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PART I: AGENT ACCOUNTABILITY

Why is a course on ethics important? Yes, the State of California mandates it, but perhaps you might take a keener interest if you knew how you could be effected when a transaction goes bad or client conflict arise. The fact is, you **are** very accountable and probably very reachable for violating a number of state codes dealing with familiar, and not so familiar, issues such as money laundering, consumer protection, credit scoring, fair trade practices, fair claims practices, fair underwriting practices, fair sales practices, fraud awareness, fiduciary duties, product suitability and compliance. You might better relate to the broader meaning of these terms as market conduct and ethics.

A few years ago, no one knew what **market conduct** meant in the insurance industry. **Ethical violations** were something bad that happened . . . usually to the other guy . . . when he got caught doing what everybody else was doing anyway. And, the consequence was typically a slap on the wrist or a license suspension for a few months.

Today, however, the stakes are higher. There are class action suits and negligence claims filed against insurers and agents alike amounting to millions of dollars for a variety of legal conduct and ethical violations.

Of course, lawsuits involving agents is nothing new. You can find court cases dating back to the early 1800's. What is different nowadays is the trend toward fiduciary responsibility. In essence, the courts and clients are viewing agents as **more than mere salesmen**. Recent cases, for example, lean toward the legal theory that agents, as insurance professionals, **should have known** something was wrong compared to years ago where agent liability was generally limited to issues of **outright negligence**. Back then you had to do something really wrong like forgetting to submit an application or back-dating a policy to file a claim to land yourself in court.

Consider two examples: In Southwest v Binsfield (1995), the agent was sued because he **should have known** that a specific coverage option was important to the business he insured. In Brill v Guardian Life (1995) the agent **breached his fiduciary duty** by not using an **optional** conditional receipt. Would you consider these to be breaches of ethical duty or malpractice? In today's litigious society they are nearly one and the same.

What is happening is an expansion of a decision by some judge 30 or 40 years ago. Dozens of cases have twisted and distorted the original intent of the law to the point where the level of agent duty has notched higher and higher. This is known as the **legal precedent theory**. In a nutshell, 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 and attorneys get better at convincing juries that agents should be held more accountable.

Court Cases

Agent accountability can come with a hefty price tag. Consider the following court cases where the actual dollar losses incurred by client victims was extremely low compared to the **high punitive damages** levied against agents and their insurers:

| | | |
|-------------------------------|-----------------------|-------------------------------|
| <i>State Farm v Grimes</i> | \$1,900 Actual losses | \$1.25 Million Punitive Award |
| <i>Independent v Peavy</i> | \$412 Actual losses | \$250,000 Punitive damages |
| <i>National Life v Miller</i> | \$258 Actual losses | \$350,000 Punitive damages |

As you read these amounts you may be thinking that the damages were high because insurance companies have **deep pockets**. They can afford to pay these sums of money, which is why juries awarded them. That's true, but, you must also keep in mind that virtually every agency agreement in existence, including the one you signed, has some kind of **indemnification clause** or wording that entitles the insurer to demand reimbursement from you, the agent, for malpractice, negligence or action leading to a jury award. In other words, if you have a contributing exposure to a problem that caused the insurer to pay-out big bucks, you probably have the same exposure when the **insurer** comes after you personally!

Courts make decisions about your behavior based on past court cases. So, as you read through this course and see an old court case, don't be fooled into thinking it can't apply to you. In Daniel v. Brickman (1998), for example, a court made a decision that effected an insurance agent based on a trial decision made in 1917!

Also, don't assume that a **casualty** court case has no application to you if you sell **life insurance** and vica versa. In fact, in National v. Valley Forge Life (2002), the actions of a **real estate agent** were analyzed in a decision against an **insurance agent**! So, many legal matters concerning duties or negligence are fully portable and transferable between classes of agent.

You may also read about cases where the agent "won" the case. Well, don't forget, he may have escaped the huge cost of a trial or punitive damages, but attorney fees alone could amount to the same you might pay for your kid's entire college education.

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. But, there is always the possibility of an *appeal*. In fact, many of the cases we researched were appeal cases that initially dismissed the agent of any wrongdoing. A different judge and jury can reverse these decisions and find you liable even if you prevailed at the original trial.

PART II:

MARKET CONDUCT & ETHICS

Less-than-honest selling is nothing new: ***Caveat Emptor*** (*buyer beware*) is said to have appeared on buildings in ancient Rome. But in the insurance business, it is the magnitude of damage that heightens the dishonesty. An unsuspecting client who buys the wrong retirement plan or building coverage is hurt a lot more than someone who buys a fake Rolex for \$20 on the street corner. This is why agents need to understand market conduct. Market conduct is the behavior you adhere to because the State says you must. Laws and codes range from consumer protection issues to fair trade to product suitability. ***Ethical conduct***, on the other hand, is a higher level of responsibility you ***choose to uphold*** in order to do a better job for your client. If you need more reasons why you should be an ethical agent, 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.*
- Ethical 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.*
- Ethical conduct problems erode the public trust and *that can cut into your sales.*
- Ethical conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

Since we are already on the topic, let's talk more about ethical selling and integrity, followed by the market conduct issues of choosing product, choosing Companies and presentations of quotes and illustrations.

ETHICS

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 ***Selling With Integrity, Principled Persuasion*** or ***Selling With***

Honor, The Ethical Challenge, Leading Quietly and more. 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.

Possessing a moral code is not all that is needed to set a professional apart from a salesperson. However, maintaining a Code of Ethics can inspire us to do better — 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. It means more than being silent when something needs to be said, because saying nothing can be the same as a lie. Take the case of Bell v. 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. In Grace v. 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. We summarized many of these in the box on the next page titled simply . . . ***An Agent's Code of Ethics***

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 v. 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.

AN AGENT CODE OF ETHICS

In all my professional relationships, I pledge myself to the following rules of ethical conduct:

- I will make every conscious effort to help my clients in a manner in which I would want to be helped myself.
- I will maintain the highest standards of professional competence and integrity and give the best possible advice to clients.
- I will offer advice only in the areas I have competence and within the scope of my licensing.
- In a conflict of interest situation, the interest of the client shall be paramount. I will always place the interest of clients above my own.
- I will take responsibility for knowledge of the various laws and regulations affecting my services.
- When approaching prospective clients, I will immediately identify myself (verbally or in writing) as an insurance agent / company and disclose the product I am selling.
- I will avoid sensational, exaggerated and unwarranted statements. My proposals and quotes will be clear so clients may know exactly what is being offered and the extent of their commitment they are considering.
- I will make full and adequate disclosure of all facts necessary to enable clients to make informed decisions.
- I will constantly improve my professional knowledge, skills and competence.
- I will be truthful about client testimonials and endorsements.
- I will hold all business and personal information pertaining to my clients in the strictest confidence.
- I will maintain a professional level of conduct in association and when referring to peers and others in my industry. And I will be fair in any product or company comparisons.
- I will conduct my business in a way that my example might help raise the professional standards of insurance agents everywhere.
- I will cooperate with others whose services are constructively related to meeting the needs of my clients.

How can agents develop a sense for long-term ethics? The best way is to fully understand what ethics is and the many levels it plays in your career. Following are some special areas of interest you should know about ethics:

Ethics Defined

Just what is ethics? A simplified definition of ethics is a **set of values** that constantly guides our values. These values are typically **aligned** with what society considers correct and positive behavior within legal boundaries. Ethics is also the **balancing** of an individual's good with the good of the whole. Let's say you develop a seminar series on "asset protection". At the event, you have a person pass around a clipboard asking people if they would like to be informed of future seminars. The real purpose of this exercise, however, is to create a mailing list to market insurance products. Smart marketing? Or, breach of ethics? Are you really concerned with your clients education (the whole) or only what you will get out of their business (the one)?

Balancing the good of the one with the good of the whole is not as easy any more. The whole that we have to consider is everybody, not just a competing agent down the street or in the next town. Survival is important, but not at any cost. True survival requires long-term, successful relationships with customers and companies, as well a co-workers and competitors. When people do not understand their role in the "whole" and are completely self and survival oriented, it throws the ethical system we once knew out of whack.

How can you stay on track? Most important is that you know your personal core values and the values that your company or agency stands for and then live and work congruently and consistently with those values. The people will know you as a person of integrity. And, with integrity comes trust.

The authentically ethical person in our seminar example would have simply disclosed the purpose of the clipboard or simply buy a mailing list from someone else. Respect for privacy would be honored and remembered.

Shades of Grey

One of the problems with ethics today is that we have so many different mores or values that guide our society. The values that guide each individual and/or company can vary tremendously, therefore an individual or company may be **ethical** according to their values and not to yours or the definition above. Several major shifts in right or wrong standards means that we are faced with more and more gray areas in our personal and professional lives. The shifts are occurring at such a pace that they may even hinder our ability to cope and process the changes.

Take the example of two agents who met with numerous company officials at Universal Manufacturing Company ("Universal") for the purpose of securing permission to offer interested Universal employees a "unique," "local" product. The agents explained that purchasers of the product would receive allegedly **better coverage** than that provided by their current insurer which issued the policies then-held by many employees.

More specifically, the agents explained that what they were offering was not an ordinary life insurance policy; rather, it was a **supplemental retirement program with a death benefit** and an "immediate cash benefit plan" containing a \$ 1,000 "check" which, in the event of an insured's death, could be cashed immediately to pay for such burdensome expenses as funeral arrangements. Of critical significance, the agents assured that employees who decide

to enroll in this "retirement program": (1) could allow their current policies to lapse, and (2) would be covered (insured) "immediately" and unconditionally upon completing an application and "upon signing . . . the[ir] payroll deduction card."

In essence, the agents guaranteed all-important **risk aversion** and **peace of mind**. This was critical to those who were currently insured and were concerned about being without coverage once they allowed their policies to lapse. The so-called \$ 1,000 "check" was not actually a check which can be taken to a bank and cashed. The only purpose it seems to serve is as a misleading gimmick to promote sales of the policies.

Clearly this is a **shade of grey** bordering legal issues like misrepresentation and fraud. The practice, **unfortunately**, is widespread.

Moral and Market Values

The American economy depends on ethical standards upheld by responsible business leaders. Unfortunately, this unwritten rule was violated in recent ethics scandals occurring in many corporate boardrooms. Respected companies lost credibility and innocent investors lost millions in the late 1990's and early 2000's. Cheating became rampant because it was the norm. It was no longer seen as wrong. In fact, at the peak of the problem, much of our economy resembled a giant pyramid scheme, taking in money from new suckers to pay those who invested earlier. A so-called **bubble economy** developed where businessmen willing to gamble with other people's money were rewarded handsomely. Stock prices were rising so fast that if you cut corners to meet projected numbers, you probably thought you were doing your shareholders a favor. And, there was always new money pouring in to make up the difference.

The insurance industry is not without its own horror stories. Take the case of Joseph and Annette Cooper. They purchased a "vanishing premium" life insurance policy insuring the lives of himself and his wife Annette Cooper.

Agents Steinhardt and Fish, whom Cooper had known for many years, and considered to be trustworthy friends, told Cooper that they were **highly skilled insurance experts** who understood complex insurance projects, and encouraged him **to rely on their expertise and prior relationship of trust in choosing a policy**. Steinhardt and Fish recommended a \$ 1 million Berkshire "disappearing premium" policy, and told Cooper he would have to pay the annual \$ 9,000 premium for nine years. "Neither Steinhardt nor Fish showed him a 'Supplemental Footnote Page' or anything else that indicated the disappear-year was not guaranteed." To the contrary, they specifically told him that he would **not have to pay any premiums beyond the illustrated disappear-year**.

Even though Cooper thought it was **too good to be true**, he decided to buy two policies, one for the Trust, with a \$1.5 million death benefit, and a second, with a \$1 million death benefit for the Associated to endow a charitable fund.

About six years later, the Coopers learned for the first time that they would have to pay premiums for many years longer than the insurance agents originally represented. Fish disclosed this to Cooper during presentation of a "Life Insurance Policy Reprojection" as part of a meeting that he scheduled to sell them additional financial products.

The Coopers asserted that the **assumptions** underlying Berkshire's illustrations of the premiums that the Coopers would have to pay were inconsistent with Berkshire's own internal forecasts and estimates, and were based on abnormally high dividends that, to the

defendants' knowledge, Berkshire could not sustain. If the illustration had been based on Berkshire's real investment earnings rate, the Coopers claim, it would have shown the "disappear year" to be **later than** the ten years represented to Cooper.

An "expert in the field of life insurance and actuarial science was brought in to testify to this conclusion. His opinion was that the ten year premium illustration was **materially misleading** at the time it was used to sell the policy to the Coopers because, contrary to Berkshire's claim, the illustration **did not accurately reflect current company experience**. He also stated that the agents should have known that the **disappear date** portrayed in its sales illustrations were **false** and that the actual "disappear date" would be later. . . . Based on Berkshire's Net Investment Yield during the five years before the Coopers purchased their policies (i.e., 1985-89). In fact, it was steadily declining. Thus, it was not realistically possible for Berkshire to continue paying dividends as represented in the illustrations while increasing their book of business. In short, Berkshire and the agents knew or should have known in 1990 that the Coopers would have to pay more premiums than illustrated.

The court agreed that a reasonable jury could find that the illustration constituted a materially misleading and inaccurate representation regarding the prospect of a ten year "disappear date" for the Coopers, and that the Coopers **reasonably relied** on that misleading illustration in deciding to purchase the Berkshire policy.

In insurance as well as the corporate world, people who rely on your word can be sucked in during times of market sensitivity. When interest rates are crashing down, for example, people will be intently interested in your interest rate programs. Some agents could take advantage of this enthusiasm. What about hard markets where a certain sector of the industry refuse to insure. Insurers often play the game by offering higher commissions on the less attractive programs. The hope is that it does not get out of hand. During the bubble period, for instance, the economy resembled a giant pyramid scheme, taking in money from suckers to pay those who invested earlier.

Will tougher laws and longer prison sentences be a deterrent. It can't hurt. But, the fact is bubbles burst quicker than a business climate can change. If a crooked practice doesn't pay off, a lot fewer people will take the risk of using them. So, the real challenge is to create a new business culture that matches the market. Think about a system that rewards and reinforces the honest and careful agents and businessmen just like the bubble economies made heroes out of the gamblers.

Moral Compass

During times of fundamental change, values that were previously taken for granted may be strongly questioned. These are the times when the attention to business ethics is critical. Leaders, workers and agents must sensitize their actions -- they must maintain a strong moral compass.

John Kennedy Jr's last flight went wrong because he lost sight of land. In the growing dark around him, the horizon line became blurred and he became disoriented eventually flying his plane right into the ocean. When nothing is stable or dependable, you also can lose your own sense of moral direction. When it happens, you start accepting ambiguity as real. You begin making up your own rules. You cut corners. This is exactly how things started going bad at Enron. Accountants simply made-up their own accounting standards. They lied, cheated and waffled because it was to their economic advantage. Over time, they began justifying their unethical behavior as acceptable.

How can you keep this from happening to you? You can have a strong, unfailing sense of what is right and stay focused on it at all times. It's called **integrity**. When you have it, it allows others to trust you, even when things go bad.

Kim Cameron, Professor of Organizational Behavior at the University of Michigan, says that it is not enough to simply encourage ethical behavior, honesty and integrity because these concepts in themselves imply an **absence of harm**. A **strong moral compass** means that you strive for **virtuousness** where your actions rise to doing good, honoring others, taking a positive stance -- i.e., . . . "behaving in ways where **self-interest is not the driving motivation**."

Too soft and fuzzy for you? Well take note, Kim's research proved that businesses with high scores on virtuousness significantly outperformed those with low scores. **It pays to have a strong moral compass!**

Example: You investigate two proposal quotes for a client. Proposal A is the least expensive policy, but it meets the client's needs. Proposal B also meets the client's needs with a few bells and whistles added at a much higher premium. And, because it includes significant exit penalties, it also pays a much higher commissions. The client relies entirely on your recommendation and doesn't have a clue what a competitive premium might be for a comparable policy. What do you do? As an agent with a strong moral compass, you present Policy A, but explain the options available on Policy B and the fact that premiums and commissions are higher. If the client wants Policy B the honest response is that it is not the one you want him to buy as long as Policy A meets his protection needs.

This is a simplified example for sure, but you get the idea. You are legally able to sell either policy but what is the fairest deal for the client? Truly honest and ethical people live by the choice to do what is right, even when it is not pleasurable. This is how reputations are built. And, regarding reputations, **Alan Greenspan** summed it up quite nicely . . . "Your reputation is your stock and trade. If you do something to undermine that, then you very well may not have a company any more."

Moral Distress

Have you ever thought about why people make bad decisions? One reason is dissatisfaction with your work or how about near impossible objections. When either one of these occurs, a person experiences growing pressure to engage in unethical behavior. You are left in a situation where every decision must weigh your own survival against the care and attention you give your client. The end results is that shortcuts will be taken or you become frustrated, resentful, angry or guilty about your bad decisions.

What can you do?

Stakeholders: Experts suggest that, among other things, you adopt a long-term stakeholder mentality, and, to be ethical under social justice theories you should be fair to all **stakeholders**. What does this mean? A stakeholder is anybody that can be affected by your actions. Your client is a stakeholder in that he depends on you and your insurance products to protect is economic well-being. Your insurer is a stakeholder in you representing product fairly and within the scope of the law. The shareholders who have invested in the insurance company are also stakeholders and when it comes down to it, you are a stakeholder yourself. That's right! You owe it to yourself to survive in your chosen field. And, as we have already described, the best way to do this is long-term, with integrity and respect for others and all stakeholders.

Remember, customers ultimately pay your commissions and insurers enable you to make a living. That's something that should be important to you. So, how could you be a bystander and watch either of them be injured in any way by your actions?

Pace Yourself: Another way to reduce moral distress is to operate at a reasonable pace. We have already explained that when you cut corners it promotes unethical practices. For instance, if you fail to budget time to read a client's policy, they go out without being reviewed raising ethical questions and moral distress. What about when you forgot to get a client's initial on an application. It's awful tempting to sign it yourself when you know the client will approve it anyway rather than drive 30 miles back out to meet the client a second time. Again, moral distress raises its ugly head. Of course, the solution is to allow more time the first time out. But, this will mean less production which creates economic stress. At times like this, you have to assure yourself that you are in this for the long-term. Being genuine and ethical means that you live by the choice to do what is right, even when it is not pleasurable. You could also look at it in more positive terms. Why not make a **client for life** by taking that 30 mile drive and explaining why you did it!

A Tolerance For Problems: When you succeed at something, it's normally because you are doing something that other people do not want to do. In a sense, you have to "tune-up" your instincts to be **satisfied** at meeting objectives that others find hard to take or when people don't want you to succeed. What does this have to do with moral distress. A lot, because you can reduce your level of moral distress by increasing your tolerance for problems. Think about it. You can convince yourself that external forces are never-ending anyway, so there is no reasons to sweat it so much. The fact is, you're in the problem solving business and you're a pro! Just remember the immortal words of Saturday Night Live's Rosanna Rosanna Danna -- "It's always something!"

Loss Control

Being ethical does not mean you have to be the town's whipping boy. Use some of your own sales logic to understand this one. You've probably said this to a client or two . . . "People don't buy insurance and pay premiums so they can run in to every station wagon simply because they hate station wagons. In fact, if they own a small car, they are likely to **avoid** station wagons".

In a similar vein, you need to avoid problems that could cause major financial havoc to you and other stakeholders. When you do, your levels of moral distress will be lower. Of course, this is easier said than done, since there is NO foolproof method to avoid a conflict. There are, however, some steps that agents can use to help reduce the possibility of liability developing.

- Know your basic **legal responsibilities as an agent** and only exceed them when you are absolutely sure what you're doing. Then, pull out your agency agreement and **read it . . . right now!!!** And, 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 you and your company from becoming a commissioner's target for suspension or revocation.
- 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. Countless lawsuits, for instance, surface due to something an agent

wrote down in an application causing the policy to void or a claim denied. The insured typically denies they responded in that manner. If applications were made out in an insured's own handwriting, however, there is little they can say.

- Be aware of and avoid current industry conflicts that could develop into problems for your agency, e.g., mold prevention, viatical settlements, life insurance acting as retirement plans, etc. 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.
- 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.
- 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.
- 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.
- 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. And while we're on the subject, **spend more time with client applications**. 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 a position and reasoning. For instance, assuming your state regulator and company approve, the applicant could be asked to write "I have read everything on this page. The answers are true".
- 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".
- Maintain and understand your errors and omission insurance. This policy is your "first line of defense", but know its limitations and gaps.

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 **demystify 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.

Misuse of Position

What are you doing that might **influence** people in an unfair or abusive manner. For example, do you represent yourself as an **insurance expert** when you are not? Do you claim to have special **insurance knowledge** when you don’t? The point is, when you **disguise** your actual position you deceive clients with the intention of influencing their purchasing decisions. It is certainly unethical and may be illegal.

Here are examples of several insurance conflicts that developed because of influence.

Campbell v. Valley State Agency

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 exceeded 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.

European Bakers v. Holman

After handling the client’s insurance needs for approximately six years the agent proposed that the client change its business interruption coverage to a policy that included a coinsurance provision. The insured accepted the proposal but found that it covered only 28 percent of his loss caused by the interruption of business when an oven accidentally exploded. The agent was sued for negligence by the bakery which was seeking the full amount of the lost business production it suffered. The court held that the agent was responsible since he had a duty to advise the client about its business interruption needs, especially since agent held himself to be an “expert” in this area and client had relied on him in the past.

Seascope v. Associated Insurance

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.

Sobotor v. Prudential Property & Casualty

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.

Wright Bodyworks v. Columbus Agency

Client requested business interruption insurance from agent. Agent agreed to adequate coverage based on agent’s yearly inspection of client’s books to determine premium. Coverage was placed but agent calculated premiums based on client’s “gross profits” rather than it’s “gross earnings”. When a major loss occurred the client was underinsured in a big way. The courts determined that the agent assumed a “dual agency” role because of his special arrangement to audit the books and the fact that agent advertised himself as an expert in this field of insurance. The insurance company paid their limits and the agent was liable for any deficit.

These court cases offer some evidence that many agents might be better off to accept and position themselves as **insurance agents**, not a “special consultant” or “expert”. Customers can learn to accept that **you are who you are** without titles that could, influence, mislead or instill false promises.

This is the basic concept behind the **Preferred Registered Agent™** proficiency designation. The Preferred Registered Agent is an insurance agent who always practices due care, yet operates 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 as good as they can. Their goal is simply to be the most responsible agent possible. **Preferred Registered Agents™** are bound to a strong code of ethics **and** a code of procedures.

Ethics Are Not Laws

Many agents believe that ethics and the law are the same. It is important to realize that **ethics are not laws, yet they can be guided by laws**. Proof of this exists in the fact that you can be unethical yet still operate within limits of the law. A perfect example of this is the insurance client who fears he has physical problem yet he is allowed to withhold disclosing it on an application. He has no duty to disclose his “fears” of a medical condition. It’s legal, but not too ethical.

Laws in the United States are abundant, growing in numbers every day. The courts attempt to legislate protections from those without values or with values in opposition to what most of us would consider right and wrong. We have more laws than any one lawyer can ever know.

And more and more lawyers seem to be necessary to handle the litigation that results from what seems to be a trend in "making others pay".

Privacy

Protecting a client's privacy is an ethical responsibility as well as 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.

The following case demonstrates how privacy issues can be violated and taken to the extreme. You won't believe how the sides get whipped into a frenzy with accusations like wiretapping and review board shams.

Richard Fraser joined Nationwide Insurance as an employee in 1986. Fraser later signed the standard Agent's Agreement to become an exclusive career agent with Nationwide.

Fraser also leased computer hardware and software from Nationwide for use in the automation of his office and insurance business. The lease agreement explicitly stated in the Preface that the Agency Office Automation ("AOA") system "will **remain** the property of [Nationwide]." Further, anytime someone logged on to the AOA system, a notice appeared on the screen that said:

Please note: for everyone's mutual protection, your AOA SYSTEM, including electronic e-mail, MAY BE MONITORED to protect against unauthorized use.

Problems developed when Fraser and other Nationwide agents met to form a Pennsylvania chapter of the Nationwide Insurance Independent Contractors Association ("NIICA"). NIICA had previously been in existence for some years in other states. Nationwide refused to officially acknowledge NIICA. Fraser was elected to an office of the local chapter. He was also asked to create and write a chapter **newsletter**, which became known as The Pennsylvania View.

Fraser raised some of the business practices believed to be illegal with Nationwide's Office of Ethics. Thereafter, Fraser initiated a complaint with respect to these practices with the Pennsylvania Insurance Department and the Pennsylvania Legislature. The agents' ongoing efforts to report these practices resulted in media publicity. Nationwide was aware that Fraser and other NIICA members were reporting business practices to state authorities. Nationwide was forced to enter into a series of consent orders with the Pennsylvania Insurance Department, by which Nationwide paid a fine and agreed to cease the business practices about which Fraser had complained. The Pennsylvania View publicized Nationwide's concessions under the consent order.

A short time later, Nationwide drafted a **warning memo** headed "Inappropriate Communication" to the entire agency force, including Fraser. The memo stated that Nationwide was aware of communications with the Pennsylvania Insurance Department and the State Attorney General. Citing examples of such communications, the memo asserted that many of these communications included "false statements or unsupported allegations that Nationwide has or intends to violate the law," and that they "have had a damaging effect on the business operations and reputation of Nationwide and its agents." The letter also stated that:

Nationwide recognizes and respects your right as a citizen to communicate with government agencies and the public. However, you do not have the right to make false statements or accuse Nationwide of wrongdoing, unless your allegations are reasonably supported by the facts and the law. Such actions will not be tolerated, and if they occur in the future, Nationwide intends to exercise its legal rights, which could include legal proceedings in addition to canceling your Agent's Agreement.

At or about the same time, Nationwide implemented a new business policy, to which Fraser and other agents were opposed. The policy changes were related to Nationwide's new publicized growth plan to establish "multiple distribution channels." Under the new plan, policyholders could buy insurance directly, rather than through an agent. The agents feared that the new policies would undermine their work and their independence.

Fraser, through the NIICA decided to make Nationwide's management aware of the agents' opposition to the plan. NIICA members asked Fraser to prepare a letter to competitors of Nationwide to solicit interest in acquiring the policyholders of the approximately two hundred NIICA members in Pennsylvania. In drafting the letter, the agents' did not intend to actually separate from Nationwide, but to send a warning that they would leave if Nationwide did not cease the objectionable policies. This letter was ultimately sent to at least one competitor.

A top-ranking officer of Nationwide learned of the letter and another "inappropriate communications" memo was soon sent out. Since they were not sure if the letter was actually sent to a competitor, they conducted a **search of their electronic file server** for e-mail communication used by all agents, including Fraser. Stored e-mails belonging to Fraser and other agents were opened, including an exchange of e-mails between Fraser and another agent of indicating that the letter had been sent to at least one competitor.

Subsequently, Nationwide **cancelled** Fraser's Agent's Agreement and retrieved its computer systems. Fraser immediately appealed the cancellation to an internal Review Board which determined that Nationwide had the right to terminate its relationship with Fraser for any reason or no reason at all, and that, nevertheless, Fraser's breach of loyalty to the company provided them with a good reason to terminate him.

Fraser filed a lawsuit contending his status as an independent contractor was undermined by Nationwide's policy changes as well as federal **wiretap violations** resulting from the unlawful interception of Fraser's e-mail communications.

However, the court determined that Nationwide's alleged conduct, although ethically "questionable," **did not** constitute an "interception" of an electronic communication under the Wiretap Act or unlawful "access" to an electronic communication under the Stored Communications Act. Why? Because Nationwide retrieved Fraser's e-mail **from storage after** the e-mail had already been sent and received by the recipient. Therefore, Nationwide acquired Fraser's e-mail from post transmission storage.

Fraser's second claim involved his right to **free speech**. The court's decision, however, was that Nationwide is a private corporation and a private actor under the law. Therefore, Nationwide's decision to terminate Fraser's Agent's Agreement is not subject to constitutional requirements of free speech. Further, the court stated that even if it is true that Nationwide terminated Fraser for reporting to government authorities Nationwide's alleged unlawful practices, for drafting the letter to Nationwide's competitors, or for associating with NIICA, Nationwide is not liable under the constitution.

Opt-In / Opt-Out

It is your ethical and legal duty to honor a client's wishes concerning the handling of his personal and financial statistics. **Opt-out** is the process of having one's personal information removed from databases and lists that are often sold for marketing purposes. Personal information is collected on individuals in a variety of ways such as when they are applying for a credit card, telephone service, or entering contests. Credit bureaus also sell information for marketing purposes. If the consumer has active accounts with a brokerage house, credit card company, or insurance company, he will receive a privacy notice from these institutions. The term "financial institution" includes companies such as payday loan companies, collection agencies, and travel agents. For this reason, it is particularly important for the consumer to carefully review all preprinted notices that he receives in the mail or electronic mail messages.

Federal law now gives one some minimal rights to protect his personal financial information. The law gives him the right to prevent a company he does business with from sharing or selling certain sensitive information to non-affiliated third parties. The term "opt-out" means that *unless and until* the consumer informs his bank, credit card company, insurance company, or brokerage firm that he does not want them to share or sell his customer data to other companies, they are free to do so.

When this law was debated in Congress, consumer advocates argued unsuccessfully for an **opt-in** provision. This stronger standard would have prevented the sharing or sale of the customer data *unless* the consumer affirmatively consented. The opt-in standard did not prevail. Therefore the *burden is on the consumer* to protect his financial privacy.

Opt-in does not enhance consumer privacy. Since it is the consumer who makes the final and binding decision regarding the use, non-use, or misuse of his personal information under either "opt-in" or "opt-out", there is no privacy advantage to "opt-in". Neither approach provides the consumer with greater or lesser rights than the other. If this argument is valid, and both "opt-in" and "opt-out" fully reflect consumer preferences regarding the use of their personal information, then all the other arguments are invalid – sellers would receive the same amount of information under either approach. Thus, implementing "opt-in" would not impose any additional costs on either producers or consumers, as compared with implementing "opt-out". However, the choice of scheme – "opt-in" or "opt-out" – does distort consumer preferences by imposing transaction costs on one choice or the other. After acknowledging that transaction costs cause both "opt-in" and "opt-out" schemes to reflect imperfectly the "true" privacy preferences of the consumer, the policy debate can move forward and tackle the next question. Does "opt-in" or "opt-out" reflect the true preferences of the consumer better? Presumably, transaction costs under "opt-in" lead consumers to provide less information than their true privacy preferences would suggest; conversely, transaction costs under "opt-out" lead consumers to provide too much information. The structure of the seller-producer relationship suggests one reason why "opt-in" might represent the consumer's true privacy preference better. The seller can adjust the level of transaction costs involved in "opting" in or out, whereas the consumer cannot. Since the seller has an obvious interest in collecting information, it has an incentive to make it easy and simple to opt in, under an "opt-in" system, and an incentive to make it difficult and time-consuming to opt out, under an "opt-out" system. Whatever regulations exist to make opting out easier, the seller has an incentive to push the envelope, to make opting out as difficult as possible within the letter of the law. Thus, transaction costs under an "opt-out" scheme are likely to be higher than under an "opt-in" scheme, and the outcome under "opt-out" is likely to be concomitantly farther away from the correct outcome than under "opt-in".

Opt-in reduces consumer privacy by hampering efforts to fight fraud and identity-theft. Since an “opt-in” approach reduces the amount of information available to sellers regarding the consumer’s preferences, spending habits and typical behavior patterns, it hampers sellers’ efforts to detect unusual purchases and alert the consumer to possible fraud. This makes it easier for criminals to assume false identities and engage in other fraudulent behavior at the expense of law-abiding consumers. Not only is this an invasion of privacy in itself, but also the rectification of the situation often requires the consumer to provide personal information about himself. This is a valid point, which, under an “opt-in” scheme, producers might wish to present to consumers in order to convince them to permit use of their personal information. Under an “opt-out” scheme, this point could be presented to consumers to deter them from exercising their “opt-out” option.

Opt-in imposes significant costs on sellers, which are then passed on to consumers. Opt-in increases the costs to a seller of expanding its range of services, because of the necessary expenditure of resources to obtain consumer permission to use the additional personal information that enables the better service. *Opt-in also increases marketing costs* because, instead of sending promotional materials to a neatly identifiable population segment that is likely to find such materials useful, the seller must send the promotional materials blindly to broader population segments. Some believe that in the “distance shopping” market through catalogs and online sales, enforcing an “opt-in” scheme will result in increased costs, which will then be passed on to consumers. The data restrictions inherent in the “opt-in” scheme would affect catalog marketing more than online marketing. This is because the interactive nature of the Internet can counteract the lack of third-party information about prospective customers. To properly understand the aggregate impact of an “opt-in” scheme on sellers, one would need to look at the reliance of other industries on catalogs, as opposed to more interactive means of marketing. One of the factors slowing the growth of e-commerce, though, is consumer hesitation over conducting business online. In a report to Congress on online privacy, the Federal Trade Commission presented surveys showing the extent to which privacy concerns hamper the growth of e-commerce. Recent survey data demonstrate that 92% of consumers are concerned and 67% are **very** concerned about the misuse of their personal information online. Concerns about privacy online reach even those not troubled by threats to privacy in the off-line world. Thus, 76% of consumers who are not generally concerned about the misuse of their personal information, fear privacy intrusions on the Internet. This apprehension likely translates into lost online sales due to lack of confidence in how personal data will be handled. Indeed, surveys show that those consumers most concerned about threats to their privacy online are the least likely to engage in online commerce, and many consumers who have never made an online purchase identify privacy concerns as a key reason for their inaction. There are benefits of adopting and enforcing an “opt-in” scheme, in which consumers are assured that no one will make use of their personal information without their prior and express consent. The resulting burgeoning in e-commerce would reduce sellers’ costs, by enabling them to make more extensive use of the efficiency inherent in interactive marketing tools such as the Internet. This effect may offset, and perhaps even outweigh, the increase in costs attributable to the data restriction effect.

Opt-in reduces the amount of competition in the market. By raising costs of operation, “opt-in” will drive marginally profitable companies out of the market altogether. By requiring new entrants to go through a laborious process of obtaining personal data permits from each new consumer, “opt-in” creates a barrier to entry into the market. Market incumbents, on the other hand, will benefit from an established consumer base that has already given permits. Essentially, “opt-in” helps entrench market incumbents. Since consumers are more likely to “opt-in” to companies they know and trust, such a scheme will favor large firms with established brand names over smaller firms. Competition is most reduced in the industries

that rely the most on expensive means of obtaining permission, such as telephone or paper-mail, rather than on website-notices and e-mail. As e-commerce continues to grow, and technology becomes more pervasive, there is likely to be a shift from the former to the latter, and a reduction in the height of the entry barrier. A new entrant, though forced to beseech consumers for information-permission, could do so inexpensively through mass e-mailing.

Opt-in costs to sellers will be passed on disproportionately to less wealthy consumers. A study of distance shopping in the apparel market (catalogs, online purchases) reveals that inner city and rural consumers are significantly more reliant on distance shopping than the average U.S. household. These populations will be hit hardest by increased prices or decreased discounts which will result from implementation of "opt-in", as companies seek to recoup the increased costs of providing the "distance shopping" option. These are also the consumers who can least afford such price hikes.

Confidentiality

Some confuse the confidentiality with privacy. Privacy demotes the right to be left alone and control information about oneself. Confidentiality concerns the communication of private information and personal information from one person to another. If you surreptitiously collect information for marketing purposes, you are **intruding** on an individual's privacy. If you pass on information without permission, you are **violating confidentiality**.

The key ingredients of confidentiality are trust and loyalty. As an agent, you gather personal and confidential information from your clients. You must be willing to take responsibility for handling this sensitive information. For instance, do you take measures to secure client data? Do you unknowingly publicize a client's address, phone or e-mail address, exposing them to unwanted mail? Do you forward e-mail messages and attachments without reading them? Share passwords? Neglect to change your own password?

In a nutshell, it takes a combination of legal, technological and individual actions to preserve confidentiality.

Ethical Decision-Making

Before the Enron fiasco, Arthur Anderson had a steadfast reputation. When big organizations wanted him to falsify their accounting he said . . . "No, we'll find other ways to make our money". The point is, to maintain ethical standards, you have to be able to think around problems, cultures and differences. Here are some ways to accomplish this:

Get The Facts: The Makkula Center for Applied Ethics suggests you find the relevant facts about a situation. This means identifying the individuals or groups who have an important stake in the outcome. Some may have a greater stake because they have special needs or because you have a special obligation to them.

An example might be elderly clients. Due to their status or cognition, they may need to rely more on your advice than other clients. Your ethical standards may have to be raised in matters that concern them.

Sizing Up The Problem: Michigan University Business Ethics Professor Tim Fort suggest you ask the following questions when faced with an ethical decision:

What's the moral issue?

Who has been harmed? Or who could be harmed?
In what ways?
What are the alternatives that exist?
What facts need to be known to make a reasoned decision?
What are the personal impacts on the person making the decision?

Working within a format like this helps bring the issues away from your own self-interests over the interests of others.

Persuasion: If an ethical dilemma arises between you and a peer or client, why not solve the problem with your powers of persuasion. Be convincing. Have convictions. The influence you exert may very well change their mind.

Taking Risks: The more you are paid, the more complex the decisions you must make. Things are rarely "black and white" and a lot of your decisions will challenge your integrity. But, these are the risks you must be prepared to assume in a sometimes difficult world. You must constantly weigh **short-term results** with **long-term consequences**.

Evaluate Alternative Actions: Which option will produce the **most good** and do the **least harm**? Which option respects the rights and dignity of all stakeholders? Will everyone be treated fairly? Which option will promote the **common good**. Which option will enable the deepening or development of the core values you share with your company? Your profession? Your personal commitment?

Solicit Client Feedback: Before you make the final decision ask the client if your solution meets with his approval. Always ask these important 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?

Reflect on Your Decision: Was your position defensible? Would you do it again? How did it turn out for all concerned? Was your decision successful for both you and your client?

Confronting Unethical Conduct

In a lot of ways, we have become a **no-fault society**. Popular thinking dictates that as long as you don't own the problem you don't need to get involved. A crucial shift is needed to avoid this bystander mentality. People need to think of themselves as members of a community. And, their life in this community entails **mutual obligations** and **interdependence**. In other words, be part of the solution, not part of the problem.

How can this be accomplished. Well, you can learn to help solve ethical dilemmas rather than walk away or simply ignore them. Here are a few ways to do this:

State Your Position: Ask those who want you to perform an unethical task to **state their position clearly**. This forces them to make an ethical choice. If your manager wants you to fudge an application, for example, pose the following question: Are you asking me to lie on this application? It is probably a safe bet that he will back away from his unethical request.

Present A Case: Many ethical dilemmas result because someone has taken a short cut. You can sometimes turn their thinking around by presenting things statistically or in an organized manner. Take the manager who wants you to submit an inaccurate application. If you use some of your CE materials, you could easily find a recent court case where an agent did a similar thing and faced a huge penalty and loss of license. When presented this way, it would be hard to ignore the correct path.

Don't Ratify Unethical Actions: One of the easiest ways to become entangled in the wrong deeds of someone else is to ratify their behavior. Not only is it unethical, but it can come back to haunt you in the form of rather large lawsuit. Take the case of Agent Roger McCall, a licensed life insurance agent and/or broker with Alexander Hamilton Life. McCall sold client Richard Barton a life insurance policy. Barton alleges that a number of representations regarding the policy were untrue and fraudulent, that the administration of the policy was fraudulent, and that Mr. McCall had falsified documentation, forged Mr. Barton's signature, and actually took out taken out an unauthorized loan on the policy.

Ratification of Misconduct

Ratification generally occurs where, under the particular circumstances, the employer demonstrates an intent to adopt or approve oppressive, fraudulent, or malicious behavior by an employee in the performance of his job duties. The issue commonly arises where the employer or its managing agent is charged with **failing to intercede in a known pattern of workplace abuse**, or **failing to investigate or discipline** the errant employee once such misconduct became known. Corporate ratification in the punitive damages context requires actual knowledge of the conduct and its outrageous nature."

A jury found that Mr. McCall made the intentional and negligent false representations, and the false promises, as an agent of defendant Hamilton. Further, it found that Hamilton had expressly authorized Mr. McCall to make the statements that were found to be misrepresentations or false promises. The court awarded over \$850,000 in compensatory damages!

Obviously, Roger McCall did not operate within ethical boundaries. The real question is did his company or anyone in it **ratify** or endorse his actions, and in the process, become part of his scheme. Absolutely not! As soon as Hamilton became aware of Mr. Barton's complaint, it terminated Mr. McCall's agent agreement and initiated an investigation. It hired an attorney to interview Mr. McCall and it reported Mr. McCall's conduct to the Department of Insurance and the local Police Department. It contacted policyholders, and it reimbursed them for their losses in the total sum of approximately \$1.2 million. In other words, instead of ratifying or approving of Mr. McCall's conduct, it tried to **solve the problem by restoring the stolen funds**. Hamilton also offered Mr. Barton the opportunity to rescind the policy and it offered to reimburse him for any money that he was out of pocket as a result of Mr. McCall's acts.

Such conduct, said the court, cannot be considered ratification of Mr. McCall's conduct. Instead, it falls within the established principle that, when the agent exceeds his authority, there is no ratification when the principal **repudiates** the agent's actions as soon as the principal learns of them. Despite Mr. Barton's contrary argument, the court did not view Hamilton's conduct as an improper attempt to ratify Mr. McCall's conduct. His misrepresentations were, in fact, not authorized or approved by Hamilton, and they did not provide a basis for an award of punitive damages.

That's how ethics in insurance work!

A Moral Agency Climate

If you **don't** create an agency culture that reinforces values and ethics, other agents and employees will only do what is right so many times and then they will either leave or give in to outside pressures to cut corners, lie, fudge, etc.

In order to reinforce this theme, you can't punish people for taking actions they need to take. You have to **support** good, moral decisions, even at the **cost of production**.

What happens if no one else cooperates? You must continue to forge forward, even if you are the only one doing the right thing. Why? It's a fundamental choice you are making to be an ethical leader. And, it will pay off in time.

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 v. 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 v. 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 v. 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 v. 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". 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.

MARKET CONDUCT

Choosing A Company

Agents choosing safe companies to insure their clients undertake many disciplines, including: disclosure, diversification among multiple carriers, product variation diversification, regulatory knowledge, multiple rating verification, key ratio comparisons, periodic monitoring and more. A Money Magazine survey is a painful reminder to the industry that the road to agent diligence may still be cluttered with potholes and a fair share of detours. Twenty insurance agents on their accuracy and clarity in explaining their insurance products and the role they played in a client's financial planning. Most of the agents **failed** simple standards of due care, including the ability to demonstrate simple financial assumptions concerning the solvency of a chosen insurer -- either at time of purchase or later. Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status.

No doubt, it will be the same attorneys who expect an agent to quote code and verse about the company, a policy or illustration when something goes wrong. There is no question that young lawyers, and some very rich lawyers alike, are increasingly aware of the numerous legal theories available to hold the insurance producer liable for failing to meet some kind of professional standard. Could a jury be convinced, for example, that an insurance

professional, especially one who has earned a designation such as CLU or CFP, neglected his professional duties in not explaining the full impact of estate taxation to a now deceased, but underinsured client? Is a casualty agent, possibly a CIC or CPCU, liable for placing a client with a B-rated carrier that liquidates at the very time a client files a claim or failing to recommend a specific policy option that later involves losses?

The answers to these questions are continually being litigated. The **significance**, however, is that the courts in just about every state, have made it absolutely clear that insurance agents are selling a lot more than a mere contract of insurance. They are selling security, peace of mind and freedom from financial worry in the event of a catastrophic claim.

Company Choices

An agent's **legal** conduct in choosing a company centers on the ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations. Proper **ethical or sales conduct**, however, considers more: **Diversification**, to spread risks among carriers and to meet state guaranty fund protection, and **on going monitoring** by private rating services. Sales conduct is a noticeably higher level of service.

Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency. Agents help businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss. Sometimes, however, policy owners find that the "safety net" they purchased is not always as safe as it started out to be. In the late 1980's and early 1990's, the increase in frequency of insurance company failures and inability to pay claims is proof. It is further substantiated by the substantial increase in claims submitted to state guaranty funds during this period which are forced to step forward and make good on failed promises of defunct or faltering companies.

An agent is engaged by a client because of his knowledge. Clients should expect to be placed with financially reliable insurers. Too often, it is believed that state regulators are monitoring solvency closely and will advise agents and brokers by some mysterious "hot line" — it just doesn't happen that way — and we have recent examples to prove this is not the case. Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations could initiate a complete collapse similar to what happened with Mutual Benefit Life years ago. By stepping in without public warning or fanfare, regulators hope to avoid the severity of a takeover and minimize consumer panic. That is why an agent will not receive advance warning from regulators. Unless the agent is tracking solvency by demanding full disclosure from an insurer BEFORE AND AFTER involving a client, he may experience the unpleasant experience of dealing with a disgruntled client or his attorney who just read about an insurer's demise, complaints filed with the insurance commissioner, or worse, a surprise visit from the "60 Minutes" investigative team!

There are NO set rules on **solvency due care** techniques since the actual process must consider the risk capacity of a client, the current economy and the specific financial result or exposure needing coverage. However, there are some steps that agents might take to help mitigate bad choices. It is hoped that at least a few of the following sources and considerations will have application and will involve the agent in an area of due care that has been largely ignored. If this is considered too time consuming, an agent would be advised to

concentrate only on those companies where this information can be acquired. In some cases, due care is not simply a matter of collecting a financial ratio. The story behind the numbers is often as important.

Using the Rating Services

An agent choosing a company for his or her client would be advised to consult the **major** rating services. The activities of insurance company rating agencies have become increasingly prominent with the industry's past financial difficulties and the well-publicized failures of several large life insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policyholders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems.

There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s. Questions have been raised about the motivations and methods of the raters in light of the recent sensitivity regarding insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, lowered their ratings arbitrarily in reaction to declines in the junk bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

One consultant suggests a way to determine if an insurer is running into **difficulty** is to **monitor several ratings sources**. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. An example is United Pacific Life. In 1992 it was rated A-Plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

On-Going Monitoring and Policy Replacement

In the past, there has been no legal premise to hold agents responsible for **monitoring** solvency of a company after the initial sale. However, in Higginbotham v. Greer, it is *suggested* that agents need to keep clients informed about **significant changes** in the financial condition of the company *on an on going basis*. **Sales conduct** goes much further by emphasizing on-going due diligence, and when replacement is considered, documentation of files and published and third party testimonials as justification, *especially for any recommendation to move a client's coverage from a company rated "A" or better to a lesser rated carrier*. Even if the intent was to provide superior coverage, the client's security position has technically downgraded.

Company Deals

Agent sales conduct should carefully consider companies that offer deals that are "too good to be true". Agents might be advised to at least be suspicious of a company offering a "better deal" than anyone else. It is common sense that something along the way will suffer, as it did in the case of some life companies that invested in junk bonds and many casualty companies which participated in deep discount premium wars where expenses and claim

costs at times exceeded income. This can only represent a degenerative financial condition for the insurer.

Also remember that insurance agents, as salesmen, want to believe something is a better product or a better company. By their very nature, salesmen often **get sold** as easy or easier than some clients. It would be wise to be critical of all brochures and analysis distributed by a carrier which portray it to be the "best" or "safest".

Company Diversification, Business Lines & Parent Affiliation

In the quest to exercise proper sales conduct, a strategy of **multiple company** coverage may be the answer or at least a diversification of product among the same company's menu. For instance, if you can't provide a choice between companies, a client's life insurance needs might combine term, whole life, variable life or universal life to spread the risks among product lines. The variable life component could be diversified even more by using multiple asset purchases. On the casualty side, similar diversification might be employed between business and homeowners policies, workers' compensation, professional liability, primary and umbrella coverage, etc.

The insurance consumer should also be educated by agents about the different types of insurers, i.e., stock versus mutual company, although it might be considered an error to generalize about the safety of an insurer or the price of its coverage or the service it provides, based solely on the insurer's legal structure. This disclosure may be particularly appropriate where an insurer, due to its legal structure, may NOT be covered by state guaranty fund protection, e.g., non-profit Blue Cross and Blue Shield. Or, where the legal structure of the product offered may NOT be "insured" by state funds, e.g., variable annuities.

An agent may not have many **choices** concerning the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider the nature of multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line of business or by affiliation. If health carriers become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

Who or what kind of company **owns** the insurer is another consideration. Is the parent sufficiently solvent that it will not recruit or siphon funds from the insurer? In a like manner, does the insurer own an affiliate that may likely need capital infusion from the insurer? Has the insurer recently created an affiliate, and are the assets in this affiliate some of the non-performing or under performing investments of the original insurer? Is a merger in the offing that might mingle your client's A-rated company with a larger B+ company? In what partnerships or joint ventures does the insurer participate? Do these entities own problem real estate properties of the original insurer? Has the insurer invested in other insurance companies, and have those companies, in turn, invested back in the original insurer or one of its affiliates?

Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non insurance" parent. Conversely, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes, including sale and leaseback arrangements and the securitization of future revenues.

Conflicts of Interest

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission for selling a particular company's product is a huge conflict of interest from the get go -- But, this is the insurance business. An ethical agent should disclose this fact in reference to the choice of the company selected. Where the **commission is higher than normal**, one might question the specific policy elements that will be affected, higher surrender or cancellation charges, etc or considerations about the financial qualifications of the insurer and include these facts in any disclosure. Years ago, for instance, a California insurer with a known history of paying higher than prevailing policy interest and higher than normal commissions was eventually placed in liquidation. Why didn't more agents question these practices? Does it make sense that one company could substantially outperform another year after year? Would this have been a reasons to, at the very least, diversify among other companies.

Reinsurance

Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary company, however, are **only as strong** as the financial strength of the reinsurer. Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus. Agents should also be concerned about foreign reinsurance since U.S. regulator control and jurisdiction is difficult. See how much of the foreign reinsurer's assets are held in the United States. Ask if the reinsurer has **directly guaranteed** the ceding company or used bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past. Also, under terms of the ceding contracts, can the reinsurance be **retroceded** or assumed by another reinsurance company - - it is possible to have layers of reinsurance which could create difficult legal maneuvering during a liquidation? Does the ceding contract have a **cut-through** clause which allows the reinsurer to pay deficient policy owners or insureds directly, rather than to the liquidator? Is the insurer writing a significant amount of new business that may require costly amounts of first- year reinsurance?

Reinsurance surplus relief is another area of concern to investigate. The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year, such as commissions, etc. A loss to an insurer also reduces a company's **surplus**. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to **shore up** their surplus from the losses of first year policies. This may be accomplished by raising additional capital or through some form of financing. More often than not, however, an insurance company will simply call up the local reinsurance company and obtain **surplus** relief reinsurance. Once in place, surplus reinsurance provides the ceding company, the insurer who uses the reinsurance funds, with assets or reserve credits which improve the insurers earnings and surplus position. The major difference between using reinsurance to cover first-year losses and a loan is how the transaction is reported. When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is **NOT considered an accounting liability** under statutory laws because the repayment is tied to future profits of the policy or policies being reinsured. Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay. The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided.

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: ". . . If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged". The reinsurance market has taken some heavy blows in past years.

On the demand side, traditional buyers are looking for new approaches that bring together reinsurance and investment banking techniques to manage both capital and risk. Further, the industry has recorded heavy casualty losses from earthquake and hurricane catastrophes. Finally, there is the Unicover Pool fiasco. Primary insurers were ceding away significant amounts of their potential losses while only retaining a **small exposure** and managing agents were given too much writing authority without adequate controls. The Unicover Pool was packaging blocks of business for reinsurers to buy where the premiums received did not cover the risks assumed. Most of the losses were in the worker's comp arena, but the effects have shaken the entire industry.

As a result of these problems, reinsurance may be harder to come by and more expensive when you can. In essence, this is a huge wake-up call for the entire industry. Agents who were not fully aware of their company's reinsurance arrangements should be more alert in the future.

Size of Company & Loan Portfolio

What percentage of an insurer's non-performing or under performing real estate projects have been **restructured** -- sold and self-financed to a new owner at favorable terms to eliminate a "drag" on surplus?

Statistically, fewer failures have hit companies with assets **greater than** \$50 million. It is thought that larger companies have more diverse product lines, bigger sales forces, better management talent — in essence, they are better equipped to ride out financial cycles. In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over \$600 million category. However, another advisor feels that a small, well-capitalized companies can deliver as much or more solvency protection as a large one suffering from capital anemia.

State Admission

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries. Some states will also divulge the rank of an insurer by the number of complaints per premium volume. Agents should realize, however, that to date no court has allowed an insured who has suffered a loss as a result of an insurer insolvency to recover from a state run department of insurance for failure to regulate the solvency of the insurer.

Risk Based Capital

Risk Based Capital guidelines could prove to be one of the most useful tools for quantitative analysis. In a nutshell, it is a **capital sufficiency test** that compares actual capital, surplus, to a required level of capital determined by the insurer's unique mix of investment and underwriting risks.

Guidelines for this new regulation took effect in 1994 for life and health companies and 1995 for property/casualty insurers. Risk Based Capital is the brainchild of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners have strived to create a national regulatory system by the passage of **model acts** or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners.

The **Risk Based Capital Model Act** defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners. Formulas, under risk based capital, will test capitalization thresholds that insurers **must maintain** to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single-state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed 5 percent of total business written. The risk based capital system will set **minimum surplus capital amounts** that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control. Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year.

It is clear that Risk Based Capital encourages certain classes of investment over others. For example, an **asset-default test** under Risk Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the **C-1 surplus requirements** alone could be far greater than all other categories of Risk Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risk Based Capital reports are based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus

capital was found to be at 189 percent of their respective Risked Based Capital levels. Even though, a majority of companies exceeded the 150 percent threshold — thus, not requiring regulatory correction — the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when Risked Based Capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.

On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state to state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate -- performing or not.

Some in the industry also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and "bad press". This, in turn leads to a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized. Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remains to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with risked based capital guidelines by selling their large scale real estate investments and junk bonds.

Choosing Product

If an agent is truly using due care in selecting the right policy, he or she should:

- Obtain specific information on the client's current and anticipated risk / liquidity exposure and review all existing policies.
- Review a "specimen" policy and policy amendments for every insurance contract he is marketing.
- Make sure that the client clearly understands the type and limit of coverage being purchased; the responsibilities of each party, the insured and the insurance company; and the services that will be provided by the agent.
- Monitor policy needs on a continuing basis. Regardless of the sequence of policy decisions, agents must recognize that the choice of a policy is viewed differently between agent and client.

An agent seeks coverage as a means of transferring pure risk. A client views a policy in terms of obtaining reduced uncertainty, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in any insurance purchase. The greater agent due care exercised, the more valuable the service. Agent choices were at the heart of the issue in recent class-action suits involving pensions and life products. Allegations that agents marketed life policies and annuities to tax-qualified pension plans have led to multi-million dollar settlements. Even though the insurance industry defends the choice of this product, the courts say that placing a tax-deferred product inside a tax-deferred retirement plan is redundant, unnecessary and costly to consumers. The critics say that mortality and expense costs associated with life products, like variable

annuities, make them a poor choice compared to mutual funds. In addition, the tax-deferral feature is unnecessary. Oddly enough, the issue here does not focus on performance, where some variable annuities inside pensions have outperformed mutual funds. Rather, the focus is on disclosure and suitability.

Disclosure is also why, when viewed from an agent's liability, ALL options of the policy chosen should be disclosed. The textbook case here is Southwest v. Binsfield - 1995. A client requested coverage for his business and relied on the agent to make an appropriate policy choice. At no time was "employee dishonesty coverage" discussed and it was NOT included in the coverage even though it was a widely available option. A company employee embezzled over \$150,000 and the insurer refused the claim. The agent was found liable because he was duty bound, but failed to advise his client that this type of coverage was an option. This case has broad application in all areas of coverage — life, disability and casualty — and agents would be wise to adhere to the simple principle of disclosing widely available policy options.

Policy Choices & Risk Management

The process by which agents help clients select the most suitable policy is known as **risk management**. The two basic rules concerning risk management are: 1) The size of potential losses must have a reasonable relationship to the resources of the client, and 2) Benefits of risk reduction must be related to its cost

In essence, these rules advise risk takers not to risk more than they can afford to lose, to consider the odds and not to risk a lot for a little.

The agent must also consider a client's **pure risk vs. speculative risk**. Both pure risk and speculative risk involve uncertainty, but in pure risk, the uncertainty relates only to the occurrence of the loss. In other words, there is no chance for a profit to be made. Speculative risk offers the opportunity for both gain and loss. An example of a speculative risk is when a dilapidated apartment burns and is replaced with new housing. Society can gain from speculative risk. However, the agent would do better to concern himself with the pure risk losses of the client. In the above case, for example, does the apartment policy provide pure risk provisions, such as a "lost rent clause" to provide the client and his family sufficient cash flow while the new apartment is being built?

The **process of risk management** requires setting and achieving goals in at least four areas: pure risk discovery, options to deal with the risk, implementation and on going risk monitoring.

Pure risk discovery: Requires knowledge about a client's assets, income and activities of his family or business. Several sources can be valuable, including: financial records (balance sheet and income statement), specific information on each asset (location, title replacement cost, perils, hazards they are exposed to). Questions about sources of income and expenses help determine the client's ability to self-insure all or a portion of any potential loss. Physical inspections of the client's home and business might also pinpoint additional liability loss hazards. This can even include a study of all existing contracts such as leases, employment contracts, sales and loan agreements.

In the case Aetna v. Rodriguez - 1988 the agent chose a policy based on what he **believed** his client was saying. The courts determined that even though the client used words that could have been interpreted two ways the agent should have investigated the "real" need

and not simply wrote the policy in a manner that was legally advantageous to the insurance company.

Even when exposures are detected, no estimate of the maximum loss potential can be made with absolute confidence, since matters concerning the timing of a client's death, disability or health problem can change the desired resource amount. The same is true concerning property and liability exposures -- depth and breadth are hard to quantify.

Options to deal with risk: These can be evaluated after specific risks have been identified. The risk manager's goal is to reduce the "post loss" resources needed by the client using the most efficient method. In essence, this is the age old battle of balancing costs and benefits. That is why risk management is maximized when using more than one insurance company to carry the burden. In this decision, however, there is temptation to resist paying for excess coverage of any type which can rob the client of cash flow that could otherwise be used to build assets more quickly and less expensively -- specifically, assets that are needed to provide for the present or to create a "living" for the future. As part of this consideration, it may just be that the client pays premiums for many years, is never disabled or does not die earlier than his life expectancy. Or, he may never sustain a loss of property. The responsible agent should advise the client that this too, is a possible outcome.

Factors to consider include personal and business resources the client may wish to devote to covering losses (cash, assets, bonds, etc), available credit resources, the use of higher than average deductibles and any possible claims for reimbursement the client may make against outside parties who may be legally responsible to help pay all or part of the loss. Of course, it is likely that the major transference of risk, or the final source of loss coverage, is the insurance contract.

Implementation: Made after the agent has developed specifications for coverage, established criteria or standards for insurers; compared rates and terms for the most efficient contracts and arranged for all contractual requirements, like the application, rating history, specimen tests, inspections, etc. Probably the most important contribution the agent can make at this phase is in aiding client indecision. Clients and agents alike can be frequently confused by the continuing arguments favoring term versus whole life or the value of an inflation rider to protect future property values. The result of these conflicting considerations and advice can be that too much time is spent wallowing in indecision about levels and type of protection for what reasons. The fallout may be over insurance or under insurance or no insurance at all. The professional agent who practices due care will also provide counseling to bring these decisions to settlement.

On-Going Risk Monitoring: This can be as crucial as any one or all of the processes involved in risk management. Simply put, after the implementation of the appropriate policy, it should be the agent's duty to review coverage annually, evaluate on going adequacy, stay current with new coverage that might better suit the client's needs, alert the client when the policy needs to be renewed and be available to assist in servicing needs such as title changes, claims assistance, alternative payment planning, etc.

While the process of risk management is conceptually similar across most product lines . . . life, health, disability, property, casualty . . . the analysis of exposure is quite different.

Too Good To Be True

Fundamental to choosing appropriate product for your clients is the understanding that all insurance is constructed of the same elements -- expenses; experience (claims risk or

mortality); and return or profit. Therefore, a policy that appears to be significantly better than others in the marketplace should be suspect. Once a suitable product can be found, the decision to buy should be based on the assumptions in the policy and the financial stability of the company. Policy illustrations and quotes are one method to make this assessment. Unfortunately, agents and clients rely too much on these presentations to the extent that policies are rarely read. As a result, agents should be sure that any projection or estimate disclose the assumptions that went into the projection and the fact that variations in these assumptions can significantly change insurance results. Recent laws have even made it mandatory to include (in cases of certain product eliminate illustrations) and/or bold or highlight any "guaranteed" portions, as compared to simple projections. It is further suggested that illustrations be run again, using realistic input, to see if they still meet client expectations. And, always obtain a specimen policy, and if applicable an outline of coverage, to get to the bottom of glowing terms and/or "too good" features and benefits.

PART III: SUITABILITY

In the world of insurance, client's must decide **when** to insure, **what** to insure and **how much** to cover and pay. As an agent, it is your job to analyze these needs and be an advocate or problem solver to make sure the requested risk has been transferred.

A client views policies in terms of obtaining **reduced uncertainty**, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in solving client needs. The greater agent due care exercised, the more valuable the service.

There are variety of techniques that are accepted and used to determine customer needs or suitability. Some are more traditional than others. Most are seen as solutions to **identify** a certain customer segment. They give logical, rational explanations about where the customer fits in but do not explain how the customer **feels and cares**. Policy applications are an example of information an agent might use to identify who he is about to insure.

Suitability Duties

At this point, you may be asking . . . what's the bid deal? People need insurance I provide it! Why does everything have to involve the law? Well, it may not be your **legal duty** to secure **complete** insurance protection against every conceivable need an insured might have, but there is definite legal obligation to explain **policy options** that are **widely available at a reasonable cost** (Southwest Auto Painting v Binsfield - 1995). Likewise, an agent has a legal duty to use **reasonable skill** in asking certain questions during the application process to determine types of coverage needed (Smith v Dodgeville Mutual Insurance – 1997). Further, failing to determine the nature and extent of the coverage requested as in Butcher v Truck Insurance Exchange - 2000, may subject you to a lawsuit.

For a majority of suitability lawsuits, the basis of liability is relationship and purpose. Legally a **personal relationship is created** when a prospective insured consults an insurance agent, provides that agent with specific information about his unique circumstances and relies on the agent to obtain appropriate coverage tailored to these circumstances. Courts have recognized that the relationship between a prospective insured and an insurance agent (like the relationship of attorney and client) is that of principal and agent, for the purpose of negotiating a policy suitable to the client's needs (Nu-Air Manufacturing Co. V. Frank B. Hall & Co. - 1987). Further, an insurance agent owes the prospective insured a duty of unwavering loyalty similar to that owed by an attorney to a client. It is the special **fiduciary nature** of the relationship between a prospective insured and an insurer that lends the relationship a **personal character** similar in scope to the lawyer-client relationship. For this reason, alleged acts of negligence on the part of an insurance agent who has been consulted for the **express purpose** of meeting a client's unique needs create a **personal tort**.

In Forgione v. State Farm Insurance - 1995, it was determined that the insureds made **express representations** to the agent about the importance of arranging a set of policies that would prevent a gap in coverage. The insureds **relied** on these agents to obtain the appropriate coverage, and the agents failed to use reasonable care, skill and diligence to procure **suitable policies**. The allegations in the complaint make clear that the insureds

expected the agents to respond to the couple's unique, personal insurance needs. A \$600,000 claim proved that a gap in coverage existed and therefore it was not a suitable policy.

In another case (Anderson v. Knox - 1961) agent Leland Anderson had specialized in the sale of what is referred to as bank financed insurance or insurance under the bank loan plan. The plan was that premiums would be provided by borrowing the amounts thereof from a bank and securing the bank by assignment of old and new policies.

In theory, Knox would only the interest on the bank loans, but since his interest payments would be tax deductible the annual net out-of-pocket payment required to be made by Knox in order to carry the plan would be only the interest on the loan less the amount of taxes he would be able to save by deducting this interest in his income tax return. (Obviously the net cost to Knox calculated in this manner would depend in a substantial degree upon the tax bracket in which his income tax was calculated. This saving through deduction of interest paid was deemed to be the main attractive feature of the bank financed plan of paying life insurance.)

The court discussed the issue that a bank finance plan could be useful for a person whose income and financial condition is such that his income tax puts him in high brackets and who has the means to liquidate the steadily increasing debt out of other sources. Such a man gets an immediate large coverage of insurance with premiums based on his early age at a time when he is sure of his own insurability.

What brought about the controversy in this case was that Knox was **not** that kind of man. Premiums for the plan were over \$7,000 per year. Knox had an annual salary of \$8,100 per year and investment income of \$1,600 per year! In his position as superintendent of the sugar plantation, Knox had the free use of an ample dwelling house and the free use of a company automobile. However, the court found that Knox's income was such that he was placed in the 26 per cent tax bracket.

Was Anderson guilty of a breach of duty in a failure to make disclosure of certain facts? Was this product suitable? What about the rather large commissions, not ordinarily possible with a client in this income category? The courts decided as such in both instances -- a devastating blow to the agent.

Meaning of Suitability Conduct

So, what does this all say about suitability conduct? Is your job more than just handling transactions? Yes it is! Your gut tells you so and some very important court cases make it your duty. In essence, beyond being the most responsible agent you can be, you should **size-up your client** and **anticipate his needs** when he can't. How can this be accomplished? You'll need more than luck. Aside from determining current and future risks that you know about, you need to expect those that haven't happened. For instance, shouldn't you know that a 50-year-old baby boomer client is a far more complex individual than his parents before him. His insurance needs are also more complex: higher life limits to cover college and entrepreneurial pursuits; medical coverages, long-term care and bigger retirement "pots" for a longer life span; higher primary and umbrella coverages as a buffer against the litigation explosion; etc.

To really uncover as many of these client needs as possible, you must know more about your clients. Of course, a client profile is the best way to accomplish this. Customer profiles

can provide a lot more information than you would glean from an application. You must also **ask** clients what about their needs. Three important questions might be:

- *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?*

In addition, you should do research about their needs as a group so you can **better anticipate insurance needs**.

Every additional bit of information you learn about your client helps you get closer to knowing what makes him "tick" and how he ticks could be a best indicator of how you need to insure him. Are you uncovering his or her "core beliefs"? Is he or she following generational trends? Where do they see themselves five years from now? How will they get there? These are not questions you will find on insurance applications nor many client profiles. In some cases, your clients will not know the answers to these questions themselves -- you may need to interpret for them. But, by all means never do this without involving them in the process.

And, of course, once you have asked all the questions you must be sure that you implement or **meet their needs to the best of your ability**.

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 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 chapter. 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.

PART IV: CONSUMER PROTECTION

Rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed agents that fall under the category of consumer protection. Some of these laws live and breathe **outside** the venue of insurance codes. However, they are just as lethal and can't be ignored.

Conflicts that surface in the consumer protection area are usually the result of violations in advertising and deceptive or unfair trade practices. Agents in the real world find it near impossible to know each and every consumer statute, yet a single mistake could jeopardize a career and personal assets. Sometimes, it is the tiny indiscretions in business that create the problem. For example, placing a small and seemingly harmless "sub-title" on your letterhead that says "Professional Services Guaranteed" could hold you accountable for more than you bargained. Knowing what is expected of agents in the consumer protection arena is the best place to reduce and avoid these problems.

Insurance Advertising

Insurance advertising is highly regulated with guidelines that differ from state to state. These guidelines determine what is communicated in an advertising message, how it is communicated, and how it looks. In fact, much of what agents communicate probably falls under the legal definition of advertising. Failure to comply with state laws could require the insurer and agent to cease doing business and incur penalties.

What is Advertising?

Insurance advertising includes **all materials** designed to create **public interest** in an insurer, its products, an agent or broker. This may include, but is not limited to: Product Brochures, Prospect Letters, Sales Presentations, Agent Recruiting Materials, Newsletters, Business Cards, Trade Publication Ads, Point-of-Sale Illustrations, Print/Radio/TV/Internet Advertising, Stationary, Telemarketing, Telephone Conversations, Yellow Page Ads, Videos, etc. Most insurance companies require agents submit these forms of advertising to compliance departments for approval prior to publishing.

Blind ads which do not identify product features or rates are particularly vulnerable to mistakes since they are typically not reviewed by compliance departments, although many insurers will look them over as a courtesy. Due to violations in this area of advertising, many states now require an agent's license number be displayed in ALL forms of communication, including blind ads.

What Isn't Advertising?

Communication used purely for **internal purposes** and not intended for public use is not considered advertising, as well as policy holder communications that DO NOT encourage policy modifications.

Advertising Compliance

The consequences of using nonapproved advertising are both severe and damaging. Insurance regulators concerned about an advertisement's content may require that ALL future advertising for the entire company be submitted for **prior state approval**. This would be disruptive and time-consuming. Additionally, a violation in advertising may carry fines of \$1,000 or more **per violation**. As an example, 1,000 misleading flyers could be assessed a fine of **\$1 million** (\$1,000 X 1,000). To avoid these kinds of conflicts advertising should comply on several fronts:

Identity of Insurer or Product

If advertising focuses on a specific company it is advised that the FULL NAME of the company be used along with the home office address (City and State). Initials or abbreviations are not acceptable to most companies or insurance regulators.

For specific product ads, the policy or contract type should be clearly and accurately identified.

Accuracy and Truthfulness

As a general rule, the advertising piece, when examined as a whole, cannot lead a person of average intelligence to any false conclusions. These conclusions can be based on the literal meanings of words in the ad and impressions from pictures or graphics as well as materials and descriptions omitted from the advertising piece. In one case (McConnell v. Ehrlich - 1963) the agent lost his license for using prospecting letters that closely resembled official correspondence from the Department of Motor Vehicles.

Specific words like "safety" should be supported using A.M. Best Ratings, etc., while terms like "LEGAL RESERVE" should not be used at all. Absolute words like "all", "never" and "shall" should be avoided, while words such as "free", "no cost" and "no extra cost" can be included IF actually true and then ONLY if the one paying for the benefit is identified or if the copy indicates that the charge is included in the premium.

Words that are not typically used in connection with a policy, like "investment", "personal pension plan", "asset protector", etc., should not be used in a context which leads a purchaser to believe he is getting something other than an insurance product.

Illustrations and Quotes

There are many proposals by states, professional groups and organizations like the National Association of Insurance Commissioners. Most require that agents disclose all assumptions in the illustration or quote and explain and highlight any guaranteed portions as opposed to anticipated results. Almost as important is whether *nonguaranteed* elements of the policy are shown with *equal prominence and close proximity* to the *guaranteed* elements. Representations concerning withdrawals cannot be made unless reference is also made to any prepayment or surrender charge. Where words like "tax free" or "exempt" are used, they should be explained.

Comparisons, Ratings and Competition References

Comparisons made between policies and investment products, e.g., comparing an annuity to a savings account or a split limit quote to a single limit estimate, must be complete, accurate

and not misleading. Agents have lost their license by using solicitations and letters that inferred that insurance is available at lower rates than others because of a special “volume plan”. All statistical information should be recent, relevant and the source and date identified. Any reference to a commercial rating should be clear in describing the scope and extent of the rating. If an A.M. Best, S&P, Moody’s or other rating is advertised, the appropriate disclosures should be given.

References to the competition should be factual and not disparaging. Comparisons to competitor’s products ought to be fair and complete and there should never be a reference to State Guaranty Associations as a means to induce the purchase of an insurance product.

Disclosures

If you display a rating from a commercial company you should use a disclosure similar to this:

“A.M. Best has assigned (Company) an “A” (Excellent) rating, reflecting their current opinion of the financial strength and operating performance of (Company) relative to norms of the insurance industry. A.M. Best utilizes 15 rating classifications from A++ to F.

If your agency is located in a bank or other prominent corporate institution, the following disclosure is appropriate:

Contracts are products of the insurance industry, and are not guaranteed by any bank or company, or insured by the FDIC.

Also, if your product aligns with estate planning, financial planning, taxes or asset protection, you might display the following caveat:

Neither (Company) nor any of its agents give legal, tax or investment advice. Consult a qualified advisor.

Testimonials and Endorsements

Never use or imply an endorsement or testimonial by a person or organization without their approval. Further, if a person or organization making an endorsement or analysis is an employee of or has a financial interest in the Company or receives any benefit, it should be prominently displayed.

More Unfair Insurance Practices

While advertising is the most obvious trade practice violation, agents should be certain they are not also participating in other unfair methods of competition or unfair or deceptive act or practice in the course of their daily business, the subject our of next discussion.

Agents in question of unfair trade practice methods are typically subject to a hearing, usually before the State Department of Insurance, to show cause why a cease and desist order should not be made by the appropriate regulatory agency or board. After a hearing, if it is determined that the agent's actions violate the rules of unfair competition and practices, a formal cease and desist order may be served -- **a warning**. Violating such a cease and desist order is typically subject to various dollar penalties and administrative penalties such as injunctions, loss or suspension of license, and severe civil penalties such as high dollar

fines, damage awards, and court fees to the injured parties. In addition to advertising, discussed above, areas of specific importance include:

Identification

Agents should clearly identify themselves as insurance agents promoting or selling an insurance product.

Defamation

Defamation violations occur where an agent is involved in making, publishing, disseminating, directly or indirectly, any oral or written statement, pamphlet, circular, article or literature which is **false or maliciously** critical of or derogatory to the financial condition of any insurer or which is designed to injure any person engaged in the business of insurance.

Boycott, Coercion & Intimidation

Most states consider it unlawful for licensed agents to enter into any agreement or commit any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

False Financial Statements

Restrictions are very clear that an agent violates the law when filing with any supervisor, public official or making, publishing, disseminating, circulating or delivering to any person, directly, or indirectly, any false statement of financial condition of an insurer with intent to deceive. This also includes making any false entry in any book, report or statement of any insurer with intent to deceive any agent, examiner or public official lawfully appointed to examine an insurer's condition or any of its affairs. Willfully omitting to make a true entry of any material fact pertaining to the business of such an insurer in any book, report or statement are similar violations.

Stock Operations

It is considered unlawful to issue, deliver or permit agents, officers or employees to issue or deliver company stock, benefit certificates or shares in any corporation promising returns and profits as an inducement to sell insurance. Participating insurance contracts, however, are excluded from this category.

Discrimination

An agent clearly violates insurance law in making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable by such contracts. Similarly, there shall be no discrimination between individuals of the same class and of essentially the same casualty hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable under such contracts. Discrimination can also occur where individuals of the same class and of essentially the same hazards are refused renewability of a policy, subject to reduced coverage or canceled because of geographic location.

Rebates

Rebates permitted by law are authorized. Otherwise, it is a violation in most states to offer, pay or rebate premiums, provide bonuses or abatement of premiums or allow special favors or advantages concerning dividends or benefits related to an insurance policy, annuity or contracts connected with any stock, bond or securities of any insurance company. A rebate may also be classified as any readjustment in the rate of premium for a group insurance policy based on the loss or expense experience at the end of the first year, made retroactively only for that year.

Deceptive Name or Symbol

Agents shall not use, display, publish, circulate, distribute or caused to be used or distributed any letter, pamphlet, circular, contract, policy, evidence of coverage, article, poster or other document, literature bearing a name, symbol, slogan or device that is the same or highly similar to a name adopted and already in use. This includes ads designed to associate you with or resemble government notices.

Deceptive or Unfair Business Practices

In addition to specified insurance codes, insurance agents must answer to generalized consumer protection laws carrying titles such as "**Deceptive Trade Practice Laws**" or "**Unfair Trade Practices**". For the most part, these **consumer** laws apply to insurance and agents because an insurance policy is deemed a **service** and the purchaser of a policy is deemed a **consumer**. Therefore, insurance services fall within the meaning of widely adopted consumer protection acts. Agents are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by agents where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insureds or policy owners were not considered to be "consumers". By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked.

The Uniform Consumer Sales Practices Act

The UCSPA was enacted by the federal government and adopted by many states to protect consumers from deceptive marketing practices and establish a uniform policy. The essence of this legislation, as well as local and state laws, is that "buyer beware" is an **old attitude** now replaced by real laws and enforceable legal limits. The courts frown on oppressive and unconscionable acts and consider it the duty of any sales person and agent to disclose information available to him which gives him an unfair advantage in a sale. False statements constitute fraud, and the fine print in contracts may be construed, under certain conditions, as an intent to conceal.

Unlawful Trade Practices

False, misleading or deceptive acts or practices in the conduct of any trade or commerce are unlawful and subject to action by the appropriate codes of consumer protection. Such acts, which may apply to insurance agents and brokers, include, but are not limited to the following:

- Passing off services as those of another.

- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered.
- Causing confusion or misunderstanding as to affiliation, connection or association with another.
- Using deceptive representations or designations of geographic origin in connection with services.
- Representing that services have sponsorship, approval, characteristics or benefits which they do not have.
- Disparaging services or the business of another by a false or misleading representation of facts.
- Advertising services with intent not to sell them as advertised.
- Advertising services with intent not to supply a reasonable expectable public demand, unless the advertisements disclose a limitation on quantity.
- Representing that an agreement confers or involves rights, remedies or obligations which it does not have or involve, or which are prohibited by law.
- Misrepresenting the authority of a salesman or agent to negotiate the final terms or execution of a consumer transaction.
- Failure to disclose information concerning services which was known at the time of the transaction if such failure was intended to induce the consumer into a transaction which the consumer would not have entered had the information been disclosed.
- Advertising under the guise of obtaining sales personnel when in fact the purpose is to first sell a service to the sales personnel applicant.
- Making false or misleading statements of fact concerning the price or rate of services.
- Employing "bait and switch" advertising in an effort to sell services other than those advertised on different terms or rates.
- Requiring tie-in sales or other undisclosed conditions to be met prior to selling the advertised services.
- Refusing to take orders for the advertised services within reasonable time.
- Showing defective services which are unusable or impractical for the purposes set forth in the advertisement.
- Failure to make deliveries of the services advertised within a reasonable time or make a refund.
- Soliciting by telephone or door-to-door as a seller, unless, within thirty seconds after beginning the conversation the agent identifies himself, whom he represents and the purpose of the call.
- Contriving, setting up or promoting any pyramid promotional scheme.
- Advertising services that are guaranteed without clearly and conspicuously disclosing the nature and extent of the guarantee, any material conditions or limitations in the guarantee, the manner in which the guarantor will perform and the identification of the guarantor.

Burden of Proof

To recover under deceptive or unfair trade practice acts, it is the claimant's burden to prove all elements of his cause of action and that he is a "consumer" within meaning of the act.

Legal Remedies

Whenever the courts or consumer protection division of an insurance department have reason to believe that any person is engaging in, has engaged in, or is about to engage in

any act or practice that may violate a trade or practices act, and that proceedings would be in the public interest, the division may bring action in the name of the state against the person to restrain by temporary restraining order, temporary injunction, or permanent injunction the use of such method, act or practice. In addition, there may be a request by the consumer protection division, requesting a civil penalty for each violation, possibly \$2,000, with a maximum total not exceed an established amount (typically \$10,000). These procedures may be taken without notification to such person that court action is or may be under consideration. Usually, however, there is a small waiting period, seven days or more, prior to instituting court actions.

Actions which allege a claim of relief may be commenced in the district court -- usually where the person resides or conducts business. The Court may make such additional orders or judgments as are necessary to compensate those damaged by the unlawful practice or act. Usually, there is a statute of limitations, typically two years, to bring such action.

The United States Post Office

The Postal Service has jurisdiction over situations where the mail is used to transfer money for products or services. It administers a powerful law but has insufficient resources to deal with the vast number of frauds it encounters.

Most mail-order schemes attempt to exploit people's fears. Their promoters are usually "hit-and-run" artists who hope to make a profit before the Postal Service stops their false ads. When a scheme is detected, postal inspectors can file a complaint or seek an agreement with the perpetrator. When a complaint is contested, a hearing is held by an administrative law judge. If the evidence is sufficient, this judge will issue a **False Representation Order (FRO)** enabling the Postal Service to block and return money sent through the mail in response to the misleading ads. Although the order can be appealed to the courts, very few companies do this. Each voluntary agreement and FRO is accompanied by a cease-and-desist order that forbids both the challenged acts and similar acts. Under the Mail Order Consumer Protection Amendments of 1983, if this order is violated, the agency can seek a civil penalty in federal court of up to \$11,000 per day for each violation.

Unfair Competition and Business Practices By Insurers

Agents should know that the insurance companies they represent are also subject to the insurance and practice rules above, as well as to specific deceptive or misleading acts in the areas of advertising, settlement practices, reporting procedures, discrimination (by race, disability, rates, renewal, benefits), investment practices, reinsurance restrictions, liquidations and more.

Violations of consumer protection issues by insurers will be met with an array of fines and penalties ranging from hearings before the commissioner, public hearings, judicial hearings and review, additional periodic reporting (beyond annual statements), investigative audits, dollar penalties, civil penalties to the more severe cease and desist actions and revocation of an insurer's certificate of authority to conduct business.

The following are some areas of consumer protection violations by insurers that should alert agents:

Unauthorized Insurer False Advertising

The purpose of consumer protection laws in this area is obvious -- insurers not authorized to transact business in the state should not place, send or falsify any advertising designed to induce residents of the state to purchase insurance. This legislation is usually directed at "foreign or alien insurers" and defines advertising to include ads in the newspaper, magazine, radio, television and illustrations, circulars and pamphlets. Violations can also include the misrepresenting of the insurer's financial condition, terms and benefits of the insurance contract issued or dividend benefits distributed.

Unfair Settlement Practices

Insurers doing business in a state are subject to rules and regulations detailing unfair claim settlement practices such as:

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages.
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies.
- Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.
- Compelling policy holders to institute lawsuits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in the suits brought by these policy holders.
- Failures of any insurer to maintain a complete record of all the complaints which it has received during recent years (usually three years) or since the date of its last examination by the commissioner. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of these complaints and the time it took to process each complaint.

Discrimination by Handicap

An insurer doing business in a state may not refuse to insure, continue to insure or limit the amount, extent, or kind of coverage available to an individual, or charge an individual a different rate for the same coverage solely because of handicap or partial handicap, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonable anticipated experience.

Discrimination by HIV Testing

In recent years, HIV-related testing in connection with an application for insurance has become commonplace. If an insurer requests or requires applicants to take an HIV-related test, he must do so on a nondiscriminatory basis. An HIV-related test may be required only if the test is based on the person's current medical condition or medical history or if the underwriting guidelines for the coverage amounts require all persons within the risk class to be tested. Additional stipulations require that an insurer may not make a decision to require or request an HIV-related test based solely on marital status, occupation, gender, beneficiary designation or zip code. Further, the uses that will be made of the test must be explained to

the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer.

An insurer may not inquire whether a person applying for insurance has already tested negative from a previous HIV test. The insurer may inquire if an applicant has ever tested positive on an HIV-related test or has been diagnosed as having HIV or AIDS. The results of an HIV test are considered confidential, and an insurer may not release or disclose the test results or allow the test results to become known, except where required by law or by written permission from the proposed insured. Then and only then can results be released, but only to the proposed insured, a licensed physician, an insurance medical information exchange, a reinsurer or an outside legal counsel who needs the information to represent the insurer in an action by the proposed insured.

Discrimination in Rates or Renewal

An insurer may not discriminate on the basis of race, color, religion, or national origin, and, to the extent not justified by sound actuarial principles on the basis of geographical location, disability, sex, or age, in the setting or use of rates or rating manuals or in the nonrenewal of policies.

Benefits Protection

Insurers are duty bound to protect all money or benefits of any kind, including policy proceeds and cash values to be paid or rendered to the insured or any beneficiary under a life insurance policy or annuity contract. In essence, these benefits must inure exclusively to the person designated in the policy or annuity contract. They must be exempt from attachment, garnishment or seizure to pay any debt or liability of the insured or beneficiary either before or after the money or benefits are paid. They are also exempt from demands of a bankruptcy proceeding of the insured or beneficiary.

Health Policy Benefits

In the health insurance industry, benefit payments are commonly assigned to a physician or other form of health care provider who furnishes health care services to the insured. An insurer may not prohibit or restrict the written assignment of benefits. When such an assignment is requested, the benefit payments shall be made directly by the insurer to the physician or health care provider and the insurer is relieved of any further obligation. Of course, the payment of benefits under an assignment does not relieve the covered person from any responsibility for the payment of deductibles and copayments. Further, a physician or health care provider may not waive copayments or deductibles by acceptance of an assignment.

Contract Entirety

Every policy of insurance issued or delivered within the state by any insurance company doing business in the state shall contain the entire contract between the parties. Furthermore, the application used to secure the insurance is usually made part of the contract.

Insurer Mergers

The conditions and regulations necessary for two insurance companies to merge or consolidate are well documented in state insurance codes. Concerning consumer protection,

however, it is important to know that all policies of insurance outstanding against an insurer must be assumed by the new or surviving corporation on the same terms and under the same conditions as if the policies had continued in force with the original insurer.

Reinsurance Assumptions

A method used by one insurance company to insure or reinsure another insurance company is called stock assumption. Most insurance codes do not affect or limit the right of a reinsurer to purchase or to contract to purchase all or part of the outstanding shares of another insurance company doing a similar line of business for the purpose of reinsuring all of the business including the assumption of its liabilities.

Despite the practice of assumption reinsurance, some members of Congress in recent years have objected to the process, since there is no requirement to inform policy holders in advance that the insurance company behind their policy is relinquishing responsibility to another company, that is, the reinsurer. The reasoning behind their concern is that policy holders who have purchased coverage based on the financial condition and reputation of one company may suddenly find themselves insured by another company without warning or knowledge of the new company's abilities to pay their claims. To date, however, there is no definitive legislation passed to change reinsurance assumption.

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