the business operations before insurance is issued. There are several different methods that can be used for systematically locating risks that may be reduced through risk management or loss control processes. Insurers often have checklists, called exposure checklists, that are available for use to locate risks in a business. Another method used to identify risks is through the review of financial statements. Each item on the financial statements is analyzed in terms of risks that arise from that item. A third method is to identify all business activities such as hiring, training, customer services, record keeping and accounting, and to identify the risks related to them. Actual losses can also be reviewed and the risks that led to each loss identified. A fourth method is to use a flowchart of the businesses operations. A chart perhaps beginning with the receipt of an order through the receipt of payment for delivered goods, that follows the flow of the business from inventory management, processing and packaging of goods, as well as follow-up, may help to discover areas of risk that might be missed if a less thorough analysis were made. A fifth method is to conduct interviews with managers, supervisors and the actual workers in each business area. Such interviews serve to familiarize the risk or loss control staff with business operations, and add to information found in written documentation about each business function. An inspection of the premises and the operations conducted within is often used to find and verify risks.

Once the inspection and interviewing process is done, the findings are reduced to a report, which is provided to the underwriting department. From the report, the underwriters are able to evaluate risks, and may include requirements, such as requiring certain safety devices to be installed, safety training to occur, and so on, in order to issue a policy.

Insurance Maps

Insurance maps are special maps that include risk information based on location. An insurance map may be designed for use to determine the risk levels related to automobile accidents, automobile theft, property theft, exposure to damage from windstorms or flood, fire, and so on. These maps are used by underwriters to determine the risks associated with the location of property and the territory in which it is used, and therefore to assign the rate appropriate to the risk. Insurance maps may not be used in conjunction with unfair discrimination in redlining, as will be discussed in the next chapter.

Company Records

An insurer will use its own company records as a resource for specific information about the applicant and for general loss statistics related to similar risks. An applicant may have policies in force from the same insurer underwriting the new application. If so, the underwriters will check the information on the existing policies to see how they compare to the information on the current application. The underwriter also wants to determine the total coverage an applicant has with the insurer. Insurers establish certain maximum coverage levels they will provide for a certain risk or a certain applicant.

The company's loss statistics pertaining to the type of risk being underwritten are also used by the underwriters. An insurer must not have too much exposure to any certain risk. If an application represents a potentially high level of exposure for an insurer, the underwriter may look to reinsurance as a way to reduce its own exposure.

Insurance Industry Statistics and Reports

The National Association of Insurance Commissioners and Insurance Services Office, Inc. are two important sources of insurance industry statistics and reports. There are other organizations, such as the Risk and Insurance Management Society, Inc., the Inland Marine Underwriters Association, the Health Insurance Association of America, the Insurance Research Council, the National Association of Health Underwriters, and many, many more, that provide research, statistical data and reports for various types of insurance. Underwriters utilize this data in determining the appropriate rates to charge for applicants. Often this type of data is used when standard rates and manual rates are determined, on both the state and insurance company levels.

Hazards

The underwriting process may involve reviewing many of the resources just identified. The application, reports such as medical reports, consumer reports, credit reports, site inspection reports, and financial statements, and insurance maps, company files and industry statistics are all evaluated. One of the purposes of the evaluation is to determine whether the application includes indications that there may be certain hazards inherent in the risk to be insured. A hazard is the term used to describe conditions that increase risk. Insurers are generally concerned about three types of hazards: *moral hazards*, *morale hazards* and *physical hazards*.

Moral Hazard

When used by an insurer, the term moral hazard means a condition or conditions that increase the likelihood that an insured or a person in a position to be paid by an insurer will intentionally cause, overstate or increase a loss. When insurance is used to manage a risk, the insurer takes care to make sure that the amount of the insurance coverage issued is not excessive. Excessive coverage can contribute to moral hazard. In addition, the insurer may require an applicant to authorize a credit check or other financial review by the insurance company to make sure the applicant is financially healthy. Such financial checks are undertaken to reduce the likelihood that the insurer issues a policy to someone likely to falsify a claim due to financial pressures.

Morale Hazard

A morale hazard is a condition or conditions that increase the likelihood that the attitude of the insured or a person who will be paid by the insurer will cause a loss. For example, once an item or operation is insured, it is possible that its owner will be less prudent concerning it. For this reason, insurers require safeguards in order to insure certain types of property or operations. A property insurer may require that sprinklers and smoke alarms are installed in a building. A liability insurer will include a question on an application asking if required continuing education

hours are maintained. A crime insurer excludes any person who has ever been discovered to have committed a dishonest act from Employee Dishonesty coverage. All these actions are attempts to reduce morale hazards.

Physical Hazard

A physical hazard is a condition or conditions of property, people, or operations that can increase loss. For example, a construction site that allows access to structurally incomplete and unsound buildings increases the possibility that someone who wanders onto the site will be harmed. Insurers are interested in eliminating as many applicable physical hazards as possible prior to insuring a property, a person, or an operation.

Underwriting Decision

Once all the factors are weighed, an underwriting decision is made. As was discussed in the previous chapter, the application will either be accepted as a standard risk, a substandard risk, a preferred risk, or will be rejected. Any application that is accepted may include underwriting requirements that must be fulfilled in order for the insurance to apply.

The Role of the Agent in the Underwriting Process

The agent is crucial in the underwriting process. Agents are often referred to as field underwriters, or even simply as underwriters. This is because they gather underwriting information, evaluate risk, often do a preliminary assignment of premium, may authorize preliminary coverage, and may reject applicants on behalf of the insurer. During the underwriting process, the agent is often responsible to gather additional documentation and information to assist the home office underwriting team.

Suitability

An important part of the agent's function in underwriting is determining a suitable financial product for the client. Agents involved in offering life insurance and health insurance products are most affected by the requirements and processes involved in suggesting suitable products.

Many elements are included in determining a client's suitability. These include the age of the client, the tax status of the client, what type of investments the client already owns, the investment objectives of the client and the net worth and overall financial health of the client.

Determining Client Needs

Often the insurance company the agent represents provides procedures and forms to aid in determining a client's needs. Depending upon the types of products the agent offers, the needs analysis or fact-finding process may be relatively simple, or it may be very detailed.

Basic Information

The first part of a needs analysis generally focuses on basic information about the client. The agent will ask for the client's full name, address, occupation, marital status, number and age of minor children, and age of the client, for example. This basic information can help the agent begin to see certain potential needs of the customer. For example, the marital status of a client may indicate a need to protect loved ones from financial loss. The age of a client can indicate that a client is nearing retirement or at an age when long-term care planning is prudent. The occupation of a client may indicate that he is likely covered by a healthy benefits plan or they he may need full or supplemental coverage. However, the agent needs more information before the agent may make any judgments about potential product needs.

Sample Needs Assessment Questionnaire

I. Personal Information	
1.	Customer Name
2.	Customer Address
3.	Customer Phone Number Day: _____ Evenings: _____
4.	Customer Birth Date
5.	Customer Occupation
6.	Customer Marital Status
7.	Number and Age Of Dependent Children Living At Home
II. Financial Information	
8.	Estimated Net Worth (not including primary residence)
9.	Value Of Primary Residence
10.	Monthly Income from Employment
11.	Monthly Income from Retirement Plans (Identify Each Source And Amount)
12.	Other Income: Income Amount and Source
13.	Marginal Tax Bracket
III. Current Savings and Insurance	
14.	Mutual Funds: Fund Company, Objective, Amount
15.	Bank Certificates of Deposit: Maturity, Interest Rate and Amount
16.	Life Insurance In Force: Company, Type of Policy, Face Value and Cash Value
17.	Annuities in force: Company, Type, Accumulated Value and Yield
18.	Individual Stocks: Company and Amount
19.	Individual Bonds: Type and Amount
20.	Other Investments (e.g., real estate): Type and Value
21.	Investments previously held but now liquidated: Type, when held, why

liquidated
IV. Risk Tolerance
22. Able to tolerate significant degree of fluctuation in return for opportunity for high return _____
23. Able to tolerate some fluctuation of principal in return for opportunity for moderate return _____
24. Conservation of principal is primary consideration _____
Comments:
V. Financial Plans
25. Retirement Savings: Type of plan, how long has it been in existence, value, amount and frequency of current contributions, satisfaction level, concerns and questions
26. Estate planning: Will? Living Trust? Testamentary Trusts? Key objectives of these tools, satisfaction level, concerns and questions
VI. Goals
27. Short-term (1- 5 year): Financial goals, amount needed.
28. Intermediate term (5-10 year): Financial goals, amount needed
29. Long-term (10+): Financial goals, amount needed
COMMENTS:

Financial Information

After basic information is gathered from the client, the agent must ask for financial information. Sometimes a client is hesitant to give this information to the agent. If so, the agent may explain that client information is held confidentially and that the agent has a responsibility to the client to understand his or her financial situation in order to give the best advice possible. If a client absolutely will not provide financial information, generally the agent should explain to the client that the agent will have to suspend the interview until such time as the client is willing to provide this information. Trying to assist a client with a life insurance product without knowledge of the client's financial situation can compromise the agent's fiduciary responsibilities to the client.

Generally, the agent will need to know the client's net worth. The agent may ask for an item-by-item list of the clients' assets and liabilities, or may just ask for a net worth figure from the client. The agent will also ask for the client's monthly income earned from his or her occupation, and the amount of income the client receives from any other source. Another critical piece of financial information is the tax status of the client. The agent will generally find out whether the client is in the 15%, 28%, 36% or higher tax bracket.

Current Investments

A third area that the agent will explore is that of the current investments and financial plans of the client. The agent will ask for an inventory of the mutual funds, certificates of deposit, insurance products, individual stocks and bonds, and any other financial products the customer owns. If the agent finds that the client owns any life insurance products, it is important that the agent follow replacement procedures if the agent determines that a different life insurance plan should be suggested.

The agent will also ask if there were investments the client previously owned but are currently liquidated. The agent should ask if the client was dissatisfied with these liquidated products, and if so, why? Finding out what type of products a client uses or has used helps the agent to understand the financial experience of the client and the types of products the client likes and does not like.

Related to discovering the types of financial products a client currently owns and has owned is determining the risk tolerance of a client. The agent will generally ask the client a question such as: *Which is more important to you, Mr. Client, to earn a high return, or to be sure that you never lose a nickel of the money you invest even if you earn a low return? Or, Are you cautious, or a risk-taker?* Sometimes, a client may answer such questions in a manner that seems contrary to the information gathered by the agent. For example, a client may say that higher return is more important than conserving principal, but have all his or her money in bank certificates of deposit and money market funds. The agent must take into consideration the kind of products the client has invested in, and not just what the client says when trying to determine the risk tolerance of a client. Perhaps with more information a conservative client will be ready to invest in products with a higher opportunity for growth than a bank CD, but the agent must proceed carefully before suggesting a higher risk product if a client's history shows that the client has purchased solely conservative, non-variable products.

Current Plans

The agent will then often proceed to asking questions about the kind of financial planning the client has undertaken so far. For example, the agent will ask about retirement plans, estate planning, whether a will is in place, and so on.

Goals

Another area of questioning involves the client's goals, both short-term and long-term. The agent generally will ask whether the client has goals such as saving for college educations, whether the amount of retirement savings so far will meet the client's retirement income needs, or whether the client is working toward getting out of debt or paying off a mortgage. The agent will also ask about shorter-term financial goals such as going on a vacation, purchasing a home, renovating a home, or purchasing a new car or recreational vehicle. Besides discussing goals, the agent will ask whether the client believes he or she will be experiencing any major changes in his or her life in the near future, such as children getting married, an elderly parent coming to live at the client's home, or the client's own marriage or remarriage.

Providing Product Suggestions

Once the agent has completed the fact-finding process with the client, the agent may be ready to discuss specific products and plans that may meet the client's needs. Or, the agent may want to spend time analyzing the information gleaned from the discussion with the client, and meet with the client in a few days or in the next week to discuss the agent's recommendations. Whenever the agent begins to discuss product and plan options with the client, the agent has a responsibility to provide clear and accurate information about the programs discussed. It is important for the agent to explain both the risks and benefits of any product or plan offered to the client.

Depending upon what product the agent is offering or in what environment the agent works within, the agent may be required to provide specific disclosures to the client regarding the product. For example, if an agent sells to customers of a bank, the agent is generally required to provide a disclosure to the client stating that insurance products are not FDIC insured. If the agent is offering a variable product, the agent may be required to provide a disclosure stating that returns on the product are not guaranteed. If the agent is offering long-term care insurance, the agent may have to provide a disclosure regarding the insured's ability to exercise of certain rights under the policy, or regarding certain tax information such as that related to qualified and non-qualified long-term care contracts.

Documentation

Whether or not the client actually purchases the product offered, the agent should keep a detailed record of the information gathered from meetings with the client, and it the documentation, brochures and other information shared with the client about the product. Copies of signed disclosures, the application, the fact-finding document, and any other customer-related forms, should be kept on file by the agent. Such a file will not only help the agent should there ever be a question about the suitability of the agent's recommendations, but will also assist the agent in his or her ongoing relationship with the client.

Model Life Insurance and Annuities Suitability Act and Regulation

The NAIC has developed both a *Life Insurance and Annuities Suitability Model Regulation* and a *Life Insurance and Annuities Suitability Model Act*. Under these models, rules have been created governing recommendations by agents to consumers regarding fixed life insurance and annuity products. The regulations do not generally apply to:

- registered contracts;
- long-term care insurance products;
- products sold to sophisticated purchasers;
- policies or contracts that fund employee pension or welfare benefit plans, 401(a), 401(k) or 403(b), 414, 457 plans, or nonqualified deferred compensation plans;
- group life insurance or annuity products that are not directly solicited by an insurance producer;

- open-end credit life insurance, and group life insurance; and
- annuities used to fund prepaid funeral contracts.

According to the model regulations, insurers must adopt guidelines and procedures for their insurance producers regarding making suitable recommendations. Under the regulations, a suitable recommendation is a recommendation for the purchase of a life insurance or annuity product that assists the consumer in meeting that consumer's insurable need or financial objective. The insurer must:

- Inform insurance producers of the requirements in the model act and regulations
- Develop procedures regarding the information that must be in from the consumer before making recommendations to that consumer
- Create and maintain a system to determine whether insurance producer practices are in compliance with guidelines and procedures in the model act. Systems an insurer might use include consumer surveys, interviews, confirmation letters and internal monitoring programs
- Provide a system for dealing with noncompliance

The insurer must also create guidelines and procedures, along with data collection processes to collect relevant information regarding the customer's insurance needs and financial objectives. Data collection tools may include customer information forms, product applications and other fact-finding tools. The insurer must also provide training and materials to help agents analyze customer's needs and objectives.

Under the model act and regulation, agents also have important responsibilities. Agents must make suitable recommendations. They may use their discretion to determine what information is relevant for making specific recommendations regarding an insurance transaction.

By keeping a record of the information gathered and processes used to comply with the act, agents and insurance companies may demonstrate that they have made a suitable recommendation. Each state that adopts the model act and regulations may have different requirements regarding the number of years that these records must be kept.

Taking the Application

After the agent has recommended a suitable product, the agent is responsible to take the application. It is critical that the agent ensure that the application is as accurate and complete as possible. Almost every piece of information on the application is used to get a fair and accurate picture of the risk to be insured. The agent has a responsibility to the insurer to faithfully represent the applicant on the application, and the applicant also must provide accurate information to the agent.

Screening Risk

The agent must screen out unacceptable risks for the insurer. The agent may determine that insurable interest is not present, or that an applicant does not meet minimum underwriting standards. In some cases, the agent must inform the applicant that the insurer will not be able to write a policy for that applicant. Or, the agent may try to work with the applicant to determine if there is another method of covering the risk that will meet insurable interest requirements and minimum underwriting requirements. This may mean restructuring the ownership of a life insurance contract, or writing a policy with lower policy limits than the applicant had hoped, for example. Sometimes cases may be written on a substandard basis that may have been rejected if the agent is able to provide sufficient documentation to the underwriter that adequately explains the reasons behind circumstances that normally would have caused a rejection. For example, a business that had significant losses through theft may have installed new security systems. The agent writing an application for such a business should submit

documentation about the new system so that the underwriters are able to determine if such a system is likely to reduce future losses.

Risk Management and Loss Control

When certain types of insurance is applied for, the agent is responsible to act as a risk manager or loss control manager on behalf of the insurer. This was touched on briefly earlier as it applied to site inspection reports. Particularly in commercial property and casualty insurance, as well as in Workers Compensation and other forms of employer liability insurance, risk management and loss control are critical components of the insurance process. The agent may have a significant role in this area.

The risk management process has the objective of reducing loss. Loss is reduced by identifying risks, evaluating them for frequency, severity and type, determining the best risk response, implementing the response, monitoring the results and making changes as necessary.

Identifying Risks

There are several different methods that can be used for systematically locating risks. Insurers often have checklists available for agents and clients which can be used to locate risks in a business. Another method used to identify risks is through the review of financial statements. Each item on the financial statements is analyzed in terms of risks which arise from that item. A third method is to identify all business activities such as hiring, training, customer services, record keeping and accounting, and to identify the risks related to them. Actual losses can also be reviewed and the risks which led to each loss identified.

Evaluation of Risks

Each identified risk must be analyzed for its potential frequency and severity. Frequency refers to the number of times a loss is likely to occur, and severity to the amount of financial loss that is likely to come from each loss. A loss which is likely to be infrequent and small is less important to a business than one which may be infrequent and large, and even less important than a loss which may be both frequent and large. After reviewing each risk based on loss frequency and severity, the risks with the potential for the most serious impact on the business can be given a higher priority. Each risk from the highest to lowest priority are then subject to the processes of determining and implementing a response.

Risk Response

Risks can generally be responded to in five ways - avoiding, preventing, retaining, reducing and transferring.

Avoiding Risk

A business may want to avoid a risk because its potential for financially ruining the company is high. For example, new medical studies may indicate that a certain procedure has some serious negative health consequences. A doctor may decide to immediately stop performing that procedure, and thereby avoid the risk of harming a patient because of it from that point forward. An accountant may believe others are in error by interpreting a tax regulation in a manner he feels will not be upheld by the IRS, so he decides to provide more conservative advice. As a fiduciary, the accountant may even decide to refer customers affected by the regulation to an accountant who specializes in that area. Avoiding risk may be an appropriate response for high-risk circumstances such as these.

Preventing Risk

Action can be taken to prevent some risks. For example, the risk that someone will fall through rotting boards on the steps to a building can be prevented by fixing the steps. The risk of

shortage may be prevented by inventory control procedures. The risk of spreading germs or disease through the use of unsanitary medical tools can be prevented by using new, disposable tools for each patient.

Retaining Risk

Some risks are retained. They may be retained because the loss exposure is small, there is no way to transfer or reduce the risk, or because the risk was not identified. In some cases, risk is partially retained. Purchasing insurance with a deductible results in the partial retention of risk.

Reducing Risk

Reduction of risk occurs when steps are taken to minimize loss. The reduction of risk may be accomplished several ways. Safety procedures may be implemented, disclosures and warranties may be provided to customers, employees may be trained not to answer certain questions but rather to refer them to specialists within the firm, contract language may be rewritten to reduce ambiguity, etc.

Transferring Risk

Risks may be transferred. They may be transferred through contracts, or through the purchase of insurance. Risk is transferred in contracts such as automobile and apartment rental agreements, construction contracts or through a loan agreement that requires a guarantor to assume the risk should the borrower default on the loan. When a business changes hands, liabilities of the business may be transferred through contract to the new business owner. Risk is transferred from the insured to the insurer under an insurance contract. Insurance is often the primary mechanism used to transfer risk.

Risks are not always responded to in just one way. A business owner may put into place procedures to reduce risk and purchase insurance on the risk as well. Insurers often encourage loss reduction and prevention techniques and will reduce premium in some circumstances if loss reduction steps are taken. Or, a risk may be transferred in part through a contract and the remaining exposure transferred through the purchase of insurance. For example, a renter may be contractually liable for damage to a home rented, but the owner will generally carry property insurance on the dwelling as well.

Implementation and Monitoring of Risk Responses

After risks have been identified and evaluated and an appropriate risk response has been determined, the response must be implemented. Steps to do so should be documented and monitored.

Once the appropriate responses have been implemented, the process is not over. Risks need to be evaluated on a regular basis. Businesses tend to change over time – new services are offered, new staff is hired, new locations are purchased. Each change can bring new loss exposures. The insurance agent can assist a business or individual in the ongoing monitoring of risk management and loss control by reviewing the risk management program each year when insurance is to be renewed. By doing so, the agent can make sure the right types and amounts of coverage are offered

Underwriting Requirements and Risk Management

As a result of the risk management process and the thorough review of the business, its property and operations that occurs during the process, the insurer may require that certain actions are taken in order for insurance to be issued to the business and remain in force. For example, the insurer may require a safety program to be implemented, require a formal process for reporting injury or loss at the workplace, require the replacing of unsafe equipment or faulty

door and window locks, the installation of a sprinkler system, and so on. The agent is often responsible to assist the applicant in the implementation of such requirements, and to perform an inspection to verify that the underwriting requirements have been fulfilled.

Premium Discounts

The insurer, underwriter and agent may not always require change, but may provide an incentive to a business to make certain changes by offering reduced premiums if such changes are made. For example, if fire doors are installed, the business may qualify for a premium reduction. Some insurers offer complete loss control programs that include a reduced premium for things such as key business personnel attending a certain number of insurer sponsored seminars and training classes regarding loss management and safety.

In the individual lines of insurance, premium discounts are also used to help manage risk and loss. A homeowner with a security system may qualify for a premium discount. Teenagers who have taken formal drivers' education courses may qualify for a lower auto insurance rate than those who have not. The agent can help both the client and the insurer by clearly informing the client of premium discounts for which the client may qualify.

Submitting Documentation

Besides taking the application and participating in the risk management and loss control process, the agent is responsible to submit documentation that supports the application and is used in the underwriting process. In some cases, the insurer has standards regarding what type of documentation must be submitted with every application of a certain type of insurance. In order for the application to be processed as quickly as possible, the agent must make sure to obtain and submit this documentation as required.

Other documentation may be asked for by the underwriters after the application is submitted. The agent may have the responsibility to coordinate the collection and submission of such documentation. If so, the agent must do so as promptly as possible to make sure that the underwriting process moves forward.

Binding Coverage

Agents may be able to bind coverage once the application is completed. The agent carefully reviews the information provided by the applicant, and if the applicant and application meet certain criteria, the agent may bind coverage until the underwriting process is complete. Once the underwriting process is complete, coverage will continue in force, or may be denied. Obviously, binding coverage is an important responsibility for the agent, and the agent must be careful to follow insurance company standards in so doing.

Handling Premium

One of the important duties of an agent related to his or her role as field underwriter is the collection and remitting of premium. The NAIC has developed a new model law governing agent trust accounts used to hold insurance premiums. This law may be adopted in many states. It governs the important responsibility of agents to handle client funds properly. The model law applies to all funds received as premiums or return premiums for a policy or binder that are received by any person acting as an insurance producer, agent, sub-agent, managing general agent, broker, solicitor, life agent, licensed general agent, life analyst, surplus land broker, a special lines surplus lines broker, motor club agent, permittee, solicitor or any other representative of an insurer or any other person in the effectuation of an insurance contract.

Under this law, premiums and return premiums that are not made payable to the insurance company, and funds received for soliciting, negotiating, effecting, procuring, renewing, continuing or binding policies, may be placed into the agent's trust account. In addition, any

funds that an agent collects from a policyholder or premium finance company and that are paid to an insurance company, its agents, or to the agent's employer may also be placed in the trust. The agent may also place voluntary additional funds in the trust account to use for the advance of premiums, to establish reserves for return premiums or for other contingencies that arise in the business of receiving and transmitting premium.

Agents must place the trust account in a recognized financial institution that is subject to the jurisdiction of the courts within the state in which the agent is doing business. In addition, the account must be insured by an entity of the federal government. The account may be a checking account a demand account, savings account, or other account with such a financial institution. The account may also be interest bearing. Another option available for a trust account is the use of an investment fund that invests solely in U.S. government bonds, treasury certificates or other obligations backed by the full faith and credit of the United States. The trust account must be titled as a *Premium Fund Trust Account*.

If the account is interest bearing, the agent may keep the interest from the account. The agent must keep records of the interest and these records may be examined by the insurance commissioner.

Withdrawals from a trust account may be made for the following reasons only:

1. Making payment of premium to the insurance company or other producers.
2. Returning premiums to an insured or other person entitled to them.
3. Withdrawing money the agent had placed in the account on a voluntary basis as additional funds.
4. Transferring interest to another account.
5. Transferring actual or average commissions to another account. If it is common practice to transfer average commissions, the agent must keep on file documentation in the form of a letter signed by each principal regarding the percentage of average commission.
6. Paying of bank fees and charges.
7. Moving funds to another trust account in accordance with the model law.

It is prohibited for an agent to treat the funds in a trust account as a personal asset, as collateral for either a personal or business loan, or as a personal asset on a financial statement. The insurance commissioner may have the trust account examined and audited at any time.

If an agent violates the provisions of the *Agent Trust Accounts Model Law*, the agent is considered guilty of theft and is subject to prosecution as prescribed in the laws of the state.

Additional Underwriting Duties

The agent may undertake underwriting duties after a policy is in force. Changes in coverage may require a full or partial underwriting process to be carried out. If new property is acquired, for example, a change in coverage form and documentation about that property may need to be submitted to the underwriters. Additional premium may need to be collected and a site inspection performed as well. Depending upon the line of insurance to which a change is made, other tasks may need to be performed by the agent in order to effect the change in coverage.

Underwriting Responsibilities Of The Managing General Agent

A managing general agent is a person, firm, association or corporation who manages an insurance business of an insurer and acts as an agent for the insurer. In order to be recognized under the law as a managing general agent, a written contract must exist between the insurer and the managing general agent. Within this contract, important responsibilities of a managing general agent are delineated, including those related to underwriting.

Generally, the contract between the managing general agent and the insurance company will include underwriting guidelines that the managing general agent must follow. These include:

- maximum annual premium volume,
- the basis of rates to be charged,
- the types of risks which may be written,
- maximum limits of liability,
- applicable exclusions,
- territorial limitations, if any,
- policy cancellation provisions, and
- the maximum policy period.

When a managing general agent's responsibilities include settling claims, a managing general agent must generally follow these rules:

- The managing general agent must report all claims to the insurance company in a timely manner.
- A copy of the claim file must be sent to the insurance company as soon as the insurance company requests or as soon as it is known that the claim has the potential to exceed an amount set by the company, involves a coverage dispute, or exceeds the managing general agent's claim settlement authority.
- The managing general agent must also notify the insurance company of claims that are open for more than six months or are closed.

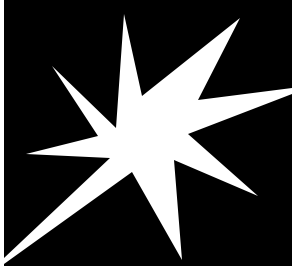
Many states prohibit the managing general agent from committing an insurer to participate in insurance or reinsurance syndicates, appointing any producers without first making sure that the producer is lawfully licensed to transact the insurance for which he is appointed, or collecting payments from a reinsurer or committing insurer to any claims settlement with the reinsurer without prior approval of the insurance company.

Under insurance law in many states, managing general agents must keep separate records of the business they write from the records of business written by other agents. When a managing general agent acts as a producer, the managing general agent is subject to the same rules, requirements and laws to which any other producer is subject.

Summary

- At the home office of the insurer, the underwriting process begins when an application is received. The first characteristic that is generally evaluated by underwriters is whether or not insurable interest is present.
- Another important factor the underwriters look for in an application is whether a policy issued on an application would result in a valid contract. A contract must include the elements of consideration, the assent of both parties, competent parties and legal purpose in order to be valid.
- The underwriters must also verify that the risk represented by the application is an insurable risk. In order to be an insurable risk the risk must be a pure risk, represent a definable and calculable loss, must not occur to many people simultaneously and not result from intentional loss.
- Once insurable interest, the validity of a contract and the insurability of the risk is established, the underwriters evaluate the basic characteristics of the risk using the application and supporting documentation.
- After the information on the application and supporting documentation is evaluated, the underwriters determine the premium rate to be charged.

- The three major rate determination methods are the *judgment rating*, *manual rating*, and *merit rating* methods. The three types of merit rating are *experience merit rating*, *retrospective merit rating*, and *scheduled merit rating*.
- The presences of a competitive market may impact rate determination and filing requirements.
- Besides determining rates, the underwriters may also specify terms and requirements in order for the insurance to be issued or to remain in force.
- Several resources are used for the underwriting process. The primary resource is the application. Also used are supporting reports, site inspections, insurance maps, insurance company files and industry statistical reports and data.
- One of the purposes of evaluating the applicant's information is to determine whether a moral, morale or physical hazard exists.
- In the life and health insurance arena, the agent is responsible for determining the suitability of insurance products offered to clients. The agent must perform a thorough needs analysis, and should keep documentation regarding the information collected and suggestions made to clients and potential clients.
- The agent has several important duties in the underwriting process. These may include:
 - Taking the application
 - Screening risk
 - Reducing loss through risk management
 - Assisting in the implementation and verification of underwriting requirements
 - Informing the applicant about applicable premium discounts
 - Submitting accurate and timely information to the insurance company home office
 - Binding coverage



How Legislation Impacts Underwriting

Insurance regulations have a significant impact on underwriting. Insurance regulations encompass all facets of the insurance transaction. Those most important to underwriting deal with adequate rates, privacy laws, unfair trade practices, required coverage, and unfair discrimination.

Adequate Rates

In almost every state, insurance regulations address insurance rates. The basis of these laws is that rates must be adequate, not be excessive, and not be unfairly discriminatory.

An example of an insurance law addressing rates can be found in the Virginia Code:

§ 38.2-1904. *Rate standards.*

A. Rates for the classes of insurance to which this chapter applies shall not be excessive, inadequate or unfairly discriminatory. All rates and all changes and amendments to rates to which this chapter applies for use in this Commonwealth shall consider loss experience and other factors within Virginia if relevant and actuarially sound; provided, other data, including countrywide, regional or other state data, may be considered where such data is relevant and where a sound actuarial basis exists for considering data other than Virginia-specific data.

1. No rate shall be held to be excessive unless it is unreasonably high for the insurance provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate applies.

2. No rate shall be held inadequate unless it is unreasonably low for the insurance provided and (i) continued use of it would endanger solvency of the insurer or (ii) use of the rate by the insurer has or, if continued, will have the effect of destroying competition or creating a monopoly.

3. No rate shall be unfairly discriminatory if a different rate is charged for the same coverage and the rate differential (i) is based on sound actuarial principles or (ii) is related to actual or reasonably anticipated experience.

B. 1. In determining whether rates comply with the standards of subsection

A of this section, separate consideration shall be given to (i) past and prospective loss experience within and outside this Commonwealth, (ii) conflagration or catastrophe hazards, (iii) a reasonable margin for underwriting profit and contingencies, (iv) dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, (v) past and prospective expenses both countrywide and those specifically applicable to this Commonwealth, (vi) the loss reserving practices, standards and procedures utilized by the insurer, (vii) investment income earned or realized by insurers from their unearned premium and loss reserve and the Commission may give separate consideration to investment income earned on surplus funds, and (viii) all other relevant factors within and outside this Commonwealth. When actual experience or data does not exist, the Commission may consider estimates.

2. In the case of fire insurance rates, consideration shall be given to the experience of the fire insurance business during a period of not less than the most recent five-year period for which such experience is available.

3. In the case of Workers Compensation insurance rates for volunteer firefighters or volunteer lifesaving or volunteer rescue squad members, the rates shall be calculated based upon the combined experience of both volunteer firefighters or volunteer lifesaving or volunteer rescue squad members and paid firefighters or paid lifesaving or paid rescue squad members, so that the resulting rate is the same for both volunteer and paid members, but in no event shall resulting premiums be less than forty dollars per year for any volunteer firefighter or rescue squad member.

Regulation of life insurance rates is generally different from those of property and casualty rates. Property and casualty rates are often regulated by rate approval laws, while life insurance rates do not generally require approval by the insurance department.

There are five methods that may be used by states regarding the setting and use of property and casualty rates. These are known as 1) flex-rating, 2) prior approval, 3) open competition, 4) file-and-use and 5) use-and-file laws.

Under the *flex-rating system*, an insurer may establish rates within a stated range or band of rates without prior approval from the state insurance department. The insurer must always comply with the state laws that rates requiring are adequate, may not be excessive and may not discriminate unfairly.

Under the *prior approval system*, which is the most commonly used rate system applicable to property and casualty insurance, the insurer files the rates it intends to use with the insurance department prior to using these rates. In addition to filing the rates, the insurer also files supporting data and its projected expenses. The insurer may have compiled the rates and data itself, or may use rates and data from a rating bureau. The state insurance department then approves or disapproves the rates submitted. In most states, if the department does not disapprove the rates within a specified time period, the rates are considered to be approved.

Under the *open competition system*, also known as a no-file system, the insurance department does not require rates to be filed or approved. Rather, the insurer is allowed to set rates based on its own experience or based on rates supplied by a rate bureau. Competition is seen under this system as the force governing rates. Only a few states use this system for property and casualty rates.

File-and-use laws require that rates and rate changes be filed by the insurance company, but the insurer may use them immediately. The insurance department may disapprove the rates at a later time under this system. Under *use-and-file* laws, the insurer must file rates with the insurance department, but does so for informational purposes only.

Life insurance rates are regulated more indirectly by the states. Mortality tables and interest assumptions used for determining policy reserves are regulated for life insurance contracts, which impacts rate setting from the standpoint of adequacy. Regulations governing dividends and surplus accumulations impact life insurance rates from the standpoint of excessiveness. However, no filing of life insurance rates is generally required by the states, and state insurance departments do not approve or disapprove life insurance rates.

Privacy Laws

Another type of regulation that affects insurance underwriting is regulation dealing with privacy laws. Privacy laws affect underwriting because they regulate and limit the ways in which information may be collected and used. They also regulate how and when collected information may be disseminated to others, if at all.

Model Insurance Information and Privacy Protection Act

The National Association of Insurance Commissioners (NAIC) adopted a Model Insurance Information and Privacy Protection Act in 1979. This act has been adopted by sixteen states. This Act includes and expands upon some provisions of the Fair Credit Reporting Act as it was originally enacted. The model Act covers insurance institutions, agents, brokers, reinsurers, and organizations supporting the insurance industry. It applies to personal lines of insurance within life, health and property and casualty insurance. The purpose of the Act *is to establish standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance support organizations.*

Under this model Act, three types of information are defined and regulated: 1) medical-record information, 2) personal information, and 3) privileged information. *Medical-record* information is information relating to an individual's physical or mental condition, medical history or medical treatment. Medical record information is also defined to be information obtained from a medical professional or medical-care institution, from the individual or the individual's spouse, parent or legal guardian. *Personal information* is information that is identified with the individual and is used to make judgments regarding the individual's character, habits, avocations, finances, occupation, general reputation, credit, health or other personal characteristics. *Privileged information* is information identified with the individual that is collected in connection with or in reasonable anticipation of an insurance claim or with or in reasonable anticipation of a civil or criminal proceeding.

Under Section 3 of the model Act, pretext interviews are discussed. A *pretext interview* is defined in the Act as an interview in which a person, attempting to obtain personal information about someone else, 1) pretends to be someone else, 2) pretends to represent a person they do not represent, 3) misrepresents the purpose of the interview, or 4) will not give his or her identity when asked. A pretext interview may only be conducted if there is a *reasonable basis for suspecting criminal activity, fraud, material misrepresentation, or material nondisclosure* in a claim situation. This reasonable basis must include *specific information available for review* by the insurance commissioner.

Under Section 4 of the model Act, insurance applicants must be given a written disclosure of the insurer's personal information collection methods, the disclosure practices of personal and privileged information, and a description of the applicant's privacy rights within the Act. Under Section 6, disclosure authorization forms are discussed. Such authorization forms must include what persons are authorized to disclose personal and privileged information and the nature of information that is disclosed to the insurer, insurance producer, or insurance support organization. Disclosure authorization forms for life, health and disability insurance are valid for thirty months under the Act and property and casualty insurance disclosure authorizations are valid for twelve months. Disclosure authorizations related to collecting claim information are valid for the claims process period.

Section 7 of the model Act discusses *investigative consumer reports*. An investigative consumer report is defined as consumer reports, or portions of consumer reports, that are based on personal interviews with the subject's neighbors, friends, associates, acquaintances or others. Information provided during these personal interviews concern the person's character, general reputation, personal characteristics or mode of living. Under the Act, investigative consumer reports may not be requested or prepared unless the subject is notified that such a report may be prepared and that he or she may receive a copy of the completed report if he or she so requests.

Section 8 provides rights to individuals to personal information an insurer, insurance producer or insurance support organization is reasonably able to locate and retrieve. The individual must

make the request in writing. The insurer, insurance producer or insurance support organization must respond to the request within not more than thirty business days. The response must inform the requestor of the *nature and substance* of the personal information, include allowing the requestor to see and obtain a copy of the information either in person or through the mail, disclose the identity of any persons to whom the information has been released, and provide an explanation of how the individual may request that information may be corrected, amended or deleted. An individual may not have access to information that is *collected in connection with or in reasonable anticipation of a claim or civil or criminal proceeding*.

Section 9 provides the process of correcting, amending or deleting information disputed by the individual. The individual must request the correction, amendment or deletion in writing. Once the insurer, insurance producer or insurance support organization researches the matter, they must correct, amend or delete the information if they find such action should be taken. If the insurer, producer or support organization determines that a correction, amendment or deletion is warranted, the individual must be notified, and the change must also be provided to any 1) *person specifically designated by the individual who may have received the information in the previous two years*; 2) *any insurance-support organization that has systematically received such information over the preceding seven years, unless the organization no longer maintains information on the individual*; and 3) *any insurance support organization that supplied the information that has been changed*. If the insurer, producer or support organization does not change the information based on the individual's request because it does not believe such a change is warranted, the individual has the right to file a *concise statement* disputing the information in question, and the statement must be provided to anyone who reviews the information.

Section 10, 11 and 12 deal with the circumstance of *adverse underwriting decisions*. Under the model Act, an adverse underwriting decision is a denial of insurance, a termination of coverage, or the failure of an agent to apply for a coverage that the applicant requested. Under property and casualty insurance, *adverse underwriting decision* also includes the placing of coverage with a residual market mechanism or with an insurer specializing in substandard risks, or the charging of a higher rate on the basis of information that differs from the information provided by the applicant or policyholder. Under life, health and disability insurance, an adverse underwriting decision also includes offering to insure the applicant at a higher than standard rate.

Under Section 10 of the model Act, the applicant or policyholder must be informed that he or she is able to request reasons for an adverse underwriting decision. The individual also has the right to obtain the specific information and the sources of information that support the reasons for the adverse underwriting information. The individual must also be informed of his or her right to dispute the information, as was discussed above in the information related to Section 9 of the Act.

Section 11 of the model Act gives insurers, insurance producers and insurance support organizations the right to information about an individual regarding previous adverse underwriting decisions or any previous coverage obtained through a residual market mechanism and the reasons for the adverse underwriting decision or coverage through a residual market mechanism.

Under Section 12, an insurer or insurance producer may not base an adverse underwriting decision on a prior adverse underwriting decision of another insurer, or because the applicant was placed in a residual market mechanism by another insurer. This Section also prohibits an underwriting decision to be made on information received from insurance support organizations whose *primary source of information is insurance institutions*. Rather, the insurer or producer

must investigate and verify that the information is accurate before it may be used in an adverse underwriting decision.

Section 13 provides that the insurer, insurance producer or insurance support organization may only disclose personal or privileged information if the subject individual has provided written authorization to do so, or if the disclosure is for the purpose of protecting against fraud, providing information to state regulators or other governmental bodies, providing information due to a potential sale, transfer, merger, or consolidation, or other business purposes. If information is used for a research report, identification of the individuals whose information is utilized is not allowed in the report, and the researchers must return or destroy materials used during the research process that identifies individuals. If information is disclosed for marketing purposes, it may not include medical, privileged or personal information regarding the individual's reputation, mode of living, habits. Under the model Act, individuals may stipulate that they do not want any personal information disclosed for marketing purposes.

Also under the model Act, if the insurance commissioner of the state determines that a party has violated any portion of the Act, the commissioner may issue a cease and desist order. The Act calls for a penalty of \$500 for each violation, to a maximum of \$10,000. If a cease and desist order is violated, a penalty of \$10,000 may be assessed. In addition, an insurer or producer that commits a violation may have its license suspended or revoked.

Gramm-Leach-Bliley Act

Another important Act that includes privacy provisions that was recently passed is the Gramm-Leach-Bliley Act. This Act is also known as the *Financial Services Modernization Act*. This Act is broad in scope and regulates many aspects of financial transactions. Title V of this Act includes some specific privacy provisions applicable to insurance transactions. This Act applies to insurers, as well as other types of financial institutions.

Under Title V, Subtitle A, Section 501, the Act states that *each financial institution has an affirmative and continuing obligation to respect the privacy of its customers and to protect the security and confidentiality of those customers' nonpublic personal information.*

The specific requirements related to this obligation as put forth in the Act include that appropriate standards must be followed:

- *to insure the security and confidentiality of customer records and information*
- *to protect against anticipated threats or hazards to the security or integrity of such records*
- *to protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer.*

These appropriate standards are to be established by the appropriate authorities over the various types of financial institutions. Generally, the respective state insurance commissioner's office and state statutes are in authority over insurers doing business in each state.

Section 502 of Title V of the Act includes provisions regarding disclosure of personal information. A financial institution may not disclose to any nonaffiliated third party any nonpublic personal information unless:

- a consumer notice is provided that informs the consumer that such information may be disclosed to a third party;
- the consumer is given the opportunity before information is disclosed, to direct that the such information may not be disclosed to a third party; and
- the consumer is given an explanation of the method that may be used to direct that such information not be disclosed

This section also prohibits a nonaffiliated third party that receives nonpublic personal information from disclosing such information to any other nonaffiliated third party of the financial institution, unless such disclosure would be lawful if made directly from the financial institution to that other party.

Excepted from these disclosure rules is disclosure of nonpublic personal information

(1) *as necessary to effect, administer, or enforce a transaction requested or authorized by the consumer, or in connection with--*

(A) *servicing or processing a financial product or service requested or authorized by the consumer;*

(B) *maintaining or servicing the consumer's account with the financial institution, or with another entity as part of a private label credit card program or other extension of credit on behalf of such entity; or*

(C) *a proposed or actual securitization, secondary market sale (including sales of servicing rights), or similar transaction related to a transaction of the consumer;*

(2) *with the consent or at the direction of the consumer;*

(3)

(A) *to protect the confidentiality or security of the financial institution's records pertaining to the consumer, the service or product, or the transaction therein;*

(B) *to protect against or prevent actual or potential fraud, unauthorized transactions, claims, or other liability;*

(C) *for required institutional risk control, or for resolving customer disputes or inquiries;*

(D) *to persons holding a legal or beneficial interest relating to the consumer; or (E) to persons acting in a fiduciary or representative capacity on behalf of the consumer;*

(4) *to provide information to insurance rate advisory organizations, guaranty funds or agencies, applicable rating agencies of the financial institution, persons assessing the institution's compliance with industry standards, and the institution's attorneys, accountants, and auditors;*

(5) *to the extent specifically permitted or required under other provisions of law and in accordance with the Right to Financial Privacy Act of 1978, to law enforcement agencies (including a Federal functional regulator, the Secretary of the Treasury with respect to subchapter II of chapter 53 of title 31, United States Code, and chapter 2 of title I of Public Law 91-508 (12 U.S.C. 1951-1959), a State insurance authority, or the Federal Trade Commission), self-regulatory organizations, or for an investigation on a matter related to public safety;*

(6)

(A) *to a consumer reporting agency in accordance with the Fair Credit Reporting Act, or*

(B) *from a consumer report reported by a consumer reporting agency;*

(7) *in connection with a proposed or actual sale, merger, transfer, or exchange of all or a portion of a business or operating unit if the disclosure of nonpublic personal information concerns solely consumers of such business or unit; or*

(8) *to comply with Federal, State, or local laws, rules, and other applicable legal requirements; to comply with a properly authorized civil, criminal, or regulatory investigation or subpoena or summons by Federal, State, or local authorities; or to respond to judicial process or government regulatory authorities having jurisdiction over the financial institution for examination, compliance, or other purposes as authorized by law.*

Under Section 503 of Title V of the Act, the financial institution is required to provide a *clear and conspicuous* disclosure to the customer regarding the institution's policies and practices with respect to:

- disclosure of nonpublic personal information to affiliates and nonaffiliated third parties;
- disclosure of nonpublic personal information of people who are no longer customers of the financial institution; and
- protection of nonpublic personal information of consumers.

The disclosure must include:

- the policies and practices used by the institution for disclosing nonpublic personal information to nonaffiliated third parties;
- the categories of persons to whom information may be disclosed as required by the Act;
- the policies and practices used regarding disclosing nonpublic personal information of people who are no longer customers of the institution;
- the categories of nonpublic personal information that are collected by the financial institution;
- the policies that the institution maintains to protect the confidentiality and security of nonpublic personal information; and
- other disclosures as required under the Fair Credit Reporting Act.

Enforcement under the Act for any person engaged in providing insurance is placed under the applicable State insurance authority of the State.

Under Section 521 of Title V of the Act includes provisions related to privacy protection for customer information of financial institutions. This Section prohibits obtaining customer information by false pretenses:

(1) by making a false, fictitious, or fraudulent statement or representation to an officer, employee, or agent of a financial institution;

(2) by making a false, fictitious, or fraudulent statement or representation to a customer of a financial institution; or

(3) by providing any document to an officer, employee, or agent of a financial institution, knowing that the document is forged, counterfeit, lost, or stolen, was fraudulently obtained, or contains a false, fictitious, or fraudulent statement or representation.

This prohibition does not generally apply to law enforcement agencies when obtaining customer information of a financial institution in connection with the performance of the official duties of the agency. It also does not apply to insurance institutions or any officer, employee, or agency of an insurance institution, from information *as part of an insurance investigation into criminal activity, fraud, material misrepresentation, or material nondisclosure that is authorized for such institution under State law, regulation, interpretation, or order.*

Section 523 provides for a fine or imprisonment, or both for anyone who knowingly and intentionally violates, or knowingly and intentionally attempts to violate Section 521 of this Act.

Unfair Trade Practices

The agent has the responsibility to act fairly in the transacting of insurance business. State insurance laws and regulations include descriptions of what acts are considered unfair practices. An agent is prohibited under law from participating in any unfair trade practice.

Misrepresentations And False Advertising Of Insurance Policies

Misrepresentation and false advertising are both considered unfair trade practices. The agent may not make, issue, circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement, sales presentation, omission or comparison that:

- Misrepresents benefits, advantages, conditions or terms of a policy;
- Misrepresents dividends or shares of the surplus to be received on a policy;
- Makes a false or misleading statement regarding the dividends or share of surplus previously paid on a policy;
- Misleads or misrepresents the financial condition of an insurer or the legal reserve system;

- Uses a name or title for a policy or type of policy that misrepresents the true nature of the policy;
- Misrepresents for the purpose of inducing or attempting to induce the purchase, lapse, forfeiture, exchange, conversion or surrender of a policy;
- Misrepresents for the purpose of effecting a pledge or assignment of or effecting a loan against a policy; or
- Misrepresents any policy as being a share of stock.

False Information and Advertising

In addition, the agent is prohibited from making, publishing, disseminating, circulating, putting before the public, or causing to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or any other publication, or in a notice, circular, a pamphlet, a letter or poster, whether over a radio or television station, or any other way, an advertisement, announcement or statement containing any untrue, deceptive or misleading assertion, representation or statement regarding the business of insurance or regarding any insurer in its insurance business.

Defamation

The agent is also prohibited from defaming an insurer. The agent may not make, publish, disseminate, or circulate, or aid or abet, or encourage the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature that is false, maliciously critical of or derogatory to the financial condition of any insurer, with the purpose of injuring that insurer.

Boycotting, Coercion and Intimidation

Boycotting, coercion and intimidation are also prohibited practices. The agent may not enter into any agreements to commit, or commit any act of boycott, coercion or intimidation that results in an unreasonable restraint of the business of insurance.

False Statements And Entries

Another unfair trade practice is making false statements or entries to a supervisor or public official or any insurance department official. The agent may not knowingly file with any supervisory or other public official, or knowingly make, publish, disseminate, circulate or deliver to any person, or put before the public, or knowingly cause to be made, to any person, or the public, any false material statement of fact as to the financial condition of an insurer. The agent also may not knowingly make any false entry of a material fact in any books, reports or statements of an insurer, or knowingly omit to make a true entry of any material fact that pertains to the business of the insurer.

Rebates

Most states consider the use of rebating as unfair discrimination. A rebate is generally defined as paying, allowing or giving, or offering to pay, allow, or give, directly or indirectly as inducements for buying a policy, a return of premiums payable on the policy; providing any special favor or advantage in the dividends or other benefits of the policy; giving any valuable consideration or inducement not specified in the policy; purchasing, or offering to give, sell, or purchase as inducements for the purchase of a policy or annuity, any stocks, bonds or other securities of any insurance company or other corporation, association or partnerships; or giving anything of value whatsoever not specified in the policy.

Misrepresentations in Insurance Applications

Another unfair trade practice is making false or fraudulent statements or representations regarding an application for a policy for the purpose of obtaining a fee, commission, money or any other benefit from any insurance provider or individual person. The

Unfair Financial Planning Practices

An unfair trade practice also occurs when an insurance agent calls himself or herself a financial planner, investment adviser, consultant, financial counselor, or any other specialist that engages in the business of giving financial planning or advice related to investments, insurance, real estate, tax matters or trust and estate matters when the agent is only engaged in the sale of policies. If an agent actually does hold some kind of financial planning designation, the agent may, of course, use that designation.

If an agent engages in the business of financial planning, the agent must disclose that he or she is also an insurance sales person and that a commission for the sale of an insurance product will be received by the agent in addition to a fee for financial planning, if such a fee structure is used by the agent. The agent may not charge any fees other than commissions for financial planning unless the fees are stated in a written agreement signed by the customer in advance of the performance of the services under the agreement. The written agreement must include:

- the services for which the fee is to be charged,
- the amount of the fee or how it will be calculated, and
- a provision that the client is under no obligation to purchase any insurance product through that producer or consultant.

An agent must keep a copy of this agreement for at least three years under most state laws from the date of completing the services for the client.

Long-Term Care Unfair Trade Practices

In the area of long-term care insurance, many states consider the failure to file or certify information regarding the endorsement or sale of a long-term care insurance policy as an unfair trade practice.

Coercion of Debtors

Another unfair trade practice involves coercing customers to use a specific agent or insurer for insurance policies that are required for or related to a loan. Generally, it is prohibited for any person, depository institution, or affiliate of a depository institution to require as a condition of a loan or extension of credit that the borrower purchase an insurance policy through a particular insurer or group of insurers, or agent, broker or group of agents or brokers. A lender or any person also may not reject an insurance policy used in conjunction with a loan or offer of credit just because the insurance policy is issued or underwritten by someone who is not associated with the lender or person.

It is also prohibited for any person, depository institution or affiliate of a depository institution to require that the customer obtain insurance some from any particular depository institution or affiliate of the depository institution or a specific insurer or producer.

No person may unreasonably reject a policy furnished by a customer or borrower for the protection of property used to secure the loan. Standards used for determining whether insurance meets the requirements of the lender may not discriminate against any particular type of insurer, nor may include rejecting a policy because it contains coverage in addition to that which is required for the loan.

It is also prohibited for any person to require that any customer, borrower, mortgagor, purchaser, insurer, broker or agent pay a separate charge for the handling of any policy required as security for a loan or pay a separate charge to substitute the policy of one insurer for another.

No one may require any procedures or conditions of producers or insurers that are not customarily required of producers or insurers that are affiliated or any way connected with the person many money or extending the credit.

Selling Insurance in Conjunction With a Depository Institution

Insurance is sometimes offered in a bank or depository institution environment. It may be possible for a customer of a financial institution to believe that insurance products offered through or in cooperation with the bank includes guarantees not found in insurance offered through other channels. This is of course incorrect. To ensure that bank customers are not confused, specific regulations are in place or will be in place in each state that prohibit those offering such insurance from using an advertisement or other insurance promotional material that would cause a reasonable person to believe that the federal government or state is responsible for the insurance sales activity of, or stands behind the credit of, a person, depository institutions or an affiliate. It is also prohibited for anyone offering insurance to use an advertisement or other insurance promotional material that would cause a reasonable person to believe that the federal government or the state guarantees any returns on an insurance product or is a source of payment on any insurance obligation to offer.

If insurance is sold in conjunction with a credit transaction, it is generally prohibited to sell the insurance through the credit documents unless the insurance is credit insurance or flood insurance. It is also generally prohibited to include the expense of insurance premiums other than credit insurance or flood insurance premiums in the primary credit transaction without the express written consent of the customer.

Insurance sold in a ***depository institution*** or in conjunction with a depository institution must be sold in an area that is physically separated from the area where retail deposits are routinely accepted. Insurance transactions also are required to be recorded in separate and distinct books and records from being normal retail deposit records of the depository institution.

When the insurance is related to a loan for real or personal property, every person, depository Institution, and affiliate of a depository institution, must disclose to customers in writing that insurance related to the loan may be purchased from an insurer or producer of the customer's choice, subject to the lender's right to reject a given insurer or agent according to legal standards. The disclosure must also inform the customer that the choice of the insurer or producer will not affect the credit decision or credit terms of the loan in any way, except that the depository institution may impose reasonable requirements regarding the creditworthiness of the insurer and the scope of coverage of the policy.

A disclosure must also be provided in transactions where the insurance offered is an insurance product or annuity primarily used for personal, family or household purposes. The disclosure must state:

- that the insurance related to the loan is not a deposit,
- is not insured by the FDIC,
- is not guaranteed by the depository institution, and its affiliate or any person solicitation or selling insurance on its promises, and
- depending upon the insurance product, state that the product involves investment risk, including the potential loss of principal.

When disclosures are required, the person selling the insurance must obtain written acknowledgement of the receipt of the disclosure from the customer at the time the customer receives the disclosure, or at the time of the purchase of the insurance policy. If insurance is offered over the telephone, the person offering the insurance must obtain an oral acknowledgement of receipt of the disclosure, and maintain documentation to show the acknowledgement was given by the customer. In addition, a reasonable effort must be made to obtain a written acknowledgement from the customer. If a customer agrees to receive disclosures electronically, and the disclosure is provided in a format that the customer may retain or obtain later the use of electronic media for the disclosure and the acknowledgement of the receipt is acceptable.

Discrimination Laws

The agent may not practice unfair discrimination in the transaction of insurance. In the area of life insurance, unfair discrimination involves charging different rates to individuals of the same class and equal expectation of life for any life insurance policy or annuity or providing to such individuals different benefits payable or any other terms and conditions of a life or annuity policy.

In health and accident insurance, it is unfair discrimination to charge a different amount of premium, policy fee or rate to individuals of the same class and of essentially the same hazard ,or to provide differing benefits payable or terms or conditions of a policy to such individuals.

In property and casualty insurance, it is unfair discrimination to refuse to insure, refuse to renew, to cancel or to limit the amount of insurance coverage solely because of the geographic location of the risk, unless the action taken is based on the application of sound underwriting principles related to actual or reasonably anticipated loss experience. Is also unfair discrimination to refuse to renew, or limit the amount of insurance coverage on a residential property or personal property within the residence solely because of the age of the residential property. It is also considered unfair discrimination to terminate or to modify coverage or to refuse to issue any property and casualty policy solely because the applicant, the insured or any employee is mentally or physically impaired.

In all types of insurance, in most states, it is unfair discrimination to refuse to insure or refuse to continue to insure or limit the amount of insurance available because of the sex, marital status, race, religion or national origin of the individual. However, it is not an unfair discrimination if an insurer takes marital status into account in order to define what persons are eligible for dependent benefits.

Unfair discrimination is also considered to exist when an insurer or agent refuses to insure someone solely because another insurer has refused to write a policy, has canceled a policy or has refused to renew an existing policy for that person.

Discrimination laws affect underwriting because such laws prohibit or limit an insurer using certain characteristics in the underwriting process. The general discrimination rule related to rates found in most states' insurance law allows that, *(t)here is unfair discrimination if one rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the differences in expected losses and expenses. Rates are not unfairly discriminatory because different premiums result for policyholders with like loss exposures but different expense factors, or like expense factors but different loss exposures, so long as the rates reflect the differences with reasonable accuracy. Rates are not unfairly discriminatory if they are averaged broadly among persons insured under a group, franchise or blanket policy, as is found in New Mexico's Insurance Code.*

Discrimination Law under the Financial Services Modernization Act

The Financial Services Modernization Act also includes some provisions related to underwriting and discrimination laws. It particularly disallows an insurer to discriminate on the basis of domestic violence. It states that in the case of an applicant filing for life or health insurance, whether or not the applicant or insured is a victim of domestic violence or, is a provider of services to victims of domestic violence cannot be used *as a criterion in any decision with regard to insurance underwriting, pricing, renewal, or scope of coverage of insurance policies, or payment of insurance claims, except as required or expressly permitted under State law.* Domestic violence is defined under the Act as *the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner, or caretaker:*

(A) Attempting to cause or causing or threatening another person physical harm, severe emotional distress, psychological trauma, rape, or sexual assault.

(B) Engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm.

(C) Subjecting another person to false imprisonment.

(D) Attempting to cause or cause damage to property so as to intimidate or attempt to control the behavior of another person.

Genetic Information and Discrimination Laws

Coming along with the advances in science and technology of genetics are many decisions regarding how these advances should or should not be utilized in society. One of the concerns in this area is that of the use of genetic technology in determining the likelihood of individuals becoming sick or disabled in some way. There has been movement, especially in the area of health insurance, to enact legislation that prohibits the use of genetic information in insurance underwriting. Below is a summary of some of the insurance laws in various states that address this issue:

Alabama – Insurance statutes in Alabama prohibit health benefit plans from requiring genetic tests for predispositions to cancer, and from using genetic test results regarding cancer to set benefit rates.

Alaska – Insurance statutes in Alaska prohibit group health insurers from establishing rules for eligibility based on genetic information, and prohibit them from charging a rate to an individual that is higher than a rate charged to another individual with similar risk characteristics based on genetic information. Group health insurers may not consider a condition discovered through genetic information a pre-existing condition without a diagnosis of that condition.

Arizona – Arizona's insurance statutes state that health insurers may not deny coverage based on genetic information, may not require genetic testing without the consent of the applicant, and are required to ensure that results of genetic tests are privileged and confidential and may not be released without the consent of the policyowner or applicant. Life insurers may not refuse to consider applications based on genetic information. Disability income insurers may not use genetic information as a basis to refuse to consider applications and may not set rates or conditions strictly on the basis of genetic information but must have a diagnosis of the condition.

Arkansas – Insurance statutes in Arkansas require that health insurers may not use genetic information as a pre-existing condition. Group health insurers may not establish eligibility rules based on genetic information and may not charge a rate to an individual that is higher than a rate charged to another individual with similar risk characteristics based on genetic information

California – California's insurance statutes provide that in employer sponsored health plans, eligibility rules may not be based on genetic information and individuals may not be excluded

from coverage based on genetic information. Health insurers may not refuse to enroll individuals based on genetic information and may not charge higher rates or apply limited terms or conditions based on genetic information. In addition, health insurers may not inquire for genetic information for other than therapeutic purposes, may not require genetic tests for the purpose of determining insurability, and must receive the consent of the insured prior to any genetic test. Life and disability insurers must pay for all required genetic tests. Life insurers may not fail to issue, sell or renew insurance based on genetic information, may not establish higher premiums based on such information, and may not require genetic tests. Disability insurers may not deny coverage, not renew coverage, or charge a higher rate based on genetic information.

Colorado – Insurance statutes in Colorado prohibit health insurers from using genetic information to deny access to health insurance. Genetic information may not be accessed by health insurers for non-therapeutic purposes, and insurers may not use genetic information to deny access to health insurance. In addition, the health insurance statutes provide that genetic information belongs to the individual to whom it pertains. The insurer must also generally receive written consent from the individual in order to disclose information to third parties. Group disability insurers may not seek, use, or keep genetic information for the purpose of underwriting, and may not use genetic information to deny access.

Connecticut – Under Connecticut’s statutes, health insurers may not use genetic information as a pre-existing condition without a diagnosis of a condition related to the information. It is considered an *unfair trade practice* for insurers to refuse to insure, to renew or limit the amount or kind of insurance, or to charge rates based on genetic information.

Delaware – Insurance statutes in Delaware provide that health insurers may not discriminate in the issuance, denial or renewal or rates, terms or conditions of insurance based on genetic information.

Florida – In Florida, health insurers may not cancel, limit, deny coverage or establish rates based solely upon genetic information, but a diagnosis of the condition must also be present. Health insurers may also not require or solicit genetic tests, and group health insurers may not establish rules for eligibility based on genetic information.

Georgia – Georgia statutes also disallow the use of genetic testing for non-therapeutic purposes.

Hawaii – Insurance statutes in Hawaii prohibit health insurer’s from using, requesting, or requiring information on an individual or that individual’s family in order to deny, limit or establish eligibility, or insurance rates.

Idaho – Idaho’s insurance statutes generally prohibit managed care plans, large employer health plans, and small employer plans may not consider genetic information a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information.

Illinois – Illinois insurance statutes prohibit group health insurers from establishing rules for eligibility based on genetic information, and from considering genetic information as a pre-existing condition without the presence of a diagnosis regarding the condition. Accident and health insurers may not seek genetic information, and if it is received, it may not be used for non-therapeutic purposes. If genetic tests are voluntarily submitted and are favorable, insurers may consider such tests.

Indiana – Insurance statutes in Indiana require that accident, sickness, group, self-funded employee plans, and government health care plans may not require nor consider the results of genetic tests in an adverse manner to an individual or the individual's family. Health insurers may not base adverse decisions on genetic test results in medical records, and may not cancel, refuse to issue or renew or establish premiums or limits for health coverage based on genetic information. Insurers may also not request results of genetic tests and may not ask questions designed to ascertain the results of genetic tests. If genetic tests are voluntarily submitted and are favorable, insurers may consider such tests.

Iowa – Iowa's insurance statutes require that group health insurers may not establish rules for eligibility based on genetic information and genetic information may not be considered as a pre-existing condition in the absence of a diagnosis related to the information.

Kentucky – In Kentucky, group health insurers may not use genetic information to establish rules for eligibility and may not charge higher rates to an individual that is higher than a rate charged to another individual with similar risk characteristics based on genetic information. Individual health insurers may not consider genetic information a pre-existing condition in the absence of a diagnosis of the condition.

Louisiana – Insurance statutes in Louisiana prohibit health insurers from terminating, restricting, limiting, canceling, or refusing to renew coverage based on prenatal test results. Group health insurers may not use genetic information as a basis for eligibility rates and may not charge higher rates to an individual that is higher than a rate charged to another individual with similar risk characteristics based on genetic information.

Maine- Maine's insurance statutes prohibit group health insurers from using genetic information for the purpose of establishing rules for eligibility or requiring higher payment than for a similarly situated individual. Individual and group health insurers may not consider genetic information a pre-existing condition in the absence of a diagnosis of the condition. Health, hospital and dental insurers may not discriminate against an individual on the basis of genetic testing. Under life and disability insurance laws, using the results of a genetic test in a manner that is not reasonably related to claims experience is considered *unfair discrimination*.

Maryland – Health insurers in Maryland, including HMO's and non-profit health service plans may not reject, deny, limit, cancel, refuse to renew, increase rates or affect the terms of health insurance on the basis of genetic testing. Genetic testing may not be required or requested to determine eligibility for coverage. Disability income insurers may not refuse to insure or make rate differentials based solely upon a genetic trait.

Minnesota – In Minnesota, insurance statutes prohibit health insurers from determining eligibility, limiting coverage, establishing premiums, renewing coverage, or making any other underwriting decision by requiring or requesting genetic testing of the applicant or a blood relative. Insurers are also prohibited from making inquiries into whether an individual has had a genetic test or inquiring into the results of such a test, or taking into consideration that a genetic test was refused, or taking into consideration the results of genetic testing of an individual or a blood relative. A life insurer may not require an individual to submit to a genetic test unless the insurer pays for the test.

Missouri – In Missouri, insurers may not require or request an individual or blood relative to provide genetic information, take a genetic test, or make inquiries about a genetic test in order to determine eligibility, limit coverage, establish premiums, renew coverage or make any other underwriting decision.

Montana - Health insurers in Montana may not require or request genetic testing of an applicant or blood relative to determine eligibility, limit coverage, establish premiums, renew coverage, or make any other underwriting decision. The insurer may also not take into consideration the fact that a genetic test was refused or take into consideration the results of a genetic test of an individual or blood relative. Group health insurers are prohibited from considering genetic information a pre-existing condition without the presence of a diagnosis. Group health insurers also may not establish eligibility rules based on genetic information. A life insurance company must pay for the cost of a required genetic test, and may not refuse to consider an application for life insurance on the basis of a genetic condition. Also, under both life insurance and disability insurance rules, it is considered *unfair discrimination* to base rates or policy conditions on genetic condition unless the applicant's medical condition and history along with the insurer's claims experience or actuarial projections demonstrate that substantial differences in claims are likely to result from the genetic condition.

Nevada – In Nevada, group health insurers, individual health insurers, HMOs, and small-employer health insurers may not require a genetic test, require disclosure of a genetic test, or determine rates based on genetic testing. Group health insurers, individual insurers and small employer health insurers may not include genetic information as a pre-existing condition without the presence of a diagnosis of the condition. Small employer health plans may not establish eligibility rules based on genetic information.

New Hampshire – Insurance statutes in New Hampshire prohibit health insurers from requiring or requesting an individual to take a genetic test, requiring an individual to disclose whether a genetic test has been taken or disclosing the results of such a test. Health insurers are also prohibited from using genetic testing as a basis for eligibility and from using the results of genetic tests to establish rates and may not use genetic information if it is received.

New Jersey - Group and individual health insurers in New Jersey may not exclude an individual, and may not establish rates or policy terms based on genetic characteristics. Genetic information may not be treated as a pre-existing condition by health insurers without a diagnosis of that condition being present. Life insurance statutes classify the use of results of a genetic test in the issuance, withholding or renewal of life insurance as *unfair discrimination*. Disability income insurers are prohibited from discriminating against anyone on the basis of genetic information for the issuance, withholding, extension or renewal of policies.

New Mexico – New Mexico's insurance statutes prohibit health insurers from discriminating on the basis of genetic analysis, genetic information, or genetic propensity. Also prohibited is the used of a genetic propensity, susceptibility, or carrier status as a pre-existing condition. Group health insurers may not establish eligibility rules based on genetic information. Life and disability income insurers may use genetic information if the use of the information is based on sound actuarial principles or related to actual or reasonably anticipated experience.

North Carolina – Insurance statutes prohibit health insurers, non-profit hospitals, HMOs, and multiple employee welfare arrangers from raising premiums and rates paid by groups based on genetic information about an individual of the group, and also prohibit refusing to issue or deliver a health benefit plan, or charging a higher rate due to genetic information. Group health insurers may not establish rules for eligibility based on genetic information.

North Dakota – In North Dakota, group health insurers may not consider genetic information as a pre-existing condition in the absence of a diagnosis related to this information.

Ohio – Group and individual health insurers and self-insurers in Ohio may not require an individual to submit a genetic test, may not take into consideration the results of a genetic test, may not make inquiries into the results of genetic tests, or make decisions adverse to the

applicant based on entries in medical records regarding genetic screening or testing. Health insurers may not base decisions to cancel, refuse to issue, or renew, or limit benefits of health care coverage on genetic information.

Oregon – In Oregon, health insurance providers are prohibited from using genetic information to reject, deny, limit, cancel, refuse to renew, increase rates or affect the terms and conditions for hospital or medical expense policies. In addition, an insurer must obtain specific authorization from an applicant prior to a genetic test, and must provide the results of the genetic test to the applicant.

Pennsylvania – Insurance statutes in Pennsylvania provide that health insurance policies must provide coverage for formulas on medically necessary and critical to the treatment of PKU and other rare genetic metabolic disorders.

Rhode Island – Group and individual health insurers in Rhode Island may not use results of genetic tests to reject, deny, limit, cancel, refuse to renew, increase rates, or affect the terms of health insurance policies. Such insurers also may not request or require genetic testing to determine eligibility for coverage. They also may not ask for the results of genetic testing.

South Carolina – South Carolina's insurance statutes provide that in order for a health insurance provider to be considered a *bona fide association*, it may not condition membership on genetic information. Group health insurers may not establish eligibility rules on genetic information. No health insurer may terminate, restrict, limit, cancel, refuse to renew, exclude from coverage, impose a waiting period or establish rates based on genetic information.

South Dakota – Under South Dakota statutes, small employer health plan carriers may not establish eligibility rules based on genetic information.

Tennessee - Insurance statutes in Tennessee provide that health insurers may not:

- cancel, deny or vary premiums and terms for an individual on the basis of whether or not that individual or a family member has had genetic services, nor
- request or require an individual to disclose genetic information.

Group health plans insurers may not establish rules for eligibility on genetic information.

Texas – Group health insurers in Texas may not use genetic information to reject, deny, limit, cancel, refuse to renew, or increase premiums. If such an insurer requests a genetic test, the insurer must notify the applicant, disclose the purpose of the test, and obtain written informed consent from the applicant. Genetic information is also confidential and privileged, regardless of its source.

Vermont –Under insurance statutes in Vermont, health insurers may not underwrite or condition a policy on the basis of requiring an individual to undergo genetic testing, or on the basis of results of any genetic testing.

Virginia – Group, individual and small employer health plans in Virginia may not terminate, restrict, limit, cancel or refuse to cover, set rates, exclude or impose a waiting period on the basis of genetic information.

West Virginia - Insurance statutes in West Virginia provide that in order for a health insurance provider to be considered a *bona fide association*, it may not condition membership on genetic information.

Wisconsin – Wisconsin's insurance statutes prohibit health insurers from requiring or requesting genetic tests, from disclosing genetic test results or disclosing whether or not an individual or a family member has had a genetic test. The provision of health insurance may not be conditioned on taking a genetic test, and rates and benefits may not be based on genetic tests. In addition, group plans may not consider genetic information a pre-existing condition without a diagnosis of the condition. Group disability insurers also may not use genetic information as a pre-existing condition without a diagnosis of a condition related to that information, and may not establish eligibility rules based on genetic information.

Wyoming – Under Wyoming statutes, small employer and group health plans are prohibited from using genetic information as a pre-existing condition without a diagnosis of a condition related to that information.

Note: These statute summaries are for information purposes only and not intended as legal advice. In addition, statutory provisions may change at any time.

The Americans With Disabilities Act

Another important Act that effects insurance underwriting is the Americans With Disabilities Act, or ADA. This law was passed in 1990 to establish standards of conduct related to Americans with disabilities. Section 2 explains the reasons behind the Act.

SEC. 2. FINDINGS AND PURPOSES. 42USC 12101.

(a) Findings. The Congress finds that

- (1) some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older;*
- (2) historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem;*
- (3) discrimination against individuals with disabilities persists in such critical areas as employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting, and access to public services;*
- (4) unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;*
- (5) individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities;*
- (6) census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged socially, vocationally, economically, and educationally;*
- (7) individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to, society;*

(8) the Nations proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals; and

(9) the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity to compete on an equal basis and to pursue those opportunities for which our free society is justifiably famous, and costs the United States billions of dollars in unnecessary expenses resulting from dependency and nonproductivity.

(b) Purpose. It is the purpose of this Act

(1) to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities;

(2) to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities;

(3) to ensure that the Federal Government plays a central role in enforcing the standards established in this Act on behalf of individuals with disabilities; and

(4) to invoke the sweep of congressional authority, including the power to enforce the fourteenth amendment and to regulate commerce, in order to address the major areas of discrimination faced day-to-day by people with disabilities.

Section 3 of the Act defines disability as:

- a physical or mental impairment that substantially limits one or more of the major life activities of such individual;*
- a record of such an impairment; or*
- being regarded as having such an impairment.*

Section 501 of the Americans With Disabilities Act addresses insurance and disability:

(c) Insurance. Titles I through IV of this Act shall not be construed to prohibit or restrict

(1) an insurer, hospital or medical service company, health maintenance organization, or any agent, or entity that administers benefit plans, or similar organizations from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this Act from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws that regulate insurance.

The ADA Technical Assistance Manual gives further information on this issue:

III-3.11000 Insurance.

Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer. Because of the nature of the insurance business, however, consideration of disability in the sale of insurance contracts does not always constitute "discrimination." An insurer or other public accommodation may underwrite, classify, or administer risks that are based on or not inconsistent with State law, provided that such practices are not used to evade the purposes of the ADA.

Thus, a public accommodation may offer a plan that limits certain kinds of coverage based on classification of risk, but may not refuse to insure, or refuse to continue to insure, or limit the amount, extent, or kind of coverage available to an individual, or charge a different rate for the same coverage solely because of a physical or mental

impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The ADA, therefore, does not prohibit use of legitimate actuarial considerations to justify differential treatment of individuals with disabilities in insurance.

ILLUSTRATION: A person who has cerebral palsy may not be denied coverage based on disability independent of actuarial risk classification.

Can a group health insurance policy have a pre-existing condition exclusion? Yes. *An individual with a pre-existing condition may be denied coverage for that condition for the period specified in the policy. However, the individual cannot be denied coverage for illness or injuries unrelated to the pre-existing condition.*

Can an insurance policy limit coverage for certain procedures or treatments? Yes, *but it may not entirely deny coverage to a person with a disability.*

Does the ADA require insurance companies to provide a copy of the actuarial data on which its actions are based at the request of the applicant? *The ADA does not require it. Under some State regulatory schemes, however, insurers may have to file such actuarial information with the State regulatory agency, and this information may be obtainable at the State level.*

Does the ADA apply only to life and health insurance? No. *Although life and health insurance are the areas where the ADA will have its greatest application, the ADA applies equally to unjustified discrimination in all types of insurance, including property and casualty insurance, provided by public accommodations.*

ILLUSTRATION: Differential treatment of individuals with disabilities, including individuals who have been treated for alcoholism, applying for automobile insurance would have to be justified by legitimate actuarial considerations.

BUT: An individual's driving record, including any alcohol-related violations, may be considered.

May a public accommodation refuse to serve an individual with a disability because of limitations on coverage or rates in its insurance policies? No. *A public accommodation may not rely on such limitations to justify exclusion of individuals with disabilities. Any exclusion must be based on legitimate safety concerns (see III-4.1200), rather than on the terms of the insurance contract.*

ILLUSTRATION: An amusement park requires individuals to meet a minimum height requirement that excludes some individuals with disabilities for certain rides because of a limitation in its liability insurance coverage. The limitation in insurance coverage is not a permissible basis for the exclusion.

BUT: The minimum height requirement would be a permissible safety criterion, if it is necessary for the safe operation of the ride.

The Americans With Disabilities Act is important because it restricts an insurer or others such as underwriters and agents, from using certain disabling characteristics as a reason to deny coverage. If an agent has any questions about whether there are special rules concerning a disability of any applicant or policyholder, he or she should contact the insurance company's underwriting department for direction.

Fair Housing Act

The Fair Housing Act regulates discriminatory practices in housing. Title 24, Part 105 explains the reasoning behind the Act:

(a) It is the policy of the United States to provide, within constitutional limitations, for fair housing throughout the United States. No person shall be subjected to discrimination because of race, color, religion, sex, handicap, familial status, or national origin in the sale, rental, or advertising of dwellings, in the provision of brokerage services, or in the availability of residential real estate-related transactions.

The insurance agent and insurer are impacted by this Act because it prohibits the insurer from having any part in this form of discrimination through improperly rejecting coverage. Part 100.70 includes such action under the heading "Other Prohibited Sale and Rental Conduct:"

b) It shall be unlawful, because of race, color, religion, sex, handicap, familial status, or national origin, to engage in any conduct relating to the provision of housing or of services and facilities in connection therewith that otherwise makes unavailable or denies dwellings to persons...

d) Prohibited activities relating to dwellings under paragraph (b) of this section include, but are not limited to:

1) Discharging or taking other adverse action against an employee, broker or agent because he or she refused to participate in a discriminatory housing practice.

2) Employing codes or other devices to segregate or reject applicants, purchasers or renters, refusing to take or to show listings of dwellings in certain areas because of race, color, religion, sex, handicap, familial status, or national origin, or refusing to deal with certain brokers or agents because they or one or more of their clients are of a particular race, color, religion, sex, handicap, familial status, or national origin.

3) Denying or delaying the processing of an application made by a purchaser or renter or refusing to approve such a person for occupancy in a cooperative or condominium dwelling because of race, color, religion, sex, handicap, familial status, or national origin.

*4) Refusing to provide municipal services or **property or hazard insurance** for dwellings or providing such services or **insurance** differently because of race, color, religion, sex, handicap, familial status, or national origin.*

The Fair Housing Act in its original form was enacted in 1968. Since then it has had amendments, revisions, and has been the subject of many court cases. The insurance industry has responded by careful construction of its underwriting requirements to ensure compliance with the Act. The agent must be careful to work within these underwriting requirements so that fair housing practices are not violated.

Redlining

The practice of refusing to offer insurance to someone due to location is known as *redlining*. Although this course has made reference to the fact that insurers use location as a factor in determining rates, there has been opposition to such use when it results in a high percentage of minorities or poor being denied coverage, as may occur when insurers deny coverage or charge high rates to residents of an urban area. Insurers have been accused of unfair discrimination in their use of redlining when it affects or appears to affect minority applicants in higher ratios than non-minority applicants. Race may never be used as a factor in rate setting.

One of the ways in which states have responded to the issue of redlining is to establish insurance plans that provide insurance to high-risk applicants who are not able to purchase or afford coverage through primary market insurers. Twenty-three states have established FAIR plans, or *Fair Access to Insurance Requirements* plans. The regulations vary from state to state, but generally, FAIR plans involve a group of participating insurers who offer insurance to those outside of the standard market. In many states with FAIR plans, all property insurers doing business in the state must participate in the FAIR plan. The insurer may be required to write a volume of FAIR plan policies based on the total amount of business written in the state. Approximately thirty states have FAIR plans, including Connecticut and Pennsylvania.

Health Insurance Discrimination Rules

The Health Insurance Portability and Accountability Act of 1996, or HIPAA, includes discrimination rules related to group health plans. Generally, a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following factors applicable to the individual or dependent of the individual:

- Health status
- Medical condition (including both physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

However, the regulations found in this Act are not to be construed to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment or service) other than those provided under the terms of the plan, nor to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for *similarly situated* individuals enrolled in the plan or coverage.

HIPAA also does not allow group health plans to discriminate on the basis of the factors listed previously (health status, medical condition, etc.) in determining premium payments. A group health plan may not require any individual to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on these factors. These regulations state that they are not intended to restrict the amount that an employer may be charged for coverage under a group health plan or to prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention.

Mental Health Discrimination

Another area of discrimination that has been the subject of federal law is mental health. In 1996, as part of HIPAA, the Mental Health Parity Act was passed. This Act prohibits insurers that include benefits for mental health services from applying a lifetime or annual benefit limit on mental health services that is different from such benefit limits on physical health services.

There is no requirement that health insurers include mental health services in their coverage under the Mental Health Parity Act. The Act applies, as do most provisions of HIPAA, generally to group health plans with more than fifty workers.

The Mental Health Parity Act provisions do not prohibit group health plans from increasing copayments or placing a limit on the number of covered visits for mental health services. The

Act also does not prohibit group health plans from requiring higher coinsurance payments or other cost-sharing arrangements that result in higher payments by a member for mental health services than for other types of services provided under the health plan.

Required Coverage and Preexisting Conditions

Underwriting is also impacted by state and federal laws that mandate that certain coverage must be provided under certain types of insurance policies or that mandate that certain conditions may not be considered pre-existing conditions, so may not be subject to waiting periods before coverage is applied. Required coverage is generally found in personal lines of insurance, rather than in commercial lines, and is particularly prevalent in health insurance.

COBRA and Required Coverage

The *Consolidated Omnibus Budget Reconciliation Act of 1985*, or COBRA, includes requirements for group health plans regarding health care continuation. COBRA has been amended and expanded by the Omnibus Budget Reconciliation Act of 1986 (OBRA '96), the Tax Reform Act of 1986 (TRA '86), the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), the Small Business Job Protection Act of 1996 (SBJPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under these regulations a *group health plan* is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. The regulations also apply to certain individual health plans, if maintained by an employer or employee organization for employees.

Under COBRA, generally, *qualified beneficiaries* must be given the opportunity to continue health care coverage provided through an employer's health plan. A *qualified beneficiary*, under IRS final regulations issued December 28, 1998, is in general, (1) *any individual who, on the day before a qualifying event, is covered under a group health plan either as a covered employee, the spouse of a covered employee, or the dependent child of a covered employee, or* (2) *any child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage.* *Qualifying events*, or events that trigger COBRA continuation coverage, include termination from employment, resignation, death, entitlement to Medicare, reduction in hours to a level below that required by the employer for health care coverage, employer bankruptcy, and in certain cases divorce, legal marital separation, and a child's loss of eligibility for coverage.

If a health plan covered by COBRA does not comply with requirements under COBRA, an excise tax is imposed on the employer and/or the plan. In addition, qualified beneficiaries who are harmed by this lack of compliance can file a lawsuit against the plan or employer for damages. The terms of COBRA allow for the qualified beneficiary to be required to pay for the continuation of coverage; the employer does not have to pay the premium. In addition, the plan may charge additional administrative

The Mental Health Parity Act
UNITED STATES CODE SERVICE
TITLE 42. THE PUBLIC HEALTH AND WELFARE
CHAPTER 6A. THE PUBLIC HEALTH SERVICE
REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

GROUP MARKET REFORMS; OTHER REQUIREMENTS (42 USCS § 300gg-5) (1999)
§ 300gg-5. Parity in the application of certain limits to mental health benefits

(a) In general.

(1) Aggregate lifetime limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

(A) No lifetime limit. If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.

(B) Lifetime limit. If the plan or coverage includes an aggregate lifetime limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable lifetime limit"), the plan or coverage shall either--

(i) apply the applicable lifetime limit both to the medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any aggregate lifetime limit on mental health benefits that is less than the applicable lifetime limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different aggregate lifetime limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(2) Annual limits. In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits--

(A) No annual limit. If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan or coverage may not impose any annual limit on mental health benefits.

(B) Annual limit. If the plan or coverage includes an annual limit on substantially all medical and surgical benefits (in this paragraph referred to as the "applicable annual limit"), the plan or coverage shall either--

(i) apply the applicable annual limit both to medical and surgical benefits to which it otherwise would apply and to mental health benefits and not distinguish in the application of such limit between such medical and surgical benefits and mental health benefits; or

(ii) not include any annual limit on mental health benefits that is less than the applicable annual limit.

(C) Rule in case of different limits. In the case of a plan or coverage that is not described in subparagraph (A) or (B) and that includes no or different annual limits on different categories of medical and surgical benefits, the Secretary shall establish rules under which subparagraph (B) is applied to such plan or coverage with respect to mental health benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(b) Construction. Nothing in this section shall be construed--

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits; or

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

(c) Exemptions.

(1) Small employer exemption. This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

(2) Increased cost exemption. This section shall not apply with respect to a group health plan (or health insurance coverage offered in connection with a group health plan) if the application of this section to such plan (or to such coverage) results in an increase in the cost under the plan (or for such coverage) of at least 1 percent.

(d) Separate application to each option offered. In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(e) Definitions. For purposes of this section--

(1) Aggregate lifetime limit. The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit.

(2) Annual limit. The term "annual limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount of benefits that may be paid with respect to such benefits in a 12-month period under the plan or health insurance coverage with respect to an individual or other coverage unit.

(3) Medical or surgical benefits. The term "medical or surgical benefits" means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include mental health benefits.

(4) Mental health benefits. The term "mental health benefits" means benefits with respect to mental health services, as defined under the terms of the plan or coverage (as the case may be), but does not include benefits with respect to treatment of substance abuse or chemical dependency.

(f) Sunset. This section shall not apply to benefits for services furnished on or after September 30, 2001.

HISTORY: (Sept. 26, 1996, P.L. 104-204, Title VII, § 703(a), 110 Stat. 2947.)

HISTORY; ANCILLARY LAWS AND DIRECTIVES

Other provisions:

Applicability of section. Act Sept. 26, 1996, P.L. 104-204, Title VII, § 703(b), 110 Stat. 2950, provides: "The amendments made by this section [adding this section] shall apply with respect to group health plans for plan years beginning on or after January 1, 1998."

costs of up to 2% of the premium fees. The coverage under COBRA is required to be generally the same as the coverage the qualified beneficiary had before the qualifying event. The employer can give the beneficiary the option of eliminating benefits that are considered *noncore*, such as dental and vision care.

Preexisting Conditions Under HIPAA

HIPAA regulations, under *Section 9801, Increased portability through limitation on preexisting condition exclusions*, state that, generally, a group health plan may only impose a preexisting condition exclusion if the exclusion relates to a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date and the exclusion is in force for not more than 12 months, or up to 18 months for late enrollees. Under certain conditions the maximum exclusion period may be reduced by periods of *creditable coverage*. For example, if an individual was enrolled in a group health plan upon being hired by an employer, the new group health plan must give the employee credit for the time covered by the original health plan. The regulations define creditable coverage to include coverage under the following:

- A group health plan.
- Health insurance coverage.
- Part A or part B of title XVIII of the Social Security Act.
- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928.
- Chapter 55 of Title 10, United States Code.
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under chapter 89 of title 5, United States Code.
- A public health plan.
- A health benefit plan under section 5(e) of the Peace Corp Acts.

Also under HIPAA, a group health plan may not impose any preexisting condition exclusion to:

- a newborn who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage;
- a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last thirty-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage; or
- any condition related to pregnancy.

Certain coverages may carry additional waiting periods, however. These coverages include:

- Prescription coverage
- Vision coverage
- Dental coverage
- Mental health coverage
- Substance abuse coverage

However, if the individual had coverage under creditable coverage for any of these items, no additional waiting period can be applied.

Enrollment Eligibility

HIPAA also includes regulations regarding eligibility requirements for group health plans. Generally, a group health plan may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the plan based on any of the following factors applicable to the individual or dependent of the individual:

- Health status
- Medical condition (including both physical and mental illness)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

However, the regulations found in HIPAA are not to be construed to require a group health plan to provide particular benefits (or benefits with respect to a specific procedure, treatment or service) other than those provided under the terms of the plan, nor to prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for *similarly situated* individuals enrolled in the plan or coverage.

Long-Term Care Insurance Required Coverage and Preexisting Conditions

Long-Term Care insurance has been the subject of legislation that mandates that certain coverages be provided. The National Association of Insurance Commissioners has adopted a Model Long-Term Care Insurance Act. This Act includes standards for many elements of long-term care insurance, including required policy provisions and limits on pre-existing conditions. Many states have adopted portions of this model Act into their state statutes.

One of the provisions within the model Act prohibits the cancellation, nonrenewal or termination of a long-term care policy due to the age or deterioration of the physical or mental health of the insured.

Preexisting Conditions

Another key portion of the model Long-Term Care Insurance Act, states that unless a long-term care policy is a group policy issued to employers or labor organizations or to a trust or a fund established by employers or labor organizations, or a combination, for employees or members of the labor organization, the policy may not use a definition of preexisting condition that is more restrictive than this definition in the Act: *“Preexisting condition means a condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person.”* Also, unless a policy falls into a group policy as defined in the Act, coverage for a loss or confinement that is the result of a preexisting condition may not be excluded unless the loss or confinement begins within six months following the effective date of coverage.

Waiting Periods

Under the model Act, a new waiting period may not be established if a long-term care policy is replaced by or converted to another long-term care policy with the same insurer. However, if an increase of benefits is voluntarily requested by an insured, a new waiting period may be applied.

Skilled Nursing Care Only

Long-term care policies generally include various levels of care, including skilled nursing care, intermediate and custodial care. The model Act includes a prohibition against policies including skilled nursing care only or including providing significantly more coverage for skilled nursing care than for lower levels of care.

Prior Hospitalization

Prior hospitalization may not be used as a determiner of eligibility for benefits under the model Act. Also prohibited is requiring a higher level of care prior to eligibility for institutional care

benefits and requiring institutional care prior to eligibility for most benefits, other than waiver of premium, post-confinement, post-acute care or recuperative benefits. Also under the Act, if institutional care is required under a policy before non-institutional care benefits are provided, the length of the required institutional stay may not be greater than thirty days.

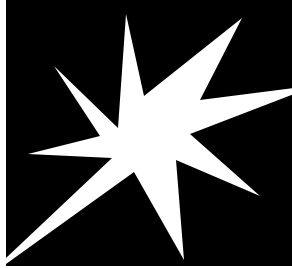
Burial Insurance

There is no type of insurance in the personal lines market that is not affected by unfair discrimination laws or accusations of unfair discrimination. In Florida, an insurer has recently been accused of charging twice as much to black policyholders than to white policyholders for burial insurance. The insurer agreed to a settlement that resulted in the insurer paying over \$200,000,000 to over two million black customers. Charging rates to applicants purely on the basis of race is a clear violation of unfair discrimination insurance laws as well as state and federal discrimination laws.

Summary

- Underwriting is impacted by state and federal insurance regulations. Regulations in the area of rate setting, privacy, required coverages and discrimination have the greatest impact on underwriting.
- States generally require that rates be adequate, not be excessive, and not be unfairly discriminatory.
- In property and casualty insurance, states generally use one of five rate setting methods. These are flex-rating, prior approval, open competition, file-and-use and use-and-file.
- Insurance related privacy laws regulate and limit the ways in which information may be collected and used.
- Sixteen states have adopted the National Association of Insurance Commissioners Model Insurance Information and Privacy Protection Act. This Act establishes *standards for the collection, use and disclosure of information gathered in connection with insurance transactions by insurance institutions, agents or insurance support organizations.*
- The Financial Services Modernization Act also includes privacy provisions applicable to insurers and provides that appropriate standards must be followed:
 - *to insure the security and confidentiality of customer records and information*
 - *to protect against anticipated threats or hazards to the security or integrity of such records*
 - *to protect against unauthorized access to or use of such records or information which could result in substantial harm or inconvenience to any customer.*
- Insurance agents are also prohibited from using unfair trade practices. These include misrepresentations and false advertising of insurance policies, defamation, boycotting, coercion and intimidation, false statements and entries, rebating, misrepresentations on insurance applications, unfair financial planning practices and coercion of debtors.
- When insurance is sold in conjunction with a depository institution, special regulations must be followed by the agent.
- Insurance law in most states mandate that rates are *unfairly discriminatory* if persons in similar situations are charged different rates. However, if rates are different due to different expense factors or different loss factors, such rates are not considered to be unfairly discriminatory.
- The Financial Services Modernization Act also includes some provisions related to underwriting and discrimination as it relates to domestic violence. Under this Act, domestic violence may not be used as *a criterion in any decision with regard to insurance underwriting, pricing, renewal, or scope of coverage of insurance policies, or payment of insurance claims, except as required or expressly permitted under State law.*

- Many states have also passed statutes regarding the use of genetic information. Most states prohibit group health insurers to use genetic information alone for establishing rates or eligibility.
- The federal Americans with Disabilities Act also includes provisions applicable to insurance and insurance underwriting, particularly health and life insurance.
- The federal Fair Housing Act prohibits discrimination based on race, color, religion, sex, handicap, familial status or national origin in the provision of property and hazard insurance.
- Redlining is also forbidden when it is done on the basis of unfair discrimination.
- HIPAA includes discrimination rules applicable to group health plans.
- The federal Mental Health Parity Act prohibits group health insurers from establishing annual or lifetime benefits on covered mental health services that are lower than benefits for other health services covered by the policy.
- COBRA includes required coverage rules related to continuation of coverage of group health plans.
- HIPAA also includes rules related to pre-existing conditions. It limits pre-existing condition exclusions generally to a maximum of twelve months, and provides a method of reducing the pre-existing conditions period through the application of creditable coverage periods.
- Long-term care insurance regulations include both required coverages and limits on pre-existing conditions.
- No form of insurance may charge rates that are unfairly discriminatory. A case of such unfair discrimination has recently been settled in Florida regarding burial insurance.



Reinsurance and Underwriting

Reinsurance plays an important role in the underwriting process. A critical part of analyzing risks is determining whether the insurer will be able to pay claims associated with a policy issued on that risk. The insurer must not assume more risk than it can support through the premium it collects. However, insurers also want to meet the needs of their policyholders and do not want to turn business away, nor make a policyholder buy multiple policies with essentially the same coverage from more than one insurer. Reinsurance provides a method for an insurer to take on risks that are larger, or take on a larger number of similar risks, than it otherwise would be able to do.

Reinsurance is generally defined as the transfer of all or a portion of the insurance written by one insurer to another insurer. The insurer that originally wrote the insurance passes on, or *cedes*, the insurance to an insurer that accepts the insurance. The original insurer is known as the *ceding* insurer or the *direct writer*. The insurer accepting the risk is known as the *reinsurer*.

There are two general types of reinsurance methods. One method is known as *facultative reinsurance* and the other is known as *treaty reinsurance*. Facultative reinsurance is done on a case-by-case basis, and treaty reinsurance is effected through an on-going agreement between the direct writer and the reinsurer.

Facultative Reinsurance

Facultative reinsurance, also called *street reinsurance*, is utilized when an application is received by the direct writer that exceeds its maximum underwriting standard. At the time the application is received, the insurer looks for a reinsurer to take on a portion of the policy limit. If a reinsurer is found, the direct writer is able to write the policy. Facultative reinsurance is the oldest form of reinsurance, and is not utilized as frequently today as is treaty reinsurance.

Treaty Reinsurance

Treaty reinsurance involves an on-going agreement between the ceding insurer and the reinsurer. There are several methods of treaty reinsurance in the property and casualty insurance line and a few methods in the life insurance line.

Surplus Treaty

One of the reinsurance methods used by property and casualty insurers is known as the *surplus treaty* method. Under a surplus treaty, the reinsurer agrees to accept a specified amount of insurance on each application that exceeds a certain level, known as the *retention level* or *net retention level*. (When discussing reinsurance, the *retention level* is the amount of insurance the direct writer retains.) Under this method, the direct writer may enter into agreements with several reinsurers, with each reinsurer agreeing to take a specified portion of risks above a certain level. The reinsurer that has an agreement to take the first dollars of an application above the retention level enters into what is known as a *first-surplus treaty*, the reinsurer that has an agreement to take the dollars of an application that are higher than those of a first-surplus treaty reinsurer enters into a *second-surplus treaty*, and so on.

For example, assume Insurer C establishes a retention level of \$100,000. This \$100,000 amount is known as a *line*. The first-surplus treaty reinsurer, Reinsurer A, accepts the excess of policies above \$100,000 with two lines, or policy amounts above \$100,000 up to \$300,000. The second-surplus treaty reinsurer, Reinsurer B, accepts the excess of policies above \$300,000 with three lines. If a \$500,000 policy is written, Insurer T will accept \$100,000 of insurance, Reinsurer A will accept \$200,000, and Reinsurer B will accept the remainder, \$200,000.

Losses under surplus treaties are shared among the ceding insurer and reinsurers based on the proportion of the policy accepted. In the example above, Insurer C will accept 20% of the losses from the \$500,000 policy, Reinsurer A will accept 40% of the losses and Reinsurer B will also accept 40% of the losses.

Quota Share Treaty Reinsurance

A second type of treaty used by property and casualty insurers is the *quota share treaty*. Under quota share treaty reinsurance, the ceding insurer and the reinsurer agree that each will share policies on a specified percentage basis. Both the premium and the loss are shared based on this percentage. For example, assume Insurer C enters into a quota share treaty with Reinsurer A. Insurer C agrees to accept 60% of each policy and Reinsurer A agrees to accept 40% of each policy. If a \$500,000 policy is written, Insurer C will accept \$300,000 and Reinsurer A will accept \$200,000. Should a \$100,000 covered loss occur, Insurer C will accept \$60,000 and Reinsurer A will accept \$40,000.

Excess-Loss Treaty Reinsurance

Property and casualty insurers may also use *excess-loss treaty* reinsurance. Under an excess-loss treaty, the reinsurer agrees to accept losses above a specified amount, up to a maximum amount. The agreement may include terms that the reinsurer will pay the loss related to a specific risk, or may pay on a per occurrence basis, should the loss level exceed the specified amount. For example, a treaty may specify that the reinsurer will pay for loss above a specified amount that occurs to covered property, or may specify that the reinsurer will pay for the total loss from several policies above a specified amount arising from a particular peril, e.g. a windstorm.

Reinsurance Pools in Property and Casualty Insurance

The fourth method of reinsuring used by the property and casualty industry is through *reinsurance pools*. A reinsurance pool is a group of insurers that jointly underwrite risks. Reinsurance pools generally are formed to provide insurance for high-risk, high limit coverage. For example, aviation pools cover the property and liability risks of commercial jets, which may be \$500 million or more. Other types of insurance that may be provided by reinsurance pools are risks related to nuclear energy, marine insurance, oil refineries, and risks in foreign countries such as those in the Caribbean. Workers Compensation insurance may also be underwritten by reinsurance pools.

Reinsurance pools may agree to share losses on a percentage basis – every insurer pays the same percentage of each loss. Or, they may agree that each insurer in the pool pays losses on the insurance it writes up to a specified amount, and the pool shares in the losses above that amount.

Life Insurance Reinsurance

Life insurers may use three methods of reinsurance, the *term insurance approach*, the *coinsurance approach*, and the *facultative obligatory approach*. Under the *term insurance approach*, the insurer purchases term insurance on the difference between the face value of the policy and the reserve. Under the *coinsurance approach*, the ceding insurer and the reinsurer

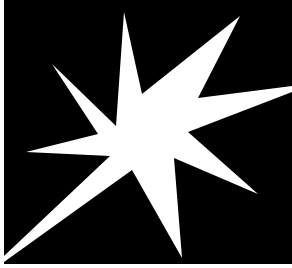
share the policy and its losses. Another type of life insurance reinsurance is known as *facultative obligatory reinsurance*. Under this form of reinsurance, the reinsurer has the right to decline individual risks submitted to it under certain circumstances.

Disability Income and Long-Term Care Reinsurance

In the disability income and long-term care reinsurance market, insurers may use the *excess of time reinsurance* method. Under this method, the ceding company pays claims on a policy for a specified period of time, and the reinsurer pays claims after that period of time.

Summary

- Reinsurance is the transfer of all or a portion of the insurance written by one insurer to another insurer.
- Facultative reinsurance involves looking for a reinsurer to take on a portion of the policy limit at the time an application is received.
- Treaty reinsurance involves an ongoing agreement between the ceding insurer and reinsurer. Treaty methods include surplus treaty, quota share treaty, and excess-loss treaty. These methods are used by property and casualty insurers.
- Reinsurance pools are groups of insurers that jointly underwrite risks.
- Life insurers use three methods of reinsurance. These are the term insurance approach, the coinsurance approach and the facultative obligatory approach.
- Disability income and life insurers may use the excess of time reinsurance method.



Better Underwriting

Every agent should strive for better underwriting practices. Think about it . . . If you continually submit higher-than-normal amounts of applications that are rejected, your income suffers and your clients suffer an emotional downer. Likewise, if you do not follow some basic suitability rules and sell people policies they cannot afford (*suitability underwriting*), you will experience a higher-than-normal *lapse rate* among clients who buy now and later drop their policies. You will lose thousands of dollars in trailing commissions, future business that same client may have generated for you and in some states you may be "categorized" as an irresponsible agent leading to fines, penalties and possible loss of license.

Ratings should be of interest to you because it is the system insurers use to "price" policies. Why should you be concerned about premium stability after you have sold a policy? Well, for one thing, you might be sued for not disclosing the possibility that rates for the class of policies you sold can increase. Rate increases are also harmful to your future business. Not only can they cost you a client, but they create the need for new selling requirements be added to the already existing minefield of disclosures you must present to your clients. As of the writing of this sales system, for example, the NAIC (National Association of Insurance Commissioners) is recommending that some forms of insurance include special disclosures showing your insurer's rate increase history and a signed acknowledgement that rates on his policy can increase in the future. What is your company's rate increase history?

Underwriting Problems

Insurers are not always the "victim" in the underwriting process, sometimes they ARE the problem. Years ago, for example, insurers sometimes approved policies on a *post claims underwriting* basis (now illegal). The company accepted applicants with little or no real underwriting, but when individuals attempted to file claims, the company engaged in vigorous investigations of the individual's application in an attempt to demonstrate that he or she did not adequately disclose a certain condition. The company would then rescind the policy instead of paying the claim alleging misrepresentation of a condition on the part of the applicant. The company used a vague or confusing questionnaire to aid in this practice. These tactics were only used by a few less than reputable companies and are now prohibited in most states.

There have also been many publicized, criticized and possibly abusive rate increase tactics. in the life industry, for example, insurers continually promise they will not raise premiums due to age or health, but that does not guarantee that the premium will stay the same for the entire class. And, it happens more than you think. Lawsuits have been filed in North Dakota and Florida over premiums that have increased as much as 700%, even though the products were promoted as having level premiums. Granted, this is unusual. Rate increases in the 25% to 50% range are more apt to occur. Either way, rate increases especially hurt your customers, especially those on fixed incomes. Since it may take many years for rates to be raised, people who originally bought on non-fixed incomes typically transition to fixed incomes. They are affected too.

Underwriting Factors You Can't Ignore

A new effort to simplify the application and approval process is underway featuring easier-to-understand policies and applications, "bundled benefit packages" which give consumers three or four good policy choices and "express" applications where a simple application pre-qualifies the insured and third party representatives complete the application with the client over the phone.

Even when these policies become widespread you will need to face the fact that between 10% and 30% of your clients will be rejected or rated for higher premiums. Underwriting can be tough on clients and you! But, before you start complaining, you need to understand that a consistent, fair process of evaluating potential insureds is your best guarantee that the company you represent is going to be around long enough to actually pay your client benefits. Some recent events involving a popular insurers have brought underwriting to the forefront. Rampant sales and minimal underwriting practices have brought companies to the brink of liquidation. High claims have depleted company reserves to less than half required by state regulators. Lawsuits have been filed which may involve agents. Besides the embarrassment and financial exposure of a situation like this, no agent wants to hear that a policy sold to a client is worthless *when he really needs it*.

How To Improve the Underwriting Process

- Read carefully the General Underwriting Guidelines from your insurance company.
- Obtain a specimen policy and clear-up any questions you have before submitting an application.
- Spend at least 50% more time on applications than you do now. Strive for accuracy and completeness fewer rejections and quicker processing.
- Submit your applications in a timely manner. Most companies consider apps stale dated if submitted after 30 days.
- Allow underwriting time to process applications: you're the only customer. Underwriters review each application individually -- if it fits the required guidelines, it will be issued.
- Know whether or not your state has special rates, disclosures forms, etc. Use the proper paperwork, especially if you work in more than one state.
- Provide underwriters as much information on the prospect as possible. You are legally bound to make personal observations about premises, client mobility, living conditions, attitude, etc., on a separate piece of paper. Anything less could result in an insurer claim against you for breach of duty. Anyway, why would you waste your time trying to get an obviously unqualified individual approved.
- If a paramed exam or inspection has been scheduled and the confirmation number has been recorded, make sure you put it on the application before submitting the policy for approval.
- If an Attending Physician Statement (APS) is necessary, get the name of the applicant's personal physician who has the insured's medical records. Call the physician's office and ask how much the fee for an APS is and include this information with the application. Sometimes, the physician's fee is more than the check sent by the insurance company. A delay to send more money can slow the entire process.
- Make sure all sections and questions on the application are completed.
- Don't ask for benefits or riders that are not available for the plan selected.
- Be aware of issues limits.

**Spend at least
50% more time
on applications
now than you
have before.**

- While individuals with certain controllable conditions or properties might not qualify for the best rates at a top-tier company, an agent who knows the market may still be able to write a policy at standard rates with a top-notch company. Also, there is nothing wrong with calling underwriters and making a case for a client.

Are Insurers Doing Their Job?

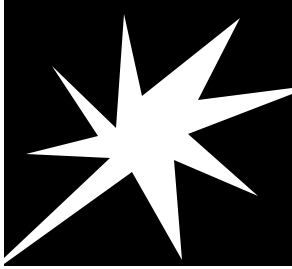
Make sure that minimum sales requirements are being met:

- Applications should contain clear, unambiguous, short questions designed to ascertain the health condition of the applicant. Questions shall be limited to yes or no answers. If a question asks for the name of a prescribed medication or prescribing physician, then any mistake or omission shall not be used as a basis for denial of a claim or rescission of a policy or certificate.
- The following warning should always be printed in a conspicuous place on the application: "Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your coverage."
- If an insurer does not complete underwriting and resolve all reasonable questions arising from the information submitted with an application before issuing the policy, then the insurer may only deny coverage for a valid claim based on convincing evidence of fraud or material misrepresentation.
- A copy of the complete application should be delivered to the insured at the time of delivery of the policy or certificate.

Your state may also go beyond these requirements and need a checklist of required documents and disclosures such as outline of coverage, receipt of a shoppers guide, a suitability worksheet, replacement policy guidelines and/or specific terminology concerning preexisting conditions, etc.

How else can you help your clients?

Stay abreast of the news. Watch your company ratings and their reserves. Inform clients of any changes and discuss the need to move, if possible, and when necessary. Of course, most states have state guaranty funds that can help preserve your clients coverage. However, the guaranty systems are a last resort system with limitations. Further, most states do not permit agents to use state guaranty fund information as an incentive to buy any form of insurance.



Glossary

Agent: The person who is given authority by the insurer to solicit insurance, obtain applications, delivery policies, collect premium and provide service. The agent represents the insurance company, not the policy owner, although the agent has certain responsibilities to act in the best interests of both the insurance company and the policy owner.

Application: An insurance form completed using information from the prospective insured pertaining to the risk to be insured.

Appraisal: An estimate of the value of property, loss or damage.

Boilers and Machinery Insurance: A form of insurance that provides coverage for property damage from boilers, electric machinery and other higher risk types of machinery that are excluded by the commercial property and businessowners property forms.

Ceding Insurer: In reinsurance, the insurer that passes on, or *cedes*, the insurance to an insurer that accepts the insurance. Also known as the *direct writer*.

Coinurance Approach: A life insurance reinsurance method where under the ceding insurer and the reinsurer share the policy and its losses.

Commercial General Liability Form: A liability insurance form for commercial risks which covers bodily injury and property damage liability, personal and advertising injury liability and medical expenses incurred for bodily injury caused by an accident on or by the premises owned or rented by the insured, or that arise from the insured's operations and excludes professional liability risks.

Crime Insurance: A form of insurance that protects a business against certain types of crimes. Forms include but are not limited to Employee Dishonesty, Theft, Disappearance and Destruction, Premises Burglary, Robbery and Safe Burglary and Computer Fraud.

Direct Writer: see ceding insurer

Dividend: The payment of surplus to policyholders due to favorable experience related to return, mortality rates, and/or expense charges.

Excess-Loss Treaty: In reinsurance, an agreement where under the reinsurer agrees to accept losses above a specified amount, up to a maximum amount.

Excess Policy: A policy specifically designed to provide coverage on an excess basis over other insurance the insured owns.

Excess of Time Reinsurance: A reinsurance method used by disability income and long-term care insurers where under insurers the ceding company pays claims on a policy for a specified period of time, and the reinsurer pays claims after that period of time.

Facultative Reinsurance: A form of reinsurance that is utilized when an application is received by the direct writer that exceeds its maximum underwriting standard. At the time the application is received, the insurer looks for a reinsurer to take on a portion of the policy limit. Also known as *street reinsurance*

Facultative Obligatory Reinsurance: A life insurance reinsurance method where under the reinsurer has the right to decline individual risks submitted to it under certain circumstances.

Floater: Marine and fire policies whose coverage follows the movement of the property at risk.

Guaranteed Renewable: A policy provision that guarantees that the contract may be renewed as long as premium is paid.

Hazard: An insurance term used to describe conditions that increase risk.

Indemnity Policy: An insurance policy which pays benefits to reimburse the insured for payments made for covered claims.

Inland Marine Insurance: Insurance that covers a wide variety of transportation risks.

Insurability: The overall acceptability of an individual as an insurance risk.

Insurable Loss: A loss which is considered to be insurable has five elements: (1) the loss must arise from a pure risk, (2) the loss must be definable, (3) the loss must be calculable, (4) the loss must not occur to many people simultaneously, and (5) the loss may not be intentional.

Moral Hazard: A condition or conditions that increase the likelihood that an insured or a person in a position to be paid by an insurer will intentionally cause, overstate or increase a loss.

Morale Hazard: A condition or conditions that increase the likelihood that the attitude of the insured or a person who will be paid by the insurer will cause a loss.

Nonparticipating Insurance: Life insurance that does not include the payment of dividends because the policy owner does not participate in the surplus of the policy.

Ordinary life insurance: Also known as whole life and straight life. Life insurance that requires a level premium payment, has a guaranteed death benefit and a guaranteed minimum rate applicable to cash values.

Participating Insurance: Life insurance policies that may include the payment of dividends because the policy owner participates in the earned surplus of the insurance company

Peril: An insurance term meaning a cause of loss.

Permanent Life Insurance: Life insurance policies that include the accumulation of cash values.

Premium: Money paid to the insurer to pay for the risk the insurer assumes for paying claims.

Physical Hazard: A condition or conditions of property, people, or operations that can increase loss.

Property Coverage: Insurance which provides protection against the risk of financial loss due to property damage.

Pure Risk: A risk which cannot result in the possibility of gain.

Quota Share Treaty: In reinsurance, an agreement where under the ceding insurer and the reinsurer agree that each will share policies on a specified percentage basis. Both the premium and the loss are shared based on this percentage.

Reinsurance: The transfer of all or a portion of the insurance written by one insurer to another insurer.

Reinsurance Pool: A group of insurers that jointly underwrite risks.

Renewability: Feature of life insurance policies that allows policies to be renewed without evidence of insurability.

Retention Level: In reinsurance, the amount of insurance the ceding insurer retains.

Risk Management Process: A process with the objective of reducing loss. The process includes identifying risks, evaluating each risk for frequency, severity and type, determining the best risk response, implementing the response, monitoring the results and making changes as necessary.

Surplus Treaty: A reinsurance method where under the reinsurer agrees to accept a specified amount of insurance on each application that exceeds the retention level.

Term Insurance Approach: A life insurance reinsurance method where under the insurer purchases term insurance on the difference between the face value of the policy and the reserve.

Workers Compensation Insurance: A form of insurance that covers employer risks such as injury, disability or death that occurs to employees while on the job.

