

Personal Lines / Agent Liability

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The Sources of Personal Lines Liability

The term “buyer beware” may have been around since ancient Rome, but it means little to a disgruntled insurance client. Why? Because no matter how personal lines agents try to avoid it, they are principals to every insurance transaction.

Face it, an unsuspecting client, who on the advice or silence of his agent, buys the wrong coverage or fails to acquire a proper endorsement, is hurt a lot more than someone who buys a fake Rolex for \$20 on the street corner. Consequences to the agent for his negligent acts are similarly severe when one considers malpractice judgments in today’s litigious society. These are reasons why agents need to understand agent liability issues and practice loss control for themselves and their personal lines practice.

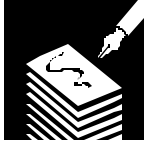
Furthermore, courts recognize the severity of “botched” insurance. Let’s look at some of things that can and do go wrong:

- Agent Jim “covers” Bill and Mary’s house that is leased to their son Dave, the sole resident of the house. Bill and Mary are also full-time residents in their own home. A pit bull owned by Dave attacks a neighbor who sues Bill and Mary as the homeowners and Dave as the owner of the dog. Dave claims “residency” under his parent’s policy, but lacking any evidence that Bill or Mary actually reside with him, coverage for the \$2 million claim is denied.
- Agent Cathy tells a homeowner Harry that his riding lawnmower is “covered”. Harry’s neighbor is away for two weeks, so Harry plans to surprise him by mowing his lawn. While Harry is cutting the neighbors lawn he injures a small child passing through the yard. Since his policy states that covered vehicles include those “used to service an insured’s residence”, his claim is denied.
- Agent Mike advises his client that their son’s computer is “covered” by their homeowner’s policy while he is away at school. Toward the end of the school year, the son’s roommate left the door unlocked and someone removed the \$2,000 computer. The claim was denied because the son was enrolled with only 11 units making him a part-time student. The client’s HO 2000 policy defines an “insured student” enrolled in school full time. A special endorsement for part-time students living away from home was cited as the reason that the claim might be denied.
- Agent Lucy recommends that her insured Bob does NOT purchase the Collision (or Loss) Damage Waiver for a rental car he needs while his own auto is in the shop. What Lucy missed is that her PAP (Personal Auto Policy) Covers the lesser of the “actual cash value” of the vehicle or the amount “necessary” to repair or replace the damaged property. Unfortunately, the auto rental company’s agreement obligates Bob for the “full value” of the vehicle. Can you see a potential problem?
- Mike is a personal lines agent with many affluent clients. Sally and Rich ask Mike to cover their home but fail to mention that it is actually titled in the name of their personal trust. The HO 2000 ISO, however, requires a special “residence held in trust” endorsement for full benefit of all coverages. Are Mike’s clients covered or not?
- Mark and Suzy have asked their agent Paul his opinion on writing a separate auto policy for their teenage daughter Hailey. Paul said “sure” it can save you a lot of money because at 17 she only needs to buy the minimum coverage. One day, Hailey’s brother, Dirk, borrows her car for a quick trip to pick up parts for his own car which is not running. A major accident occurs with a vascular surgeon who, because of his injuries, loses his ability to practice. Mark and Suzy submit their claim only to find that a special “family member” exclusion in their policy means they have no coverage for any resident member (Dirk) using the auto of another resident member unless that auto is insured under the parents’ policy.

- Erica and John are getting a divorce. In a fit of rage, John, who is named on the title to the couple's four vehicles, faxes you over a demand to remove Erica from the policies. Can you do it? Or should you discuss with John the legal implications of both him and you trying to remove someone who may have an interest in all four autos, regardless of the titling?
- You just insured a client's new boat which he intends to take out this weekend with his 3 teenage sons. Did you remember to remind your client about the coverage exclusion for operation of the boat by minors?
- Your client operates a good size business out of his home, including \$1 million in inventories and 5-6 employees. You knew that this business existed, but when the client purchased a new, larger home, you failed to ask him if he intended to operate a business there. Is he covered under his homeowners policy? Probably not. Are you open to an E&O claim? Probably so.

The list is endless, but the point is made. There is a lot you are responsible to know as a personal lines agent. In addition, the more you hold yourself out as an expert, the more liability you accept, whether you want it or not.

To understand the full extent of the exposure, we need to discuss legal responsibilities, the failure of insurance contracts, managing conflicts and various modes of agent conduct.



Agent Responsibilities

Legal compliance is an important duty in any business – especially insurance – where the cost of a single mistake can devastate you or your client. Your legal conduct is a responsibility *you cannot chose to ignore*.

Do You Cross The Line?

Few agents can say they have never “crossed the line”. . . went out on a limb for a client . . . looked the other way or fudged just a little when selling or serving a client. These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong an agent’s biggest fear comes true. . . **a malpractice lawsuit**. Anyone involved in one can tell you its a living nightmare. Beyond the financial liability, victims are dragged, kicked and punched through the legal maze known as our “justice system”. It is the domain of judges, attorneys and plaintiffs, a place **no one** cares to revisit.

If you are worried about this happening to you, you won’t be able to put this portion of the course down. If you think it can’t happen, you should know that almost 15 percent of the agent population is sued each year, and nearly three-fourth’s of these claims are “frivolous”, virtually **beyond your control**. The longer you stay in the business and the more expertise you develop, the bigger the target you become. YES, the litigation explosion is coming to a neighborhood near you and it might just end up on your door-step.

The reason this threat is greater now than ever before is a matter of public record. Insurance companies are **fighting back**, evolving from an almost cavalier attitude in settling nearly every claim, to a wholesale frenzy for **standing firm . . . taking plaintiffs to trial**. Of course, this has come at the great expense and frustration of every personal injury attorney who liked the old methods of settling a claim . . . **before trial**, but hated the big battles and courtroom antics glorified in “THE PRACTICE”.

For the more lucrative cases, attorneys are pushing back. Others are looking for greener pastures . . . directions where there is less resistance. In the case of insurance conflicts, can you think of anyone these attorneys might pursue who might be easier to get at than a major insurance company? Someone without staff attorneys, little time to spare and a lacking a huge legal pocketbook. Are there individuals who might fold quicker than a big insurer and “belly-to-the-bar” to settle a claim to avoid a long and protracted trial? If you haven’t guessed by now . . . **its you, the working insurance agent!** You could be the next victim of a clever attorney looking to cash-in on a quick settlement when something goes slightly astray with your client’s coverage.

Even if you are lucky enough to avoid a claim for now, every time another agent is sued, it gets closer to you because our court system makes **legal decisions based on precedents**. AND, JUST BECAUSE THE PRECEDENT TO DO WITH A COMMERCIAL OR LIFE INSURANCE CASE, DON’T THINK FOR A MINUTE THAT IT CAN’T BE USED AGAINST A PERSONAL LINES AGENT. IT CAN!

You see, each decision in the chain of legal precedent cases sets the stage for the next step of expansion. For example, the recent **Southwest vs Binsfield (1995)** case decision automatically creates added exposure for MOST agents, i.e. **a legal precedent is established**, even though it involved a commercial auto painting business. Agents who fail to comply in their personal lines practice, are now potentially closer to a lawsuit than he was prior to the case. This, coupled with the willingness of judges and juries who sanction the expansion of legal

theories in our courts, means that liability gets closer and closer to you for all kinds of violations – related to your practice or not! As a matter of fact, you will learn from these pages that you can be held responsible for matters related to the fact that you are a licensed insurance agent and your client is not! You will also learn that the root of most agent conflicts lies in the inability to understand **statutory and fiduciary duties**. When you know what is expected of you, proper **legal and sales conduct** can be followed and conflicts minimized.

Thanks to our legal precedent system, seemingly innocent events of the past are potential big problems today. To survive it all you need to justify your actions, manage your errors and plan ways to avoid making them in the future, i.e., **you must change the way you do business**. There are many suggestions and guidelines provided under these covers to help you develop office and sales procedures that may be critical if a lawsuit develops.

Agent Liability

The agent of the new millennium deals with stiff competition, fast-paced decisions and some very unpredictable insurance markets. To aggravate this condition, we live in an era where courts are very sympathetic to consumers. People feel entitled to seek complete and generous compensation for the smallest problems, even when they are contributors or the discovered source. Furthermore, the consumer of our time has lost all respect for the status of the professional, any professional. This includes doctors, lawyers, teachers, clergy, real estate brokers, stockbrokers and insurance agents. Few would think twice about suing any one of these professionals to receive satisfaction for an honest mistake, let alone one leading to a financial loss or injury. Understanding this, it is easy to see that the selling of insurance can lead to conflicts and legal disputes.

When an insurance agent and his client cannot resolve differences, agent liability can result, even when the agent is right. In fact, about 75 percent of all insurance malpractice claims are frivolous, and while an agent may never pay any damages from these claims the process of responding is very costly, BOTH in money and lost production.

Claims against you may surface as a result of events that occur **before or after** a policy is issued, and they may involve you and a client, your insurer or a third party who is an **intended beneficiary**.

Cases can be built around issues of legal conduct as well as sales conduct. Throughout this book you will learn the “triggers” that launch insurance related lawsuits. They can be as basic as failure to secure the type or amount of coverage requested by the client to more complex and seemingly “blue sky” claims where clients demand recoupment of losses and damages simply because of a relationship that existed between agent and client. Other claims span the gamut from client losses due to an insurance company failure to refusal to pay a claim.

Sometimes, an agent’s liability is the result of simply being too busy to witness a signature or too rushed when entering a policy premium payment . . . **small “blunders”**. Of course, a single incorrect digit or a blank you forgot to fill can make the difference between a policy “in force” and a cancellation or denial of claim -- a matter that is a guaranteed BIG DEAL to a client when an accident, death or problem occurs.

Agents who have never been sued are sometimes lulled into believing that the way they do business must be working. Unfortunately, this ignores the real possibility that the same events of the past, that weren’t a problem, can now become a problem. It is a world of legal rights and little trust. The long-term client who you trusted, can change. Also, regulations change, industries change, economies change and no one can really keep up or control every aspect of

their present business, let alone the future. Can you imagine, for example, the changes that will occur over the life span of a whole life policy between today and when it endows in fifty or sixty years? Will a state or federal regulation change the way automobile or health policy benefits are triggered? Will the IRS retroactively disallow tax benefits for an annuity contract or single premium policy you sold three years ago?

No one knows the answers to all these questions, but it should be clear by now that as an insurance agent you are prone to errors, some beyond your control. As a business person you need to accept the fact that your business carries risk. Then, you need to find ways to manage and plan for these risks to minimize the fallout when a claim occurs. You will notice we said “**when**” a claim occurs not “**if**” a claim occurs. We say this because statistics prove that anyone who stays in the business long enough WILL suffer the wrath of a client or insurance company claim.

You can try to avoid conflicts, make friends with your clients, buy errors and omissions insurance, incorporate and practice other means of asset protection, but you will always be at risk for the one problem that seems to “fall through the cracks” and rear its ugly head at your doorstep. You have to plan for that day NOW.

Now, let’s look at the deciding issues that establish your legal conduct and create agent liability.

Basic Agent Duties

The agent/broker generally assumes duties normally found in any agency relationship. One of the most important documents controlling duties is the **agency agreement**. Agents who continually refer to their agency agreement shall have a better chance of remaining within the **scope of their agency**, thereby limiting liability. Caution is always advised, however, in light of recent cases where terminology in the agency agreement appeared to limit agent exposure only to be overruled by common law (**Goebel vs Suburban – 1997**).

With respect to client activities the primary obligation is to **select a company and coverage and bind the coverage** (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically **request** coverage, the basic duty may expand to include the agent deciding whether the requested coverage is **available** and whether the insured **qualifies** for it (**Harnett, Responsibilities of Insurance Agents - 1990**).

The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to **advise** the insured on specific insurance matters (**Jones vs Grewe - 1987**). Duty also DOES NOT require the broker/agent to secure **complete** insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are **widely available at a reasonable cost** (**Southwest Auto Painting vs Binsfield - 1995**). Also, there is reason to believe that the agent has a duty to use reasonable skill in asking certain questions during the application process to determine types of coverage needed (**Smith vs Dodgeville Mutual Insurance – 1997**).

An agent’s duty to provide correct coverage is not triggered by a client’s request for “full coverage” because that request is NOT a specific inquiry about a specific type of coverage (**Small vs King - 1996**). In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a **specific type of coverage**, the agent is responsible to see if it is available and determine if the client qualifies.

An insured is entitled to rely on an agent/broker’s advice on the content and meaning of policy provisions. In **Perelman vs Fisher – 1998**, the insured sued an agent for not informing him

about the lack of cost of living benefits even though the agent advised the insured to review the policy which clearly did not provide it. In **Stivers vs National American Insurance - 1957**, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent “is in patent conflict with the terms of the policy”.

It is a clear legal responsibility of agents to understand the difference between two products that he is attempting to sell (**Benton vs Paul Revere Life - 1994**). Whether an agent has an affirmative duty to inform a client of possible ***gaps in coverage*** depends on the relationship of the parties, specific requests of the client and the professional judgement of the agent (**Born vs Medico Life Insurance Co - 1988**).

Once a policy is issued, traditionally theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy (**Gabrielson vs Warnemunde - 1988**). In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage ***at the time of sale***. Recent departures from this opinion include a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client (**Grace vs Interstate Life - 1996**). In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (**Free vs Republic Insurance - 1992**), i.e., agent duties may also include informing clients their coverage is appropriate ***after the sale***. Although each case stands on its own, the underlying determinant of “after sale” duty may be the “special relationship” that exists between client and agent, e.g., an agent handling the client’s business for an extended period of time may assume a higher standard of care.

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. For example, in **Mate vs Wolervine Mutual – 1998**, it was determined that an agent had a ***special relationship*** with an insured, demonstrated by years of experience and notes in the agent file, that created additional ***duty of care*** to know about the insurance needs of members of the family. When a lawsuit arises, however, it is the client’s burden to show that ***greater duty*** is the result of an express or implied agreement between agent and client (**Jones vs Grewe - 1987**) where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed. In the **Fitzpatrick vs Hayes – 1997** case, no special duty to procure “umbrella coverage” was determined where the agent’s brochure simply promoted a ***family insurance checkup***. A special duty might have been imposed if the agent held himself out to be an expert in umbrella coverage.

Another area of legal conduct involves the Law of Agency.

The Law of Agency

The ***Law of Agency*** is a universal area of the law that determines producer status and specifically binds the agent/broker for his acts and his omissions or errors. Simply stated, the law of agency, for most states, establishes many categories of insurance agents and concludes that the authorized acts of the agent automatically create duties and obligations an agent must follow. These responsibilities occur between agents and principals (insurance companies) and as between agents and third parties (clients or intended beneficiaries).

An ***agency relationship*** begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be ***created by contract or agreement*** or it can take the form of casual mutual consent. What is interesting about the business of insurance is that most agents start out as an agent for the client, when coverage is requested, and then become

an agent for the company, when business is placed. As you will see later, the exact status you occupy when a problem occurs affects your liability exposure.

A person who markets insurance is typically referred to as a **producer**. The insurance market and many state laws describe different kinds of producers -- **general agents, local agents, brokers, surplus or excess-line brokers or agents and solicitors**. Following is a brief description of these categories:

General Agents

The general agent assumes many responsibilities, greater liability and usually incur higher business expenses. As a result, they are typically paid the highest commissions. In the property/casualty field, many sales agents with general agent contracts do not serve all the functions of a general agent but are important enough to their insurers to receive general agent commissions. In all lines of insurance, general agency contracts, or similar classifications, are frequently awarded as a competitive device to obtain or retain a particularly outstanding agent or firm.

Local Agents

The local agent represents the insurer. He or she may represent more than one company. Commission schedules are typically lower for local agents because they do not usually perform technical services usually reserved for the general agent or branch/regional office; such as underwriting, policy implementation, claims support, etc., and are subject to a lower level of liability than other agent categories. The local agent is principally a sales representative of the insurer who acquires business and counsels clients.

Brokers

Theoretically, brokers are agents of insurance buyers and not of insurers. Their job is to seek the best possible coverage for clients. This can be accomplished in a direct manner with the broker acting as salesperson or through a network of agent contacts. Premiums paid by clients include the cost of commission paid to the broker by the insurance company, so the client indirectly pays the commissions of both the broker and agent. In the liability/casualty area, some brokers maintain a loss-control staff to help counsel clients on safety and prevention matters thereby aiding clients to secure a lower premium. In a sense, these brokerage firms act as insurance and risk managers.

Surplus Brokers / Agents

Sometimes a client will seek a highly specialized coverage not written by an insurer licensed in a home state. Examples might be an unusually high excess liability plan, auto racing liability, strike insurance, oil-pollution liability, etc. To handle these limited lines of coverage with "non-admitted" insurers, states typically license surplus or excess line agents and brokers.

Solicitors

Another type of producer is the solicitor who usually cannot bind the insurer or quote premiums. The solicitor seeks insurance prospects and then handles the business through a local agent, broker, branch office or service office.

Marketing Organization & Clusters

A off chute form of producer status occurs when agents join **marketing organizations or clusters**. Neither is a legal entity, but both can represent exposure to the agent if operated in a certain way. Most marketing groups and clusters are a simple banding of individual agents operating as sole proprietors for the obvious advantages that come with numbers (better contracts, group perks, access to information, etc. In this instance, member agents have no responsibility for one another or the entity itself. However, these groups are potentially more dangerous arrangements if the member agents have formed a general partnership to operate as a group. Here, the acts of one agent can hold ALL others responsible.

Producers can also be classed as **actual agents/brokers** -- those given express or implied authority -- or **ostensible agents/brokers** --those whose actions or conduct induces others to reasonable believe the they are acting in the capacity of an agent/broker. An agent binds his principal when he acts within the scope of his authority. The exception is when an agent and an insured are proved to have colluded with intent to defraud an insurance company. In such a case, the principal or insurer is not culpable or bound by the policy.

Insurance companies always attempt to tightly define or narrow the authority of agents to limit their exposure to agent wrongdoing. In practice, however, the law **generally** considers the agent and the insurer as one and the same, even though the agent works as an independent contractor.

So, the insurer is most often legally responsible for the acts of the agent and are regularly sued by third parties (clients of the agent) who feel they have been wronged. Of course, when a policy owner sues his insurance company, agents are often named for various breaches of duty between client and agent. Agent liability may also exist where insurance companies sue their own agents. Insurance companies and errors and omission carriers alike exercise their right to sue an agent under various legal theories, typically for indemnity of any judgement losses they may have incurred through a policy owner claim.

Insurance Producer Status

When marketing insurance, the agent may assume the character of a mere sales representative or the specified agent of the client. As mentioned earlier, agents generally start out representing the client who requests coverage and then become the agent for the company when business is placed. Other than brokers, agents rarely retain **principal status** throughout a transaction.

When a dispute occurs and a producer's status cannot easily be determined the courts usually rule in the direction of **agency relationship**. This bias is commonplace for two reasons. 1) It is easy to establish that an agent is representing his insurance company since there is typically a preexisting, written **agency contract** between the parties (the agent and the insurer). This relationship is distinguished from a **principal-agent relationship** where the client requests that the agent accomplish a **specific** result such as "Buy \$150,000 of coverage from XYZ Company". 2) Holding a producer to be a true principal could block many claims a client might have against the "deep pockets" of the insurance company (**Canal Insurance vs Harrison - 1988**). If the insurance company was not made part of the claim, the client's only recourse would be the resources of the agent which are likely to be a lot less than the insurer.

In cases where the producer's status is unknown at the time a problem occurs, the courts have the difficult task of trying to determine **who initiated the relationship**. Here again, when in doubt the law leans to the assumption that the **majority** of insurance transactions are **agency**

relationships even though the client may have called the insurance agent first. Otherwise, the mere fact that clients request coverage . . . which they do in virtually every instance . . . would establish a principal-agent status every time. The courts feel this is NOT an appropriate conclusion.

A huge problem for agents occurs when they ***act as principals***, when, in fact they are not, or when they have neglected to identify the principal, i.e., an ***undisclosed principal***. An agent who advises a client that he is ***covered***, with knowledge that the intended insurance company has not yet agreed to accept such coverage ***acts as the insurance company until coverage is accepted***, i.e., the client has FULL RECOURSE against the agent for any uncovered loss. If it can be proven that it was reasonable for the client to assume that the agent ***actually*** had real authority to act for the principal, the client can hold the insurer to the contract, even when one did not exist (**Stock vs Reliance Insurance Company - 1968**). The client who incurs coverage shortfalls is in a much better position to recover from the agent where a principal (insurance company) is NOT disclosed.

Of course, a **written disclosure agreement** indicating that the agent was a representative of the insurance company, acting as principal or not disclosing the principal for a specific reason would go a long way to clarify that the status between the agent and client, or agent and company. In commercial insurance transactions, agents go to great lengths to "clear the air" concerning agent status by using a ***broker of record*** letter. These letters authorize or terminate agency and stand as proof of evidence that an agent is representing the client/principal or "out of the loop".

In some agent liability cases, status is not the consideration at all, rather claims are filed for a variety of activities outside the scope of an agency contract. In essence, agents create ***dual agency***, when representing themselves as agents of the insurance company ***and*** as principal to the client in the form of an "expert or consultant". As you will see, outside activities such as these create additional liability. Further, it is doubtful that the court will care whether an agency status or agent-principal relationship actually existed because wrongdoing will be actionable against any agent acting as a principal. Additionally, claims of this nature are difficult for agents to defend and NOT typically covered through errors and omission insurance.

Producer status problems also occur when ***unlicensed employees*** of the agent are found to be doing the work of a licensee. A small mistake here can become a big deal (**Williams Insurance Agency vs Dee-Bee Contracting Co -1984**). You can be held responsible for any claim or shortfall and it will likely void your errors and omission coverage. Insurance department sanctions, fines and possible revocation of license could also follow.

Agent vs. Broker

In actions against an insurance agent, the plaintiff's attorney will first try to **determine** whether the agent's status is that of an agent or a broker (primarily casualty agents). The outcome of this initial task will provide the malpractice attorney with legal procedures and strategies to proceed against the agent, his insurer, his errors and omissions insurer or ALL OF THE ABOVE. For this reason, it is extremely important for agents to know their ***legal status***.

An ***agent*** is legally defined as "a person authorized by and on behalf of an insurer, to transact insurance". Agents must be licensed by the state and typically require a **notice of appointment** be executed. This document appoints the licensed applicant as an agent of that insurer in that state. Thus, an insurance agent is the agent of the insurer, NOT the insured (client). Of course, an insurance agent may be the appointed agent of more than one insurer.

An insurance **broker** is "a person who, for compensation on behalf of another person, transacts insurance, ***other than life*** with, but not on behalf of, an insurer". Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer's agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file. In **Kioutas vs Life Insurance Co of Virginia – 1998**, the agent was deemed to be a "broker" representing the insured to obtain the most suitable and affordable life insurance from among various insurers. Specific rules that determined this status included: 1) who set the agent in motion (who called the agent); 2) who controlled the agent's actions; 3) who paid the agent; and 4) whose interest did the agent represent.

Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance (**Maloney vs Rhode Island Insurance Company**). Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them.

The **purpose** of determining whether the insurance producer was **acting as a broker or as the insurer's agent** when an insurance contract was placed helps establish the theories of liability that the client may plead and what defenses the agent or his insurer may raise. In many court cases, it is not clear whether the producer was acting as a broker or an agent. So, attorneys typically plead their case under the banner of each status thereby plucking the feathers of the agent **and** the "deep pockets" of the insurance company at the same time. Agents should be prepared to prove or disprove legal status at any given time.

Under basic liability theory, a client and his attorney may find it quite difficult to seek recovery from a producer acting ONLY as an agent. **Traditional agency law** in most states concludes that the **insurance agent, acting as agent of the insurer**, owes duties primarily to the insurer. Of course, this assumes that the agent performed in the ordinary course of his or her duties as agreed between the agent and insurer per terms of the **agency contract**.

Where an agent is acting properly, a person wronged by an agent's negligence has a cause of action against the **principal or insurance company**, although this does NOT preclude clients from naming the producing agent also. Another general rule of agency law states that if an insurance agent acts as the agent of a disclosed principal, the principal -- NOT THE AGENT -- is liable to the client (**Lippert vs Bailey - 1966**).

Broker liability is different. The insurance broker is normally considered the insured's agent and owes a much higher level of care to the insured. Brokers can be liable if these duties are not adequately performed. Additional liability can accrue where the broker is ALSO acting as the agent of the insurer. Here, the insurance company may pursue the broker for breach of duty.

Where a dispute arises and the insurance company can make out the party who solicited the insurance business to be a broker, rather than an agent, then any errors and omissions on the part of that party will exempt the insurance company for the broker wrongdoings. One very important **reason** why broker liability is greater than agent liability lies in the fact that the broker, when acting within the scope of authority granted by the client, **binds or obligates the client to perform**. Obviously, the broker is in a position of greater trust and, therefore, bears greater liability.

Agent vs. Professional

Despite rules which seem to offer reasonable protection of the agent producer, it should be made clear that **agent wrongdoings** outside the **agency contract** and other torts, WILL subject the agent to additional liability exposure, and it is easier than you think to step outside your agency agreement. A few pages back, we described a “dual agency” as the situation where the agent first represents the client as agent, then switches to agent of the company when business is placed. Now consider that **dual agency**, and the added liability it creates, also occurs when an agent assumes non-agency duties by agreement or simply by professing to have special expertise. A slogan on a business card, letterhead or company brochure may have sufficient information to establish you as an agent and a **expert** in the eyes of the law. When dual agencies such as these exist, the agent may be held liable for a breach of fiduciary duties owed directly to clients (**Sobotor vs Prudential Property & Casualty - 1984**) and, perhaps, contract and statute duties to the insurer. (**Kurtz, Richards, Wilson & Co vs Insurance Commun Marketing Corp - 1993**).

It is clear that activities beyond the scope of an agency contract can be dangerous to your financial health. If you go there you need to proceed cautiously. This is NOT an indictment of any agent who seeks to improve his practice by becoming a true insurance professional, complete with degrees and designations. The existence of these honors, by themselves, is not the problem nor a target. As a matter of fact, some feel that the presence of these awards may inhibit a client’s willingness to file a claim. Rather, it is the agent who, regardless of his degrees or credentials, professes to be an expert but fails to deliver.

In essence, we are talking about **failed promises**. Agent wrongdoings in this area represent the majority of ALL insurance conflicts. For example in **Fitzpatrick vs Hayes – 1998**, an agent merely promoted a **family insurance checkup**. He did not promise special knowledge and was found innocent when an insured claimed he had a duty to obtain additional coverage. Compare this to the **Blumberg vs Paul Revere Life – 1998** case where an agent was found liable where he marketed **guaranteed disability insurance**, regardless of previous medical history, to an association. The agent intended this coverage to apply to existing members of the association but was held to personally cover any new members as well.

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAls, ARMs and more, who practice **due care** for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional designations for fear that the added exposure can’t be managed. Perhaps there is room toward the middle. A position we call **responsible agent**. These individuals also practice due care, yet operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but “pass” on outside inquiries, not because they don’t know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

Contract Disputes

Regardless of producer status, agent or broker, disputes develop where terms of an insurance contract are violated or promises are not kept. Producers can be liable under **two principles**: 1) The existence of an insurance contract or principal-agent agreement or an implied agreement, and 2) The breach of contract or nonfulfillment. A violation of contract terms is fairly clear cut. **Primary breach of contract**, however, can surface under any of the following headings:

Failure to Act/Procure Coverage

This is one of the most important areas of agent/broker liability because an estimated 60 percent of all claims result from agent malpractice in failing to procure coverage. In a typical transaction, a broker or agent agrees to procure a certain type of coverage for an insured. It is well established that the broker has a duty to exercise ***reasonable care*** in procuring that coverage. Consider the following cases: (**Jones vs Grewe - 1987**) -- a failure to actually procure coverage; (**Keller Lorenze Company vs Insurance Associates Corp - 1977**); -- a failure to perform some function related to the insurance coverage or a failure to see that policy was actually provided (**Port Clyde Foods vs Holiday Syrups - 1982**); or, failure to forward premiums to prevent lapse (**Spiegel vs Metropolitan Insurance**). In general, when an agent negligently fails to obtain coverage for a client, he steps in the shoes of the insurance company and becomes liable for loss or damage the limits of the policy until insurance is found (**Robinson vs J. Smith Lanier Co - 1996**) and (**Blumberg vs Paul Revere Life - 1998**). Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate (**Hamacher vs Tummy - 1960**).

Failure to procure coverage may also be used in cases where the agent has prior knowledge of the insured's condition and failed to disclose it on the application (**Soho Generation vs Tri City Brokers - 1998**).

Failure To Notify Lack of Coverage

Agents/brokers can also be liable for silence or inaction, as in an agent's failure to reasonably notify the applicant that he is ***unable*** obtain insurance (**Bell vs O'Leary - 1984**). The key here is "how long" a delay is normal before informing the client. The courts have not established any parameters other than that what is ***reasonable***. In one case this meant 2 days, in another four weeks. The best advice is keep clients fully and continually informed. This was proved in the **Alaniz vs Simpson (1998)** case where an agent faxed a letter to an applicant that he was uninsured several hours before an accident. The victim of the accident (a third party) was unsuccessful in his attempts to blame agent for negligently misleading the applicant to believe he was insured.

Failure To Place Coverage At Best Available Terms

As part of the duty to exercise good faith, reasonable skill, and ordinary due diligence in procuring insurance, a ***broker*** has a higher duty than agents to be informed of the different insurers and policy terms and to place coverage at the best available terms. If other brokers working in the same market knew that better terms were readily available, the broker who failed to obtain these terms for the client could be liable for the client's loss (**Colpe Inv. Co vs Seeley & Co - 1933**). This case dealt primarily with the fact that the broker failed to obtain "coinsurance" clauses that were commonly available and carried a lower premium. This must be distinguished from cases proving that the broker does NOT have an absolute duty to obtain the lowest possible rate (**Tunison vs Tillman Ins. Agency - 1987**).

Failure To Renew / Notify

If an agent has a history with a client of automatically and voluntarily renewing or reminding them to renew a policy, he can assume exposure for the "one and only" time he forgot (**Siemorama vs Davis Manufacturing Co - 1988**). With the trend toward "direct billing" of

clients by insurers, agents are not as close in contact as before. However, agents may still have renewal responsibility if the client depended on this service in the past.

In another recent case **Eyerly vs Gregary – 1999**, the agent neglected to notify the insurer of a claim due to some strange titling of the property. The insurance company was still made to pay but the agent was responsible for a judgement in excess of the policy limits.

Other issues concerning breach of contract include the following:

Policy Promises & Provisions

Agents should ALWAYS review client policies and retain "specimen policies" on file to answer prospect/client questions and compare with policies received. In most states, agents are legally bound to accurately describe the provisions of policies they procure for their clients (**Westrick vs State Farm Insurance - 1982**) and point out the difference between different products he is selling (**Benton vs Paul Revere Life - 1994**).

Many lawsuits have been pursued on misunderstood policy time limits which restricted the clients ability to perform or file a claim. Agents can easily become a focus of these dispute. Another misinterpretation might be: What is an "accident" defined to be? An insurer may deny a claim for lack of requirements establishing an "accident". Or, what is "reasonable medical treatment"? Some agents might be taught NOT to volunteer information on an issue such as this. But, insurers and agents have a fiduciary duty to their insureds to disclose full and complete information. Failure to do so may result in a claim of fraud (**Ramirez vs USAA Casualty Insurance Co - 1991**). Overall, an agent can reduce his exposure by knowing that his policy contains clear and unambiguous descriptions (**Dahlke vs John Zimmer Agency – 1997**).

Agent Promises

From time to time, agents make promises that EXCEED what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverages and exclusions. Agent liability also existed in a case where a producer promised to arrange "complete insurance protection" for a business or where an agent promised, but never did, to evaluate an appraisal of an individual's property or to determine its "insurable value" in order insure a certain percentage of that value. In **Blumber vs Paul revere Life – 1998**, the agent went so far as to market ***guaranteed disability insurance*** to a company regardless of previous medical history. He was found liable for covering new employees.

Additionally, an agent might promise to implement or increase a client's coverage "immediately" yet actual coverage might not be in force for 24 hours or until expiration of the existing policy. Less obvious, but equally as serious, are failed promises. A recent example is the marketing of "personal pension plans". Clients, who were promised a "pension plan", received a universal life insurance policy. Agents involved in this scheme are now subject to huge fines, client actions and possible license revocation.

Advertising Promises

Advertising violations are among the most costly mistakes. Regulators have been known to levy stiff fines of \$1,000 or more ***per violation***. In other words, 1,000 non-compliant flyers distributed in the mail or otherwise could amount to a fine of ***\$1 million or more*** (\$1,000 X 1,000 flyers). By contract, agents are required to secure company approval of all advertising. Few agents, however, would think twice about scrutinizing company provided ads. However, it

is suggested that agents carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy. For example in **Cunningham vs PFL Life – 1999**, information from the insurance company and agent touted life insurance policies as ***investment vehicles***. The insurance company was ultimately held liable for claims for failure to train and supervise its agents. Most violations of this type would probably not be actionable against the agent, but may name the agent nonetheless or may establish some form of "alleged" agreement that binds the agent / insurer.

What Policies Say vs What They Mean

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of ***policy ambiguity***, generally upheld by most state courts, goes something like this: If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage DOES extend to the policy holder. Agents may easily be involved in claims resulting from contract ambiguity.

Client Understanding and Reading of Policies

In days gone by, courts required people to be accountable for their actions. Clients were required to live up to the terms and conditions of a policy even though they did not read them or fully understand what they read. Agents have been cleared in many policy conflicts simply by pointing out the applicable clause or meaning. Consumer groups kicked and screamed and pushed for simplified wording.

Today, policies are indeed more user friendly ***and*** the courts are still sympathetic to consumer confusion about their policies. Now, policy conflicts are determined by whether it was ***reasonable*** for a certain client to have read his policy and/or understand its meaning. The decision can be based on how simple or complex the policy is written or the client's level of sophistication (**Karem vs St Paul - 1973**), (**Greenfield vs Insurance inc - 1971**), (**Perelman vs Fisher – 1998**) or (**Dahlke vs John Zimmer Agency – 1997**). Each case stands on its own.

Minimum Standards

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Agents owe a duty of good faith and fair dealings to their clients ***and*** their insurer (**American Indemnity vs. Baumgart - 1982**).

Agent Torts

In an action against an agent or broker, the plaintiff's (client's) attorney rarely distinguishes between contract and tort wrongdoings. BOTH are routinely pleaded. In the case of tort action, agents can be pursued on two fronts 1) Applicable professional standards and 2) The broker/agent's acts or omissions that do not meet these standards. Who decides what these standards are? In most court cases, the plaintiff's attorney will arrange for "expert testimony" by an agent or broker working in the same field. The fundamental issue is whether the accused broker's professional judgment and methods were appropriately exercised in line with acceptable standards. Following are some important areas of agent wrongdoing (torts) considered be outside acceptable standards:

Negligence & Misrepresentation

Agents and brokers can be liable for failure to procure the requested coverage (**Mayo vs American Fire & Casualty - 1972**). Wrongdoing also occurred where an agent promised to procure "complete" business premises liability coverage and represented that a policy he procured afforded the desired protection when, in fact, it omitted coverage for a freight elevator occasionally used to transport people (**Riddle-Duckworth inc vs Sullivan - 1969**). In **Hardt vs Brink**, the agent was negligent in failing to advise fire insurance coverage on a leasehold made known him by the client in advance. Another agent negligently obtained non-owner motor vehicle liability coverage for a client knowing it would NOT provide the coverage desired (**Rider vs Lynch - 1964**). In **Walker vs Pacific Indemnity Co - 1960**, the agent negligently obtained a policy with smaller limits of coverage than had been agreed upon. In yet another case, the agent notified the client that the original insurer was insolvent and that a replacement policy would be needed. The broker replaced this policy with a new policy having LESS coverage. The broker was held personally liable for \$150,000 because of the gap between the insured's primary and excess coverage (**Reserve Ins Co vs Pisciotta - 1982**). Liability was also upheld in the case where a lending institution which was licensed to sell credit life insurance failed to offer it to a client who later died (**Keene Investment Corp vs Martin - 1963**). Finally, in **Anderson vs. Knox - 1961**, an agent represented that \$150,000 of life insurance, where premiums were so high that they had to be bank financed, was a suitable plan for an individual earning less than \$10,000 per year knowing that it was not suitable. Another case of misrepresentation involved an application of life insurance with critical blanks (missing information). The deceased's widow held that the agent told her husband that the missing information did not need to be disclosed on the application (**Ward vs Durham Life Insurance Company - 1989**).

Bad Faith

The insurance agent runs a great risk of personal liability in the event that he is less than fair or reasonable when dealing with either a client or claimant. Bad faith actions and violations of various statutes, such as the Unfair Claims Practice Act, are considered a breach of the implied duty agents have deal with clients in complete good faith. Agent liability may accrue due to unfair conduct by agents or allegations of fraud, deceit, misrepresentation or the statutes dealing with unfair settlement practices (where the agent is acting as a claims representative for the insurance company or in his individual capacity, independent of the agency).

Agents must remember that the number one reason that people purchase insurance policies through agents is for service. When an insured makes a request to procure coverage or turns in a claim, he is not bargaining for promises, but rather action. Additionally, the insured is under the assumption that, due to his prudence in securing insurance in the first place, he will have peace of mind in knowing that he is being protected by the insurance company. Any breaches of this **reasonable expectation** will usually subject the insurance company and the agent to the exposure of insurance bad faith practices and a breach of the fiduciary duties owed to the insured. Licenses have been revoked for misrepresenting benefits of policies and entering false medical information on an application (**Hihreiter vs Garrison - 1947**) or in the making of false and fraudulent representations about the total cash that would be available from a policy (**Steadman vs McConnell - 1957**).

In the property/casualty arena, many bad faith issues surface under the title of "claim avoidance". Some agents play judge and jury with client claims by advising them to NOT submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a breach of his fiduciary duty to the insured as well as a breach of the implied-

in-law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages (**Independent Life & Accident Ins Co vs Peavy - 1988**).

Client / Agent Relationships

The insurance agent/broker is increasingly regarded as a professional whom clients turn to for advice and guidance in insurance matters. In some states, the insured's pattern of reliance on the broker's advice has been the basis for a **higher standard of duty (Hardt vs Brink - 1961)** and (**United Farm Bureau Mutual Insurance vs Cook - 1984**). Relationship liability generally occurs on two fronts 1) Contributory and 2) Agents as Fiduciary.

Contributory Liability

When an agent holds himself out to be an "expert", a "specialist" or a "professional", he is creating **contributory liability** and may be held to higher than normal standards or standards beyond the disciplines of insurance. The earning of credentials or designations further compounds the agent's exposure, since he is considered, in the eyes of the law, to be subject to a higher standard of knowledge and responsibility. Yet, faced with stiffer competition, agents are somewhat compelled to upgrade their image by creating marketing "niche" expertise with titles, credentials and job descriptions like: financial planner, estate planner, retirement planner, "one-stop" insurance agency, loss control consultant, etc. Contributory liability relationships have also been cast simply because an agent has **"ALWAYS"** handled a clients business over the years, so much so, that clients have **blindly depended on their advice**. The result of these "titles" and "agent trust" is a higher level of culpability. In fact, plaintiff attorneys have and continue to develop **legal strategies** that establish contributory liability of agents by multiple approaches, including:

Lack of Client Knowledge

The insurance purchaser usually is not versed in the intricacies of the insurance business. Prospective insureds seek the assistance of the insurance "specialist" and come to rely on his knowledge. In some cases, the reliance on the agent is total and complete. When the agent procures coverage that turns out to be defective in some way or fails to make arrangements, the applicant should have a cause of action against the agent. This takes on more meaning today as agents and brokers have increasingly promoted their "professional expertise" in serving the public's insurance needs (**Sobotor vs Prudential Property & Casualty - 1984**).

Improper Advertising

Advertising has clearly effected the importance and desirability of acquiring insurance, especially where the agent claims to have substantial or special expertise that can be used to guide the consumer. Advertising has lead clients to have reasonable expectations, true or not, that these agents are independent business entrepreneurs and, in some instances, are capable of expertise in a wide variety of business areas, e.g., financial planners, health specialists, catastrophe experts, business continuation consultants, etc.

Dual Agency

In many insurance transactions, the agent can generally be shown to have acted as a "dual agent" -- representing BOTH the insurer and client. As such, he owes a duty to exercise due care and reasonable diligence in the pursuit of the client's insurance business regardless of the insurer chosen or represented by the agent.

Errors & Omissions Insurance

The availability and wide subscription of errors and omissions insurance for agents creates an argument that agents can be liability targets in any insurance disputes. In some cases, the absence of errors and omissions coverage has practically absolved the agent of liability where attorneys assume there is nothing to go after. But, who wants to risk going bare in this market?

Client / Agent Interaction

There is a lot of discussion about building solid relationships with clients. Considerable study has been done on customer satisfaction and the close association that develops with agents who are responsive to customer questions, explain policies well and are able "get it right" the first time. Some feel that the close ties often stop a lawsuit in its track . . . after all, they say, who wants to sue a friend!

Agents as Fiduciaries

New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable "deep pocket". A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent's contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent's liability as a fiduciary simply comes with the territory . . . ***it's part of selling insurance***. In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies **Glenn vs Leaman - 1983**. Other fiduciary related liabilities relate to an agent's duty of care. These cases even rear-up in a one-time business transaction, i.e., you don't have to be a longstanding advisor to be liable. More often than not, the issue of fiduciary exposure surfaces where an agent proposes a "full coverage" policy but failed to describe a certain provision or exclusion that existed in the written policy (**Eddy vs Sharp - 1988**). In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have special "expertise" where the client is unsophisticated (**Sobotor vs Prudential Insurance -1984**) / **Kurtz vs Insurance Communicators -1993** / **Cunningham vs PFL Life - 1999**, or when an agent promises to provide "complete coverage" (**Magnavox Co of Tennessee vs Boles & Hite - 1979**) The exposure also seems to exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer. (**Glenn vs Leaman & Reynolds - 1983**). Another area of fiduciary responsibility concerns disputes dealing with **Employment Retirement Income Security Act (ERISA)** qualified funds. Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An **ERISA fiduciary** has been interpreted to be **any person exercising managerial control over the plan or its assets, regardless of their formal titles**. In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers be labeled ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries. The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that a

commissioned agent who helps establish a retirement plan and recommends products to fund the plan violates these rules? The answer lies in whether the agent is actually deemed a fiduciary. **If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary. If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent's proposals without advice from other consultants, he can be classed as a fiduciary of the plan.** On the other hand, where the agent is only acting in the capacity of an agent, offering a choice of products from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan "relied" heavily on the agent's advice in the purchase of insurance contracts. In **Brink vs Dalesio - 1981**, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In **Reich vs Lancaster - 1993**, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In **Kerns vs Benefit Trust Life**, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible. In yet another case, a Louisiana district court held that an insurance agent was a fiduciary a profit sharing plan, even though he only **sold** a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (**Schoegal vs Boswell**), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was "**...clearly more than a mere salesman**". In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that agent Boswell lacked the necessary authority and control over the plan investments and because there was no underlying agreement that his advice would serve as the primary basis for investment decisions for the pension plan. While this is a favorable decision for agents, it demonstrates the extremes and aggressive legal action to which agents are vulnerable, **particularly if the insurance transaction does NOT produce the anticipated or desired results for plan participants.**

New fiduciary conflicts may also develop in the area of **Medicaid planning**. Agents who routinely counsel clients on methods of transferring assets so as qualify for Medicaid benefits may be subject to fines and penalties under **H.R. 3101 The Health Insurance Portability & Accountability Act of 1996 (Kassenbaum-Kennedy)**. Under this bill, if the transfer of assets results in a "period of ineligibility" BOTH clients and agents could be subject to misdemeanor fines of between \$10,000 and \$25,000 **per violation** and/or one five years in prison. Many agents recommend that clients purchase annuities, previously "exempt" in calculating assets qualify for Medicaid. Under these new rules, if the payout of the annuity contract does not match the payout schedules established by the Department of Health (most don't) a disqualification of asset transfer and ineligibility period can be established. Look for future court cases here.

Insurer Claims Against Agents

When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal, (the insurer), **fiduciary duty** of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself (**Southland Lloyd's Insurance vs Tomberlain - 1996**). Beyond fiduciary matters, agents are bound to his insurer by other **statutory duties**. They include Duty of Care and Skill, *using standard care and skill*; Duty of Good Conduct or *acting so as not to bring disrepute the principal*; Duty To Give Information *by communicating with the principle and clients*; Duty To Keep Accounts *by keeping track of money*; Duty To Act as Authorized; Duty To Be Practical *not attempt the impossible*; and Duty To Obey or *comply with the principal's directions*. A violation of these duties can be considered grounds for termination and represent legal exposure for the agent.

Following are some examples:

Basic Agency Violations

When an agency agreement exists between agent and insurer, the agent/broker has a duty to exercise reasonable care. The agent is considered a fiduciary of the insurer. He or she must exercise skill and diligence and is liable for negligence that induces the insurer to assume coverage on which it suffers a loss. Brokers who have agency agreements with insurers have been found liable to the insurer for clerical mistakes -- incorrect policy dates, erroneous limits of liability and omissions of endorsements. A recent case, **Goebel vs Suburban - 1997**, points to the what can go wrong even though an agency agreement is spelled out in writing. Here, a conflict regarding a clause in the agency agreement led the agent to believe one thing, yet it was ruled out by another clause in the agreement which stated that the agent and insurance company agreed to abide by common law. The common law, in this instance, did not grant the agent the right to be reimbursed by his insurance company for a frivolous claim.

Misappropriating Premiums

As representatives of the insurer, agents and brokers owe a fiduciary responsibility to the insurer to remit premiums collected from clients promptly or hold them in a trust account. In **Maloney vs Rhode Island Insurance Company - 1953**, the agent converted premiums his own use, facing liability to the insurer and possible criminal charges for embezzlement.

Failure To Disclose Risk Factors

An agent has a duty of good faith and loyalty to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss (**Clausen vs Industrial Indemnity - 1966**). In this case, it was successfully argued that an insurer may obtain indemnity from a broker, if the broker knows or should know that insurer is relying on the broker to supply information about the client; the information furnished is incomplete or incorrect; the incomplete or incorrect information is material to the decision accept or decline the risk; and the insurer is forced to pay a loss under a policy that the insurer would NOT have issued if complete and accurate information had been provided by the broker. In a similar case (**New Hampshire Insurance Co vs Sauer - 1978**), the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to

the agent's negligence. In similar cases the insured sued the agent for failure to ask if the insured had been cancelled (**Smith vs Dodgeville – 1997**); or failed to indicate a known pre-existing heart condition (**Life Investors vs Young – 1999**); or failed to accurately disclose a client's prior loss history (**Soho Generation vs Tri City Brokers – 1998**).

Failure To Cancel or Notify of Cancellation

Agents do not normally have an obligation to the insurer with respect to canceling an insured's coverage. For example, if the policy is billed directly, the insurer usually notifies the insured directly of the insurer's intent to cancel and, thereafter, of the actual cancellation. The broker/agent is typically "out of the loop". However, a broker who has undertaken responsibilities in canceling coverage (**Gulf Insurance vs The Kolob Corporation - 1968**) through agreement with the insured, owes the insurer a duty to follow the insurer's instructions promptly and correctly.

In **Mitton vs. Granite State Fire Insurance Company - 1952**, an agent was accepted as the insurer's general agent for purposes of signing policies, issuing endorsements, etc. As the insurer's agent, the broker was instructed by the insurer to obtain a flood and landslide endorsement from an insured. If the insured refused to accept such an endorsement, the agent was to notify the insurer who would cancel the policy. The broker failed to do either and was held liable to the insurer for the insured's flood damage.

Authority To Bind

An agent may be a general agent with general powers, or his powers may be limited by the insurer. Some agents are authorized to issue insurance contracts that bind the insurer, they have binding authority (typically casualty agents). Some agents may have binding authority only as to certain classes or lines of coverage.

Legally, the agent possesses the powers that have been conferred by the company or those powers that a third party has a right to assume he possesses under the circumstances of the case. In **Troost vs Estate of DeBoer - 1984** the agent exceeded his binding authority yet his acts and representations were relied upon by the insured. The agent was held liable for the insurers' losses.

Premium Financing Activities

Frequently, brokers play a role in helping clients finance their insurance premiums by bringing the insured and the financing entity together. There have been cases where the financing company has been the victim of fraudulent schemes misleading them into issuing loans to nonexistent insureds. In an effort to recover its losses, the financing entity may look to the insurer on grounds that the broker was acting on the insurer's behalf in arranging the financing, even though the insurer may not have given the agent explicit authority to engage in premium financing activities. In **New England Acceptance vs American Manufacturers Mutual Insurance Company - 1976**, an insurer was held liable for its agent's actions in such a financing scheme because it was "implied" that the agent had been authorized to conduct premium financing. In a similar case, **Cupac vs Mid-West Insurance Agency - 1985**, the court held that the insurer had ***not authorized*** its agent to engage in premium financing activities because nothing in the agency agreement referred to such activity. The agent was held liable. Various states have split on the decision that the business of premium financing is an integral part of the business of insurance.

Unfair Practices

Insurers may also lash out against agents under the National Association of Insurance Commissioners "**Unfair Trade Practices Law**" which many states have enacted. The thrust of this code is contained below.

"Persons (defined to include insurance companies and insurance agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

Under this act, it is conceivable that an insurer could commence litigation naming an agent where the company's insolvency was related agent "derogatory" actions. Consider a case similar to **Mutual Benefit Life**, where agents were actively involved in the disintermediation or withdrawal of "blocks" of client policies after rating drops occurred. Ultimately, this "run on the bank" was deemed the single greatest issue contributing to the companies liquidation. Were agents exercising "due care" for clients or breaching their legal and "unfair practice" duties to their contracting company?

Liability by Insurance Company Failures

To date, few courts have held that insurance brokers or agents are liable for the losses that policy owners might suffer from an insurer insolvency. Be assured, however, agents continue to be sued and pursued for malpractice in this area, and there are countless legal theories being proposed to force accountability. The basis for most tort actions where an insolvent insurance company is involved lie in certain cases and written code sections. At first glance, these regulations imply that agents are not responsible for involving a client with an insolvent company or a carrier that eventually is state liquidated. Here is how the law of liability is interpreted in most states:

"The general rule in the United States is that an insurance agent or broker is not a guarantor of the financial condition or solvency of the insurer from which he obtains coverage for a client." (Harnett, Responsibilities of Insurance Agents and Brokers - 1990).

In an actual case against a California agent, **Wilson vs All Service Insurance Corp (1979)** similar results accrued:

"An insurance broker has no duty to investigate the financial condition of an insurer that transacts business in California pursuant to a certificate of authority because the scheme of licensing and regulation of insurers administered by the Insurance Commissioner was sufficient for this purpose and could be relied upon by the broker when placing insurance."

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried and a trend is developing that places greater legal responsibility on agents concerning insurer insolvency. In **Wilson vs All Service Insurance**, for example, the client commenced a lawsuit in 1975 and even though the agent prevailed, the decision was not rendered until 1979 -- that's four years of attorney and court fees! So aggressive was the client that two different appeals the State

Supreme Court were attempted involving more defense fees. One must also ask . . . If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies **REFUSE to defend and REFUSE indemnify** agents where an insurer insolvency arises?

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the results of a 1971 lawsuit -- **Williams-Berryman Insurance vs Morphis, (Ark. 1971)** 461 S.W.2d 577, 580. It proclaims the following:

"The agent or broker is required to exercise reasonable care, skill and judgment in procuring insurance, and a failure in this regard may render him or her liable for losses covered by the policy but not paid due to the insolvency of the insurer." What is "reasonable care"? In *Wilson v. All Service* (above), the fact that the carrier was an admitted company proved to be adequate care. In **Higginbotham & Associates vs Green - 1987**, however, the courts further clarified:

"If, for some reason, it is shown that the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss caused by insolvency." A prime example is **Moss vs Appell – 1998**. An agent knew or should have known of pending problems with an insurance company when he received a letter from the company indicating the need to find capital to bolster reserves.

In all these cases, the agents won, or prevailed on appeal. The reader should be aware, however, that in addition to the expense of lengthy trial a pattern is established. To summarize, the burden of **agent liability involving financially distressed insurance companies is greater today for two reasons:** 1) Because more liquidations are in process, and 2) Because the courts want agents to be more responsible for their actions.

In addition to these known precedents and cases, agents are continually subjected to harassment suits from disgruntled clients and others that are settled out of court. Because these settlements are not published, it is impossible to know the depth and breadth of the problem. Most agents, however, know someone or has had some personal experience realize they occur frequently. One such case involved an Oregon couple who invested their \$26,000 retirement fund in an annuity with Pacific Standard Life in 1987. About three years later, they attended a financial planning seminar where they learned that their insurance company had been taken over by the California State Insurance Department due to losses in "junk bond" holdings. The couple immediately demanded a surrender of their policy. Of course, they were blocked from withdrawing their money by the conservators and the six-month payment delay provision in their policy. Seven months later they received a check for about 70 percent of their annuity value. The agent was threatened with legal recourse to pay the deficiency. After weighing the possibility of a lengthy court case and to keep an action from going public, the agent agreed pay. From the above court recitals, this agent clearly had no exposure. The least path of resistance, however, was to pay the client and move on. Fortunately, the dollars involved were controllable. But what of the situation where multiple clients are seeking reimbursement or the numbers are significant? The answer is not easy to predict, but the solution involves a multi-faceted approach to managing exposure while still providing service.

Misrepresentation & Insurer Failures

Insurer insolvency cases against agents may be based on **misrepresentations** by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds. An even worse situation occurs where an agent knowingly distorts actual

capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a **detailed investigation** of the insurer when, in fact, he did not. Examples where agent liability is not so clear, however, include cases where an agent convinces a client to surrender or cancel a policy from one company for a policy of another company and it is determined that the second insurer is weaker and maybe even be liquidated at some later date. In this instance, the law might interpret the agent actions to be more than just a "usual transaction", where a policy product is simply "sold". Here, the agent acted more as an **advisor**. His actions might appear to be assurances that the new company is better than the old company when, in fact it was not, for purposes of generating a commission.

In yet another legal strategy, agents may be culpable by his statements of confidence. Saying things like, "**trust me**" or "**I guarantee it**" could be construed as a warranty by the agent. Since most agents find it impractical to "clear" every representation with compliance departments, many oral declarations are made in the course of a sale or counseling clients. Technically, a guaranty should be in writing, but this would not stop an attorney from pursuing a talkative agent who made similar representations to more than one client. A common example is in the area of "safety" regulations. The following are terms probably used everyday by agents and though they stop short of creating an absolute financial guarantee for policy owners, they infer financial stability and give the purchaser a measure of confidence that the company behind the product is financially secure. An agent who cites these utterances is likely to be responsible for their truth:

Claims of Regulation by the State Insurance Department

An agent might say: "All insurers are regulated by the State Insurance Departments in the states in which they do business. These departments enforce the states' insurance laws. These laws cover such areas as insurer licensing, agent licensing, financial examination of insurers, review and approval of policy forms and rates, etc. Generally speaking, an insurer's and reinsurer's operations are at all times subject to the review and scrutiny of state regulators."

Claims of Minimum Capital and Surplus Requirements

"Among the requirements imposed by state laws are minimum capital and surplus requirements. These provide that an insurer or reinsurer will not be allowed to do business unless it is adequately capitalized and has sufficient available surplus funds with which conduct its operations."

Claims of Minimum Reserve Requirements

"State laws require insurers and reinsurers to post reserve liabilities to cover their future obligations so that financial statements accurately reflect financial condition at any given point in time."

Claims of Annual Statements

"Insurers and reinsurers are required to file annually a sworn financial statement with each insurance department of the state in which they do business. This detailed document provides and open book of the insurer's financial posture and is reviewed closely by state regulators."

Claims of Periodic Examinations

"State regulators perform examinations or audits in the home office of insurers and reinsurers as often as they deem necessary, but generally no less frequently than every three years. The primary purpose of such examinations is to verify the financial condition of the insurer. In addition, a reinsurer may perform period audits of the company they reinsure. Finally, an annual audit is also conducted by a public accounting firm."

Claims of Statutory Accounting

"In reporting state regulators, insurers and reinsurers are required by state laws to practice "statutory accounting", as opposed to conforming with "generally accepted accounting principles (GAAP). The statutory method is generally acknowledged to be a more conservative approach and thus much less likely to overstate a company's true financial condition."

Claims of Investment Restrictions

"State insurance laws restrict the manner in which insurers and reinsurers can invest the funds they hold. Insurers and reinsurers generally may invest only in assets of a certain type or quality and must diversify their investments to minimize overall risk."

Guaranty Fund Claims

"It is possible that, in spite of these and other safeguards, an insurer could become insolvent. If this should occur, there still remains the likelihood that a policy owner will retain most, if not all, of the value of his policy from funds still remaining with the insolvent insurer through the state guaranty fund."

Virtually every state has enacted what are commonly know as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policy owners, wherever located, of insurers domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there. The law in some states, however, limits protection on several fronts: There are coverage limits or caps ranging from \$50,000 to \$1 million per claim; some completely eliminate claims or place severe restrictions on certain policies including life, variable life blends, disability, mortgage guaranty, ocean marine, surplus lines, HMOs, PPOs and other non-traditional markets.

Many states disallow advertising or use of any statements regarding state fund insurance prior to the sale. The premise is that guaranty fund warranties made to fortify the financial security of a weaker insurer could lull the public into overlooking the need to deal with sound companies. Further, violations of sales tactics using guaranty funds may cost an agent more than a liability suit. It may result in additional monetary fines and license suspension.

Agent Relationships & Insurer Failures

Often, agents develop special relationships with clients which can result in additional liability exposure. This can occur when an agent has handled all the insured's business or when a client has come completely depend on the agent for all his insurance decisions and the agent knows it. In these cases, there may be legal authority to proceed against the agent where losses are due to an insolvency. Even when faced with limited success, policy holders and their attorneys have pursued agents asserting a "personal" claim -- that is, the culpable conduct of a **third party** (the agent) was personal to the policy holders, who relied upon that wrongful conduct. Also, never let it be said that policy holders cannot sue an agent for any reason. This "right" has been upheld under **Matter of Integrity Insurance Co., 573 A.2d 928 (1990).**

One justification for placing **tort responsibility** on the agent is the conclusion that :

"The risk of loss in an insolvency setting should not rest with the insured or the claimant."

Cal Ins Code, 780-790.1 (Dearing 1991), N.Y. Ins Laws, 2401-2409 (1990), Mass Ann Laws ch 175, 2B (1990).

In essence, the courts are sympathetic concerning an insured's need for complete protection. This stems from the ***special circumstances*** that surround an insurance contract, i.e., ***the insured and insurer are not equal partners since the insured cannot protect itself by contract. Also, the insured cannot bargain or require a provision of the policy protect or indemnify for a potential insolvency. The insured can only seek other insurance with a more stable company. And, even when an insured is informed about the financial condition of an insurer, the courts feel that they would lack the knowledge and experience necessary to evaluate financial statements, reports and solvency terms like surplus, reserves, etc. Finally, an insured cannot mitigate or control his damages since insurance cannot be purchased after a loss, i.e., the insured could have already paid for a benefit he cannot receive if an insolvency occurs.***

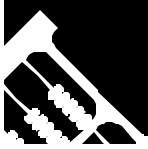
Recent legal research, which will be cited in claims against agents, presents a clear and loud indictment of agent and broker responsibility (A Proposal for Tort Remedy For Insureds of Insolvent Insurers Against Brokers, Ohio State Law Journal, vol 52, 4 (1991):

"When one considers all of the factors of tort recognition, including the social policy aspects, the argument for the establishment of a tort duty on the part of the collateral parties (agents, brokers, reinsurers, etc) to the insurance relationship is compelling. Placing a duty on the collateral parties to investigate and monitor reasonably the solvency of insurers with which they deal yields a much more socially advantageous result. This duty logically extends the duty already existing for brokers to exercise care in the placement of insurance with solvent insurers. The proposed duty, however, requires affirmative investigation and monitoring. This investigation and monitoring should, at least, include an evaluation of National Association of Insurance Commissioners' data, Insurance Regulatory Information System data, ratings service data, and any other public information and general information circulating within the industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."

"The duties of these public parties is a high duty that encompasses nonfeasance (Pennsylvania v. Roy, 102 U.S. 451, 456). Imposing a duty on collateral parties (agents, brokers, reinsurers, etc) to conduct a reasonable investigation and monitoring of the solvency of insurers, and imposing liability for a failure to abide by that duty accords with prior treatment of public entities."

Congress has also chimed in by suggesting that:

"Brokers should be required to check the integrity of the people and records which determine ultimate premiums and losses charged on policies". "Failed Promises", Testimony before the Subcommittee on Oversight and Investigations for the U.S. House of Representatives (1990).



Why Insurance Fails

Insurance can fail to insure in many ways. The source can be an agent's negligence in providing coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to pay, e.g. insolvency of the insurer. In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent. This is definitely an area to practice loss control.

What goes wrong?

Coverage Shortfalls

Many Americans consider themselves dutiful to purchase and maintain insurance often buying multiple policies with varying features and limits. Occasionally, situations arise where a liability surfaces from an unanticipated source, beyond the scope of these features and limits, resulting in ***an insurance shortfall***. Such is the case where a breadwinner who bought a paltry \$50,000 whole life policy dies prematurely leaving a family with young children. Or consider a high wage earner who is the cause of a serious auto accident that disables a neurosurgeon for life. Obviously a \$300,000 policy limit will not satisfy the surgeon's family and their attorney. When events like this occur the agent may find himself in the position of breaking the bad news or worse, liable for the shortfall.

Sometimes, insurance shortfalls cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference (**Insurance Company of North America vs J.L. Hubbard - 1975**). Then too, there are times when the coverage purchased or sold to a client exceeded what was needed in one type of insurance at the expense of another insurance coverage being under funded and under covered, e.g., a high premium whole life policy leaves no monthly budget for health insurance, or an auto policy with low deductibles is chosen or sold instead of a higher deductible policy permitting the additional purchase of umbrella coverage. Where clients depend on an agent for multiple lines of insurance or simply because it's right to do so, agents need to consider the balancing of coverage to avoid critical shortfalls.

Coverage Disputes

In the midst of the litigation explosion, the stakes are high. Insurers are offering increasingly high policy limits, and insureds, who cannot secure coverage or who fail to be awarded coverage, risk losing a lifetime of assets. Given this scenario, conflicts between insureds and insurers and agents can easily gather steam. To further confuse the issue, the courts are constantly "bending" statutes while public attitudes produce more and larger plaintiff verdicts, this despite the fact that the industry operates under fairly standard contracts. In essence, there has never been a time for greater disputes in coverage.

One form of coverage dispute results when the agent fails to secure the promised coverage (**Bell vs. O'Leary - 1984**). The courts have found that when an insurance broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to

notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

A more common form of dispute occurs when the insured and the insurance company simply do not agree on the interpretation of coverage provided. In practice, insurance coverage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage, i.e., life, health, casualty, excess, umbrella, from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large. Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be litigating coverage for the same underlying claims or addressing the same coverage issues. In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

Legal Maneuvers -- Attorneys at Work

Where coverage disagreements persist beyond an initial settlement, policy holders or their attorneys must begin the tedious task of processing documents and information relating to the insurance companies' interpretations and meanings of their policies. This often leads to a ***drafting history***. The drafting history contains detailed records of the insurance industry's deliberations regarding policies and seeks the original meaning of policy terms and the manner in which they were intended to apply. Courts have found such histories to be relevant and material, as well as filings made by insurance industry organizations on behalf of their members to state insurance departments and insurance regulatory agencies.

Policy holders and their attorneys also seek ***underwriting and claims handling manuals*** written by insurance company experts that are used to provide guidance to insurance company employees. These manuals may demonstrate how the insurance company interpreted their policies. In addition, they may contain the company's official position on coverage, claims and loss control. Many courts have ordered the production of such manuals and guidelines in the early stages of coverage cases.

Another valuable source used by attorneys is ***reinsurance documents***. Communications between an insurance company and its reinsurer can provide information on whether and how policies may apply to underlying claims and may offer assessment of the insurance company's coverage obligations. Access to reinsurance documents is a hotly contested issue in insurance litigation discovery, and some courts have refused access to such documents.

Disputes also lead to discovery of ***insurance company marketing policies*** by documenting company advertising and agent/broker representations, as well as how the insurer has handled other policy holders with similar coverage claims. Also investigated is the possible cause and effect of the insurance company's involvement in other coverage litigation.

Agent Records

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in ***the ordinary course of business***. In other words, if you use as operations manual or stick "post-it" notes in you client files as ***standard operating procedure*** they are generally

admissible. The test will be: Do you use these methods for **every** client? An example might be a standard checklist of coverages that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available.

Keep in mind that most parties to a claim will eventually gain equal access to your records. So, you want to keep all legally required records and be consistent from file to file. Also, never write derogatory comments about clients or the company in files. This could work against you in a trial or settlement.

Agent Cooperation

The *Managing Conflict* section discusses several issues regarding defense of an insurance claim. A few of the more important items focus on agent cooperation. In a nutshell, most suits settle before going to trial so cooperation on all sides is generally desired. However, you should proceed with caution in any dispute or potential claim. Check with your errors and omissions carrier before discussing matters with clients or your represented companies. Don't try to settle the case, it could void your E&O policy. Don't make any promises to clients about resolving the matter or give them legal advice of any kind. Don't ever try to cover-up mistakes -- it mostly backfires. If your errors and omissions carrier wants to settle it is usually best to agree. If you don't, you could be liable for court judgements that exceed the settlement already proposed by your E&O carrier.

Insurance Litigation

Although most insurance conflicts settle prior to trial, some disintegrate into protracted and unnecessary litigation, Some areas of specific conflict include the following:

Triggers of Coverage

The term **trigger** is merely a label for the event or events that, under the terms of an insurance policy, determine whether a policy must respond to a claim in a given set of circumstances. While this definition seems clear, "trigger of coverage" disputes have been raging for decades and have been the source of much confusion.

In a life policy, the trigger seems clear: death. However, issues of whether the death was an accident or suicide within the incontestable period is often up for debate. Disability and health policies, however, have a higher propensity for dispute: What is a permanent disability? Are there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In long term care policies, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient's inability to care for himself: the prerequisite for insurance benefits.

Policy language in most casualty policies center around *three primary "trigger of coverage" issues*. First, the carrier agrees to provide coverage for "all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence." Second, an "occurrence" is defined in the policies as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured..." Third, "bodily injury" is defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period", and "property damage" is defined as "injury to property which occurs during the policy period..."

The "trigger" is plain under these three policy provisions when property damage or bodily injury "occurs" during the policy period. But, the trigger question becomes somewhat complicated when a long period of time has elapsed between the act giving rise to liability. Examples include a leak or spill involving hazardous waste or exposure to asbestos or lead which may result in problems years later.

Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage "occurs" and thus "triggers" coverage. 1) The date of exposure to the toxic substance (*the "exposure" theory*); 2) the years in which the claimant incurred tangible injury (*"injury in fact" theory*); 3) the date of manifestation of injury (*the "manifestation" theory*) and 4) the year in which damage "occurs" or "could have occurred" (*the "continuous trigger" theory*). The "continuous trigger" theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination. In essence, the courts have generally ruled that casualty insurance policies can be "triggered continuously" from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holder attorneys adopt a "continuous trigger" approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and NOT A "REOCCURRENCE".

Definitions

The following are terms that often become the focus of coverage disputes:

Bodily Injury - bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.

Property Damage - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property that has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period.

Occurrence - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

Conditions

In addition to standard provisions and definitions, coverage is further defined in a ***conditions section*** where the duties and legal requirements of the insured and insurer are established. Typical conditions are the insurer's right to inspect, and the insured's duty to cooperate with the insurer and the notice provision.

The notice provision is the most frequently litigated condition. A sample notice provision might include the following language: "In the event of an occurrence, written notice containing particulars sufficient to identify the insured, the time, the place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company".

Some courts have relieved the insured of its notice of obligation unless the insured was in some way prejudiced or harmed by the insured's delay in providing notice. The insurance company usually has the burden to prove that it was harmed by the insured's failure to comply with the notice requirement.

Exclusions

There are many standard policy exclusions as well as those relating to high risk issues such as partial disability, pollution, nuclear attack, "owned property", aircraft and liquor liability. The purpose of these types of exclusions is to limit the policy coverage to contemplated risks only. The burden of proving that an exclusion applies generally falls on the insurer in coverage disputes.

Named Insured

The definition of a "named insured" varies from policy to policy. Some define it in broad terms, while others insist on a more narrow description. Often, standard policy formats will provide a "listing" which has resulted in legal conflicts where coverage was denied a party on the listing who is no longer associated with the primary insured. The burden to prove continued association is with the insured.

Assignments

Conditions of most standard policies prohibit assignments without written consent of the insurer. Such provisions are enforceable because they ensure that the risk the insurance company agreed to insure remains the same. In fact, the majority of courts have refused to hold an insurer liable for an occurrence derived from a risk not contemplated by the insurer at the time the policy was issued. It is important to note, however, that prohibiting assignments does not bar the assignment of insurance proceeds.

Rules of Construction

The rules governing the construction of insurance contracts are usually the same as those for other contracts -- the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured. Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

Duty to Defend

The prevalent view by the courts is that an insurer has the duty to defend an insured where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. Standard policies employ language reading: "the company shall have the right and duty to defend any suit against the insured seeking damages on the account of bodily injury or property damage even if the allegations of the suit are groundless, false, or fraudulent". Insurers maintain the position that they may be contractually bound to defend, but may NOT be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer. A **PRP**

letter (Potentially Responsible Party), received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple *demand letter* which only exposes one to a potential threat of future litigation.

If there is **any doubt** as to whether the facts give rise to a duty to defend, it is usually resolved in favor of the insured, but it is the insured's burden to show that the claims come within the coverage. Claims related to acts of an insured in the area of crime, sexual misconduct, wrongful termination, contractual obligation, loss of profits or goodwill etc., have been ruled unacceptable ways to force an insurer's duty to defend.

Breach of Contract / Refusal of Coverage

Breach of contract claims typically allege that an insurance company failed to defend or indemnify the policy holder under terms of the insurance contract. To a great extent, public policy supports the policy holder in most breach of contract allegations in an effort to solidify the "strict enforcement of insurance contracts". This is why state insurance regulators will typically be involved or called upon to rule on an insurer's potential or actual violation of codes.

Many times, an insured is denied protection because the insurer knows facts which would defeat coverage. A majority of different courts have ruled that under such conditions, an insurance company is not bound to "defend" such claims simply because it cannot be bound to indemnify -- in essence, the duty to defend can be disputed. Here, the insurer has the burden to prove that the facts of the insured's claim fall squarely within a policy exclusion.

Bad Faith

There is increasing judicial recognition that the relationship between an insurer and its policy holder is fiduciary in nature. Courts have compared the relationship of an insurance company to its policy holder to that of a "trustee for the benefit of its insured". Where an insurance company allegedly has violated its fiduciary duties owed its policy holders a bad faith claim could be appropriate in addition to any breach of contract action.

Choice of Law / Venue

Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are *state law questions* even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as 1) the place where policies were contracted; 2) the location of the damage and/or 3) the principal place of business/residence of the policy holder.

Lost Policies

Some claims between insureds and insurance companies have developed over the inability of the policy holder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policy holder must satisfy two requirements to prove coverage. First, the policy holder must prove that the policy was, in fact, lost or otherwise unavailable by showing that he made a diligent search for the policy in all places where it can likely be found. Second, the policy holder must prove the existence and the contents of the policy by identifying the parties to the contract, the policy period and the subject matter of the policy. Secondary evidence includes any correspondence, certificates of insurance, claim files, management

reports, corporate records, ledger entries, receipts, licenses and agent files and agent testimony.

Coverage disputes also evolve around the nature of damages or hidden exposures such as:

Environmental Litigation

One of the hottest issues facing the personal lines industry involves toxic mold claims. Some attorneys are comparing recent multi-million dollar cases to those of asbestos and lead paint a few years back. Many feel the costs will run into the billions for damages and remediation. A single Texas case, for example, awarded over \$32 million to a homeowner for the insurer's failure to properly handle a mold claim. The award included \$5 million for mental anguish, \$12 million in punitive damages and \$8.9 million in legal fees. And, a suit for bodily harm has yet to be filed.

Bodily injury claims for toxic mold are similar to pollution claims in that they allege injury that MIGHT occur in the future. This problem is compounded by an apparent lack of authoritative, scientific evidence demonstrating a relationship between mold and serious health conditions.

Policy coverage of mold varies. Older policies included "all risks", including "pollutants". At issue is whether mold is considered a "pollutant". Further, is the damage caused by mold from a leaking pipe or as a result of high humidity conditions where mold might develop naturally? The consensus by many is that these are MAY BE covered conditions. However, cases in some states have failed where the word "pollutant" does not appear to be defined as a living organism.

Newer policies are addressing the issue with specific "fungus" exclusions. Yet, where the production of fungus was a result of a faulty pipe or roof, can still limit coverage possibilities in some states.

A related issue involves the "ordinance or law exclusion" where the passage of laws requiring toxic mold cleanup might become material to otherwise non-covered claims for at least the "tearing down", cleaning and/or disposing of mold or fungus materials.

Excess Insurance Claims

With the increase in mass tort litigation, environmental litigation and substantial jury awards, excess insurance policies and the role of excess insurance carriers have received increased scrutiny. In general, the fact that a primary carrier owes duty to its insured is well known. With respect to an excess insurer, the courts continue to struggle with the origin of duty.

In coverage disputes where the insured is bringing action against BOTH a primary and excess insurer, the excess carriers sometimes moves to dismiss the lawsuit on the basis that the actual exhaustion of the underlying primary liability limits is a prerequisite to a claim under the excess policy. Policy holders, on the other hand, argue that the mere potential that the underlying insurance will be exhausted is enough to justify a coverage dispute against the excess carrier. The courts have sided with each.

Another area of dispute is the *drop down* -- where an excess insurer "drops down" to provide insurance when the primary insurer has become insolvent. Courts are split on this issue, although a majority currently feel that an excess insurer is NOT OBLIGATED to drop down and provide coverage to an insured. The court's determination is usually based upon the language of both the primary and excess insurance policies.

In yet another decision, the courts have determined that the "trigger" of excess coverage is the amount "indemnified", not the additional costs involved in defense nor punitive damages. In **Harnischfeger v. Harbor**, for example, the fact that the insured paid \$3 million in defense and indemnity expenses could not yet trigger the \$3 million excess policy limits because the legal expenses incurred were not a factor.

Defenses of the Insurer

Much attention is devoted to the "rights" of policy holders. Insurance companies, however, have their own safeguards, which help protect their interests, but add to the growing list of things that can go wrong with insurance. Depending on the issue at hand, the result of having these "built-in" protections can completely void a policy or greatly limit its scope of coverage. Defenses consist of legal tools and techniques that help an insurer initially determine pertinent aspects of the insurance risk for purposes of deciding whether to issue the policy and at what premium. After a policy is committed, additional policy conditions help the insurer "contain" the risk within the intended bounds of the contract. Over the years, a series of standard defense devices have evolved. These can be categorized as concealment, representations of the insured, conditions, warranties and limitations to coverage.

Concealment

The insured has the duty to disclose to the insurer all material facts that might influence a decision to issue a policy of insurance at all, or issue it at a particular level of premium. The holding back of information can, in some cases, constitute fraud by the insured and can render a policy **void**. In general, the rule on determining when a policy is voided lies in the issue of "bad faith". If the insured withholds information that he knows would be necessary to the insurer in evaluating risk, the insurer has grounds to void the contract. Examples might include an life insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to disclose a medical condition that is critical to the insurer's risk decision.

The burden of proof as to fraud in concealment falls on the insurance company. In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was NOT made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information. Again, the issue of bad faith enters the picture. Only when the insured conceals a fact in bad faith, **knowing the fact to be material**, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for what causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered **material** and grounds for voidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be obvious and NOT grounds for voidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to **facts, and not to mere fears or concerns** of the insured about his health or the subject matter of the policy. There is also no requirement that

the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

Misrepresentations

A representation by the insured that is ***untrue or misleading, material*** to the risk, and is ***relied*** upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for voidance of the policy, unless the policy is beyond the incontestable period. This is true even if the misrepresentation was made by the insured innocently, with no intent to defraud. A minority of courts, however, take a somewhat less severe position limiting or prohibiting voidance where the insured's misrepresentation was NOT an intent to deceive the insurer.

Representations by an insured to an agent bind a contract because they are considered to be made to the insurer itself. However, a policy refusal or voidance could occur when the insured has reason to believe that the agent will not pass information on to the insurance company.

The insurer cannot void a policy based on a representation by an insured regarding an intention or future conduct unless it is made a condition of the contract. An example here would be an oral statement by an insured that he will install a fire alarm at the premises. The insurer relies on this representation and reduces the premium but does not include an express term in the contract regarding the alarm. On the other hand, a written commitment by an insured to install an alarm that is not followed can jeopardize the policy.

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems is where such representations are made with the intent to deceive and defraud. The burden of proving a representation *to be material* falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

Warranties & Conditions

The terms warranty and condition are generally used to mean the same thing -- a representation or promise by the insured incorporated into the contract. A warranty or condition statement that is untrue and relied upon by the insurer at the inception of the policy can void the contract. A possible exception to this rule occurs in life insurance where an "incontestable clause" prohibits the insurer from voiding a policy after the insured has survived a given period of time -- usually two years. Thus, a valid warranty/condition is a powerful tool for insurers.

In recent years, the effectiveness of warranties and conditions have come under fire. In fact, many statutes now place stiff definitions and limitations on warranties. One statute, for example, provides that all statements made by the insured will be considered to be a "representation" rather than a warranty unless fraudulently made. As previously discussed, it is much harder to void a policy for misrepresentation than for a violation of a warranty or condition. Another statute requires that the breach of warranty is a defense for the insurer ONLY if it actually contributed to causing the loss, as opposed to simply increasing the risk. This is the most severe type of statute for the insurer, since even in cases in which the breach caused the

loss, it is frequently impossible to prove the cause, e.g., a fire completely destroys a portion of a building.

Limitations on Coverage

Insurers over the years have attempted to control their exposure by tightening terms of the insurance contract. Adding personalized warranties and conditions is cumbersome and not always useful as a defense for insurers (see warranties and conditions above). Some courts, however, believe that insurers side-step warranties and conditions by creating numerous clauses that serve, instead, to **limit coverage**. The reason insurers have do this is because many of the statutes which commonly limit warranty defenses, such as incontestability, "contribute to loss" statutes and "increase the risk" statutes, do not apply to limitations to coverage.

There are several types of limitations that insurance companies can and do employ:

Limitations of Policy Subject Matter -- A homeowner's policy may cover most household possessions in general, but specifically exclude from coverage particular items like cash or coin collections. Likewise a health policy may exclude or waiver certain illnesses.

Limitations by Type of Peril -- A fire policy may except from coverage any loss caused by a fire resulting from lightening or earthquake.

Limitations on Proceeds Paid -- Casualty insurance policies frequently specify an upper limit of proceeds payable for any loss, as well as limiting the payment to the value of the insured's interest in the property damaged. Automobile policies generally fix the upper limit of coverage both in terms of maximum proceeds per person and maximum proceeds per accident.

Limitations on Period Covered -- Every policy will be specific as to the date of expiration, and in some cases, as with life insurance, will also specify a grace period beyond the date of expiration that insureds may make a premium payment. Also, the date of inception of a policy can be specified on the policy or can be subject to the occurrence of some event such as the payment of the first premium or delivery of the policy to the insured.

A limitation on coverage can cause considerable conflict between insurer and insured. One reason is the fact that in some instances, it is nearly impossible to determine from the wording of a clause whether it is a warranty or limitation. In response, the courts have developed two tests to distinguish the two.

In one test, if the circumstance which is the subject of the clause is **discoverable** by the insurer at the time of inception of the policy, the clause will be classified as a **warranty** rather than a **limitation**. An example might be a policy condition that obligates the insurer when the policy is delivered to the insured "in good health" when, in fact, the insured is suffering from a discoverable disease.

Another test deals with risk. If a clause refers to a fact which **potentially** affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit WHILE the insured is flying in a private plane. The insured can bring action to force payment of such a claim, EVEN if the insured died of a heart attack while in a private plane. The flying merely increased the risk, but need not be the actual cause of death. Such a clause is considered a warranty. On the other hand, if flying in the plane was the cause of death, it could be interpreted to be a limitation that is better defended by the insurance company.

Settlement Disputes

Some forms of insurance, like life insurance, are generally settled with ease since the amount paid in the event of loss is fixed by the contract. Similarly, in the case of accident insurance, the proceeds are measured by a specific amount agreed to be paid for loss of a particular limb or faculty, or, as in the case of health insurance, by the medical expenses actually incurred. By far, most settlement disputes occur over property/casualty policies where the payment in the event of loss is determined by an amount up to the "actual cash value" of the property at the time of loss. There are two basic approaches which insurance companies use in an attempt to arrive at a mutually agreeable value -- **reproduction costs less depreciation and market value**.

Reproduction Cost Less Depreciation

This measure is aimed at determining the cost of replacing the exact depreciated property that was lost. If this were the only option for insureds, it would represent an extreme hardship where, for example, the owner of a fifty-year old home that is destroyed would have great difficulty replacing it with a new building on the depreciated settlement. For this reason, **replacement cost insurance** is offered. Here, depending on the wording of the contract, the insured may be required to actually repair or replace the building in order to collect full payment. The most pressing problem for insureds is to keep policy limits above the 80% of market value requirement. Insurance companies require policy limits above this level to assure adequate coverage and keep premium levels high. Insureds may lose, however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

Market Value

Items of commerce that are readily replaceable in kind, e.g., a warehouse full of books, shipments of grain, etc., have a market value that is relatively easy to establish. In the case of income producing property such as office buildings, apartments or commercial buildings, market value is determined by a more detailed method using the capitalization of earnings. Disputes in this area usually require testimony of an expert witness who determines the rate of return on investment that a reasonable investor would require in investing in this type of property.

Insurer Insolvency

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval. **Liquidation** is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policyowners. **Rehabilitation**, on the other hand, allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a restructuring will still not revive the insurer, a liquidation is ordered.

If an insurer is liquidated, all policy owners and other potential claimants **MUST** be informed and permitted to file a **proof of claim** with the insolvent estate. These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal

and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

Once all appropriate values are determined, the assets of the insurer will be distributed under a statutory procedure. This process requires that certain priority lien holders be paid in full, while others may divide what is left. The typical **liquidation order of priority** is as follows:

1. Liquidation expenses and costs
2. Unpaid wages of employees of the insurer
3. Taxes
4. Policy holders, insureds and guaranty funds
5. Reinsurers and all other claims

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments. This provision, which appears in most reinsurance contracts, is called an **insolvency clause**. The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a **cut through clause** exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

State Guaranty Funds

The liquidation process can be extremely involved and lengthy. This is the reason that **guaranty funds** were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state. Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes **subrogated** to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company.

The guaranty associations are non-profit legal entities whose members comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

Exclusions

In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers. Insurance exchanges, assessment companies, fraternal, HMOs and, in many cases, the Blues (Blue Cross and Blue Shield -- especially where they have not been converted to legal reserve carriers), are commonly excluded.

The guaranty laws also commonly exclude from coverage policies or portions of policies under which the risk is borne by the policyholder or which are not guaranteed by the insurer. Variable accounts in some life policies or annuity contracts are examples.

Significant variation does exist in the treatment of unallocated funding obligations (UFOs), including GICs, which are commonly purchased as pension plan assets on professional, sophisticated advice by pension plan trustees.

Limits of Protection

Most guaranty associations limit their protection to policyholders who are residents of their own state. (It does not matter where the policyowner's beneficiaries live.) The trend toward adopting such a residents-only provision follows a major amendment to NAIC's model guaranty act adopted in 1985. Arizona, Virginia, West Virginia, Nevada, North Carolina and Oregon very recently amended their life-health guaranty laws to cover only their own residents.

However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policyholder is not eligible for coverage there. An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association. However, residents of a jurisdiction such as the District of Columbia which does not have a life-health insurance guaranty association would have no guaranty association protection, even though Executive Life was licensed there.

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policyholders live, and also cover their own residents who are policyholders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

Dollar Limits

Typical payouts to policyholders who are victims of failed or financially strapped insurance companies might read as follows:

Life and Health Guaranty Funds

Maximum death benefit	\$300,000
Maximum cash value covered	\$100,000
Maximum Annuities	\$100,000
Maximum Health and Disability	\$100,000
Maximum Aggregate Per Person	\$300,000

Property/Casualty Guaranty Funds

Maximum Claim	\$300,000 - \$500,000
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Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for \$500,000, a whole life policy with cash values of \$150,000 and a single premium annuity with an accumulated value of \$200,000, will collect ONLY \$300,000 -- the maximum aggregate limit per person regardless of how many policies. The fact that these policies may be spread among three different insurers does not make any difference. There would still be a \$300,000 maximum in most states. The same is true for property/casualty claims. Regardless of the number of policies or how they are distributed among different

insurance companies, the maximum claim that can be paid by a state guaranty fund is fixed at between \$300,000 and \$500,000 per individual.

Triggers

Generally, the guaranty associations provide coverage when the company has been declared financially impaired or has been ruled to be insolvent by a court of law. However, there are some situations preceding such a judicial action when many associations may take measures to cover the impaired insurer's policyholder obligations, particularly for health benefits, death benefits, and immediate annuity payments. However, since the primary purpose of the guaranty associations is to protect policyholders, and not to bail out impaired or insolvent insurers, most associations are reluctant to provide coverage before an order of liquidation, unless it is clearly demonstrated that to do so in a particular case will be less costly over time.

Coverage Options

Guaranty associations may provide coverage directly, or through outside administration or other insurance companies. In many cases, the guaranty association will continue coverage for the full policy period. It may do this directly or it may transfer the policy to another insurer or administrator.

In multi-state insolvencies, most guaranty associations work through NOLGHA to secure an assumption reinsurance agreement with another insurer or a claims servicing agreement with a third party administrator on a multi-state basis.

If the impaired or insolvent insurer is licensed in more than one state, as most are, NOLHGA's affected member associations try to work closely through our Disposition Committee with domestic receivers to protect policyholders and insure early and equitable access of guaranty associations to the insolvent company's assets. On behalf of its participating member guaranty associations, NOLHGA's Disposition Committee expedites reinsurance assumptions, claims processing and audits.

Reinsurance

Reinsurance and insurer safety are closely related since reinsurance plays a vital role in helping all types of insurance companies meet their everyday commitments. Unfortunately, the reinsurance market has taken some heavy blows in recent years, including some direct links to primary insurer failures. Record losses and mis-management in have caused many to leave or fold making reinsurance harder to come by and more expensive when you can. The shakeout is a huge wake-up call for the industry, including agents, who need to be more alert to their own company's reinsurance arrangements in the future.

Some primary insurance companies who also sell reinsurance have suffered the hazards of double exposure by having to pay claims from BOTH their primary and reinsurance divisions. It is also the contention of some industry groups that abuse of the reinsurance system, including some questionable reinsurance schemes by depressed insurers and foreign reinsurers, has been a key factor in almost every insolvency.

Reinsurance Defined

Reinsurance is often described as the **insurance of insurance** companies because it provides reimbursement for the insurer's losses under policies covered by the reinsurance contract. Insurance placed with the reinsurer is called the **ceded amount** , and the company that

receives the benefit of the insurance is called the **ceding insurer**. Insurance purchased by reinsurers to cover their own losses is called **retrocession**. The process of reinsurance involves a transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of its losses under policies written. It is a transaction which does not involve the policy holder who looks only to his insurer for defense and indemnity against loss. Reinsurance is purchased by a primary or an excess ceding insurer for its own benefit so that it can **spread its risks and limit its own liability** from large or catastrophic losses.

Reinsurance is often confused with excess or surplus line insurance. However, the two are totally unrelated. Excess and surplus line insurers are primary companies providing direct coverage to insurance consumers. Their function is to supplement the standard admitted insurance markets. Excess and surplus line insurers are, in turn, large purchasers of reinsurance.

Sources & Reasons For Reinsurance

Reinsurance can be obtained through **three distinct sources** : professional reinsurers, reinsurance departments of primary insurance companies and unauthorized alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is **no added charge to the policy holder**. The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the **reinsurance premium between the insurer and the reinsurer** is a separate transaction which **does not involve the policy holder**.

There are many **reasons primary insurers purchase reinsurance**. The two most important are to limit their liabilities and to increase their capacity. An insurance company may wish to **cap its exposure** to losses in one or a combination of three ways: **a per risk limitation, a catastrophic loss limitation or an aggregate of loss limitation**.

Prudent insurance management and certain insurance regulations demand that a company place a limitation commensurate with that company's surplus or equity on any one potential loss exposure, even though the company may provide coverage under an insurance policy in amounts considerably in excess of this prudent "retention". This is where reinsurance comes in. The individual company's retention may be anywhere from a few thousand dollars to several hundred thousand or even in the million dollar range. Whatever the loss exposure may be above the retention, up to the policy limits of the reinsurance contract, if any, becomes the responsibility of the reinsurer.

Most companies also seek to protect themselves from a disastrous accumulation of losses arising from a single event. For instance, a hurricane or an earthquake. No one single loss payment arising from the event might be beyond the company's individual risk retention level, but the accumulation of all the losses arising from the incident might be excessive for that company. Generally speaking, an insurer estimates the probable maximum loss to which it may be exposed, based on its business concentration in any particular geographical area, compares that exposure to its surplus and purchases reinsurance to cover the potential losses which exceed a prudent level of catastrophic retention.

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period -- say one year -- either with respect to its total combined losses for the period or the combined losses for certain lines of

insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year.

By providing a mechanism whereby companies may limit their loss exposures to levels commensurate with their surplus, reinsurance allows those companies to offer coverage limits considerably in excess of what they could provide otherwise. This is a crucial function for small to medium size companies, allowing them to offer coverage limits which meet the needs of their policy holders. If only the larger insurers could do so, there would ensue considerably less competition and insurance capacity would be much more restricted than it is today.

Reinsurance further **enhances an enlarged capacity** by a variety of other approaches which are related to accounting procedures. When an insurance company issues a policy, the expenses associated with issuing the policy, such as taxes, agent commissions and administrative expenses, become a current charge on surplus, while the premium collected must be set aside as an unearned premium reserve. The premium can only be considered as earned by the company and available to it over the life of the policy. This mismatch in accounting between premium and expenses makes good sense from a regulatory standpoint in that it allows for a more conservative accounting, commensurate with regulation for solvency. But it penalizes insurers to the extent that the more business they write, the more they must draw down on their surplus, thus reducing their capacity. By reinsuring a part of the business written, an insurer is able to limit the impact of the mismatch since the reinsurer must reimburse its client company for its proportionate share of expenses. The reinsurer then is the one which must reduce its surplus by the expenses it absorbs from its reinsured.

Similarly, when a claim is presented to an insurance company, a loss reserve must be established for the amount of anticipated claim payment. The reserve also comes from the company's surplus. However, to the extent a reinsurance recovery is anticipated on the claim and the reinsurer qualifies under state regulation, the insurer may limit its loss reserve to the extent of its own estimated "out of pocket" liability.

There are other approaches to reinsurance as a mechanism to enhance capacity. One such approach which was used perhaps to excess in the past is known as a "loss portfolio transfer". Under this transaction, the insurer "sells" a portion of its loss reserves to the reinsurer which promises to pay the claims represented by these reserves when they are finally adjusted. Assuming that the loss reserves being transferred to the reinsurer exceed the payment which the insurer makes to the reinsurer, the difference may be added to the insurer's surplus, thus, enhancing its capacity.

Reinsurers provide **other services** besides financial transactions aimed at limiting an insurer's exposure to losses, stabilizing an insurer's operation or enhancing its surplus to increase capacity. Many reinsurers are equipped to provide guidance to insurers in underwriting, claims reserving and handling, investments and even general management. These services are particularly important to smaller companies or to those which may wish to enter new lines of insurance.

Limitations of Reinsurance

First and foremost, **reinsurance does not change** the inherent nature of risk being insured. Thus, it does not make a bad risk insurable. Neither is reinsurance, nor can it be made to be, a subsidy allowing underpricing of risks. Also, reinsurance does not make a risk exposure more predictable or desirable. While it may limit the exposure to a risk from the standpoint of the primary insurer, the total risk exposure is not altered through the presence of reinsurance.

Regulation of Reinsurance

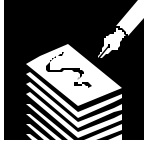
Regulation cannot substitute for good management practices. The placement of reinsurance is a major responsibility of insurance management. It is a responsibility which cannot be substituted by regulation. There are many public and private resources and controls available to check the security and management of reinsurance companies. For instance, all states today require **reinsurance contracts** to include certain clauses which are of overriding public policy. All contracts, for example, must **contain an insolvency clause which requires the reinsurer to pay all reinsurance proceeds to the liquidator**, in the case of insolvency of the insurer, without diminution resulting from the insolvency.

Probably the biggest issue with regard to reinsurance regulation is the control and policing of **offshore or alien reinsurers**. The **U.S. is one of very few countries in which alien insurers may operate** either through wholly owned subsidiaries or through branches or, in fact, both. A foreign domicile adds an additional **layer** of insulation between U.S. regulators and the reinsurer. A simplistic approach would be to limit the U.S. reinsurance market to U.S. domestic or licensed companies. Traditionally, however, the international reinsurance markets have been the main source of retrocession insurance. The influence of the London markets, in particular Lloyd's of London, has been substantial.

While it is true that reinsurers must file financial reports and are examined like primary insurers, there are some areas, where regulation of alien reinsurers fall short:

- Regulation of reinsurance cannot be so restrictive as to preclude adequate capacity. Regulators cannot be so rigid as to completely banish the supply of reinsurance.
- The channeling of reinsurance to more secure markets seems to be defeated by U.S. tax policy. The only tax on U.S. reinsurance premiums ceded to alien companies is the U.S. excise tax, a one percent gross premium tax. U.S. reinsurers, on the other hand, pay income tax equivalent to 7.5 percent of premium. The resulting difference has placed **U.S. reinsurers at a major competitive disadvantage** which is very real indeed. In a recent press interview, when asked why Bermuda is such an important reinsurance center and whether it could maintain its preeminent position, one of the island's leading reinsurance brokers answered, "because freedom from corporation tax allows reinsurers to offer highly competitive prices".
- The difficulties in regulating an international commodity such as insurance and reinsurance are, in part, due to the limited geographic reach of regulators, as noted in the report. However, the major difference is accounting conventions, country to country, are themselves major obstacles which would not disappear under a federal regulatory system. To establish minimum solvency standards for all companies doing business in the U.S. becomes a formidable task when these differences are taken into consideration. As an example, the required valuation of assets by many Continental reinsurers results in a reported capitalization which would be grossly inadequate to sustain their net written premium, based on U.S. standards. Yet, many of these companies are solid, conservative entities.
- Currency fluctuation is another element which any international regulatory system must consider. Settlement payments could lose substantial value when siphoned through the "swings" of a wild currency exchange.

This brief discussion of reinsurance leaves little doubt that mismanagement or fraud, even when limited, can lead not only to massive financial losses, but also to a loss of confidence in the integrity of insurance and its regulatory structure. To prevent future similar occurrences without unduly stifling the insurance and reinsurance competitive environment is a challenge which, if successfully attained, will be of great public benefit.



Managing Conflicts

It is estimated that one in seven agents face an errors and omissions claim each year. Conflicts of this gravity challenge your reputation, waste enormous time and could threaten your financial well-being. **Basic measures** to limit exposure always begin by **avoiding claims at the outset**. Of course, this is easier said than done, since there is NO foolproof method to sidetrack a lawsuit from a client or an insurer. There are, however, some steps that agents can use to help reduce the possibility of a claim developing and present a reasonable defense if one does.

Following are some steps to consider in managing the risk of selling insurance:

Step 1

Know your basic legal responsibilities as an agent and only exceed them when you are absolutely sure what you're doing. Pull out your agency agreement right now and ***read it!!!*** When you decide that you want to be more than an agent, i.e., ***a specialist or expert***, understand that it comes with a high price tag -- ***added liability***. Also, make sure you are complying with basic license responsibilities to keep from becoming a commissioner's target for suspension or revocation.

Step 2

Learn from other agent mistakes. The best school in town is the one taught by agents who have already had a problem. Study their errors, learn from them and make sure you don't repeat them.

Step 3

Be aware of and avoid current industry conflicts that could develop into problems for your agency. There are hundreds of professional industry publications and online sources that will help you keep abreast. Once you are aware of a potential problem, take action to make sure it doesn't end up at your doorstep.

Step 4

Maintain a strong code of ethics . As you will see from our discussion of ethics, you don't need a list of degrees or designations to be ethical. Simply be as honest and responsible as possible.

Step 5

Be consistent in your level of "due care". Adopt a code of procedures and create an operations manual that forces you to treat client situations the same way every time. Courts and attorneys alike are quick to point out any inconsistency or lack of standard operating procedures where the client with a problem was handled different than another client.

Step 6

Know every trade practice and consumer protection rule you can and act within standards of other agents. The violation of "unfair practice rules" is a really big deal to lawyers. They will portray you as something short of a "master criminal" for the smallest of violations, especially if they are outside the standards of others working in your same profession.

Step 7

Use client disclosures whenever possible. There is nothing more convincing than a client's own signature witnessing his knowledge of the situation or a note in an application offering an explanation.

Step 8

Spend more time with client applications (at least 50% more time than you do now). The information provided in an application is serious business. Mistakes, whether intentional or not, can void a policy or reduce benefits and lead to a lot of trouble for your client and you. Use mini-disclosures to evidence your position and reasoning.

Step 9

Get connected to the latest office protocol systems. The ability to access a note concerning a client conversation or the way you “package” correspondence can make a big difference in the outcome of a claim or avoiding one at the outset. You want a system that will produce solid evidence not “hearsay”.

Step 10

Maintain and understand your errors and omission insurance. This policy is your “first line of defense”, but know its limitations and gaps.

Now let’s expand on some of these steps:

Know Your Agent Responsibilities

The Agent & Client Duties

As we pointed out in a previous section, an agent generally assumes only those duties normally found in any agency relationship. Your agency contract is a good source of basic duties. Overall, the basic duty of agents is to select a company and a coverage and bind it (if you have binding authority -- casualty agents). Where clients have come to you and requested coverage, you need to decide whether it is available and if the client qualifies.

Agents have a responsibility to know the differences in product he is selling, and while you do not need to obtain “complete” coverage in every case, you have a duty to explain policy options that are reasonably priced and widely available for the policy you are suggesting.

In some cases, agents have been responsible for “after sale” duties to see that a policy continues to meet client needs. The more that your clients depend on you for their insurance needs and the longer you do business with them, the higher your standard of care is in selling and serving them.

The Agent & Company Duties

In addition to agent/client duties, you have duties to your company. Again, your agency contract is a good source to review. The problems occur in areas of ***fiduciary duties and statutory duties***.

When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal (the insurer), ***fiduciary duty*** of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Beyond this, however, agents are bound to his insurer by other ***statutory duties***. They include Duty of Care and Skill, using standard care and skill; Duty of Good Conduct or acting so as not to bring disrepute to the principal; Duty to Give Information by communicating with the principle and clients; Duty to Keep Accounts by keeping track of money; Duty to Act as Authorized; Duty to be Practical and not attempt the impossible; and

Duty to Obey or comply with the principal's directions. A violation of these duties can be considered grounds for termination or legal exposure to the principal or insurance company.

Areas of additional concern include clerical mistakes, erroneous policy limits, omissions of endorsement, misappropriating premiums, failure to disclose risk, failure to cancel or notify cancellation, authority to bind, premium financing activities and unfair trade practices.

Agent Integrity

While many agents believe that "integrity" is a characteristic of choice, many state laws set minimum agent responsibilities to follow, such as:

Qualifications

Insurance Commissioners have been known to suspend or revoke an insurance agent if it is determined that he or she is not properly qualified to perform the duties of a person holding the license. Qualification may be interpreted to be the meeting of minimum licensing qualifications (age, exam scores, etc) or beyond.

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In **Goldberg vs Barger (1974)**, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing The Law

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In **Hohreiter vs. Garrison (1947)**, the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In **Steadman vs. McConnell (1957)**, a Commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In **McConnell vs. Ehrlich (1963)**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers whose licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than

could others because of their "volume plan". Moreover, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents for the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

In addition to the specific violations above, most states establish agent responsibilities that MUST NOT violate "the public interest". This is an obvious catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (criminal) violations, etc.

License Responsibilities

There are agent responsibilities necessary to maintain licensing in "good standing":

License Authority

A person or employee shall not act in the capacity of an agent/broker without holding a valid agent/broker license. This becomes the "age-old test" of what activities constitute an insurance producer. It is generally assumed that anyone quoting premiums or terms of an insurance contract should be licensed. However, insurance departments across the country have pushed to constantly expand the definition of who in an agency should be subjected to licensing as an insurance producer. To avoid unintentional noncompliance, many agency principals have licensed almost all staff members, regardless of how limited and passive the functions they perform. By contrast, the staff of **insurance companies are exempt** from producer licensing for a wide variety of service functions such as collecting premiums, mailing and delivering insurance policies and taking additional information requested by the agent or the insurer concerning and applicant or other transaction over the phone.

At the agency level, some insurance departments require agencies to be licensed both as corporate entities and as individual agency owners and principals.

Temporary licensing can be requested when the agency principal or owner dies or to fill a void in an insurer's marketing force. This allows the surviving family to conduct business with existing clients. These licenses are usually limited to 30-days with two renewals for a total of 90 days.

Recent controversy has surfaced concerning the granting of producer licensing and special privileges (exemption from licensing) to special interest groups like financial institutions and self-insured group purchasers. Independent agents are protesting this treatment and have requested new rules be established by the National Association of Insurance Commissioners.

Notice of Appointment

In addition to license requirements, states generally require a notice of appointment be filed with the insurance department. This document is executed between the agent and insurer and authorizes the agent to transact one or more classes of insurance business. An agent may be appointed with several insurers. Upon termination of all appointments, an agent's license becomes inactive. While inactive it can be renewed and reactivated by the filing of a new appointment.

License Domicile

Agent domicile is a rapidly changing area of law. Currently, many states will grant non-residents a producer license. The rules are fairly straightforward: Agents and brokers of insureds with exposures in several states must be licensed in those states before they can collect a commission for the coverage they have written. However, since a non-resident agent "exports" premiums and business outside a given state, many states are beginning to erect barriers to prevent outside solicitation. One state (Texas) has strictly prohibited agents and firms from entering to solicit property/casualty insurance business (life and health sales are permitted) without forming a corporation or agency and physically opening a Texas office. Soliciting is defined as direct mail, telephone or any other form of communication, such as fax.

Other new rules and regulations enacted in some states require that insurance policies be countersigned by licensed resident agents of the insurer, regardless of where the contracts are made or the residency of the insureds. Many states require proof of continuing education credits for non-resident agents in those lines of insurance they are licensed or physically go to the state and pass a test before renewal or relicensing.

Display of License

Most states require that an issued license be prominently displayed in the agent's office or available for inspection. Where the business entity is a "fictitious name", such name should be registered with the insurance department.

Records

Agents, should maintain a record-keeping system that will provide a sufficient "paper-trail" to identify specific insurance transactions and dates. At a minimum, such record systems should track the name of the insurer, the insured, the policy number and effective date, date of cancellation, premium amounts and payment plans, dates premiums are paid and forwarded or deposited to a the insurer or trust account, commissions (and who gets them). Where an agent trust bank account is used, agents should maintain all bank statements, deposit records and canceled checks. Most records should be kept for a total of 5 years after the expiration or cancellation of the policy. Some states require that records be maintained "on-site" for one year after expiration or cancellation or stored off-premises but available within two business days.

Agent Files

While agent files may not be law in certain states, every policy transaction should be separately filed and include a copy of the original application for insurance or a memo that the client requested coverage, all correspondence between agent/client and agent/insurer, notes of client meetings and phone conversations, memorandums of binders (oral or written) and termination/cancellation dates with proof of notification.

Agent Business and Marketing Practices

Agents should pay particular attention to the responsibilities they have in the following areas:

Applications

Proper attention to the completion and submission of applications cannot be stressed enough. Spend at least 50% more time than you do now on applications. Mistakes by you or a client can

void, decline or reduce coverage. Be accurate, timely and explain to clients the serious nature of misrepresenting information they provide. **Tip:** Use mini-disclosures in applications to note the source of suspicious information or to justify your reasoning, e.g., if you are basing an exchange on an IRS code, include the code section in the application.

Concealment

Concealment is neglecting to communicate what the agent knows or ought to know to be true. Concealment can be intentional or unintentional: In either case the injured party is entitled to rescind the contract or policy. Communication that is generally considered **exempt** from concealment include: Matters which the client/insurer waives (refuses or declines to discuss), matters which are not material and matters which, in the determination of the "prudent man theory", the other party ought to know.

Presentations, Illustrations & Quotes

It is illegal to induce a client to purchase or replace a policy by use of presentation materials, illustrations or quotes that are materially inaccurate.

Misrepresentations

An agent, broker or solicitor shall not misrepresent any material fact concerning the terms, benefits or future values of an insurance contract. This will include misrepresenting the financial condition of an insurance company, making false statements on an application, disclosure of State Guaranty Fund backing of insurance contracts (some states), making false statements or deceptive advertising designed to discredit an insurer, agent or other industry group, making agreements that will result in restraint of trade or a monopolizing of insurance business, etc.

Twisting & Churning

The act of "twisting" or "churning" is defined as misrepresentation or unfair comparison of insurers or policies for the purpose of inducing a client to change, surrender, lapse or forfeit an existing policy. Agent violators may be subject to fines, imprisonment and/or license suspension/revocation.

Redlining

An agent/insurer may not refuse to accept an application for insurance or cancel a policy based on a person's race, marital status, sex or religion. New proposals before Congress are targeting redlining violators (insurers and agents) who are withholding insurance protection in certain metropolitan areas.

False Claims

It is unlawful for an agent to submit a false or fraudulent claim to receive insurance loss proceeds. This includes "staging" or conspiring to stage accidents, thefts, destruction of property, damage or conversion of an automobile, etc.

Unfair Business Practices

It is a violation in most states for agent/brokers to fail to act promptly and in good faith regarding an insurance claim, fail to confirm or deny coverage applied for within a reasonable time, dissuade a claimant from filing a claim, persuading a client to take less of a claim than he or she

is entitled to, fail to inform and forward claim payment to a client or a beneficiary, fail to promptly relay reasons why a claim was denied, specifically advise a client NOT to seek an attorney when seeking claim relief, mislead clients concerning time limits or applicable statutes of limitation concerning their policy, advertising insurance that the agent does NOT have or intend to sell, use any method of marketing designed to induce a client to purchase through the use of force, threat or undue pressure, use any marketing method that fails to disclose (in a conspicuous manner) that the agent is soliciting insurance and/or that an agent will make contact.

Policy Replacement (Certain states)

Agents must clearly disclose in writing, signed by the client, their intention to replace insurance with a new policy and that the existing insurance will lapse, be forfeited, surrendered or terminated, converted to a paid-up or reduced paid-up contract, etc. A copy of this "replacement notice" shall be sent to the existing insurer (by the new insurer). Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement.

Client Privacy

Protecting a client's privacy is an ethical responsibility and an area of increasing liability for insurance agents. The concern by clients is that highly personal health and financial information you collect in the process of selling insurance will get in the hands of groups who might use this data to exploit them. As a result, new legislation has passed that requires certain disclosures be made to your clients whenever non-public (personal) data is being shared with other parties. Also, they must be given the opportunity to restrict its use.

Why Is Client Privacy An Issue Today?

There are many reasons. First and foremost is the fact that the sharing of information has become complicated. The United States is in the midst of a revolution in information technology. Gone are days of a customer's financial and health records being locked in a file room at the rear of the office. New electronic distribution channels of providing and servicing insurance products and health care have created exposure of personal financial information and health histories. And, the way we get our health care is changing from one-on-one, patient/doctor relationships, to large, integrated health networks where many levels of employees have access to records. In a sense, a new by-product of trying to control health-care and insurance costs using technology and centralization has resulted in a profound potential for abuse of privacy.

In a nutshell, today, entire networks distribute and / or disclose the data you collect on your clients with a variety of affiliates and third parties; all the while, putting you and other agents in the path of tighter and more responsible privacy rules.

Information Sharing Problems

Some have a problem understanding why the sharing of client information is a problem. After all, wouldn't it be to the client's benefit for a central database to itemize a history of medications and comprehensive medical records? For example, what if you were involved in a car accident far from home and unconscious by the time you arrived at the local hospital? The emergency room doctor might conceivably access a special computer link; plug-in your social security number and instantly learn about your specific allergies, medical conditions and medications.

Life-saving therapies might be administered faster and costly re-testing for certain information might be avoided. Sounds great, right?

Unfortunately, not everyone will use this kind of information as it was intended. For example, what if the same medical records were retrieved by a prospective employer. Could he use the health and financial information in making a decision not to hire you? Insurers themselves have been accused of privacy invasion when they use personal financial information, like FICO scores (a system to determine a consumer's credit worthiness), to raise insurance premiums or rank insurability based on the types of credit cards, catalogs or cars a prospect owns and uses.

Also, consider cases where records have fallen into the wrong hands. Are the consequences of exploiting personal information sufficient to deter someone from the temptation? Think it doesn't happen? Think again. In Nevada, for example, a woman purchased a used computer and discovered that it still contained the prescription records of the customers of the pharmacy that had previously owned the computer. The pharmacy database included names, addresses, social security numbers, and a list of all the medicines the customers had purchased. What happens to the data on your old computers? In another case, a 30-year FBI veteran was put on administrative leave when, without his permission, his pharmacy released information about his treatment for depression. Or, how about a 1999 incident in which the health insurance claims forms of thousands of patients blew out of a truck on its way to a recycling center in East Hartford, Connecticut.

In all these instances, client privacy could be breached. In response, legislation has passed to address the better handling of client privacy; especially by making the "caretakers" of this information more responsible. As you might guess, insurers, financial institutions and health care corporations have been at the head of the responsibility list since they wield incredible influence over detailed records related to age, health, finances and lifestyle.

Privacy and Agent Responsibility

Agents are also involved in the privacy debate because under the definition of this privacy legislation, you are referred to as a "financial institution" or "covered entity". As such, you must comply with sweeping and complex rules and standards under HIPAA, the Gramm-Leach-Bliley Act, the Federal Medical Privacy Rule, and possibly the new Patriot Act.

To complicate matters more, your individual state may pass privacy legislation that exceeds or conflicts with these requirements. So, you may fall under "double" standards. For example, the privacy rules under HIPAA state that items such as a person's name, address, social security number and payment history are protected "health information" subject to an **opt-in standard**. Therefore, HIPAA would prohibit any sharing of this information with a third party unless an express release is signed by your client. Many states, however, would consider these same items as "financial information" subject to **opt-out standards** where the sharing of client information is allowed until he "opts-out".

Can you see where disputes might surface? And, the penalties for a mistake or not complying can be stiff, ranging from \$100 to \$25,000 per incident; and, even prison terms of up to one year. Failure to provide a required notice is also a violation of agency rules subject to enforcement by your State Department of Insurance, and enforcement action under federal and state unfair trade practices rules. In addition, an individual whose information has been shared in violation of the rules may bring their own, private civil action against you.

Required Recipients

Unless the underwriter or insurance agency qualifies for the special agent exception, they must provide a privacy notice to any individual who purchases a financial product or service through that agency that is to be used primarily for personal family or household. All **customers** are entitled to receive a GLBA privacy notice at the beginning of the customer relationship.

A privacy notice must also be provided to all **consumers** if the agency is going to share their information with a non-affiliated organization. If the agency is not going to share the information of its consumers with a non-affiliated organization, it does not owe the consumer a privacy notice.

Required Disclosure Information

In most instances, federal and state privacy regulations do not make specific requirements about the type of privacy policy that an insurance agency must use. It only tells them what facts it must disclose. The disclosure must be clear and easy to find. It must be understandable and designed in a manner that calls attention to it. A disclosure will be easy to find, read, and understand if it uses short and clear explanatory sentences or bullet lists in simple language.

Here is a short list of features you might include in your privacy notices:

- Categories of nonpublic personal financial information collected.
- Categories of nonpublic personal financial information collected.
- Categories of affiliates and nonaffiliated third parties to whom information is disclosed, except as part of an insurance transaction.
- Categories of nonpublic personal financial information about former customers disclosed and to whom disclosed.
- Categories of information disclosed and to whom disclosed as a result of contractual relationships or servicing or joint marketing.
- Explanation of consumers' right to opt-out of disclosure of his nonpublic personal financial information to nonaffiliated third parties and the methods to utilize to opt-out.
- Policies and practices for protecting the confidentiality and security of nonpublic personal financial information.
- If making disclosures (information about customers) as part of insurance transaction, that the licensee makes disclosures to other affiliated or nonaffiliated third parties, as permitted by law.

The disclosure must include the types of nonpublic personal information that the agency collects. This would describe the nature of the information collected and the way in which it is collected. The disclosure must also mention the types of nonpublic information that may be disclosed and the categories of affiliates and non-affiliated third parties to whom the disclosures may be made.

The agency must describe in the disclosure its policies and practices in sharing nonpublic personal information about former customers and consumers. If these policies and practices are the same for both groups, the same clauses may be used for both.

The notice must list the categories of nonpublic personal information disclosed according to agreements with third party service providers and joint marketers, and the categories of third parties providing the services. The notice must disclose the consumer's right to opt out of the disclosure of nonpublic personal information to non-affiliated third parties.

The notice must include any disclosures regarding affiliate information that the agency is providing. The notice must disclose the agency's policies and practices in protecting the confidentiality, integrity and quality of the nonpublic personal information it collects.

Required Distribution

The insurance agency must disclose its privacy policy when a customer relationship is established and once a year thereafter. There are different ways of providing the initial notice to customers.

The agency may choose to provide their own notice. They may provide a joint notice to the customer that represents both the carrier and the insurance agency. They may give the carrier's notice to the individual.

Regardless of which option the agency chooses, the initial notice can be provided when a purchased policy is delivered or when an agreement to provide other insurance services is completed. The notice itself can be given along with other materials that an agency delivers to the customer such as with a bill for premiums.

The annual notice may be delivered in the same way. GLBA does not require the insurance agency to provide the annual privacy notice to a former customer. Agencies that provide title insurance or other real estate settlement services in which the contact with the insured is limited to the time when the policy is sold are not required to deliver the annual privacy notice.

Agencies who sell group insurance policies are required to deliver a privacy notice to the plan sponsor. They do not need to deliver a notice to plan participants as long as they do not disclose the participants' personal information to non-affiliated organizations.

Consumer Vs Customer?

New privacy laws have a language all to their own. For instance, there is a very distinct difference in how you handle a **consumer** versus a **customer**. Here are some definitions you need to know:

Affiliate: A company that controls, is controlled by or is under common control with another company. For instance, under the Gramm-Leach-Bliley Act, insurers and banks can become affiliates. Affiliates may also be parent companies owned by your agency or common companies under the same holding company structure.

Consumers: Individuals who are seeking to obtain a product or service from an insurance company through your agency are called **consumers**. For example, an individual who has submitted an application for insurance is a consumer of the company to which he has applied. A prospect for your products and a beneficiary or claimant under an insurance policy are also considered to be a **consumer**.

Customers: These are consumers with whom you and your insurer have an on-going relationship or those who obtain financial, investment or economic advisory services relating to an insurance product or service from you for a fee. People who buy policies and investments, from you are **customers**.

Covered Entity: Financial privacy rules require that all "covered entities" issue or provide privacy disclosures. Covered entity includes any individual or entity that receives authorization from the Department of Insurance.

Insurers: This class includes insurance companies, financial institutions or other entities required to comply with the privacy regulation.

Licensees: These are individuals regulated by the Department of Insurance. All licensees are required to comply with privacy disclosures unless exempt.

Nonaffiliated third party: This is a company that is not affiliated with an insurer, agent or agency.

Nonpublic personal information: Nonpublic personal financial information is information that identifies an individual member. It may include an individual's name, address, telephone number and social security number, or it may relate to an individual's ownership of a policy, the provision of insurance services or the payment for insurance services. Nonpublic personal financial information does not include publicly available information, or statistical information that does not identify individual persons.

Opt-Out: The general rule is that information about a person will be shared unless the person notifies the holder of information that he wants his information protected. To "opt-out" is to put an agent or company on notice that a customer prohibits his personal financial information from being shared with non-affiliated third parties.

Opt-In: Under an "opt-in" standard, the general rule is that protected information is not shared unless the person who is the subject of the information signs an authorization or consent that expressly permits the sharing of his protected information with a third party.

Privacy Policy Statement: A disclosure form handed to clients or posted on a website that describes an agent's intention to share or not to share any nonpublic information about his clients with a non-affiliated third party. Statements may describe the personal information typically collected in the process of providing insurance, a list of non-affiliated parties who may share nonpublic information, a notification right for the client to "opt-out" (an instruction the agent not to share this information), normal practices concerning confidentiality and security for any nonpublic information collected, policy concerning dispute resolution, the right to sell information when the agent's business is sold or transferred, the right to change the stated privacy policy and a place for clients to acknowledge the privacy policy disclosure.

Handling Consumers

Licensees may not disclose any nonpublic personal information about a consumer to a nonaffiliated third party unless permission is granted by the consumer.

Licensees must provide consumers a privacy policy and an opt-out notice along with a reasonable time to opt-out prior to the sharing of information.

Licensees may not disclose any nonpublic personal financial or health information about a consumer to a nonaffiliated third party, unless:

- The consumer received a notice prior to the disclosure
- The consumer received an explanation of the opt-out procedure
- The consumer had a reasonable opportunity to opt-out prior to disclosure and
- The consumer did not opt-out

The GLBA notice obligation requires all insurers and financial institutions (including insurance agents) to provide an understandable notice of their privacy practices to their customers when a customer relationship is established and at least once a year thereafter. This obligation does not require agencies to adopt specific information handling practices. It only requires that they disclose the practices in which they engage. In other words, most agents can satisfy client privacy requirements by issuing or posting a simple disclosure form (two samples are provided below).

Handling Customers

A customer must be given an annual notice of the licensee's privacy policies and practices until such time as the customer relationship terminates.

A licensee may not disclose any nonpublic personal information about a customer to a nonaffiliated third party unless a notice is provided.

A privacy notice must contain a description of privacy policies and practices, an opt-out notice, and a reasonable time to opt-out prior to the disclosure of information.

Licensees may not disclose any nonpublic personal financial or health information about a customer to a nonaffiliated third party, unless:

- The customer received a notice prior to the disclosure
- The customer received an explanation of the opt-out procedure
- The customer had a reasonable opportunity to opt-out prior to disclosure and
- The customer did not opt-out

Exemptions

In general, most federal and state privacy regulations apply to agents. However, an agent does not have to comply with special disclosures and opt-out requirements if:

- The agent is appointed with a company or designated with an agency (principal) that complies with, and provides all of the notices required by the regulations, and
- The agent does not disclose protected, personal financial information to any person other than the principal or its affiliates.

In other words, if an agent wishes to disclose a consumer or customer's protected information to an entity other than the insurance company with which the agent is appointed, or the agency with which the agent is designated, the agent must give the consumer a copy of the agent's privacy notice and an opportunity to prohibit the disclosure of that information to non-affiliated parties.

In theory, this would seem to exempt most agents from the disclosure requirements. However, the question remains, are the principals (your insurer or agency) making the required disclosures in the necessary format? Can you rely on them to make them annually where needed? Any doubts? Use your own disclosure.

Agent Ethics

It is difficult to discuss matters of agent responsibility and reducing liability without exploring ethics. As it relates to insurance agents, ethics go beyond the maintenance of "moral

standards". ***Insurance ethics involves the maintaining of honest standards and judgments that place the client first.*** To keep it simple, just remember the old adage "the customer is king".

Someday, it may be real important for a court and jury to hear that you have a history of serving the client without consideration for how much commission you made or how busy you were, i.e., you are a person with good ethics. Take the case of **Grace vs Interstate Life (1996)**. An agent sold his client a health insurance policy while in her 50's. After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court did not look favorably on the agent's lack of duty to notify his client.

Ethics exist to inspire us to do good. Having high ethical standards, can be more important than being right because honesty reflects character while being right reflects a level of ability. Unfortunately, the insurance industry, like many industries still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards", few, if any, "Ethics & Due Care" certificates.

The work of an insurance agent often impacts the entire financial well being and future of businesses and families. Ethics place the interest of these clients above an agent's commission. Being ethical is being professional but the gesture goes beyond the mere compliance with law. It means being completely honest concerning ALL FACTS. It means more than merely NOT telling lies because an incomplete answer can be more deceptive than a lie.

Instilling ethics is a process that must start long before a person chooses insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in this book may not be incentive enough to sway agents to stay on track. It may be easier to explain that honesty and fair play could mean cleaner sales and lessen the possibility of lawsuits.

Disclosure

Without a proper disclosure of facts and terms, it will be impossible for your clients to make informed decisions. Not surprising, failure to disclose important policy or product information is a major area of conflict leading to denied claims and lawsuits involving agents and insurers alike. What can you do to minimize disclosure conflicts? First off, make sure you tell the truth; the whole truth; and nothing but the truth when selling product. To make sure that you clients have understood what you said, develop a standard procedure (backed up in writing) of asking the **3 closing questions:**

- Have I given you all the information you need to make a decision.
- Does the information or policy make sense?
- Is there something else I can answer for you to assure you that this is the right solution based on your needs and objectives?

In addition to this, many agents have resorted to limiting contracts and disclosures for clients to review and sign prior to any purchase decision. It may be common, in years ahead, to attach such statements to each and every policy or even require clients to sign one prior to any insurance discussions, much like doctors have patients sign disclosures in advance of services. The sample on the next page was composed by an agent's association and is provided for educational purposes only. **Before using any disclosure letter speak to an attorney for approval.** Also, know that specific products may require different wording.

Additional **attachments** to this letter could disclose options **the client chose to refuse**, such as: The opportunity to seek tax, legal or business advice prior to making any insurance purchase or the availability and cost of various options or riders to a policy that were available and suggested at time of purchase (waiver of premium, higher deductible options, exclusions, etc).

Also, you should consider using **mini-disclosures** in your applications. For instance, if you were basing the exchange of two policies on a specific IRS Private Letter Ruling, why not cite it in the application?

Agents have successfully used disclosures to qualify a promise of coverage as in **T.G.I. East Coast Construction vs Fireman's Fund Insurance (1985)**. Here, an agent's letter to a client regarding future coverage commitments included a very important disclosure: "You will be covered subject to our normal underwriting requirements." Of course, when the time came, the client automatically assumed he was covered. However, on the strength of the disclosure, the courts disagreed.

Agents may also want to use disclosures to **narrow the scope** of their duties. For example, agents have been held liable for NOT securing "complete" coverage. If an agent is unwilling to assume responsibility and take the time necessary to provide "complete" coverage, it might be wise to disclose that coverage is for a specific property, condition or a specific insurance carrier. Further, it might be appropriate to say that the agent has NOT reviewed client coverage needs concerning leases, contracts, directors, product liability, estate taxes, etc.

In **Eddy vs Sharpe (1988)** an agent proposal included the following disclosure: "This proposal is prepared for your convenience only and is not intended to be a complete explanation of policy coverage or terms. Actual policy language will govern the scope and limits of protection afforded." While this seems to cover any omission the agent might make in his proposal, he was found liable for client losses because his proposal also listed eight specific exclusions of the policy. Unfortunately, the one he left out was the peril that damaged the client's policy.

While nothing will prevent legal action by a disgruntled client, an agent would be better ahead to be able to demonstrate client knowledge in advance of the sale. Further, some legal advisors recommend inserting a binding arbitration clause to hopefully circumvent the long, expensive process of a judicial proceeding. Only a competent attorney should prepare these types of disclosures and clauses.

Insurer Disclosures

As between agent and insurer, the obligations and duties of both should be fully disclosed in the agency agreement, general agency agreement or explicitly detailed in other written documents. Agents reading these documents should be clear on issues of authority (what the agent/broker can and cannot do), advertising (what compliance is the agent subject to), waivers, venue (governing law of state), materials and records, rules & regulations, supervision, audits, commissions, special conditions, indemnification, termination conditions, etc.

As accountability grows, some agent contracts are including aggressive **hold-harmless agreements** that impose liability on agents for any claims, regardless of fault, while others contain personal indemnification clauses that place an agent's home and personal assets at risk. Here are just a couple of examples:

- Loss of insurer indemnification if there is **any** wrongdoing by the agent.

- Forfeit of all agent profit-sharing and override payments earned if the agent is terminated.
- Agent indemnification of the company even if the insurer was the significant contributor to the liability.

Clearly, you would have a difficult time defending your position if you have signed documents with this wording . . . ***read your agency agreements!***

Agents and brokers have been sued by their insurers for failure to comply with terms of agency agreements ranging from gross misappropriation of premiums to seemingly small violations involving clerical errors. In many of these cases, the attorney for the defense had to go beyond the written disclosure by defending the agent or broker on the following points of law:

Agency Relationship

Without specific contractual ties, the agent's primary duty to the insurer is to collect premiums and delivery the policy. The extent of any agency relationship between the agent and insurer beyond collecting the premium and delivery the policy is governed ONLY specific agency agreement or binding authority.

Proximate Cause & Reliance

In cases where the insurer sues a broker for failing to supply correct or complete information on the risk or client, brokers have countered that the insurer would have agreed to underwrite the risk even if he had not supplied correct or complete information. As a practical matter, it is rare to encounter liability insurance litigation in which the insurer can prove that it would not have provided coverage if better information has been provided.

Estoppel

An insurer who has had a long course of dealing with a given broker/agent may well have been willing, over the years, to overlook shortcomings in the information a broker provided the insurer. In some cases, brokers are allowed to "bind" coverage and later provide additional information. If the same insurer brings an action against the broker after a loss has occurred, the broker may be able to point to the insurer's past practices as the basis for an estoppel argument.

Ratification

When an insurer can be shown to have a practice of issuing policies even though the broker has supplied incomplete information, the broker may be able to establish that the insurer has ***ratified*** the broker's actions and adopted them as the insurer's own. Ratification of unauthorized acts of an agent can be sufficient in some cases to release the broker/agent from liability to the principal.

Errors & Omissions Insurance

Like other professionals, insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients. While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives. After all, we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some policies do not cover punitive damages).

Faced with these kinds of actions, insurers, who many times foot the bill for agent mistakes, are less timid about suing their agents and brokers for any malfeasance. Of course, to some extent, the very existence of errors and omissions insurance may be a factor in an agent being named in litigation that he may otherwise have avoided. In a case involving several security salesmen, for example, a pre-trial judge asked for a show of agents who did NOT have errors and omissions insurance. They were excused from the case! This could happen again, or not at all. Who wants to take the chance?

There is no standard errors and omissions policy. Most policies are written on a **claims-made** basis rather than on an **occurrence basis**. Claims made means the insurer is ONLY responsible for claims filed while the policy was in force. This could represent a problem down the road a few years, if the agent moves or retires. Even death is not an excuse, where a "hot shot" attorney can file his client's claim against the agent's estate!!

Policies today also have some very significant limitations, caps, gaps, consent clauses and relatively high deductibles. So many loopholes, in fact, that an agent is likely to feel the financial impact of any litigation almost immediately and under certain conditions may receive NO protection whatsoever. Some older style policies even require the agent to pay the entire claim before the errors and omissions insurer has any obligation at all. These are referred to **indemnification policies**.

In many instances, the choice of a errors and omissions policy doesn't center on the limits or features an agent wants, rather it comes down, for many, to what the agent can afford. Unless agents find a way to finance the huge premiums, through banks or association groups, this often leads to the agent accepting many **policy exclusions**.

Exclusions

Aside from the primary limits of the policy (\$1 Million seems to be the limit of choice for most agents) the **cost of defense** is the most important exclusion to watch. Does your errors and omission policy **include defense costs as part of the limit?** If so, the amount of money available to pay monetary or punitive awards will be significantly reduced. Defense costs can also be **limited to a percentage of policy limits**. Here, when the number is reached, **you** start paying for the balance of defense costs. Obviously, the best errors and omission plan will pay for all **defense costs in addition to policy limits**.

The **claims made** exclusion is the next consideration. If you have one, you will be covered for only the claims that occur while the policy is in force. If so, how will you handle a claim problem that occurs down the road, say at retirement, when you have dropped your policy? Actually, you may have little choice in the matter since most policies today are written on a claims made basis versus an **occurrence basis**. However, there are endorsements, discussed later, that can help protect you in the "down the road" scenarios.

In addition to the claims made limitation, there are many other important coverage **exclusions** an agent must consider, such as: insurer insolvency, receivership, bankruptcy, liquidation or financial inability to pay; acts by the agent that are dishonest, fraudulent, criminal, malicious or committed while knowing the conduct was wrong; promises or guarantees as to interest rates or fluctuations of interest rates in policies sold, the market value of any insurance or financial product or future premium payments; activities of the agent related to any employee benefit plan as defined under ERISA; agent violations of the rules and regulations of the Securities Exchange Commission, the National Association of Security dealers or any similar federal or state security statute; violations of the provisions of the Consolidated Omnibus Budget

Reconciliation Act (COBRA); discrimination or unfair competition charges, violations of the Racketeer Influenced Corrupt Organizations Act (RICO), and structured settlement placements.

In most of the instances above, the standard agent's errors and omissions policy **WILL NOT PAY** a claim. In the case of an insolvent company that retains client's money or refuses to make good on a claim, the agent **WILL NOT** even be defended according to specific terms that exist in most policies.

Also, be aware of **specific limitations**. You may not be covered errors and omissions in the following areas: punitive damages, business outside the state or country; failure to give notice if new employees or agents are added to your staff; fraudulent or dishonest acts of employees or agent staff; negligence may be covered, but bodily injury and property damage may not; judgements -- some policies only pay if a judgement is obtained against you; some exclude contractual obligations in the form of "hold harmless" clauses (watch them); outside services like the sale of securities, real estate or notary work.

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of **even one** protected client claim and any subsequent judgement requiring an agent to pay any deficiencies and possible attorney/court fees. The cost of the average errors and omissions policy is cheap when compared to these costs. If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy **options** that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits (\$1 million minimum), the availability of prior-acts coverage and coverage carrier solvency.

Obviously, the concerned agent would do better to avoid malpractice claims at the outset by doing everything possible to investigate safety and solvency of any proposed carrier, acting professionally, keeping current, due care, etc. Further, there is no substitute for operating in a prudent, ethical manner rather than rely only on an errors and omission policy. After all, can there be any point to work and build a practice to lose everything to the dissatisfaction of one client?

E&O Claims

If you feel you have a potential errors and omissions claim, you should first review your policy to follow the reporting requirements that need to meet. Most E & O carriers want you to report an incident right away. However, it is important to know what your company determines to be an "incident". Is it an actual claim? Is it a threat of a claim? If in doubt, you might want to call the company anyway and discuss it with them.

Generally, it is in your best interest to cooperate fully with the company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does NOT always extend to your client. Most errors and omissions insurers do NOT want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured. While you can be cordial and calm in dealing with the client, be careful NOT to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can't afford to "prejudice" your case in any

way. Violating this errors and omissions contractual promise is the sure way for coverage to be canceled.

Cooperation also extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you do not agree with, and the case ended with a higher judgment than the settlement, you could be held liable for the difference as well as any amounts that exceed policy limits.

Office Protocol

Properly used, an agent's office automation and procedures can help to avoid costly claims or at least control E&O losses. For example, a sound basis for a defense can be established if an agent produces documentation, records of phone conversations regarding binding and specific coverages or records that show a client's decision to reject a recommended coverage. The client would have a hard time proving otherwise. Some liability claims have hinged on a hastily scribbled note confirming that a disputed conversation took place.

Put It In Writing

The legal purpose of documenting client transactions is to establish evidence. Evidence can be **parol evidence** which is oral (difficult to prove in court), or it can be **hearsay evidence** (behind the scenes notes) which are written but not generally admissible unless it is collected under **ordinary business rules**. You should develop **standard operating procedures** which require the following evidence rules for the best protection possible:

- Reduce oral agreements to writing as soon as possible and indicate that the written document is the entire agreement.
- Handle ordinary course of business using an operating manual that is followed consistently, e.g., You offer a special endorsement coverage to everyone and log their acceptance or denial in the client file.
- Instead of "post-it" notes and scattered comments in client files make a point to transfer the content of these notes to a formal log kept in every client file.

Automated Equipment

Computers and the diary capabilities they present provide up-to-date documentation that can be used to verify an agent's defense. Electronic "date-stamping" can also be valuable as can fax messages concerning any client/agent contact concerning the dispute. We use a program called "Maximizer" which allows a quick location of a client file and fast entry of the conversation. Retrieval is a snap.

Applications For Insurance

Complete and legible copies of the original application for coverage are extremely important. They presumably show the "intent" of the insured when he took out the policy, what he communicated to the agent regarding his wishes, whether the agent followed his wishes as to coverage requested and whether the insurance company followed the wishes of the agent who requested a policy of insurance pursuant to the wishes of the insured. Also, a material misrepresentation of fact by the insured in his application may cause the policy to be declared void (American Family Mutual Insurance Co vs. Bowser - 1989)

The Agent's File

In a legal action involving an agent or his insurer, a client's attorney will always attempt to secure a copy of the agent's file. It will show his knowledge of the insured's intent for specific coverage, communications between the agent and the insured about securing these coverages and the communications between agent and the underwriting department of the insurer. In **State Farm Fire & Casualty vs. Gros (1991)**, lack of notation regarding a client conversation three years before the loss was evidence upon which a jury concluded that the agent misrepresented the terms of the policy to the insured.

By law, insurance companies generally have access to your files. So, it would be wise to NEVER make a derogatory comment about a client in these files. Also, when a claim or potential claim situation surfaces, it is always a good idea to check with your errors and omissions insurer before turning over any documents.

As the industry edges closer to "paper less" filing it is important to understand that ALL files (paper, electronic, fax, post-it notes, etc) are considered evidence and can be used on your behalf or against you. Certain documents, such as applications with original signatures still need to be kept in paper form.

Correspondence

Clients will often say they "never received" a letter or cancellation notice or "it was not in the envelope you sent. Experts suggest that using **window envelopes** and various methods of proven delivery, like Western Union, Certified Mail or United Parcel will provide you with a **tracking record**. Additionally, if the insured acknowledges receipt of a window style envelope he can't say there was nothing inside since the address was on the letter showing through the envelope window.

Operations Manual

As you read above, **standard operating procedures** are steps that you follow consistently in selling and serving clients. Standard procedures can be critical in establishing your notes and records as usable evidence in a trial. Further, it can be suggested that an agent who is careful to follow set procedures is usually found to be more credible in his own defense. Both are important reasons to document procedures in an **operations manual**. Some errors and omission insurers are requiring agents to have and see their operations manual before coverage can commence. You should also be aware that in an insurance dispute, the existence of such a manual may be uncovered. From a defense standpoint, the manual and your adherence to it may prove that you are a diligent agent. From a plaintiffs vantage, non-compliance of policy procedures that you establish may work against you.

Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer. The following is a basic outline of information that could be included in your manual. Because agencies and insurances differ widely, you will want to add issues that are specific to your business before implementing any procedures.

- Client needs and requests should always be noted in the file. Many agents routinely take 5 minutes after a client interview or phone call to document the needs and requests of the client in the file. Even if you have to shut the door and set the answering machine, this is important.
- Always be consistent. If you ask one client to accept or deny a specific endorsement or

make sure that you ask the same question of others.

- Note the date or nature of all correspondence that notifies a client that his application has been accepted or denied. Equally important is logging notification of clients or potential clients that coverage is NOT available.
- Create a “hot list” or “follow-up” file for ALL transactions that require additional review. A contact management or database system is excellent for noting the need to review the client file within 10 days, 20 days or on a specific date to check a renewal, ordered endorsement, etc.
- Your operations manual should also layout office procedures to be followed for handling and logging phone messages, faxes (copy thermal paper before putting in file), e-mail, photographs, microfilm, proof of mailing receipts as well as how long and where storage and “deep storage” of records will be kept. Standard procedures using window envelopes (advisable) for all notifications should also be established.
- As mentioned above, all oral agreements and binders should be reduced to writing and dated in the file.
- Policies received should be checked against “specimen policies” to be sure it is the same contract and against the client application to be sure it meets client needs
- Endorsements should be processed as soon as possible. Make notes that show the policy has been endorsed and create a follow-up system that compares any endorsement papers mailed with the endorsement received from the insurance company.
- Cancellation procedures should comply with state regulations and policy provisions. Notices to client should be tracked and posted in the client file. Also, be sure that the client does NOT continue receiving a bill after cancellation.
- Renewals should be sent within a specified time before expiration of the policy (usually 60-90 days). Experts agree that if you can’t reach the client you should order the renewal anyway. Posting and tracking any notices to file is very important.
- Expirations should comply with state and policy provisions. Always notify client of any expiration.

The Agent Call Center

Some of the biggest conflicts with customers occur over communication or lack thereof. And, the problem compounds as the world finds more ways to communicate. The insurance client of the new millennium may wish to reach you in several ways . . . phone, cell phone, PDAs, voice mail, fax, mail, e-mail, internet text chat, and voice over Internet protocol. Truly, this is an era of the “multi-channel” customer experience. As an agent who wants and needs to serve his customers, there is little you can do to keep from participating in some or all of these communication systems. However, there is much you must do for proper loss control.

Collectively, the system you establish to receive client communications is referred to as the **agent call center**. The call center concept was built on the premise that customers initiate contact, and that whatever they need can either be handled in real time by the agent, or handed off to an automated system. In the past, a typical agent call center consisted of a telephone and an answering machine. However, with the growing communication options now demanded by clients, these call centers are upgrading to the status of **call plus**. Telephones aren’t going away, but the alternative channels are now so numerous, and becoming more heavily used, that a mixture of communication methods is now needed to serve customers.

Your call center or call plus can be a vital link to serve your clients better, but it can also be vulnerable to problems or even legal exposure. Let's discuss some of the ways to improve it and minimize the obvious problems that surface with multiple modes of communication.

Principles of Communication

Whatever mode of communication used by you or your clients, there are certain general principles you need to follow to make sure you are meeting client needs and eliminating potential confusion.

Clear communication is always your goal. For instance, when handling an instruction or request, it would be wise to **repeat your understanding** to the other person. Let's say that Mr. Dean called your office and advised you drop coverage on a boat. You might respond by saying . . . "Mr. Dean, as I understand it, you want to drop the coverage on your boat . . . "

If you are making a recommendation, you need to thoroughly explain the client's **options and consequences**. For example . . . "Mr. Brighten, we recommend that all our customers buy high-deductible medical coverage. Even though you will be paying a portion of costs, your premiums and total out-of-pocket costs will be lower. But the lifetime coverage is the same as your previous policy . . . "

Always confirm that you are **meeting client needs**. "Mr. Smith, have I given you all the information you need to make a decision?" "Does this policy make sense to you?" "Is there anything else I can answer for you to assure you that this is the right solution based on your needs?"

Be sure that your client always understand his **current insurance coverage status**. "Mrs. Johnson, do you understand that you will not have coverage until the company approves your application and issues a policy?"

When you and your client are satisfied that you are BOTH communicating on the same wavelength you still need to **document what was said, what was done and what needs to be done**. For instance, it would be smart to follow-up a phone conversation about dropping a certain coverage with a letter outlining your understanding of the matter. Likewise, you would want to have a client sign-off on a rejection of coverage, the establishment of certain coverage limits, coverage NOT provided by your agency, important limitations of a policy, etc.

Telephones

For the not-too-distant-future, it is unlikely that the telephone will be totally replaced with alternative forms of communication. Instead of complicated e-mail, Internet or fax transmissions, a healthy portion of your clients will always prefer to simply dial you up with their problems and needs

One of the most important things to remember about phone calls is that they are not a permanent record of your communication with a client like letters, e-mail or faxes. There are countless lawsuits, and as many judgement awards against agents, where there were no "notes to the file" to verify the basis of a client/agent discussion. Your **standard operating procedure** should include a system to immediately document client phone calls, inbound and outbound, between you, clients and your staff. Every call should be logged into the client's file or, better yet, a **contact management system** to document what was said and the result of the conversation. Where needed, a follow-up letter documenting the basis of the phone call can be sent to the client.

As far as improving your phone calls consider the following advice:

- Call your company and ask for yourself or have someone do it for you. Try different times of the day and listen closely to the general demeanor of your employees. Are they courteous, helpful, enthusiastic, accurate?
- Call your company and pose as an existing customer or pose as a new one. Ask for different departments, voice a complaint or leave a message for a call back. Being passed from one wrong person to another can make a client feel unimportant and frustrated. The initial contact should determine who best to handle the call and solve the problem.
- Make sure that all incoming calls are answered before the third ring. Always ASK if it is OK before you put someone on hold before you do. A good phone system will let you know if the caller has been on hold too long. Offer to call ask if necessary and find out when this will be convenient.
- Take complete and accurate messages. Incomplete phone messages or lost scraps of paper are not acceptable procedures.
- Return all messages within one business day or less. If you promise to call someone back by a certain time make sure you do . . . even if you still don't have an answer for his question. It is important to do what you say you are going to do everytime.
- If your company has a menu of options, listen to it carefully. Does it make sense. Does it work?
- Try NOT to use a speaker phone unless you really need to because a caller may feel as though their conversations are less than private.
- Call new clients to make sure that their policy or information you sent them arrived.
- Call existing clients on a regular basis, just to say hello, or tell them about a new offering.
- If you leave a voice mail message for someone, speak slowly and clearly. Give the purpose for the call and a good time for them to call you back.
- If calls are taken at home, make sure family members understand the rules on message taking.
- Unlicensed people in your office need to know the proper procedures and what they can and can't say to clients.
- Hire customer service people who have insurance knowledge and a pleasant phone voice. Clients are more likely to trust a friendly, confident person on the other end of the line over one who is abrupt, uninterested or combative.

Cell Phones

Cellular phones are a modern-day marvel and a potential E&O tragedy. There are concerns about privacy and the basic inability to reach the intended party when needed. Equally important is the fact that calls are taking place outside the office where it is much more difficult to document the conversation.

Automated Messaging

Answering machines and voice mail systems are inexpensive methods to take calls in your absence. Newer systems are capable of documenting the time and date a call was received. However, all such systems are capable of breaking down when you most need them and/or distorting a message. Answering machines in an agency should not take messages. They should be limited to listing agency hours and an emergency number if needed. If you use one,

your outgoing message should clearly state that your machine does not take messages. Claims and coverage issues must ONLY be handled during normal business hours with a "live" person.

Fax Messaging

Your fax machine is an incredibly useful part of your call center. One of the most important issues in handling faxes is to make sure they are delivered to the appropriate person and responded to in the same manner as a letter.

Is it a good idea to leave your fax on 24/7? What if a client faxes a request for coverage at 3 AM on Saturday and has a claim on Sunday? While the fax may constitute a legal request by the insured, there is no acceptance of that offer. In other words, leaving a fax machine on after hours does not necessarily bind an agent.

Here are some more things to keep in mind concerning faxes:

- Most states accept fax signatures and documents as good as the original. However, the paper on some fax machines (thermal paper) is known to fade over time. For this reason and others, it is always a good idea to not rely solely on faxes. Try and get the original in your file as soon as possible.
- Faxes are not a 100% reliable delivery system. For unknown reasons, they sometimes don't get to their destination even when your machine shows a confirmation that the message was received. For important documents, it is always wise to call and confirm delivery.
- Confidential information should not be faxed without the approval of the parties involved. It is best to call the intended receiver before the fax is sent.
- Faxes you receive should be date stamped and filed.

Online Communications

The Internet is a rich component for customer service. The challenge for agents is to bring the same level of excellence they have placed on traditional call center systems to their websites.

Online communications are evolving rapidly. Unfortunately, customer care is moving at a much slower pace. Recent studies, for example, have found that only a small percentage of customers who sent an e-mail regarding an inquiry or purchase receive a follow-up e-mail. The same customer who telephoned their agent would be outraged to NOT receive a return call. To avoid this, your ***e-mails should be treated like a phone call***. Check them often and return them promptly.

E-mail messages and correspondence is fast replacing written memos, faxes, phone calls and more. The ease of use, however, may hide liabilities that you need to address. For instance, confidential notes or information can be unintentionally sent without saving a copy, or worse yet, sent to the wrong party. E-Mail users often hit the "enter" key before they think, and just hitting "delete" doesn't automatically eliminate a message or derogatory remark. The system may "back-up".

E-Mail communications are just as binding, admissible and prohibitive in court as other communications. Attorneys are finding damaging information in E-Mail files that they can't find elsewhere. That is why it is imperative to have *use guidelines* for E-Mail.

For liability purposes, all parties who have access to E-Mail in your company should apply good judgment. They should communicate with E-Mail as they would in a public meeting. Sensitive

information should be encrypted to protect it from being transmitted via the Internet. For the best protection, use software that requires passwords.

Online customers today are expecting more from e-commerce sites than just e-mail. Those who use the Internet often like the control it gives them. They can seek information, contact you and even complete transactions without ever speaking to a single person. The question of whether large numbers of customers will actually buy "end-to-end" policies online is yet to be determined. Still, it is important that any information you provide them be accurate and clear. Important terms, conditions, options and disclaimers should be as visible and noteworthy on any website as they are on paper. For example, if your site is primarily being used to advertise your services, it is recommended that you advise customers that they will have to call or write you to receive coverage.

As technology in this area progresses, it is likely that when consumers start purchasing insurance online they will be prompted through each phase of the transaction, perhaps with "live" assistance from an agent. Online delivery, e-signatures, witnessing and servicing of policies will eventually be available. For now, this appears to be a few years from being commercially successful. Until then, traditional call center systems -- phone, fax and mail -- will continue to play an important role in supplementing and serving online customers effectively.

Customer Handling

Clients may have very complex needs and you may be the best agent around at anticipating them, but, it means nothing if you don't also **meet their needs**. In fact, how clients are handled after the sale is as much a legal responsibility as disclosure and ethical practices before and during a policy transaction.

Established as such, agents must understand the importance of customer service and customer retention.

A recent survey of 46,000 businesses (InfoQuest, 2001) concluded the following about customer service:

- A **totally satisfied customer** contributes 2.6 times as much revenue to a company as a *somewhat satisfied customer*.
- A **totally satisfied customer** contributes 17 times as much revenue as a *somewhat dissatisfied customer*.
- A **totally dissatisfied customer** decreases revenue at a rate equal to 1.8 times that contributed to the business by a *totally satisfied customer*.

The point of this survey is quite obvious . . . create as many **total satisfied customers** as you can.

When it comes down to it, insurance customers do not buy products or services -- they buy **satisfaction**. They do not buy policies from you; they buy the benefits and satisfaction they produce. And, customer service is how you create satisfaction.

Unless you have clients who are satisfied and happy and who keep coming back, you have nothing. Always remember that it is more difficult and costlier to find new customers than retain old ones.

Too many businesses, look to simply reduce prices or provide other give-aways when, in fact, a focus on giving top service would be an easier path. Discounts are one thing, but real customer service is an opportunity to create a "customer for life".

Every involvement with a customer should be looked at as an opportunity to serve. This could mean something as simple as answering the phone in a more courteous manner or returning phone calls promptly. **Good customer service** involves getting to know your customers and their needs by building relationships for the future. **Excellent customer service** means going beyond what is normally expected; maybe even *thrilling your customer* with service that is a complete surprise. Examples might be returning a customer's call on the weekend, delivering a policy in person, instant account information, a monthly free newsletter, e-mail reminders about important due dates and so on.

What Is Customer Satisfaction

Almost everything you do in your business has an impact on your customers. A satisfied customer is someone who believes that the service you provided was something worthwhile, done in the way he or she likes it to be done. Generating satisfied customers, then, is a process of consistently doing something of value for customers in the way customers want it done, or more simply, always doing the right things right!

Why should you practice good service? Good service leads to customer satisfaction, which leads to customer loyalty, which leads to better profits. Good service is good business.

Customer satisfaction should be a goal because if you're doing it right, it makes it easier for customers to do business with you. Not only that, they'll **want** to do business with you.

How will you know you're doing it right? Customers will come back to do more business and they will refer their friends.

Better Service

There are a thousand ways to make your service better. Here's a few of the more important ones you need to know:

- Always be positive. This means always trying to create a situation where your customer can be satisfied. If you don't handle a particular coverage, go the extra mile and find someone who will. Take the attitude that nothing is impossible and that no effort is too much.
- Keep your word. Don't make promises you can't keep.
- Don't argue. If a problem develops between you and your customer, always remember, the customer is "king". It doesn't make sense to debate an issue to death. Even if you are right, it doesn't matter. It is the customer's perception that you are wrong that counts. In his mind, you goofed. It is better to look at it as an opportunity to fix the problem and satisfy the customer. As we saw earlier, a dissatisfied customer can cost you a lot of money and time. And they're sure to complain to ten other people. Just give him some attention and assure him it will be fixed. Then make sure you do it!
- It's ok to acknowledge your mistakes. Unless a lawsuit is at risk, don't be too proud. Let the customer know that a mistake has been made. Apologize and set in place a solution to fix it.

Handling Tough Customers

No matter how you try, you will encounter tough customers who always believe they are right and you are wrong. Here are a number of ways to handle them:

- Negotiate. Always try and find a middle ground.
- Keep you cool. Make sure you and your employees understand that it is not personal. It's business. Keep a soft tone of voice and solve the problem.
- Listen to the customer. Since they usually think they are right and you are wrong, make sure you let them know that you are aware of the problem and you are concerned that it be solved as soon as possible. You can diffuse the situation somewhat by actually taking the customer's side and agreeing with them (to some extent).
- Set a policy. While there is never an excuse for poor behavior or lack of manners, you need to develop a policy for handling problem customers and stick to it. If you are too soft, then customers can easily pick up that you are an easy mark and they will always complain. Using a database or contact manager, you can document conversations with clients to ferret the chronic complainers. As long as you are fair, you can be firm with these customers. They may not win every time, but at least they may come to respect you.

If Customers Leaves

Everyone loses a customer now and then. Some move out of the area, others find someone closer to them or just like to spread their business around. You can't beat yourself up over every lost customer, however, when they leave it is a good idea to try and find out the reason and keep it from happening again. Here's what to do:

- Find out what made them leave. Were they unhappy or just what?
- Ask their advice and suggestions on how you could improve your service to keep their business. You may not get them back, but they might really appreciate that you are concerned enough to make amends.
- Try and keep in touch with customers who have left by letting them know if you have a new product or made changes in your business that might encourage them to come back.

Never Say . . .

To keep your customer satisfaction as high as possible, never find yourself or an employee saying this . . .

"Sorry, I don't know where you can find that type of coverage . . . "

"Once you buy it, you are stuck . . . "

"I don't really care about . . ."

"Sorry, you will have to talk to the company about that . . . "

"I don't know . . . "

"I'm sorry, it's closing time (or lunch). You'll have to call back another time . . ."

Elements of Good Service

Following are the elements of good service.

- Reliability. Consistent service the customer can rely on.
- Quality performance. Make sure you do things well.

- Worthwhile outcome for the customer.
- Overall service. The ability to provide good service in **all** your dealing with clients.

Poor Service

You already know that poor service will drive your customers away. The trouble is that you may not even know about until it's too late. Why? Because a lot of people will never complain about poor service, they'll just move on to the next agent. Worst yet, when they have the chance, they'll complain to friends, family and others that your service was poor.

It is also important to realize that good service extends to everyone you deal with, not just paying customers. Providing poor service to people because they are not paying customers is a definite way to ensure that they will not want to do business with you in the future. Like others, they will also probably complain to their friends.

Best Practices

In any given industry, someone is compelled to document the strategies and tactics employed by highly admired companies. These companies are not particularly the "best-in-class" in every area -- such a company may not exist at all. Rather, due to their nature of competition and drive for excellence, the practices they have implemented and honed place them among the most admired, the most profitable and the keenest competitors in the business.

In the early 1990's the Independent Insurance Agents of America began researching ways to reverse tough market conditions present at the time. They formed a commission to identify the most successful agencies and find out what they were doing that set them apart. A series of interviews, on-site visits and conversations among 800 offices revealed a set of common practices consistent with the most successful agencies. These common business methods became known as the basis of **Best Practices**.

In reality, best practices may not be revolutionary or new ideas; they are just good, sound business practices. They may be things you already know, but having them broken down helps to bring attention and use them easier.

The IIAA Best Practice survey resulted in nine guidelines to maximize potential, improve agency operations and minimize claims against agents.

1. **Focus on customer service and satisfaction.** This means not only providing good service but looking into what the customer needs and expects.
2. **Maintain good customer contact.** Best Practice agencies use customer contacts to educate the customer, serve as the client's advocate and problem solver, and make every transaction as easy as possible. They also tend to be pro-active on pricing and introducing new products
3. **Valued staff.** Agencies' staff are continuously provided education, training and tools to do a good job. The expectation of high performance and professional growth is often rewarded with recognition, better salaries and better benefits.
4. **Participatory management.** Top managers are very active in day-to-day operations. Managers regularly seek employee input, especially about planning and budgeting processes. Fiscal information is not a secret and profit expectations are clear.
5. **Vision.** Best Practice agencies have a very clear vision of where they are and where they intend to go in the future.

6. **Win/Win supplier relationships.** Successful agencies seek to do business with companies that have a vision and embrace values like theirs. A Best Practice agency engages in joint planning.
7. **Efficiency.** Though not all agencies are completely automated, use of efficient processes and systems is common. Best Practice agencies strive to improve work flows to add value for their customers.
8. **Total account development.** Best Practice agencies seek to grow through total account development. They are looking to develop a larger share of the customers' accounts.
9. **Continuous improvement.** These agencies constantly work to improve themselves. They measure and compare themselves to peers and their own past performances.

Agents who follow best practices typically use them as a benchmark to see how they measure up with other agencies -- where they excel and where they can improve. Benchmarking is a common practice among many industries. The mission is simple: observe, learn and copy practices that lead to success. As the old adage goes: **Success breeds success.** Product or the type of agency (life, casualty, health, etc) is irrelevant. The bottom line is that these are tools and skills the agent can use to change or improve his practice.

Customer Retention

The end result of meeting customer needs and good customer service should be a certain degree of customer loyalty. And, loyalty breeds fewer complaints and reduced claims against you – loss control at its best!

Agents, like everybody else, tend to rest on their laurels by thinking that a customer who is satisfied with his services will be loyal. This is not necessarily true. Some come and go no matter what you do. Others, stick around even when they are unhappy. And, one interesting study discovered that *the number of years the customer had been with a company was a better predictor of loyalty than satisfaction.*

So, the question becomes . . . Why bother with customer service and the meeting of needs if some of my customers are going to leave anyway? The answer is that it can cost you five times or more to get a new customer than retain an existing one. And, a lot of claims against agents arise from new clients rather than longstanding, loyal clients.

To keep more of your customers sticking around longer, with fewer complaints, you need to invest in a system of **customer retention.** This goes beyond simple customer servicing or a monthly newsletter. It means building a relationship with clients and giving them the encouragement to remain active in choosing your business. The ultimate goal is keep them happy and involved long enough that their devotion to you is ingrained. Who would think of leaving a trusted advisor or friend?

Instead of resigning yourself to the fact that customer attrition is normal for any business, why not try and manage it. Be proactive. You worked hard to get them, so why let them slip through your fingers. The key to retention is to **know your clients and communicate with them often.** By conducting customer satisfaction surveys, you can determine the various levels of satisfaction and potential "mobility" of your clients. In doing so, you will be able to identify those who are likely to leave at the drop of a hat as well as the true blue "loyals". With this information, you can establish a system to keep as many customers as possible for the longest period you can.

How do you get to know customers and what do you do with the results? Conduct a customer satisfaction survey and compare the results with the length of time each customer has been with

your agency. Ideally, you may also have some information in their file as to how long they were with their previous agent as well. Once gathered, you should be able to use this information to classify your clients into specific categories as follows:

- Safe customers are considered such because they are satisfied and not likely to change services or complain even when their satisfaction drops. Just keep what you are doing with these folks!
- High risk customers are both unhappy and more likely than others to move on or complain. Even if they are satisfied, they are still prone to leaving. There may be little you can do here.
- Unhappy but static customers deserve your attention. Whether they are just lazy or fear change, they are not too interested in moving. A little more effort on your part to help improve their satisfaction can motivate them to stay longer.
- Happy but mobile people are satisfied but tend to always shop around for new deals. You need to monitor them closely for any signs of switching. A much higher degree of communication is needed here to help keep them around.

In essence, you will develop different levels of communicating with each of these groups with the ultimate goal of improving long-term satisfaction and customer retention.

Communicating and Keeping Customers Involved

Customers want to win. They like to feel they are in control and smart about the choices they make. If you are successful, you make them feel this way when they originally buy your policies and throughout the time they remain with you.

As we said before, customer retention is the process of building a relationship with them and giving them the encouragement to remain active in choosing your business. How do you foster this relationship and action? In his book Drilling Down, Jim Novo describes the steps as ***action -- reaction -- feedback -- repeat***. In a nutshell, the idea is to communicate with your customer and invoke some kind of action. You want him to "raise his hand" and say "yes" to something. Once he does, you respond with more information. The entire process is repeated on your next contact. Customers are involved and your reaction and feedback makes them feel valued and ***value*** creates long-term loyalty!

Let's discuss a few examples of how you can get clients involved:

- When it comes time for renewal of a policy, get the customer involved in the process by keeping him abreast of the companies you have shopped and the rates you found. A little back and forth conversation or correspondence will keep the client involved.
- Conduct a customer satisfaction survey and share the results with your customers. Better yet, ask them for input on the results and how they can help improve his service. When you think about it, it's hard to define the changing needs of customers without input from customers!
- Customers could become more loyal to you if you make yourself more familiar. Most agents see their customers once a year or less. Studies show, however, that the most effective plans call for at least five contacts per year. E-mails, new product offerings, birthday cards, calendars and newsletters are just a few of the ways to become more familiar. When possible, include fill-in forms for them to get some special information or local coupon.
- Asking clients for referrals is another way to get them involved. Once received, send a thank you note (reaction) and tell them how much you value their business (feedback).

- Instead of just sending your client a proposal for a new product, get him involved by ask him when he will be ready to make a decision.
- Send a "Customer Bill of Rights" outlining the services your customers can expect to receive from you. Include a feedback form and follow-up with a thank you.

In conclusion, customer retention depends on more than a process of continually improving satisfaction. It also requires dealing with the attrition that occurs even when the best service is in place.

Matching Client Needs With Product

When you are comfortable that you know your client needs and have asked the client himself, it's time to match these needs with an appropriate product.

Much has been written . . . and as much litigated . . . on the perils of matching the wrong product to a perceived client need. This is an area where agents need to exercise extra due care for the client's sake and their own financial well-being.

Questionable market conduct in the 1980's and early 1990's created new demands for today's agent. Past agent abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been occasionally tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together -- less support in marketing and support materials. The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive.

Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as you will see in this section. Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

Risk

A client's perception of risk influences how insurance dollars are spent and, to some extent, how the industry is regulated. Unfortunately, much of society has set a low priority on reducing risk, i.e., "That's why I buy insurance". Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence. When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs? Should accident victims who violate seatbelt laws receive full compensation? Should people who live in hurricane and earthquake country be responsible to better secure a structure with inexpensive metal ties? Some believe that people must realize what they can do for themselves before risk priorities can

change. Agents can play a valuable role in helping clients accept a certain level of risk and strategies to reduce it.

Loss Control

In the insurance industry, the process of risk reduction is called loss control. Loss control procedures involve the steps necessary in eliminating exposures to risk and reducing their frequency or severity. Today, loss control makes the workplace safer and reduces a broad range of liability exposures in homes as well. Offering loss control advice and services to clients has potential rewards as well as risks. Reasons agents might consider advising clients on safety issues include: client credibility, client retention, new client generation, insurer qualification and attractability, favorable insurer status and additional profits where "advice fees" are permitted by law. With competition stiff, some larger agencies are establishing entire subsidiaries to perform loss control-for-fee services. In these cases, loss control fees can represent from two percent to ten percent of total agency revenues. Smaller companies may contract to outside loss control consultants or simply rely on insurer provided services. Loss control services can run the gamut from standard, non-controversial safety recommendations to complicated compliance advice. Whatever level of service provided to attract or retain clients, agents should realize that loss control advice exposes him to additional liability. There may also be statutory violations, particularly in the commercial area, for offering safety expertise without required licensing.

Code compliance is an extremely important area of loss control. It is a discipline usually reserved for underwriters and typically outside the venue of agents. This does not mean it should be ignored by the agent. Due care should involve the agent at least to the extent of a physical inspection of the property to determine that fire sprinklers are indeed in place or that a security fence has been installed around a construction site before delivery of materials. The importance in doing so is underscored by a mitigation of exposure when an accident hits -- particularly by third parties.

Valuation

A recent survey by a well known real estate statistics firm found that almost 70 percent of the homes in the U.S. are underinsured by an average of 35 percent. With an increased awareness of this problem, many insurers of large policies are sending appraisers to high-value neighborhoods to determine if policy replacement values adequately reflect current values. In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new hurricane or earthquake standards; and illegal uses, e.g., a business run out of the home. Bringing inadequately covered premises to full coverage levels increases underwriting income, which may allow a carrier to lower rates within a class of policy owners. Equally important is the liability protection afforded carriers and agents. Both were targets of litigation for misrepresentation and negligence after the catastrophic Oakland fires in California.

Homeowners Insurance

Agents should exercise due care in several important capacities:

Selection of Policy

The selection of policy type . . . HO-1, HO-2, HO-3, HO-4, HO-6 and HO-8 . . . should be a function of client need. Obvious factors to consider include dwelling type, dwelling size, dwelling construction, dwelling replace ability, additional structures, type and extent of personal property, loss of use and basic liability. Refinement of the process occurs where agent due

diligence uncovers clients the true "limits of need" and special circumstances. This can only be accomplished by interview or systematized fact finding concerning key issues:

Value

The amount of dwelling insurance requested is typically a reflection of the mortgage amount. Does this reflect the true replacement value? Is an appraisal in order for larger policies or where a special construction has been used? Remember, like kind and quality does not mean "exact" kind and quality. Clients must understand that replacement cost is limited to the style, quality and function of the destroyed or damaged property. Few or no allowances are made for increased costs of repair or reconstruction caused by ordinances or laws regulating construction or repair. An example is new construction school fees or special fees that are currently charged for construction that were not around when the client's house was built.

Concerning personal property, does an inventory exceed policy limits? Is replacement value available? Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets, etc?

Are "sublimits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns, etc.? After primary values are established, the client's "insurable interest" must be determined since a policy owner will NOT recover for an amount greater than their insurable interest.

Eligibility

Due care discussions with clients should cover circumstances where their eligibility to recover a claim may be jeopardized. Is the policy owner the intended owner occupant or does he intend to rent the property? Will only one family occupy? Is a business being operated out of a home? Are there code violations like additions without permits, zoning violations, etc? Will the client be unable to perform his duties to mitigate losses (draining pipes to prevent freezing, maintaining heat if the structure is vacant, minimal repairs to protect the property from further damage, etc.)? Is a detailed inventory necessary to track descriptions, purchase dates, values, etc? Are clients aware that they should hold on to damaged property and make it available for adjuster inspection? Do clients need to produce books of account or fill out a proof of loss? Will the client be available to assist and cooperate with the adjuster? Are insureds aware that they should NOT make any voluntary admissions of guilt or make voluntary payments to someone they have injured? Many of these circumstances can be brought to surface in an initial meeting or physical inspection of the property.

Deductibles

Clients should be apprised of their deductible options. Although higher deductibles mean lower premiums and lower agent commissions, they represent a fair opportunity for clients accept part of the financial consequences of risk taking. This, in turn, can lead to fewer claims and a generally more stable client.

Policy Exclusions

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions. Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated

seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

Liability & Liability Exclusions

Primary to determining liability limits is the client's overall exposure. What is his or her personal net worth that could be at risk? Will the limits of the policy or an umbrella cover the exposure? Are there any liability exclusions in the policy that leave the client uncovered? Some common areas of neglect include: Boats over 50 horsepower, aircraft, motor vehicles loaned or rented by the insured, certain professional services, most business pursuits, outside premises, cases where insured is liable for worker's compensation, for damage to property used by or rented by the insured, etc.

Auto Insurance

Auto policies are typically divided into different segments covering liability, medical, uninsured motorists and damages (comprehensive, collision, towing, labor and transportation expenses). Insuring agreements traditionally offered "split limits" which apply to each person for each occurrence of liability, damage, etc. Today, the trend is more toward a single limit of liability, which can be expanded within the policy or through the addition of umbrella coverage, that applies to all covered liability losses arising out of an accident regardless of the number of persons injured or the amount of separate property damage. Minimum due care considerations in this area include:

Policy Limits

A needs analysis to determine that liability limits of the policy adequately shield client assets and meet financial responsibility laws of the state which may assign specific minimums relating to liability, bodily injury, property damage and/or uninsured motorist coverage.

Policy Eligibility

Clients should be apprised of the specific vehicles eligible for coverage, e.g., private passenger autos owned or leased, longer than six months, AND those which are NOT eligible, e.g., less than four wheel vehicles, autos used to carry persons or property for a fee and those needing to be named as additional vehicles, e.g., trailers, off-road vehicles, etc. Clients should also be advised that new or replacement vehicles must be reported within 30 days of purchase to receive full coverage. Clients with poor driving records should be referred to assigned risk plans or "fair" plans organized through state programs.

Policy Conditions

Agents should direct clients to specific areas of the policy pertaining to "duties of the insured after an accident". Clients should be told that they should promptly notify the company of the accident, the time limits within which they should act and steps that they should take to reasonably protect the covered auto from further harm or damage. Policy owners must provide sufficient evidence of loss, cooperate in any insurance investigation and notify the police if a hit-and-run driver is involved or if the covered auto is stolen.

Policy Endorsements

Clients should know the options they have to broaden their coverage to include coverage such as full replacement cost, towing and labor costs, rental reimbursements, specialized vehicle coverage, extended nonownership liability, additional damage coverage for special vehicles, named nonowner endorsements, coverage for special personal property coverage for items like tapes, CDs, CBs, portable phones, etc. Some attorneys might advise agents to prepare a written list of available endorsements and the applicable cost to present with the original quote. Clients who incurred claims but refused the option to buy these endorsements would have a difficult time pursuing agents for not making them available.

Policy Exclusions

Due care discussions should also disclose to clients items of coverage specifically excluded. Examples include: property being transported, bodily injury to an employee of a covered person, motorcycles, off-road vehicles, etc. Also excluded is coverage in areas outside the United States, its territories or possessions and Canada. Clients should understand that an endorsement for extended coverage should be considered when traveling outside these domains.

Policy Effective Date

It should be clear that coverage begins at 12:01 AM standard time on the date of inception to 12:01 AM on the date of expiration.

Named Insured

Who is the insured? Is the insured the policy owner, his spouse, a resident of the household, other family members?

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

What is the name of any other person or organization who may not use the auto but may still have legal responsibility for the acts of omissions of the covered insured?

Sales Conduct

Sales conduct is a higher level of responsibility you **choose to uphold** in order to do a better job for your client. It is a proven loss control tool. But, if you need more reasons why you should practice proper sales conduct here's a short list:

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process, i.e., *you have more control over the sales process and less compliance.*
- Sales conduct violations drive up the cost of doing business which could effect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation, i.e., *violations can mean less money.*

- Sales conduct problems erode the public trust and *that can cut into your sales*.
- Sales conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

There are several components of sales conduct, including: Ethical Selling, Integrity, Choosing Product, Choosing Companies and Presentations of Quotes and Illustrations.

Ethical Selling

Do you think you're an honest agent? Could you prove it to a jury? What would your mother say about your sales practices? In the end, how will you judge your sales career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution to "truth in selling".

In a way, the insurance industry is battling a decline of sales ethics; a **moral combat** if you will. One battlefield, where it is difficult to win, is the media where in recent times consumers read about state regulators warning 147 New York insurers on deceptive selling practices, or one company being penalized more than \$700 million for deception, or an insurer's agreement to pay \$25 million to cover the unscrupulous sales techniques of a single agent. **Ethical selling**, as portrayed by the media, is just another oxymoron.

The troops leading the "offensive" for the industry are sales and motivational speakers and industry associations. Ethics, truth and responsibility are suddenly the core of seminars and newsletters with titles like **Winning With Integrity, Selling With Integrity, Principled Persuasion** or **Selling With Honor**. Groups and associations are doing their share by promoting proprietary **codes of ethics** as the foundation to membership and/or the blueprint for all transactions.

This is not to suggest that simply possessing a moral code is something that sets a professional apart from a mere salesperson. However, maintaining a Code of Ethics does inspire us to do good — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

Having high ethical standards, or more simply being honest, can be more important than being right because honesty reflects character while being right reflects a level of ability. Unfortunately, the insurance industry, for the most part, still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards"; but few, if any, "Ethics & Due Care" certificates.

For some, ethical selling, whether by a code of ethics or just plain honesty, is reward by itself. Consider, for example, the satisfaction you would realize when the interest of a client has been served by the proper placement of insurance in the following situations:

- The capital needs of a family are met by a \$1 million life insurance policy when the breadwinner dies prematurely
- The estate of an entire family is left intact because an umbrella liability policy sheltered against a major accident claim
- A business is able to survive after the death of a partner because a life policy payment provided necessary capital to replace the devastating loss

- The retirement plans of a once young married couple are made possible through investments in pensions and annuities
- The owner of income property financially survives a major fire because his liability policy included "loss of income" provisions
- A family survives a mother's long term bout with cancer because their health insurance carried a sufficient "lifetime" benefit

The list is endless, but the point is already made: The work of an insurance agent often impacts the entire financial well being and future of businesses and families. Ethics place the interest of these clients above an agent's commission and is, in fact, the very root of what constitutes a true professional.

Being ethical is indeed professional but the gesture goes beyond the mere compliance with law. It **means** being completely honest concerning ALL FACTS. It means more than merely NOT telling lies because an incomplete answer can be more deceptive than a lie. Take the case of **Bell vs O'Leary (1984)**. An agent took an application for flood insurance but failed to notify the client that his mobile home was located in unincorporated areas that were ineligible for any coverage under the National Flood Insurance Plan. A loss occurred and the agent was sued. The courts determined that the agent had superior knowledge and failure to give the client a complete answer about the unavailability of coverage took precedence over the fact that coverage for the property was not available from anyone.

Someday, it may be real important for a court and jury to hear that you have a history of serving clients without consideration for how much commission you made or how busy you were, i.e., you are a person with good ethics. Take the case of **Grace vs Interstate Life (1996)**. An agent sold his client a health insurance policy while in her 50's. After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court considered the agent's lack of duty to notify his client a serious breach of ethics.

Perhaps this whole issue of ethics can be summed up in the very codes of conduct now in place for members of organizations like Registered Preferred Agents, The American Society of CLU and ChFC, Chartered Property and Casualty Underwriters the International Association of Financial Planning and the Million Dollar Round Table.

Ethics From The Start

Instilling ethics is a process that must start long before a person chooses insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in a forum like this course of study may not be incentive enough to sway agents to stay on track. It may be easier to explain that honesty and fair play could mean greater sales and lessen the possibility of lawsuits.

Perhaps part of the blame for modern-day ethical indiscretions is the complexity of financial products and the intense competition among sellers and agents. Both make it harder for consumers to understand what they want or need and easier for an aggressive salesperson to mislead them. Consider **Cunningham vs PFL Life (1999)**. Agents, who promoted themselves as "experts" with superior knowledge, misrepresented the life insurance policies they were selling as investment vehicles. Consumers were easily convinced that the papers they held were investment contracts. The courts found the insurer liable for reckless and wanton failure to train and supervise its agents. The case did not disclose if any suits against individual agents were launched by the insurer.

Some believe that the ethics problem reflects our current culture that glorifies short-term success at all costs. This includes awards for the most sales in a given period of time as well as “golden boy” stories of the entrepreneur who goes from lonely computer geek to multi-millionaire from a single idea. Neither of these events is meant to say that these individuals accomplished their feats in an unethical manner. It simply “raises the bar” for those who follow them. If those who follow have inadequate skills and work habits, they could employ less than ethical means to reach the same goals.

Ethics For Life

The insurance industry can do a lot more to promote ethics-building habits. At the MONY Group, for instance, building a relationship in sales and marketing is emphasized with a program called ***Client for Life***. Its premise, “When you constantly exceed the needs and expectations of your clients, you’re doing the right thing”. Sales tools such as reports and newsletters are used to educate clients in a non-threatening and highly personalized manner. Long-term success is closely associated with building long-term relationships with clients rather than a quick sale. The results may vary from agent to agent, but a surprising benefit seems to be a ***loyalty factor*** where more than 70 percent of sales comes from existing policyholders or their referrals.

Ethics From Education

The customer can’t understand what the salesperson can’t explain. Further, a customer who understands a product is much less vulnerable to deceptive selling. Both statements stress the importance and need for more education. A recent study by the Insurance Institute found that four out of every five people don’t understand their insurance policies. And, if the agent doesn’t understand his product the company and client are at risk. Agents end up concentrating on a “comfort zone” product or service B even if it is not the most appropriate one because he is uncertain about newer, more complex products.

Constant training is the answer from the company’s perspective, as well as making a long-term effort to ***demytify products***. One solution is the translating of legalese into easily understandable, everyday English. This includes brochures, advertising, applications and the policies themselves.

The process of educating ethics is also the responsibility of our schools. Currently, there is a glaring lack of attention to the selling disciplines. Besides learning the nuances of every product and the marketing behind them, young people could be taught the importance and responsibilities associated with being a salesperson. Like the athlete who trains long hours to prepare for the moment of action, salespeople can be groomed to do the right thing.

Later in life, these lessons help the insurance salesperson accept and position himself as an ***insurance agent***, not a “special consultant” or financial planner. Customers will learn to accept that ***you are who you are*** without titles that could mislead or instill false promises.

An agent who practices sales conduct is an insurance professional who always practices due care, yet operates primarily within the bounds of agency. They accurately describe policy options that are widely available but refer out if an inquiry is beyond their scope of duties B even if they know the answer. They do not profess to have expert status but know their products better than anyone. Their goal is simply to be the most responsible agent possible.

Integrity

While many agents believe that "integrity" is a characteristic of choice, many state laws set minimum agent standards to follow, such as:

Qualifications

Insurance Commissioners have been known to suspend or revoke an insurance agent's license if it is determined that he or she is not properly qualified to perform the duties of a person holding the license. Qualification may be interpreted to be the meeting of minimum licensing qualifications (age, exam scores, etc) or beyond.

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In **Goldberg vs Barger (1974)**, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing Laws

Agent licenses have been revoked or suspended for activities where the licensee (1) did not actively and in good faith carry on as a business the transactions that are permitted by law; (2) avoids or prevents the operation or enforcement of insurance laws; (3) knowingly misrepresents any terms or the effect of a policy or contract; or (4) fails to perform a duty or act expressly required of him or her by the insurance code. In **Hohreiter vs. Garrison (1947)**, the Commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants. In **Steadman vs. McConnell (1957)**, a Commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In **McConnell vs. Ehrlich (1963)**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers who licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their "volume plan". If this wasn't bad enough, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

In addition to the specific violations above, most states establish that agent responsibilities MUST NOT violate the “public interest”. This is obviously a catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (Criminal) violations, etc.

Business Conduct

Business conduct is the behavior you **chose to uphold** to be a better agent. It is also a great tool for loss control. Business conduct involves more than legal compliance and more than maintaining a code of ethics. Business conduct is the adherence to procedures that make you the most responsible agent you can be. As a positive side effect, following better procedures also helps mitigate the legal exposure you carry as an agent and should yield greater respect from your clients. Ultimately, the combination of these two aspects will lead to a higher level of success in your insurance practice.

There are many components of proper business conduct. Starting on the next page, we have boiled many of them down to a **code of procedures** that every agent should adopt. A closer look at some of the more important procedures are discussed below.

Solutions

Be solutions-based in your approach to helping clients. This means more than performing a task. It means providing solutions to their insurance dilemmas by knowing needs and financial objectives. It means **listening** to clients, **discussing** exactly what the product will do for them and be sure they **understand** the information you are presenting.

Some of the most frequent complaints that insurers and regulators receive stem from purchases where clients did not know exactly what they were buying; thought they were “fully covered”; thought the coverage was for more than the limits allowed; did not know there were surrenders, penalty charges or taxes associated with the product; and / or the product simply was not appropriate for their needs.

Solutions create satisfied customers which minimizes conflicts and prevents problems like these from ever starting. Further, if a problem does develop, you will be better prepared to respond.

Of course, before you can offer solutions, you must engage in a fact-finding process to gather information on the client's current insurance / financial needs and goals. Each client's needs are unique; based on individual circumstances and goals. You will need to consider age, health, education, employment, dependents, income, assets, debt, standard of living, net worth, tax status, financial experience, current financial status, retirement plans and risk tolerance to mention a few.

Finally, and just as important, you need to understand your products; which one is appropriate for the client and explain to them exactly how they work.

For your own protection, it is also important that you document all analyses and conversations so that if questions arise later they can be effectively answered. To accomplish this, you should keep all records pertaining to information about your client, information on their needs and the matching of appropriate product as well as your explanation on how the product works to meet their needs.

A case where agent's failed to "back-up" is **State Farm vs Gros (1991)**. The client alleged that the agent advised him that the policy covered landslides; the agent remembers advising him it did not. Three years after purchasing the policy the client filed a landslide claim which was NOT covered by the insurer. Because the agent file lacked notes regarding client conversation, the courts held that the policy was misrepresented and the insurer was bound by the agent's actions.

In another case, a policyholder claimed that she informed the agent that she would need money in three to five years for her children's college education. The agent sold her a fixed annuity with a nine-year surrender charge period. Of course, when it came time to fund college expenses there were taxes and penalties which led to a claim of misrepresentation. Unfortunately, the agent could only provide a brief narrative account with no meeting notes or written documentation. Surrender charges were eventually waived and the producer was charged-back the commissions.

How could these situations been handled better? Let's look at another case where a client alleged that a product did not meet her needs. The agent maintains a ***standard operating procedure*** of providing all applicable disclosure documents, many with the client's signature. The agent routinely sits down after each sale and makes a record of the conversation, including topics discussed, special comments regarding the clients needs, liquidity and anticipated future events. The agent's file included an objective and needs questionnaire filled in by the client which memorialized her statements regarding specific needs like liquidity. The bottom line? The agent was able to demonstrate that he knew the client and her needs by keeping notes and records of all contacts and documents. The file showed that the agent was solution-oriented and had made a good sale. All charges were dropped.

Applications

Applications are serious business where a mistake can void or decline a policy or claim and get you sued. Spend at least 50% more time than you do now to make your applications accurate and complete.

Applications are the lifeblood of the your business yet most agents regard them as a hassle. You have a legal duty to be sure that each application is completed fully without deceit of any nature. The information on all forms must be accurate to the best of your knowledge. In **Bitz vs Knox (1998)** an agent was sued for inadvertently submitting erroneous financial information on a disability application. In **Johnson vs Illinie Mutual (1958)** an agent was requested to insure a specific home at a specific address. On the application, the agent "misdescribed" the house number. The insurer refused the claim and the agent was liable for failing to follow instructions. In **BSF vs Cason (1985)** the client's claim was refused and the agent was taken to task for failing to record a client's past claim and cancellation experience. In **Lewis vs Equity National (1994)** the client alleged that the agent filled out the application and failed to list the clients many heart-related treatments. The courts awarded punitive damages. And in **Life Investors vs Young (1999)** a life insurer sued its own agent for \$26,000 when he failed to indicate a known pre-existing heart condition on a credit life application. Information must be current, especially medical and health information and all dates must be correct. Predating and postdating of applications is strictly forbidden by every insurer.

Agents should ensure that the applicant understands the questions in the application and ask the prospective insured to read it to confirm that everything is answered correctly and completely. Only then should it be signed. Under no circumstances should applicants sign blank forms. In **Smith vs Dodgeville (1997)** the agent was sued for failing to answer a standard question on the application regarding "previous cancellations". The client indicated he

would have answered the question truthfully if asked. In **Ward vs Durham Life (1989)** the agent assured the applicant that missing health history information on the application did not need to be disclosed. Coverage was denied.

It is important that applicants understand the need to complete accurate applications since errors or intentional misinformation can void a policy and lose you a commission and future business. This is especially true for your own policies or those you write for families and friends. In **Southland Lloyd's vs Tomborlain (1996)** an agent misrepresented age, purchase price and condition of property on an application for property he personally owned. The court held that an agent's fiduciary duty is highest when he writes his OWN contracts. Of course, there are thousands of cases involving clients who misrepresent information on an application. As you will learn later, these misrepresentations are considered **material** if it is relied upon by the insurer in issuing the policy.

Concerning knowledge about a potential claim or concern at the time of application, your clients have a duty to disclose information on an application **only to facts and not mere fears or concerns**. There is no requirement that applicants disclose their fears or concerns or facts that an insurance company may already know or has already waived. For example, someone who has occasional headaches does not need to disclose his fear that he has a brain tumor.

As a witness to the application, you must be sure that only the applicant himself, sign or initial and you should never leave an application, surrender form or affidavit to be signed if you are not present at the signing. In **Crobons vs St Paul Fire (1981)** an agent thought he was "helping" a family when he "witnessed" someone other than the client (who was in a coma at the time) sign a change of beneficiary application. The agent was responsible for his damages for his fraud. In **Great American vs York (1978)** an agent was responsible for the client's damages because he failed to follow insurance company instructions to submit a completed application – he accepted an application from the client's wife without the client's knowledge and signature.

Just as important as the procedures above, you have no authority to change answers on an application without the knowledge, consent and written approval of the applicant or insured. Likewise, your insurer restricts you from altering or waiving any term or condition of an application without prior consent. In **Saunders vs Cariss (1990)** a client sued his agent for signing his name without his authorization. The agent purportedly filled in a box on the application which reduced uninsured coverage. In **Commissioner vs Grossman (1986)** an agent actually back-dated an application with his postage meter to give the appearance that an application was submitted two days prior to a fire. A conviction for fraud against the agent was won.

Additionally, you have a duty to notify applicants when their applications have not been accepted. This is exactly what happened in **Boothe vs American Assurance (1976)** and the agent was found liable for his negligence.

Agency Agreements

The relationship and liability you owe to both your client and insurer should be clearly spelled out in your agency agreement. Unless you wish to assume liability beyond your license responsibilities, it is imperative that you take out your agency agreement and read it at least three times. Some agents **never** read their contracts. How about you?

Your agency agreement, if you follow its provisions, can protect your **agent status** in a lawsuit between your client and the insurer. Most insurers will attempt to focus or narrow the authority of agents to limit their exposure to agent wrongdoing. In practice, however, the law **generally**

considers the agent and the insurer as one and the same so the insurer is the ultimate “deep pocket” for problems – in essence an **agency relationship** is established. While this may help to insulate, agents are regularly and routinely named in suits against an insurer. Agents are also sued by their own insurers looking for reimbursement for violations of agency agreements.

If you don't read your agency agreements, how would you know if you routinely promise things to clients **outside** the limits of this agreement for which you could be personally liable. How would you know you violated certain fiduciary duties to your insurer that are defined in your agreement? Or, acting outside agency agreement limitations, you could be establishing yourself as an **expert** or **dual agent** with almost unlimited liability for whatever goes wrong with your clients' policies. In essence, if you choose to **push** the limits of your agency agreement in accepting new business **you act as the insurance company until coverage is accepted**. Take **Stuart vs Indemnity National (1982)**. An agent offered to **bind coverage** for a client when the agent, in fact, did not have binding authority. A loss occurred before the application was approved and the courts made the agent responsible for the applicant's losses as those he was the insurer.

In another case, **Sobotor vs Prudential (1984)**, the agent held himself out to have **special knowledge** in a certain area of insurance – again, outside the purview of the agency agreement. The client, knowing little about the technical aspects of insurance in this area, asked the agent for the “best available” coverage. A claim was denied by the insurer for “optional coverage” that was not recommended for the client and the agent, not the insurer, became liable to cover the losses. Had the agent simply promoted himself as a responsible agent of the company and promoted correct product, it is likely he would have been afforded the protection of his agency agreement and the insurer would have paid.

Simply because you have an agency agreement, do not be lulled into thinking that there is nothing that can touch you. There are clauses in your agreement that may seem to protect you, yet leave you in the lurch. For example, in the **Goebel vs Suburban (1997)** matter, an insured launched a meritless case against the agent for negligence in procuring coverage. The claim was quickly dismissed but the agent wanted reimbursement for court costs from his insurer because a clause in his agency agreement outlined indemnification for liability caused by the insurer's acts of omission. Even though the agent was “in the right” and his contract called for indemnification, the common law of his state did NOT require insurer's to indemnify agents against frivolous claims. The agent was out.

Routine reviews of agency agreements have found other, unpalatable clauses, such as:

- Unreasonably limited indemnification of the agent for insurer wrongdoing
- Loss of insurer indemnification if there was **any** wrongdoing by the agent
- Termination of agent with as little as 30 days notice or without prior notice
- Minimum net premium volume requirements
- Forfeit of all agent profit-sharing and override payments earned if terminated
- Change in commission rates without notice
- Agent indemnification of the company even if the insurer was the significant contributor to the liability
- No protection for agent ownership of expirations

Any agent would consider these terms unacceptable yet agreements with these vary clauses are signed every day. Shouldn't you take out your agency agreement and find out if they have similar weaknesses?

Communications

Be a student of consumer protection laws and unfair selling practices because practically all insurance communications you have with clients is regulated by insurance code or as consumer advertising. That's right! **Nearly ALL client contact is considered advertising** that is subject to strict state and federal laws (and penalties) with titles such as The Uniform Sales Practices Act; Deceptive Trade Practices and Unfair Insurance Practices.

In practicing better business conduct, it is important that any communication with your client (written, verbal or electronic) be clear, complete and balanced in providing benefits, costs, limitations, and contract terms of products you present or service. Remember, even though people today are generally more sophisticated and have access to more information, most clients still have trouble understanding the terminology of insurance, determining appropriate product and the amount of coverage to buy. They look to you NOT to make those decisions for them, but to guide them through the process so they can make informed decisions based on their own best interests.

Issues where conflicts abound include prior approval of advertising by insurers, identification of insurer and product sold, accuracy and truthfulness in advertising, unrealistic illustrations or quotes, unfair comparisons and competitive references, unapproved testimonials or endorsements, discrimination among individuals of the same class, unlawful rebates, deceptive name or symbol usage and at least another two dozen violations.

Agent licenses have been revoked or suspended for activities where the licensee did not actively, and in good faith, conduct proper business conduct communications. In **Steadman vs McConnell (1957)** a licensee was found guilty of making false and fraudulent representations of a policy's expected cash values for the purpose of inducing clients to buy them. In **Horeiter vs Garrison (1947)** an agent's license was revoked for misrepresenting policy benefits. And in **McConnell vs Ehrlich (1963)** an agent's misleading letters and advertising inferred he could place coverage lower than others because of his "volume plan". His license was revoked.

Be current and responsive to your clients. Promptly answering client / insurer mail, e-mails and phone messages can eliminate conflict and build confidence. There are many insurance professionals who "block off" a certain time of day just to open mail or respond to e-mail – without fail and without interruption – it's that important. There are countless documented and undocumented cases where a simple failure to respond mushroomed from a little problem to a huge liability. Take the **Gulf Insurance Vs Kolob Corporation (1968)** case. For various reasons, an insurer decided to cancel all of an agent's business policies – it happens! Because the agent had a large volume of clients to find replacement coverage, it took more than six weeks to notify a certain client. Naturally, a claim occurred and the insurer refused coverage for the agent's "unreasonable" delay in cancellation notification. Ultimately, the insurer was forced to pay but the agent was pursued for indemnification. In a similar action, **Boothe vs American Assurance (1976)**, an agent was sued for failing to mail an application and advance premium payment to an insurer. The agent was forced to cover the client's losses when a flood damaged the applicant's property.

Replacements & Exchanges

In any known replacement or exchange of policies a producer should:

- Provide and **carefully review with the client** information to help the client understand the advantages and disadvantages of replacing an existing policy; and

- **Document why** the purchase of a new policy serves the client's needs and objectives better than does the maintenance of existing coverage

A replacement may NOT be in the client's best interest because of:

- Suicide or contestability limitations in a new policy
- Higher premiums for new coverage at current attained age;
- Diminished value of the existing policy where unpaid loans will be deducted
- New acquisition expense charges may result in lower future cash values (assuming the same face amount)
- New possible surrender charges
- Loss of privileges and options under the old policy which may not be available in the new one

Replacement regulations and requirements apply if a new insurance or annuity policy is to be purchased, and it is known or should be known to the producer that, by reason of the transaction, an existing policy has or will be:

- Lapsed, forfeited, surrendered or otherwise terminated
- Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values
- Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in effect.
- Reissued with any reduction in cash value; or
- Pledged as collateral or subjected to borrowing for amounts exceeding 25% of the loan value of the policy.

Know when a replacement form or exchange form is required because there is considerable regulatory and civil litigation surrounding these procedures. Utmost in the minds of the legal powers is high standards of honesty, fairness and whether or not you clearly identified that a replacement was in your client's best interest.

*What can be especially troublesome is situations where **you may not even recognize that a replacement has occurred!** Sound impossible? Well, let's talk about a case where the money for a new annuity or life policy comes directly from your client and not another insurance company, i.e., you collect a personal check from a client yet the money that he is giving you actually came from the surrender proceeds of another policy with a different company. **Just because the money went into the client's account before it made its way to you as a "cash application" doesn't mean it is exempt from replacement regulations.** The above is also true if the client receives a check from the surrender of an existing policy and endorses it directly over to a company for the purchase of a new policy.*

Know Your Own Product

You must know your own product. Know the options available and be able to explain the differences between policies you sell. If you don't, it can land you in court. In **R-Anell Homes vs Alexander (1983)** the agent indicated a phone system would be covered under the building's blanket policy. It wasn't and the agent paid the price. In **Benton vs Paul Revere Life (1994)** an agent "upgraded" a client's disability coverage where coverage was extended for **life** for an additional premium. The new policy, however, required a higher level of

disability. The courts were clear to point out that any agent who does not understand the difference between two policies he is selling is subject to liability for fraud.

Disclosures

It is imperative that disclosure of all facts be so clients can make informed decisions. Formal disclosures (in writing or in front of witnesses) also help establish proper business conduct if a dispute surfaces. Become disclosure-oriented in your practice and always ask the **3 Closing Questions**:

- Have I given you all the information you need to make a decision?
- Does this information or policy make sense?
- Is there something else I can answer for you to assure you that this is the right solution based on your needs and objectives?

Where possible, use **client disclosure agreements** (signed by clients) acknowledging any limitations on the services you provide, e.g., premiums are subject to change, continued solvency of an insurer, the responsibility of an accurate application, etc. Additional disclosures could include options the client chose to refuse life seeking outside tax or legal advice, riders, waiver of premium, higher deductibles, etc.

Some agents use **mini-disclosures** throughout the application. For instance, if you were basing the exchange of two policies on a specific IRS Private Letter Ruling, why not cite it in the application. One of the better **disclaimers** around has application in many areas. Short but prominent notes of this nature do much to bring unsettled issues to the surface and protect both agents and clients:

This is not (legal, investment, etc) advice unless you and I agreed in writing beforehand that it is. These are complicated issues, and you need to discuss your particular fact situation with your (attorney, advisor, etc) before relying on any other advice.

There is much more to know about disclosures as you will see in the section on Managing Conflicts.

Illustrations and Quotes

Agents should follow strict procedures when using illustrations, including:

- Show the client a complete illustration – no pages should be omitted
- Carefully explain that the illustration is a **projection**, based on non-guaranteed factors, and it is not a guarantee of future policy performance
- **Do not highlight** portions of the illustration or make notations on the illustration. Such actions may be considered misleading.
- Always keep a copy of the illustration or the Certificate in Lieu of Illustration form.

The handling of illustrations has become very complex in recent years. Some policies now require them; some prohibit them; some require annual reporting updates and actuarial certification. These guidelines are established by your insurer and generally require the following of an agent:

- You and the applicant must sign the numeric summary page of the illustration
- You must provide the client a sign copy of the illustration

- You must submit an illustration with each policy (where required) during the sale
- Where an illustration is not used, you must submit with each policy application a completed Certificate in Lieu of Illustration signed by the applicant

You may also be interested to know that insurers are generally required to answer specific questions in their **annual statement filings** pertaining to the “basis” of dividend and interest rate projections in their illustrations; including their opinion of their ability to continue supporting current rates and their assumption factors if projected rates exceed their current experience level.

One of the biggest traps concerning illustrations is when a policy is issued **other than as applied for**. In these cases, a new illustration must accompany the policy as a delivery requirement (assuming an illustration is required for the particular product).

Problem areas can and should be solved before you ever arrive in the field by requesting a copy or running various illustrations for policies you wish to handle. Clear up questions as soon as possible. If company management doesn’t know the answer or they avoid questions, it may a clue that they will handle client policies in a similar way.

You should also know that mistakes in illustrations, even though made by the insurer, can cause problems. In **Metropolitan Life vs Haney (1999)** an agent used software provided his insurer. When policies were issued, however, differences between the original illustration and the policy caused several of his insureds to rescind. The agent sued the insurer for loss earnings and stress. The courts did not completely agree, saying that the illustrations were a benefit to the agent and only incidental to sales. While he kept his commissions, the agent paid legal fees for his lost case.

Casualty quotes or RFQ’s (requests for quotes) also impose specific agent responsibilities. The **Eddy vs Sharp (1988)** case is a prime example of what can go wrong. The agent prepared a standard proposal for a client wanting coverage for multiple rental buildings. The agent described coverage as “All Risk” subject to a list of eight exclusions. He even provided a disclaimer reading “This proposal is prepared for your convenience only and is not intended to be a complete explanation of policy coverage or terms. Actual policy language will govern the scope and limits of protection afforded”. The client relied on the proposal letter, bought the policy but did not read it when it arrived. Client losses resulted from the back-up of water through his drains which was NOT covered in the policy. Of course, it was also NOT one of the eight exclusions mentioned in the agent’s proposal. The courts held the agent responsible because his proposed coverage was “all risk” and client accepted same.

In any quote or proposal, be specific. If you are going to mention exclusions, you’ll have to list them all. Also be sure that the quote matches the requested coverage; disclose principals and avoid any wording that might remotely imply the client is bound unless you intend it to be.

Correct Coverage

At a minimum, your clients should expect you to provide policies that are fair and appropriate coverage at the time of the sale. Your duty to inform a client of possible **gaps in coverage** is considered preferred business conduct. Discovering gaps in coverage is to be distinguished from providing “complete coverage” – something that is difficult to promise or expect. Rather, you are more geared to providing your clients **correct coverage at the time of sale**.

The **Bayley vs Pete Satire (1987)** case is a prime example of what can go wrong. A client owned a bar-lounge and was assured by the agent that his business was “covered” . In fact the

policy purchased contained an **exclusion** for alcohol-related lawsuits. An accident caused by a patron of the bar caused a lawsuit to end up on the agent's doorstep. The court concluded that the agent was indeed negligent. In an extreme lesson, the judge also ruled that the agent was held liable for all **future** alcohol related lawsuits until proper coverage could be secured. In another case, **Free vs Republic (1992)**, an agent was asked by a client if his homeowner policy limits were sufficient to rebuild his home. The agent assured the client they were. A subsequent fire and quote to rebuild proved otherwise. The client brought suit against the agent and his insurer for failing to inform him of the inadequate limits of coverage. Even though the courts held that the agent had no legal duty to advise the client about sufficiency of coverage, once he elected to respond to the client's inquiries he acquired a special duty to use reasonable care.

Correct coverage is also obtained after you have assessed client needs, the appropriateness of a specific product and discussed any available options the policy offers that are widely available and cost effective. Client needs may also involve the investigation of **split limits** and / or the exploration of **difference in conditions insurance** where coverage gaps that are excluded in underlying contracts may be available under a separate policy. In **Lazzara vs Esser (1986)** the client requested \$100,000 of auto coverage. The agent purchased two policies, a primary with \$300,000 maximum and an umbrella covering claims from \$250,000 to \$1 million. A few years later, the primary coverage was issued "split limits" of \$100,000 per person and \$300,000 per occurrence. The client was not notified about the gap in coverage, sued and prevailed against the agent when a loss occurred.

Determining the appropriateness of a product sold **after the sale** is a matter of the relationship you wish to develop with your client. There is no legal responsibility to continue advising a client about the adequacy of his policy after the sale. However, if you decide to commit yourself to doing so, be sure you are actually monitoring the situation and not along for the ride. For instance, in the **Grace vs Interstate (1996)** case, the agent continued to collect premiums for a health insurance policy. Eventually, the potential benefits of the policy were substantially supplanted by Medicare when the client turned 65. The length of time the agent did business with the client (ten years) was a factor in the courts determining that the agent had a special relationship leading to a higher standard of care to notify the client about double or incorrect coverage. In essence, if you are doing business with a client over an extended length of time, you may be responsible for **continuous** and correct coverage whether you choose to assume this duty or not.

Standard Procedures

If you don't already have standard operating procedures, develop them **now!** Every client deserves to be treated equally and given the same level of service. It is also the best way to establish evidence and protect you in a liability suit. The best standard procedures involve the establishment of **office protocol and operations manuals** that:

- Create consistent and comprehensive steps for every sale. The offer of a special endorsement or rider, for example, should be offered to everyone and their acceptance or denial noted.
- Reduce oral agreements, scattered notes and conversations to a formal writing as soon as possible.
- Use automated equipment with database capabilities for up-to-date documentation and "date stamping" features.
- Note and file client needs and requests.

- Create a “follow-up” or “hot list” system for notifying clients about important dates, renewals and endorsements.
- Lay out set procedures for handling and logging phone messages, faxes, copies, e-mails, photographs, microfilm, proof of mailing receipts, records storage, etc.
- Review policies received to be sure they are meeting client needs.
- Complies with application and cancellation procedures with the ability to track notices sent.
- Provide quick, easy access to claim processing and claim procedures.

Mishandling Money

Virtually all agents know that the proper handling of premiums is an everyday fiduciary duty to the insurer. There can be, however, situations “beyond your control” where premiums and coverage is lost and you are still held responsible. In **Evanston vs Ticker (1989)** the agent collected premiums and sent them to an intermediary broker who failed to obtain proper coverage and refused to return the money. The good agent was sued. What most agents may find hard to believe is ***lost premiums are not covered by E&O insurance.*** The agent was personally responsible for \$75,000 in lost premiums. This is the risk in dealing with an unfamiliar intermediary.

Underwriting & More

The most important aspect of underwriting is that ***time is working against the client.*** If you are selling a life product, the client could develop complications or fall ill almost overnight. For casualty business, it could be an overnight fire or next day flood that destroys your client’s home or business. Your underwriting responsibility is to process applications in a timely manner and collect and assess accurate facts for the application. An agent practicing preferred business conduct would also be sure that the transition to a new policy ***does not leave the client unprotected.***

Assessing the facts may involve reading documents or physical inspections. Take **Hardt vs Brink (1961)**, for example. The client was a tenant in a commercial building. The client’s lease (which was NOT read by the agent) had language that specifically excluded the tenant from coverage if the building was damaged. Unfortunately, the policy that the agent wrote specifically exempted the insurer from liability for damage to leased property. An investigation fell short, the client was not covered and the agent was sued. In **Odendorf vs American Family Insurance (1982)**, even though the agent had personally visited the client’s farm he did not inspect the operation in a sufficient manner to advise client that liability coverage for farm employees was needed. An on-the-job injury caused uninsured damages and a liability suit against the agent.

In a health insurance matter, **Born vs Medico Life (1988)**, a client purchased a new health policy with a typical six-month waiting period for pre-existing conditions. The client assumed he was covered by the new policy and cancelled the old one. A health problem developed that was waived by the six-month waiting period. The client was denied coverage and sued the agent. In this case, however, the agent proved that he advised his client about the six-month waiting period. He was found innocent. Could you see this case going another direction if the agent failed to mention the waiting period?

In another example, **Jarvis vs Modern Woodmen (1991)**, an agent encouraged the client to drop an incontestable policy and purchase a new policy even after being advised about certain mental and financial problems. When these facts were found missing from the application the

new policy was cancelled leaving the client bare. The courts awarded \$500,000 in punitive damages.

These are all cases where agent knowledge of underwriting and facts of the case would have retained coverage for the client. There are also occasions where you need to assess underwriting facts and suggest a different tact. Take the case of "Mark". His application for life insurance included several notes to recent tests run by his doctor. The include three routine enzyme tests: GGT, AST and ALT. Mark's GGT test, which is the most sensitive to alcohol and accounts for 99% of most declines, was high. He claimed that he simply had too much to drink the night before. The AST and ALT tests, however, were also high indicating the likelihood of liver impairment. Again, Mark had some excuse. Further, Mark had refused his doctor's request to take additional tests including a scope and liver biopsy. When clients refuse these tests it always results in an automatic decline, which is exactly what happened with Mark. The point is, if you know more about reading test results, you can better counsel your client on how to save further delays in processing (during which time he could deteriorate further). In this case, you could advise Mark that he is likely to be declined no matter how many times and how many places you submit his application. The problem with continuing is that something could happen in the meantime, leaving him no coverage at all. From here, your skill in placing him can depend on your knowledge of the impairment or suggest an alternative path like a different rating class or in Mark's case converting existing term coverage to permanent coverage without medical underwriting, etc. Look for the "tell-tale" signs and discuss them with clients instead of incurring repeated underwriting rejections.

Conditional Coverage / Binding Authority

Time is of the essence in every insurance transaction but mismanagement of coverage is one of the highest breaches of proper business conduct. Don't leave clients stranded without protection, even temporary, if it is within your power to provide it.

In **Brill vs Guardian Life (1995)** an agent took a client's life application but failed to advise the client his option to pay a small fee for a conditional receipt that would have provided immediate, although temporary life insurance. Upon the client's sudden death the widow sued the agent for negligence and the court agreed.

In **Stuart vs National Indemnity (1982)**, an agent represented to a client that he had "full coverage" when the agent had no actual binding authority. A loss occurred and the claim denied. The agent was held completely responsible as though he was the insurer himself.

Referrals

Since you cannot control how good a job someone else will do for your client, refer only to extremely trustworthy professionals and let them do the fact-finding. In a recent case, **Rieger vs Jacque (1998)**, a client suffered financial injuries from a defective trust put together by an agent-recommended attorney. Fortunately for the agent, it was determined that the attorney did not rely on any statements made by the agent to prepare the trust, i.e., the attorney did his own fact-finding. Be careful out there!

Insurer Solvency

Always verify the ***current financial condition*** of insurers at the time of coverage. There are clear and certain legal penalties for placing coverage with an insolvent insurer or for having knowledge of pending insurer problems at the time coverage is placed. More importantly, there are severe financial consequences for your client. In the **Moss vs Appell (1998)** case, the

agent sold annuities to a client and placed them with a company that ultimately became insolvent. The client contended that the agent knew of pending problems with the insurer when he received a letter from them indicating they needed to find capital to bolster reserves. The courts determined that a breach of fiduciary duty had occurred. The agent's liability hinges on the outcome of the insurer insolvency.

Liquidity

Determining and abiding by the client's need for liquidity is a basic agent function. You need to practice reasonable care in the products you choose to be sure your client's liquidity is protected. This means that you are steering a client away from a deferred annuity with surrender charges ***through year nine*** because the client needs to have money available for her son's college expenses ***in three years***. In another case, **Campbell vs Valley State (1987)**, the agent was a manager of an agency owned by a bank. The director of the bank was known by the agent to be a millionaire. Agent obtained auto coverage for the client in the amount of \$100,000 per person and \$300,000 occurrence. A major accident occurred which exceeded the limits of the policy. The client sued for these additional damages. The original jury found that the agent had a duty to advise the client about his liability needs since a special relationship existed. The agent knew the client needs to protect his liquidity but chose a product that fell short.

Privacy

Respecting a client's right to privacy is paramount and being sensitive to proprietary client information is a preferred business conduct. It may seem obvious and oversimplified, but the information in the agent's file is extremely confidential and all efforts to make it secure should be practiced. Remember, ***agent files are accessible by an insurance company and / or a plaintiff's attorney***. Always check with your errors and omissions carrier before turning over any documents with client information.

Considerable discussion is made concerning the lack of privacy in client e-mail messages and correspondence. The problem is two-fold: You can unintentionally send a copy without saving it or send it to the wrong party -- E-mail users often hit the "enter" key which could send a message to a wrong party. Just as likely, you could "delete" something you do not want someone to know about your client and a plaintiff's attorney, with help from a programmer, could recover it from your computer.

The best approach to client information is to have guidelines for handling files and communications (including e-mail). It also goes without saying that since others have access to your files, it would be wise to NEVER make a written derogatory comment or reveal some personal information about a client. Either could be damaging to you and your client. Extremely sensitive information on your computer may need to be encrypted to protect it from being accidentally transmitted. Software that uses passwords is always recommended.

Policy Delivery

After all the work you put into a sale, it only makes sense for you to close the sale by promptly delivering the policy. The time between the application and delivery can cause the new policyholder to forget the reasons for and benefits of the purchase, and how the policy works. Prompt delivery of the policy or contract provides an opportunity to build upon your relationship with the client. It allows you to review the reasons for buying the policy, how it meets a real need and how it works, and to explain any changes in the policy if it is other than what was applied for.

Prompt delivery is also important because you may be subject to a “free look” period. During this period, a policyholder may change his mind and return the policy for a full refund of premium – no questions asked. The free-look period does not expire until specified number of days AFTER you deliver the policy. Commissions may be charged back for any policy returned during the free-look period.

If a policy cannot be delivered personally and has to be mailed, you should use “certified mail, return receipt requested” to document delivery. Some require a producer to obtain a policy delivery receipt.

Occasionally, a client may ask you to hold his policy. If you do agree to keep the policy at the client’s request, you should document your policy file with the client’s dated, written consent to your holding the policy.

Complaints and Claims

Quality customer service and customer satisfaction should be important to you. You must ***take all customer concerns very seriously and be sure that you and your insurer resolve them fairly and quickly.***

Insurance regulations define a complaint as a written communication expressing a grievance and require companies to record all complaints. Since it is essential that all complaints be properly recorded and resolved in a fair and expeditious manner upon receipt of a complaint, an agent should immediately forward a copy of any complaint to his insurer and E&O carrier.

All complaints, either received directly from customers or from departments of insurance on behalf of clients, must be recorded and responded to. An effective response requires a thorough investigation, a sound decision, and timely communication of the decision.

Many complaints from clients involve agent misconduct. If this occurs, it is important for you to respond promptly (with the blessing of your E&O carrier) with information and documentation to support your position. In this regard, it is very beneficial to maintain thorough client records, including the how and why you made the decision to recommend a specific product or company.

If the matter escalates into a suit, the most helpful advice is: ***Don’t try to settle a case yourself.*** It could void your E&O policy. Don’t make any promises to clients about resolving the matter or give them legal advice of any kind. Don’t ever try to cover-up mistakes – it mostly backfires. And, if your E&O carrier or insurer want to settle the matter it is usually best to agree. If you don’t, you could be liable for court judgements that exceed the settlement already proposed.



Personal Lines – Agent Blunders

One of the best schools in town is the experience of other agents. The purpose of this section is to study case examples where agents were held legally responsible or accountable to defend their actions. Knowing the mistakes of others could save you from making them yourself.

A few years ago, no one knew what market conduct meant. Today there are class action suits and negligence claims filed against insurers and agents alike amounting to millions of dollars for sales and legal conduct violations. Of course, agent conflict is nothing new. Our research into “blunders” found cases dating back to the early 1800's. What is different between cases of today and the ones that occurred years ago is the trend toward fiduciary responsibility. In essence, the courts are viewing agents as ***more than mere salesmen***.

Agent responsibility, in the past generation, has evolved from contractual compliance to ethical duty. Recent cases, for example, lean toward the precedent that agents, as insurance professionals, ***should have known*** something was wrong compared to years ago where agents were generally held liable for ***outright negligence*** in a matter. There ***is*** a world of difference between the two that is best explained by the ***legal precedent theory***. In a nutshell, this theory claims that because our legal system makes legal decisions based on precedents it is destined to constantly expand. Each decision in the chain sets the stage for the next step of expansion. This chain reaction is demonstrated in some recent court cases. In **Southwest vs Binsfield (1995)** the agent ***should have known*** that a specific coverage option was important to the business he insured. In **Brill vs Guardian Life (1995)** the agent ***breached his fiduciary duty*** by not using an optional conditional receipt. Clearly, the expansion of agent liability from decades-old “negligence” issues to these types of fiduciary duties is a trend.

In reviewing the following court cases, keep in mind that issues in the past that did NOT result in agent liability might indeed represent exposure today, mostly because of the legal precedent theory and the fact that courts and juries in more recent years show a willingness to sanction this expansion. Further, an agent who escaped liability in a conflict may not have escaped the huge cost of a trial or legal fees. A lot of agents fail to insure for this contingency and errors and omissions carriers can also refuse to cover the claim. Also, don't assume that a ***commercial*** court case has no application to you if you sell ***personal lines*** and visa versa. Many legal matters concerning duties are fully portable and transferable between classes of agent. Finally, be aware that some court decisions appear to “clear” the agent of wrongdoing. These decisions can result from issues extraneous to the case or a technicality

Aetna of the Midwest vs Rodriguez (1988)

Based on a conversation, an agent believed his client was seeking insurance on a conditional sales contract when, in fact, client had purchased a home secured by a mortgage. A claim resulted in lack of coverage and a lawsuit commenced. The courts determined that even though the client used words that could have been interpreted two ways the agent should have investigated the “real” coverage and not simply wrote the policy in a manner that was most legally advantageous to the insurance company.

Ahern vs Dillenback (1991)

In 1982, clients were visiting California and purchased an automobile policy which agent said would cover them on an up and coming trip to Europe. Client requested the best policy available” and agent assured client that she and her husband would receive full insurance

coverage with policy limits that would safely protect them. In 1984, the client was driving in France and was seriously injured in a hit-and-run accident with an unidentified and uninsured motorist. Claims by the client were denied since the following coverages were not in the policy: collision, medical payments and uninsured motorist. Client's lawsuit against the agent was not successful in this case because the courts felt that the general duty of reasonable care that an agent owes a client does not include the obligation to procure complete liability protection". Further, there was NO special relationship with client that held agent to a higher standard of care.

Bell vs O'Leary (1984)

Agent took an application for flood insurance but failed to notify client that his mobile home was located in unincorporated areas that were ineligible under the National Flood Insurance Plan. A loss occurred and agent was sued. The agent tried to assert the client could NOT have purchased flood insurance from anyone and he could have known coverage was not available because the Code of Federal Regulations regarding flood coverage availability was public information. The courts did not agree rendering that agent has superior knowledge and failure to notify clients that coverage was unavailable takes precedence over the fact that coverage was not available from any source.

BSF Inc vs Cason (1985)

An agent met with a client and filled out an application for homeowner's coverage. Client supplied information that indicated he had previous claims and was canceled by another carrier. A loss resulted and the insurance company refused the claim upon learning the true experience of client which was not disclosed on application filled out by agent. The courts determined that the agent was liable for acting outside his scope of authority by failing to record the client's claim and cancellation experience.

Boothe vs American Assurance (1976)

Client requested flood insurance coverage. Agent accepted a completed application and advance premium payment and led client to believe he was protected. The application was not sent and the insurance company refused coverage which client discovered when he submitted a claim for a flood loss. Agent was sued and found liable for neglecting to follow up on application and notify clients that they did not have coverage.

Campbell vs Valley State Agency (1987)

The client was a founder and director of a bank that owned and operated an insurance agency. The agent was also manager of the agency and knew that client was a millionaire. Agent obtained automobile coverage for client in the amount of \$100,000 per person and \$300,000 per occurrence. A major accident occurred which exceed the limits of the policy. The client sued agent for these additional damages. Although the case was scheduled for a new trial the original court found that a jury could have found the agent had a duty to advise the client about his liability coverage needs due to the special relationship that existed. Thus, the agent was potentially liable for the damages that exceeded policy limits.

Commissioner vs Grossman (1986)

Agent received an initial premium from client three months prior to fire that damaged client's home. Upon learning of the fire, agent scurried to obtain insurance he had neglected to purchase by altering his postage meter to give the appearance that he processed the

application two days prior to the fire. The insurance company received the application three days after the fire and refused the claim. The insurance commissioner pursued and won a conviction for fraud.

Cuismano vs St Paul Fire (1981)

Client clearly informed agent of the need for a specific coverage. The face page of the policy suggested that the client was furnished this coverage. A claim for loss, however, proved otherwise. The court held that the ambiguity of the policy did not require the client to verify coverage, especially in light of agent's assurance. Negligence here resulted in agent liability.

Durham vs McFarland Et Al (1988)

Agent handled most of client's insurance needs for approximately 15 years. Client purchased a new residence boathouse and met agent to discuss transferring the coverages on the old residence to the new boathouse. Ten months after the meeting the boathouse was damaged by a flood and the client submitted a claim. The insurance company did not list the flood peril and denied coverage. The agent was sued and the courts agreed that he had a duty to advise the client about flood insurance on the new residence, especially since it was a covered event for the old residence.

Employers Fire Insurance vs Speed (1961)

Agent agreed to obtain fire and extended coverage on client's soon-to-be constructed building. Client was led to believe he was covered but agent failed to do so. Client relied on agent but did not request the name of agent's principal (insurance company). Upon a claim for loss, the court ruled that there was no contract for insurance, even though the same client was already insured with six of the eight companies carried by agent on other projects. The agent incurred big legal fees and lost a good client. (Compare this result to Julien vs Spring Lake Agency - 1969).

Evanston Insurance vs Fred A. Tucker (1989)

The client paid agent almost \$75,000 for fishing vessel coverage. Agent requested coverage and sent premiums to intermediary broker who failed to obtain coverage and refused to return premium money. Agent's E&O carrier refused to pay claim since his E&O policy excluded any claim for premiums lost. Agent was found liable.

Flattery vs Gregory (1986)

Agent had previous business with client where he purchased "optional" coverage on his automobile. A new policy was purchased, but nothing was said about adding the optional coverage. Naturally, the client's loss involved optional coverage damages which were not included in the new policy. The court ruled that the agent's "promise" to procure optional coverage was implied from the earlier transaction. He was responsible to provide this coverage at his own expense.

Foster vs American Deposit Insurance (1983)

Agent sent client a letter indicating that client's automobile policy was paid for 90 days. A loss occurred 89 days from client letter and client submitted his claim. The insurance company denied coverage since 90-day coverage had expired days earlier. Agent was responsible for damages due to his error in calculating coverage.

Free vs Republic Insurance(1992)

Since 1979 agent provided client homeowner's coverage and assured same that the policy limits were sufficient to rebuild his home. In 1989 client's home was destroyed by fire and insurance proceeds were found to be less than needed to rebuild. The client brought an action against agent and insurance company in that they failed to inform him of the inadequate limits of coverage despite years of assurance. The courts held that the agent was under NO general duty of care to advise client about the sufficiency of coverage to replace his home, but once he elected to respond to his inquiries he acquired special duty to use reasonable care. Due to some extraneous issues a new trial was to set to establish liability.

Gabrielson vs Warnemunde (1988)

The particulars in this case are not as important as the result. It was found that an agent's duty to inform the client that he had appropriate coverage is greatest at the time of purchase. Agents do not generally have a duty to ferret out, at regular intervals, information which brings a client within provisions of a policy exclusion or waiver. Agents typically acquire this duty by their own admission (refer to Free vs Republic -1992 and Grace vs Interstate Life - 1996).

Glenn vs Leaman & Reynolds (1983)

An independent agent obtained coverage for client in the past and was asked to do so again. An application and advance premium payment was made and coverage obtained. Shortly thereafter the insurance company was declared insolvent and client's coverage was prematurely terminated. The courts in this case established that a fiduciary relationship existed between the agent and client and that he did NOT fulfill his obligation to inform client of the premature termination even though he mailed an unregistered letter to client's last known address. For the most part, the court was disturbed that this letter was sent more as a "courtesy" and not out of any course of action designed to notify client of the insolvency and the procedure to be followed in obtaining a refund of his unearned premium. Agent was liable for losses client incurred.

Great American Insurance vs York (1978)

Agent accepted an application from client's wife without client's knowledge. In addition, a business was operated on the residential property but agent failed to make a personal inspection to discover this. Shortly after submitting for coverage a fire destroyed the home but the insurance company refused the claim since insufficient information was obtained on the application. The agent was responsible for client's damages because he had failed to follow insurance company instructions to submit a completed application, including all signatures.

Gulf Insurance vs The Kolob Corporation (1968)

For various reasons, an insurance company decided to cancel all of an agent's business policies. The agent was asked to collect and send any remaining premiums and cancel policies. Because agent had a large volume of clients to cancel and find replacement coverage, this process was delayed. Cancellation for one client did not occur for six weeks, during which time a claim occurred. The major task before the court was determining what is "reasonable" time to cancel these policies. Despite evidence of the agent's tremendous workload and possible "contributory negligence" by the insurance company in not following up sooner, the insurance company was forced to pay the client and the agent was ultimately liable to the insurance company for not taking quicker action.

Honeycutt vs Kendall (1982)

Client requested automobile coverage by tendering an application and premium payment. Before policy was issued, the insurance company discovered an undisclosed traffic violation and asked for an additional premium payment. Client was not aware of this demand and the policy was shortly canceled. Client's loss claim was denied and the agent was sued. The courts determined that the agent had a duty to provide notice to the client that coverage was not available.

INCO Express vs Marketing Insurance (1984)

This case involved a non-admitted insurance company that eventually became insolvent. When the client incurred losses, the agent and the surplus line broker he used were initially found liable because the agent failed to investigate a low-rated carrier and disclose to client that they were a non-admitted company. On appeal, the surplus lines broker was determined to have ultimate responsibility.

Independent Life vs Peavy (1988)

The specifics of this case are not as important as the lesson. An agent attempted to cheat a client out of \$412 in policy benefits. The court was so enraged with this deception that it awarded the client punitive damages in the amount of \$250,000 -- that's 606 times the compensatory damages of \$412!

Johnson vs Illini Mutual Insurance (1958)

An insurance broker was requested to insure the client's home at a specific address. The agent "misdescribed" the house number and the building and contents were subsequently destroyed by fire. The insurance company refused to pay the claim and the courts ruled that the broker was liable to his principal (client) for failure to follow instructions.

Lazzara vs Howard Esser (1986)

Client requested \$1,000,000 automobile coverage. Agent purchased two policies: A primary with \$300,000 maximum and an extended policy covering claims in excess of \$250,000 up to \$1 million. The primary coverage was issued for split limits of \$100,000 per person and \$300,000 per occurrence, i.e., a \$150,000 gap. Upon a loss client sued agent for the gap in coverage. Client prevailed because agent "had a duty to act in good faith with reasonable care, skill and diligence".

Lewis vs Equity National Life (1994)

Client was injured in a car accident and had many heart-related treatments which the insurance company refused to pay after learning that client had a preexisting condition that was NOT disclosed on the original application. Client alleged that agent was the one who filled out the application and failed to list the condition even though it was disclosed to him. The courts awarded contract and punitive damages to client because agent misrepresented information disclosed to him.

MacGillivray vs W. Dana Bartlett (1982)

Agent obtained insurance on client's boat which was later stolen. Insurance company failed to pay claim since it was declared insolvent. Client also found out that this company was not licensed to do business in state. The courts determined that the agent's failure to apprise himself of the non-admitted status of insurance company was gross negligence.

Naijmias Realty vs Cohen (1985)

Client builder asked agent to obtain "replacement cost" coverage for his rental property. Agent instead procured "actual cash value" coverage. A fire to the building and requirements to meet updated building codes resulted in damages exceeding policy limits. Agent was sued for deficit and the courts awarded same to client due to agent's breach of duty to obtain the correct coverage as instructed.

R.H. Grover vs Flynn Insurance (1989)

Client requested a Certificate of Insurance from agent. Agent's new employee issued the certificate, however no coverage was ordered. A claim was presented and denied. The courts held the agent liable to client for his negligence in supervising his new employee.

Saunders vs Cariss (1990)

In 1986 client obtained an automobile policy from agent. The policy included uninsured motorist coverage with \$100,000 in limits. The policy was in effect in 1988 when client was seriously injured in an accident caused by an uninsured motorist. When client submitted his claim the insurance company produced "Reduction Agreements" consenting to reduce uninsured coverage down to \$25,000. The agreements purported to bear the signature of Client although he denied signing them. Client sued claiming that agent signed his name without authorization. The court held that the agent was liable where his intentional acts or failure to exercise reasonable care in obtaining or maintaining insurance resulted in damages to the client.

Seascope vs Associated Insurance (1984)

Agents held themselves out to be "professional insurance planners". They had served client for several years. Client came to them to get specific advice regarding "seawall insurance". Agents advised client that this type of insurance was NOT available to them. Later, a storm damaged client's seawall and clients learned that seawall insurance could have been purchased. Clients sued agent alleging that their relationship was such that agent owed a duty to exercise reasonable care in rendering advice on insurance matters. The courts agreed.

Small vs King (1996)

The specifics of this case are not as important as the result. Client requested "full coverage". In response, agent obtained additional coverage, but the wrong kind. Client losses were attributable to the insurance company who sued agent for reimbursement. The court in this case ruled that the agent's duty to provide correct coverage cannot be triggered by a client's request for "full coverage" because that request is not a specific inquiry about a specific type of coverage.

Smith vs National Flood Insurance Program (1986)

Agent filled out a flood insurance application dated March 31. As typical with this type of insurance, coverage only becomes effective the day after the application IF the payment and application are received within 10 days of application or if mailed "certified" within four days of application. Agent used regular mail and application was received April 11 (after the deadline). Client's claim for loss that occurred after application mailed was denied. Agent was sued and the courts determined that he was negligent for using regular mail rather than certified mail, the only sure method of fulfilling his duty under provisions of the coverage. Agent was liable for the flood damage of client's home and contents.

Sobotor vs Prudential Property & Casualty (1984)

Client requested the "best available" auto insurance package from agent. Coverage options for uninsured motorist were NOT discussed and this coverage was NOT included in the policy as issued. Subsequent client losses prompted a lawsuit. The courts sided with the client by determining that even though this was a single insurance transaction between agent and client, a fiduciary relationship existed because the agent held himself out to have special knowledge in insurance and client, who knew nothing about the technical aspects of insurance, placed his faith in agent. Also, by asking agent for the "best available" package client put agent on notice that he was relying on agent's expertise to obtain desired coverage.

Southland Lloyd's Insurance vs Tomborlain (1996)

Agent made application to insurance company to cover property he personally owned. The property was later destroyed by fire but the insurance company denied coverage based on misrepresentations by agent concerning the property's age, purchase price and condition. The court held that an agent's fiduciary duty to its principal (insurance company) is highest when agent writes his OWN contract insurance.

Southwest Auto Painting vs Binsfield (1995)

Client requested coverage for his auto painting business indicating his reliance on the advice and ability of agent to obtain appropriate coverage. At no time was employee dishonesty coverage mentioned and it was NOT included in the policy as issued. Later, one of client's employees embezzled over \$150,000 of company money. The insurance company refused the claim and agent was sued. Agent was found liable, contrary to previous court cases where agents, who had no special relationship with client, had no duty to advise or recommend a specific coverage. In this case, however, expert testimony helped the court determine that the agent was duty bound to advise client about the relevant types of coverage where this coverage is **widely available for this type of business at a relatively low cost.**

Speir Insurance Agency vs Lee (1981)

Agent agreed to bind comprehensive collision and liability coverage on client's vehicle. Insurance company canceled policy prior to date of collision but agent failed to obtain replacement coverage upon learning of the cancellation. The court felt that the agent acted in bad faith and committed fraud on the client. As such, punitive damages were authorized.

State Farm vs Gros (1991)

Client built a home on the side of a hill and carried a standard homeowners policy. The policy contained a common exclusion landslide damage. However, client alleged that agent told him

“if a landslide made contact with your home, you’re covered”. Three years later, client filed a landslide claim. Agent advised client he was NOT covered for landslide. Lack of notes in agent’s file to support earlier conversations with client forced court to hold that the policy was misrepresented when purchased. The insurance company was liable and bound by the agent’s action.

Stuart vs National Indemnity (1982)

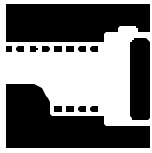
Client requested coverage and tendered initial premium. Agent represented that client had “full coverage” even though agent had NO binding authority. A loss occurred before application was approved but insurance company denied coverage. The court ruled that an agent who advises client that coverage is bound, with knowledge that the intended insurance company has not yet agreed to accept such coverage, **acts as the insurance company until coverage is accepted**. The agent was liable for client losses.

United Farm Mutual Insurance vs Cook (1984)

Agent and client had a long-standing relationship where the agent exercised broad discretion to serve client needs. Client explained a new project that he wanted agent to insure. Despite having sufficient information to know that he could NOT obtain this coverage, agent said nothing and did not procure coverage. The courts determined that agent was liable for losses of the client since he had the duty to exercise reasonable care to inform client he could not provide coverage.

Westrick vs State Farm (1982)

Client maintained insurance with agent since 1964. The agent’s office was run by a father and son team. Both shared an office but had different clients. Since they had no employees they would answer the phone for each other when one was out. In early 1977 client inquired about insuring a jeep-type vehicle to be used in his agricultural business. Agent son gave client impression that said business vehicle would automatically be insured for 30 days. Client did not purchase this vehicle. In late 1977 client **did** purchase a welding business for his son which included a six-wheel welding truck. The day client called the insurance office the father agent was alone. Client asked for son agent and then explained that he purchased the business with two vehicles for which he wanted coverage (client’s automobile coverage provided for 30 days of automatic coverage for any newly acquired auto if it replaced an auto already insured with company). Client said he offered the father agent serial numbers but the agent said his son would be in the next day. Client assumed he had coverage and that night the welding truck was involved in an accident. Father agent believed that the truck was NOT insured because client wanted to talk to son agent. Further, it was a commercial vehicle not covered by his policy. Client, however, assumed this type of vehicle was insurable based on his earlier conversation with son agent regarding the jeep-type vehicle (in court the son agent did not remember this conversation). The court originally found in favor of the agents but this was reversed on appeal because it felt that a jury would have ruled negligence on the part of agent. The case was recommended for retrial.



Beyond Insurance

The most important advice that experts give their clients concerning insurance is to ***buy insurance that really insures***. The meaning behind this advice is that insurance can fail to insure for many reasons. Likewise, in some cases, insurance is simply not available.

The purpose of this section is to explore how and why you need to help prepare your clients for these contingencies. This is a new area of planning that few agents practice. However, it can also be the most critical service you offer.

The Need to Look Beyond Insurance

Risk is a fact of life to be constantly analyzed and managed. Unfortunately, the time most people devote to this process is less than the time they spend planning a summer vacation. So, who assumes the role of unofficial “risk manager”; preserving worldly goods and family security? You guessed it . . . insurance agents. Like it or not, you are in the asset protection business. But, just how far can you expect your product (insurance policies) to go. Every agent knows that insurance has its limitations. There are times when clients are ***underinsured***; there are clients who ***cannot be fully insured***; and there are times when insurance simply ***fails to insure***. Add to this a bevy of carriers, who withdraw or are unwillingly forced from the marketplace, a few insolvencies here an there, and you know why a growing band of attorneys and financial advisers are starting to look ***beyond insurance***; supplementing insurance coverage with multiple legal strategies, i.e., ***asset protection planning***.

The next time you are assessing a client’s “real” need for coverage, consider the following possibilities; all of which point to the need for “back-up” protection:

- The need for a protection structure which can be used as a replacement to insurance when premiums rise beyond a client’s ability to pay.
- The need for a protection system that can supplement current insurance, covering gaps in protection like punitive damages or an underinsured health condition.
- The need for a protection structure that will become a back up for times when, for whatever reason, a lapse in insurance coverage occurs.
- The need for a protection structure as back-up when an insurer fails to pay or becomes insolvent
- When coordinated with estate planning, the need for a structure to protect inheritances and estates from frivolous claims and plaintiff attacks.
- The need for a structure to protect business and property owners from new and exotic environmental liability which may be excluded by their insurance or entirely unknown by present standards.

Few would argue that when clients are provided safe, appropriate and sufficient levels of coverage, insurance is the world’s most efficient asset protector . . . a first line of defense . . . a shock absorber taking the brunt of economic and legal catastrophe. Today, however, insurance by itself may not be the sole solution to protecting all assets because there are pressures at work, both legal and moral, that go beyond the resolution of good coverage.

Asset Protection Planning

Better Client Protection or Lost Insurance Sales

Some may think of asset protection as “doomsday planning”, but every agent who has spent time in the business has a file on cases where expected coverage was lost or reduced due to limits, exclusions, warranties, preexisting conditions or any one of the reasons presented above. Attorneys who routinely sue agents and insurance companies also have a file. But their cases are different. They feature smart and financially secure people who dutifully purchased insurance yet lost everything over a technicality or unforeseen claim beyond the scope of the policy.

Seeing problems like this day after day, it is no wonder that some in the legal profession may have a hard time advising a client to “insure up”. Rather, they are encouraging their clients to supplement basic insurance coverage with ***legal entity planning or, more simply put, asset protection.***

While it doesn't appear to be a watershed, a limited number of insurance sales will likely be lost to asset protection planning. Then again, there is cause to consider that ***both*** insurance and asset protection are closely linked in providing a higher level of client protection. Knowing this, it may serve the client's best interest for an agent to associate with a competent asset protection attorney and know when to refer.

Conventional Forms of Protection Are Losing Ground

The new school of thinking is that traditional methods are not working like they used to. The corporate veil is seemingly more pierce-able than ever. Further, the concerns with insurance coverage exist on three fronts: insolvency of the carrier, the willingness to continue coverage and exclusions such as punitive damages and gross negligence of associates.

Problems With Legal Entity Protection

Most asset protection programs involve the use of “holding entities” designed to isolate liability and thus contain exposure. Of course, good attorneys and financial advisors will admit that these measures are not foolproof. And, critics also point to volumes of law known as fraudulent conveyance which can void a transfer of property if it is done without adequate consideration and with intent to avoid creditors.

Fraudulent Transfers

An example is a situation where a person hastily transfers title of a property to another family member to avoid creditors. This is not the ideal form of protecting assets. In fact it is called the “poor man's asset protection”. Creditors are usually able to prove that a “fraudulent conveyance” occurred. Or, courts determine that the debtor failed to cut the strings by retaining benefits or control over the property. In either case, the creditor may proceed against the debtor and void the transfer of property.

For this method to have a chance, it must be used in the true context of “gifting” and be consistent with goals of the client (planning for college or an estate). The intent should be to have little control over the gifted asset.

Broadly speaking, a ***fraudulent conveyance is defined as*** a transfer of property without adequate consideration and with the intent that the transferee will hold the property for the

benefit of the transferor, returning it when requested, so as to defraud creditors who could otherwise seize the property in payment of their debts. If a transfer is found to be fraudulent, it can be made "null and void" by a court of law.

In essence, the law is not so naive that it will allow a person to avoid the payment of legal debts simply by making a "gift" of his property to another family member or a friend. ***Fraudulent conveyance laws protect present and future creditors against transfers of property made with the intent to hinder, delay or defraud them.***

Creditor Access

Besides suspicious transfers, creditors have many opportunities to seize or access property and/or income based on the client's existing holding entity. Following is a short list of their rights by the type of ownership entity:

Joint Tenancy

There are many ways that creditors can reach a joint tenancy.

In the case of a dwelling, a creditor attempting to reach the interest of a joint tenant can cause ONLY the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment.

For most other property, the general rule is that **the creditor can acquire the interest of the debtor.** However, if the debtor is a joint tenant, the creditor forces an end to the joint tenancy and he or she becomes tenants in common with the remaining joint owners.

In essence, holding title as joint tenants carries little creditor protection since creditors can attach a jointly held interest and petition the court to "partition" or divide up the property. If it is property that cannot be divided, creditors can order it sold to receive the debtors share.

Tenancy in Common

In the case of a dwelling, a creditor attempting to reach the interest of a tenant in common can cause ONLY the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment.

For most other property, the general rule is that **the creditor can acquire the interest of the debtor.** And as a tenant in common, the creditor can force a sale of the common asset. For this reason, it is important to select co-tenants who appear to be relatively free from financial problems.

Community Property

The general rule is that community property is liable for debts of either spouse during the course of the marriage.

Obligations incurred prior to the marriage or after a separation or divorce are consistently treated as the separate obligation of the spouse incurring the debt.

Whether a spouse contracts for individual benefit or for the benefit of the community property is irrelevant. A creditor's ability to reach marital property is not effected by the purpose for which a spouse contracts.

If a debt that is a joint obligation of a husband and wife, the community property together with the separate property of each spouse will be liable for the debt.

A spouse who pays a single payment on behalf of the other spouse is said to have granted "apparent authority" to the other spouse to contract joint debts. The spouse who paid the bill may be held liable for subsequent debts incurred by the other spouse. A spouse who wishes to avoid such joint liability should make clear to the other spouse and any creditors that said spouse incurred this debt and acted without his or her authority or consent, or that the payment being made on behalf of the other spouse does not constitute authority for the other spouse to make future contracts that might obligate the paying spouse.

Partnerships

In general, the assets of a partnership are not available to a creditor of a partner on a personal debt of the partner. In practical terms, a creditor must only look to the debtor's share of partnership proceeds AFTER the partnership has been dissolved and debts of the partnership paid.

Alternatively, the creditor can look to attach the debtors profits and surplus from the partnership. This is called a **charging order**. It does NOT make the creditor a partner. The charging order is intended to protect partners of a partnership that having nothing to do with the claims of creditors of the individual partner.

A charging order is obtained by the creditor by making application to a court which then charges the interest of the debtor partner with payment of the unsatisfied amount of the judgment. The court may then or later appoint a receiver of the partner's share of the profits, and of any other money due or to be due him from the partnership. If a charging order fails to be an available remedy, the courts have allowed the foreclosure sale of a partner's interest. At a foreclosure sale, only the partner's interest, not specific assets of the partnership, are sold. It is unlikely, however, that a partnership interest will bring a high price from third parties. If the creditor becomes the purchaser, and until the dissolution of the partnership occurs, the creditor will still be entitled to only receive the partner's profits.

Corporations

In general, creditors of the corporation can proceed only against the assets of the corporation and not ordinarily against the stockholders, officers, directors, agents or employees of the corporation.

Exceptions to the above rule include where parties in the corporation have personally guaranteed some form of corporate obligation; where employees of the corporation have been negligent or have committed a wrongful act; where officers have not paid withholding taxes or similar taxes; where specific fiduciary violations can be determined.

Legal advisors are split on the issue of creditor rights against an incorporated sole practitioner. Some assess the "key person" rule in support of complete liability. Others argue that many lawsuits are derailed simply by the existence of a corporation.

In many instances, the obstacles that must be hurdled to gain access to a debtors partnership interest help shield a partner from all but the most determined creditors.

Limited Liability Companies (LLC)

In an LLC, no one has personal liability for the debts of the partnership. All members of the LLC are liable to creditors ONLY to the extent of their investment in the company

Trusts

In general, unless there are restrictive provisions in the trust spendthrift verbiage, a beneficiary's interest may be attached by his creditors or the beneficiary may sell his interest.

Creditors have also gained access to trust assets when the following conditions exist:

- The trust was funded as a result of a fraudulent conveyance
- The settlor of the trust retained too much control over trust assets
- The settlor retained too much of an interest in the trust
- The trust is illusory (trust is non-existent or a sham)

Exemption Planning

Exemption planning takes advantage of known "safety nets" already built into the law to help place certain kinds of assets beyond the reach of creditors. Most exemptions must be filed or claimed. If not, they are considered waived.

Civil Codes

Certain civil code sections offer exemption protection from creditors. They might include payments made for child support, spousal support and family support.

The Homestead

Homesteads are claimed on the principal dwelling of the debtor or the debtor's spouse. A declaration of homestead can only be made for a residence that is real property, not a houseboat or mobile home. This exemption may also be carried over where the proceeds from a formerly homesteaded dwelling are used to purchase a new dwelling within six months. The amount of a homestead exemption is a minimum of \$50,000. This can be increased to \$75,000 for a family dwelling and up to \$100,000 for certain elderly, disabled or low income dwellers. An owner or his spouse may declare and record a homestead.

Personal Property

There are many articles of a personal and business nature that are exempt from creditors. A partial list includes:

Personal Possessions Items such as health aids, jewelry (\$2,500), household furnishings (appliances, clothing and other items determined to be "ordinarily and reasonably necessary"), cemetery plots and motor vehicles (\$1,200).

Business Property Tools, equipment and vehicles necessary to earn a living are exempt up to \$5,000 (\$10,000 for husband and wife).

Personal Injury or Wrongful Death Damage Awards

Most are exempt to the extent they are needed to support the debtor and his family.

Bankruptcy

Filing bankruptcy is another method of exempting assets from creditors when necessary. It is important to note that there are federal AND state bankruptcy codes. A federal filing alone may NOT exempt debtors from state creditors.

Well known types of bankruptcy filings include:

Chapter 13 allows an individual under court supervision and protection to develop and fulfill a plan to pay his or her debts in whole or in part over a three year period, but it can last another two years. Chapter 11 is a version of Chapter 13 for businesses. Chapter 7 is a complete discharge of debts. Assets are liquidated to satisfy creditor claims.

Miscellaneous Exemptions

Paid earnings, Veteran's benefits, unemployment benefits, workers' compensation payments and college financial aid are exempt.

Offshore Protection

The most aggressive protection strategies involve the use of foreign trusts, offshore corporations and offshore banking.

Certain foreign jurisdictions do not recognize the judgments of US Courts. To reach assets held offshore it may be necessary for the creditor to retry the claim in the foreign jurisdiction. This would require hiring local attorneys and have witnesses, exhibits and other evidence be presented in the foreign court. The costs associated with such an action may deter a creditor from pursuing the debtor further.

One method of obtaining this protection is through the use of a **foreign trust**. Typically, the trust is located in a jurisdiction with laws favorable to judgment debtors. This means that a very short statute of limitations for fraudulent conveyance and a very high burden of proof for creditors to overcome. A duress clause is added to the trust which makes the trust irrevocable in case of a lawsuit or threatened asset seizure. In the event that a creditor attempts to have the foreign court assert jurisdiction over the trust, a clause in the trust agreement provides the power to move the trust to a new jurisdiction.

Additional protection can be obtained by creating an **offshore corporation**. This corporation would achieve greater confidentiality and protection through the use of nominee officers, nominee directors and bearer shares. The corporation would hold title to bank accounts, brokerage accounts and other investments. The bearer shares would be controlled by the offshore trust. The offshore corporation would typically be formed in a jurisdiction other than the location of the foreign trust.

Offshore bank accounts are another method of using offshore protection. Accounts are typically opened in a country with strict bank secrecy laws and with modern communications and financial facilities for quick transferability. Many of these accounts can be linked to time deposits, debit card services and even financially secure mutual funds and other securities.

Despite all the advantages that offshore protection appears to offer, it is not cheap. Only the most sophisticated and wealthy can justify these strategies. Properly implemented, however, an offshore structure can result in the most comprehensive and effective asset protection available.

Multi-Entity Protection

Asset protection professionals have discovered that, like insurance, there are many approaches to legally solving a client's exposure. Offshore trusts, the subject of the last section is one option that can represent an extremely strong defense. For most, however, more affordable and manageable stateside techniques, using a multi-entity approach, are gaining favor. The multi-entity planner's arsenal may consist of a combination of two, three or four of the entity methods to achieve added wealth protection in conjunction with and beyond insurance.

A coordinated approach can have, as a goal and outcome, many advantages:

- The preservation of assets from liability claims
- The lowering of the taxable value of an estate
- Reduction of current income tax liability
- Facilitate charitable gifting while keeping a legacy intact

Following are the entity structures involved:

The Limited Liability Company

The Limited Liability Company (LLC) is a hybrid business entity which has similar characteristics to both a Corporation and a Limited Partnership. The LLC is formed by at least two partners which can be any combination of one or more individuals and/or one or more legal entities. An LLC is structured much like a Limited Partnership in that the Managing Member controls the financial organization of the company much like the General Partner of a Limited Partnership. The Members are the silent business partners who have no control over the management of financial affairs of the company but have a right to distributions (on an annual or other basis) of any income or loss of the business.

The LLC has been an available business entity in the State of California since September, 1994 and is much in demand and is thought to be the most advantageous way to structure and operate a business in America today.

From an asset protection standpoint, the LLC is the recommended way to operate a business (Note: Businesses requiring professional licenses cannot use LLC's, but can use a related statute called a Limited Liability Partnership, (LLP). The reason for this is that you, as the business owner, will not be personally liable for any of the debts or obligations of your business. Therefore, a catastrophic lawsuit or IRS tax lien will not necessarily expose any of your personal assets to the liabilities of the business.

Corporations

The most traditional way to operate a business in America is to structure your business as a Corporation. Essentially, the Corporation is a business entity which is formed by filing Articles of Incorporation with the State in which your business is operating. The Corporation is formed by the Incorporator who files your Articles of Incorporation. Thereafter, an original Shareholder Meeting is held and a Board of Directors is selected. Thereafter, the Board of Directors selects the Officers who will actually operate the day-to-day operations of the company. In California, for example, one person may be the sole Shareholder, sole Director and sole Officer of the company.

The downfall of the corporate format in some states is that the courts have indicated that if it is inequitable for the business creditor, they will not allow the corporate “veil” to protect your business or personal assets for your creditors. In essence, then, if your Corporation is sued or has an IRS problem, not only are all of your business assets completely exposed to the business liability, but your personal assets could also be completely exposed through the business liability.

The Family Limited Partnership

Asset protection planners say that the most preferred way to own personal after-tax assets is through a Family Limited Partnership (FLP). The FLP is a partnership format which requires at least two partners, like the LLC. The FLP generally will own all personal assets such as the family residence, stocks and bonds, mutual funds and other types of investments.

The general purpose of the FLP is to protect your personal assets from creditors. The FLP operates by virtue of the Uniform Limited Partnership Act which states that no creditor of yours can pierce your FLP and obtain assets held by your FLP. The only remedy that a creditor of the FLP has is to either receive an assignment or foreclose upon the individual/debtors Limited Partnership share utilizing a court procedure known as a “charging order”. The charging order entitles the creditor to become an assignee of the Limited Partnership share held by the debtor/partner. However, the great benefit of the Limited Partnership is that the General Partner (the client) does not have to make any distributions of income or other assets to any Limited Partner(s) through the course of the year. In spite of the fact that the General Partner never has to make distributions, the Limited Partners are responsible for paying all the taxes of the partnership. Therefore, if a creditor obtains a charging order or forecloses upon a Limited Partnership interest, that creditor will have to pay their proportionate share of the taxes that they have foreclosed upon or have received via a charging order. In view of this unique capability, the FLP is the best asset protection tool that can be utilized to protect your assets.

An additional benefit of the FLP is that from an estate tax perspective, the IRS will allow discounts of between 15%-40% of the value of assets held in the FLP. This is the equivalent to reducing your estate tax exposure by that percentage upon your death.

One of the most frequent questions about establishing family limited partnerships is how to unwind them. There are four basic ways to get assets out of the Family Limited Partnership:

- First, you may make pro-rata distributions from your Family Limited Partnership to the partners. Distributions will flow from the assets of the Family Limited Partnership to you or to your Revocable Living Trust, which would be recommended.
- Second, your Family Limited Partnership may pay a management fee to your Corporation. The amount of the management fee is determined by you and the terms of this fee can be very flexible. Income from that fee can be used to pay a variety of corporate expenses such as salaries, employee benefits, retirement plans, etc.
- Third, your Family Limited Partnership can loan money to you, your spouse, or other family members. Repayment of the loan is effectively repayment to yourself.
- Fourth, the Family Limited Partnership is totally revocable by you, your fellow shareholders and Limited Partners at any time. In the unlikely event that you would ever need to dismantle and revoke the Family Limited Partnership, the Corporation or the Trust, it simply takes unanimous vote by you and your spouse to do so. If this happens, title of your assets can be transferred back to your direct ownership without penalties or tax consequences.

The Revocable Living Trust

One of the most underrated legal documents which should be prepared for almost every family or individual is the Revocable Living Trust. Most people are not aware of the fact that if they have only a Will, or if they have no planning documents in place, that upon their death the probate court obtains jurisdiction of all their assets. Therefore, upon your death, your heirs would have to hire an attorney and file a petition in probate court to transfer your assets if you do not have a trust. The major problem with the probate process is that it takes anywhere from twelve (12) months to twenty-four (24) months to probate even a \$200,000 estate. In addition, there are probate fees which can range anywhere from 3% - 10% of the gross value of your estate. Accordingly, your heirs may end up paying hundreds of thousands of dollars to acquire title to assets which are legally theirs to begin with!

In view of the above, the implementation of a Revocable Living Trust is an essential to any estate protection plan.

Implementing a Multi-Entity Asset Protection Plan

Implementation of an Advanced Tax Planning and Asset Protection Program involves the transferring of title of assets to various entities which include: Family Limited Partnerships, Business Limited Partnerships, Corporations and certain types of Trusts as well as Limited Liability Companies. The only limitations to the asset protection plan espoused by asset protection professionals is that the person implementing the plan must be financially solvent in accordance with general accepted accounting principles both before and after implementation, **and the purpose of the transfer must not be to hinder, delay or defraud creditors.**

Your net worth after implementing this program will remain substantially the same. The percentage of ownership in the Limited Partnership will not change the total amount of your net worth despite the fact that you now do not own any assets directly in your own name. However, you still control them through the connection of your Family Limited Partnership and your Revocable Living Trust.

Maintaining Control of a Multi-Entity Program

To maintain effective lifetime control over the any multi-entity program, you, your family members and other shareholders enter into carefully drafted agreements. These agreements include a Family Limited Partnership as well as various other contracts which bind all members and entities to vote for you as the person in charge. With respect to the Limited Partnership Agreement, since you act as General Partner, you control each and every movement of cash and other assets in and out of the Limited Partnership. You have total lifetime control over all of your assets utilizing these entities which cannot be disrupted even by death. As a result, the plan works much more favorably than the implementation of just one Trust Agreement or just one Corporation.

Is A Multi-Entity Asset Protection Plan Right For Your Client?

Do they want to reduce the amount of income taxes they are paying?

Do they want to leave the majority of taxable estate to your family rather than to the IRS?

Do they want your assets to be preserved from expanding liability judgments?

Do they want to make a charitable gift while keeping assets intact?

If they answered "yes" to any of these questions you should consult with a multi-entity planner.

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