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SECTION 1
INSURANCE ON THE Internet

When the topic of the Internet arises, the question that many insurance agents ask is. . . should I participate? A better question would be . . . how can I participate?

Like it or not, the Internet is here and its use is about to explode. Need proof? A recent survey, by International Data Corp, asked small business owners if the Internet is key to doing business. Almost 40% responded YES! This is double the response taken in 1995. And, by 2000, the World Wide Web is expected to be a significant channel representing $95 billion in product and service activity. Users of the Internet numbered 16 milliom in 1995, jumping to 34 million in 1996 and anticipated to skyrocket to 163 million by the year 2000.

If we accept a growing consumer enthusiasm for the Internet, the next question is will people use it to buy complicated financial products, like insurance, and will direct access to insurance company websites soon eliminate the need for agents altogether? Both issues are hotly debated.

Experts believe that someday a rather exclusive group of consumers will dial up insurer sites, research policies and fill out an electronic application. Several carriers are already in place to make this happen. The best estimates are, however, that only a small segment of the population will be willing to do this. More likely, most people will find the task of Internet searches and the analysis of lengthy and complicated insurance policies too intimidating on their own. So, as long as insurance companies do not offer deep discounting as an incentive to "buy direct" over the Internet there is no reason for consumers not to take advantage of professional guidance from a licensed agent.

WILL THE Internet REPLACE AGENTS?

Experts don't believe this will happen since most insurance is purchased when an agent uncovers a need and encourages the consumer to take action. Further, only a small portion of the population is thought to be self-directed enough to log on and buy insurance without help. For future generations, however, their lifelong association with the computer may stimulate more of them to make remote purchases of goods and services like insurance.

If the Internet is not a soon-to-be vehicle for widespread direct purchasing of insurance policies what good is it to agents and the industry alike?

Currently, there at least a dozen or more great ways that the insurance industry can benefit from using the Internet.

- Clients and agents can check the status of policies or cash values
- Clients and agents can check the status of pending applications
- Premiums can be paid by credit card or electronic transfer
- Quotes and illustrations can be instantly retrieved
- Clients can stay in touch directly with their agent using E-mail
- Agents can be connected to carrier news on new products or learn of commission problems
- Insurance loss claims can be reported
- Clients can use an agent website to review benefits of their policy
- Agents can provide clients with a 24-hour information source using an electronic newsletter
- Clients will be able to buy insurance using electronic signature technology
- Agents can inexpensively market their services with their own website or as a member of an "insurance mall".
- Agents can download forms and order underwriting requirements
- Agents can learn of new regulations and licensing requirements or complete their continuing education
- Discussion groups (chat rooms) can provide valuable interaction with other professionals about policy benefits and insurance news

- Independent and employee agents alike can have access to powerful prospecting databases, professional tax and planning reference materials and rating services
- Agents in the field could log on for sales presentation / quote information
- Regulators can post "consumer-beware" bulletins and comb the web for violations and less than ethical insurance dealings.
- Insurers and agents alike can use the Internet as an inexpensive recruiting tool

Just one of these possible uses should be a reason for the professional agent to get involved and work through the Internet.

Experts predict that no major insurer will be without Internet presence in the next couple of years. Given their vast resources and ability to tap into new technology it is likely that the insurance industry will soon maintain a high profile that will not go unnoticed by the many information search services such as Yahoo, Excite, Alta Vista, AOL and Infoseek. As a result, it won't be long before consumers will be offered a stockpile of user-friendly insurance sites and links from related sites in banking, financial planning, tax and retirement planning.

All of above are reasons that agents should now begin investigating the potential use and application of the Internet. To aid in this research you will need to know some background on the Internet and some of the legal and regulatory obstacles to selling insurance on line.

THE MARKETING OF INSURANCE OVER THE Internet

In response to the increased use of electronic commerce and the unique regulatory concerns surrounding electronic commerce, the NAIC charged the Market Conduct and Consumer Affairs (EX3) Subcommittee to study and issue a white paper, including recommendations, regarding the sale, marketing and regulation of insurance through the Internet; including, but not limited to, analysis of technology issues such as digital and electronic signatures, electronic fund transfers, electronic applications, privacy and confidentiality issues, contracted policy forms, and agent, broker, producer and company licensing issues. The following section is the White Paper results with minor editing for readability.

Internet Commerce

Electronic commerce is the buying and selling of goods via an electronic medium. This is a very broad definition that encompasses the sale of goods from telemarketers to the sale of goods over the Internet. From a consumer's viewpoint, electronic commerce may provide access to more information, faster and economically, and may result in lower product and service acquisition costs with ease and greater cost savings. Electronic commerce can also help organizations meet their goals of enhanced customer service, and the economical dissemination of consumer information and increased sales.

Over the last several years, the proliferation of the Internet usage has increased importance of electronic commerce. With the Internet, companies are able to make world wide contact with potential consumers 24 hours a day, 365 days a year. Companies can also maintain this open line of communication with suppliers, independent contractors and any other entity which plays an integral role in the production and distribution of its product.

Potential uses of the Internet

consumers

The Internet provides a convenient way to learn more about products, sources and pricing. And, since people make most purchasing decisions based on information they receive through manufacturer marketing materials, companies looking for more efficient ways to target their market will find that the Internet will allow consumers to purchase a product, rather than being sold a product.

E-mail capabilities allow consumers to communicate with agents and/or companies about changes to their insurance policies and to report and process handle claims. Not only can the Internet cut down or reduce "phone tag," it can help provide instantaneous confirmations that consumers' instructions have been complied with, furnish another option for carrying out correct notification procedures, and provide "hard-copy" (print-out capability) of agents'/companies' instructions (e.g., directions to repair facilities, inspections procedures, etc.) without the need to write down or remember the information.

Regulators

Regulators in their consumer-protection and consumer education roles could benefit from near-universal consumer access to the Internet. For example, Insurance Departments can post consumer information that would appear more or less automatically in consumers' insurance-related searches. Thus, this information could be disseminated much more cost-effectively and consistently than it currently can be supplied. Many departments already provide this type of information in hard-copy format including general insurance information and premium comparisons, but its dissemination is limited and sometimes expensive because of its hard-copy format.

The marketing of insurance over the Internet also offers regulators an additional opportunity to actively monitor market conduct. Regulators, like consumers, can "surf" the Web, looking for suspicious solicitation activity. Ordinarily, regulators must wait to be made aware of market conduct problems through consumer complaints (outside normal market conduct audits). The Internet is a more pro-active approach to such audit efforts.

REGULATORS & THE Internet

The Producer Information Netwrok (PIN) and the Producer Database (PDB) are two examples of regulators systems on line that function as central repositories of producer licensing, licensing demographics & regulatory actions, agent disciplinary actions, company appointments, terminations and more!

The ease and speed of Internet communications mean that regulators could more frequently monitor insurer compliance with regulatory procedures and time frames. Once appropriate record keeping requirements are in place, "spot checking," "surprise audits," and other tools could be as simple to implement as an exchange of E-mail. This could instill greater compliance efforts in insurers with chronic service problems.

Industry

Producers and insurers recognize the vast capabilities of the Internet and the ability to provide information to prospective clients, in a format that more closely fit their clients' needs. The Internet allows their information to be easily and continuously available, to post a "presence" that accurately portrays the variety of products and services; and to provide a convenient way for consumers to contact them for follow-up.

The relatively low cost of electronic communication, compared to that of hard-copy mailings, telephone solicitations, etc., should provide potential cost savings for agents and companies that use the Internet effectively.

Insurance companies are already taking advantage of the electronic commerce available through the Internet by establishing home pages on the Internet. With these home pages, insurance companies are opening new distribution channels which could eventually incorporate all facets of the insurance transaction, from initial contact with the consumer to collection of premium, issuance of the policy, and the payment of benefits. The Internet is recognized by agents and companies as potentially more efficient than many traditional marketing methods.

The Internet allows companies to service existing markets and expand into previously untapped markets. Huge marketing possibilities are more easily possible on the Internet, allowing agents or insurers to post

their information in such a way that it will be found by people pursuing related interests, such as crop insurance information by farmers, and fine-arts coverage by art collectors, etc.

In addition to sales, insurance companies are finding the Internet a means by which to better educate consumers on the different type of insurance available and the benefits of such insurance. Insurance companies can also utilize the Internet to service current policyholders by offering on-line claim assistance, complaint handling and answering general inquiries. Finally, the Internet offers companies the opportunity to expand its communication with its agents. The Internet offers insurance companies the opportunity to offer these services with greater speed and efficiency and at a lower cost.

> **Insurers speak**
>
> A recent poll of insurers points out that helping the agent make more sales is one of the primary reasons that carriers are interested in having a presence on the Internet.
>
> California Broker 10/97

Internet Overview

The Internet began in 1968 when the Advance Research Projects Agency (ARPA) at the United States Department of Defense began developing ARPAnet, the first large-scale computer network. ARPANet was designed to give computer scientists at universities and other research institutions access to distant computers, permitting them to use computing facilities which were not available at nearby locations.

Before ARPANet, most networks depended on a central server which, if it went down for any reason, jeopardized the entire system. ARPANet used multiple servers and communications lines and protocols so that if any server had a problem, information could be re-routed through remaining servers.

In the 1980's, the National Science Foundation (NSF) created five supercomputer centers and made them available for general research purposes. Until this time, access to these supercomputing facilities was limited primarily to scientists, universities and researchers. With the advent of the NSFnet, opportunities for access by others began to open up. Regional networks were developed and interconnected within the NSFnet and these, along with the MILNet, Bitnet, DECnets, and hundreds of Local Area Networks (LANs) made up what has become known as the Internet.

A computer network is two or more computers which are connected to each other and can communicate information from computer to computer. Today, the Internet is comprised of thousands of computer networks which are located throughout the world. Common tools used to gain access to this world wide network of computers are e-mail and the World Wide Web. Because this access is available 24 hours a day and is available world wide, the Internet is revolutionizing the ability of individuals to communicate and to obtain information on almost any subject at any time.

Accessing the Internet

Access Through Commercial and Public Internet Service

E-Mail, the World Wide Web, Internet Service Providers and computer on-line services are all means by which one can obtain access to the Internet.

Electronic mail, similar to conventional mail, allows individuals to send messages to other people. The major advantage of electronic mail over conventional mail is that electronic mail is delivered immediately, at any time and is paperless. In addition, recipients can retrieve the message at any time and print out the message if the need arises.

Another way to gain access to the Internet is through commercial on-line services. These services have electronic magazines, chat rooms, and software libraries that are available to subscribers of the service. They also usually have Internet access via e-mail, newsgroups, and the World Wide Web.

A person can also obtain access to the Internet through Internet Service Providers (ISP's). ISP's are organizations that have servers connected to the Internet. ISP's charge a fee to individuals for access to the Internet through their server.

Access to the Internet is typically through a fee-based Internet Service Providers or commercial on-line services. For corporate or government entities these may be high-speed, dedicated lines, and for individual consumers they are typically ordinary telephone lines using modems. There is an increasing use of satellite and cable connections, though these are still in a distinct minority.

Many people assume that only sophisticated individuals will be using the Internet. However, with the development of low cost, simplified hardware for use exclusively on the Internet or in concert with cable television connections, electronic capabilities will be present in many, if not most, American homes. This means the purchasing of a home computer will not be necessary to access the Internet. Thus, the Internet could offer the promise of improved distribution of products and dissemination of information to households almost everywhere, especially those underserved by current distribution methods. In addition, people may also access the Internet at public libraries and schools.

However, unless the cost drops significantly, low-cost home access to the Internet may not soon become a reality for many people. Current prices for equipment necessary to access the Internet via a TV are still beyond the means of many people, and they still must pay monthly Internet access fees. It remains to be seen if these prices will drop sufficiently in the next couple of years. The limited access to the Internet of certain classes of potential insurance consumers could raise some issues for regulators concerning insurance companies, producer marketing and distribution methods.

The Internet is relatively new yet its popularity, has grown dramatically in recent years. In fact, reports of the Internet's dramatic growth have seemed common for some time. Still, the essential question for the insurance industry is not how quickly the Internet has grown, but how large and accessible it currently is and how quickly it may grow in the future.

The World Wide Web

The Internet is actually a variety of technologies including File Transfer Protocol (FTP), Gopher Servers, electronic mail (e-mail), and the World Wide Web. The World Wide Web is the interface familiar to most consumers, and uses Universal Resource Locators (URLs) also known popularly as domain names to identify web sites. This, combined with a user-friendly interface known as hypertext (HTTP) allows users to navigate by clicking with a mouse or other pointing device on select words or phrases, icons, or other graphic images. This is the methodology most people associate with the Internet.

The World Wide Web is also where many companies have set up established home pages. A home page can be compared to a company brochure in an electronic format. Like a brochure, a home page will provide basic information about an organization, such as the location of the organization, main area of business and available products. Depending upon the amount of information, an organization wishing to make a home page available may be limited to one page or may expand to include numerous pages of information. In addition, a home page often includes hypertext links to other pages; thus forming a web of information on thousands of subjects.

Sales and Service of Insurance Over the Internet

To date, current electronic commerce typically involves the sale of goods as opposed to services, such as insurance. This disparity can be tied to a variety of issues, including technology acceptance by consumers, security and regulatory concerns surrounding insurance sales on the Internet. Unlike the sale of a book or article of clothing, the sale of an insurance policy involves complicated contractual language, the transmission of sometimes confidential information and a relationship of good faith on behalf of the buyer and the seller.

Current methods by which insurance sales can occur over the Internet are either single source or via insurance malls.

Single Source Sale Sites

Single source sale sites are comprised of a single insurance company marketing its products over the Internet through the establishment of a home page. When developing a home page for a single source sale site, insurance companies can use their home pages as a promotional tool, to direct consumers to their existing agents or as another distribution channel. A survey conducted by the LIMRA International, Inc. revealed that two thirds of the companies use their home pages for name recognition. Eight percent of the companies indicated they use their home pages for lead generation for their agents while only one company indicated direct sales was the main purpose of its home page.

A single source sale site is a method of marketing insurance over the Internet which enables the consumer to select and purchase his/her insurance directly from an insurance company. This type of insurance marketing over the Internet will presumably provide the consumer with all the steps necessary to purchase insurance; from filling out an application on-line to payment of the premium and receipt of the policy on-line.

Insurers' and producers' home pages can offer marketing and/or educational information about a company and its products. For instance, a home page may explain the benefits of life insurance or explain different auto coverages.

In addition to simply providing information, some sites will go a step further and offer on-line requests for quotation (RFQ) forms. RFQ's typically involve a questionnaire which the consumer must answer in order to obtain a quotation. Once this information is obtained the consumer can obtain an instant quote for insurance. RFQ's allow the consumer to obtain information directly and relatively quickly. If a consumer wishes to obtain more information on a particular product or make a purchase, insurers could provide a list of agents that may be contacted to complete the transaction. In addition to providing a quote to the consumer, RFQ forms provide the company with valuable statistics on the profiles of the individuals visiting the site and the type of insurance being requested.

Insurance companies may also develop home pages that work in conjunction with their agents. These sites offer general information on products and help educate consumers about their insurance needs. Similar to sites which provide RFQ's, these sites direct consumers to existing agents in order to obtain quotes, more information about a particular product and to make a purchase. Insurance companies using this arrangement may be selling a more complex insurance product, such as whole life insurance. When referring a consumer to an agent, the typical referral is to the agent's phone number and address. However, some sites may refer a potential consumer to an agent.

Just as insurance companies are establishing home pages for single source site sales, insurance agents are likewise establishing home pages for direct sales over the Internet. Currently, these home pages provide general insurance information to the consumer In the future, many of these home pages, along with the single source sites of insurance companies, will presumably offer all of the features necessary to complete the sale and delivery of an insurance policy.

Insurance Malls

Insurance malls are sale sites that offer the products of more than one seller. Vertical insurance malls offer the products of multiple sellers from the same industry, while horizontal malls offer the products of multiple sellers from multiple industries. Because of the diversity of products offered at both types of malls, these malls attract a wide diversity of consumers and have the potential to become true electronic markets.

One of the key features of insurance malls is their ability to provide consumers with access to a wide

variety of products and comparisons of these products. These Insurance malls are designed to provide consumers with one or more purchase alternatives by matching consumer profiles against company underwriting criteria and present a list of alternative companies from which the consumer may selects. The consumer can then review policy information, pricing, and other aspects of various offerings from companies participating in the mall.

Apart from being wholly geared to focusing on cost comparison and sales, many sites are educational. Insurance malls also present information about the different types of insurance available, insurance companies, and ratings of these companies. Such malls may also provide a brief description of insurance terms and information on state insurance laws.
A third category are malls which combine sales-oriented information with consumer-oriented information. These sites provide the consumer with the same information available in a site geared to consumer education; however, they also provide the consumer with the ability to fill out complete RFQ forms. In addition these insurance malls may also offer a list of agents as well as hyperlinks to the home pages of these agents or to other insurance Internet resources on the Internet.

Service of Insurance Over the Internet

The more transactions a consumer has with a company via a certain medium, the more bound the consumer becomes to the company and the medium of communication. Unlike consumers in other industries, consumers who use the Internet may have increased interaction with their insurance companies -- with noted benefits. A typical insurance consumer, without Internet service, only interacts with his/her insurance carrier on four occasions: 1) when he/she purchases the insurance policy, 2) when he/she pays the insurance premium,
3) when he/she makes a claim on the policy, and 4) when he/she changes coverage or other contract provisions such as a beneficiary. Consumers may, therefore, be more likely to use this medium to make their initial purchase of insurance if all facets of the insurance transaction are available over the Internet.

Many websites are already increasing the interaction insurance companies have with consumers by offering educational information. It has been stated that these types of interactions not only increase the general public's understanding of insurance but also create a familiarity and level of comfort in terms of a company's on-line services.

Another method of increasing consumer familiarity and confidence in a company's on-line services might be its provision of complaint and claim services over the Internet. Because the processing of claims, complaints and policyholder services is probably the most important aspect of the insurance transaction for consumers, providing them on-line might be an added benefit.

The increased use and demand for services over the Internet should be a constant reminder to insurance companies and regulators that an increasing number of consumers have a strong desire to access more information that is relevant to their individual interests and needs, insurance services being among them. Once all facets of the insurance transaction are available over the Internet, consumers may begin to use this medium to make their initial purchase of insurance. And as capabilities increase, so should insurance commerce on the Internet.

Company/Agent Communications

The Internet also is a tool which could enhance company and agent communication. With the use of the Internet, agents can have a continuous line of communication to their insurance companies. This could enhance the educational level of agents and thus enhance the information agents pass on to consumers during the sales process. In addition, the Internet has the potential to permit the electronic transmission of policy forms; thus cutting down on the cost of the application and policy issuance process.

Elements of Insurance Transactions

The insurance contract - i.e., the promise by the insurer to perform at a future date, coupled with the policyholder's promise to pay premiums - is a fundamental principle of to the business of insurance. To better understand this principle, it is essential to understand the elements of a contract. We can then examine the elements of an insurance transaction.

Elements of an Insurance Contract

Insurance policies generally contain the above elements. However, the process of achieving a fully executed insurance policy may vary based on a number of factors, including among others things, the type of insurance (e.g., personal lines property and casualty vs. life vs. health vs. commercial/business, etc); the type of policyholder (e.g., group, individual, corporate); and, as we are seeing, the method for memorializing the agreement (written vs electronic signature and/or other methods).

Even though differences may exist among the various types of insurance, the following steps typically represent the general means for achieving a binding insurance policy:

Offer - the act of a person applying for coverage.

Acceptance - an insurance carrier applying its underwriting standards and issuing the policy is commonly considered the act of acceptance. In those instances where a risk is not acceptable to the underwriter, but coverage could be provided at a higher premium, the issuance of a policy at the higher rates or for different coverages would be considered a counteroffer which could be rejected or "accepted" by the consumer.

Consideration - in an insurance policy, consideration is obtained by the policyholder paying premiums in exchange for the insurer agreeing to pay benefits at some future date (if certain conditions are met).

Legal Purpose - pursuant to the regulatory power of the respective state, insurers cannot enter into insurance contracts for products or services which are unlawful. (For example, business interruption coverage for a drug dealer would be illegal.)

Legal Competency of the Parties - the above basic rules as to legal competency generally apply in the context of the insurance contract.

Legal Effect of Electronic Commerce on Insurance Transactions

From the consumer's standpoint, the primary issue is not whether all of the elements of a contract exist. Rather, the consumer primarily seeks to know one thing at the time of sale: "Is my coverage effective?" Typically, with an insurance policy, there are several methods for validating the "binding effect" of coverage following completion of the application process by a consumer - e.g., a conditional receipt may be given or the insurance policy or contract may be issued immediately. However, to achieve this validation of coverage, the consumer typically signs an application form indicating an offer to purchase insurance and a general understanding of the terms of coverage.
Today, electronic commerce - i.e., computer-generated, online applications - poses a number of problems for insurers and consumers seeking to ensure the validity of the "binding effect" of the insurance transaction. Among other things, an acceptable method for verifying the identity of the applicant and recording the applicant's intention to purchase the insurance product must be found. Electronic signature technology currently does exist to address these problems and many states are passing electronic signature laws to address control them. However, the question still remains whether electronic signatures affixed to an electronic application and/or policy will be legally sufficient to form an enforceable insurance contract in the remaining states.

Very few court decisions exist on the use of electronic signatures. However, as discussed below, a number

of states have moved forward to either enact or propose legislation on electronic signatures. Additionally, general principles of contract law offer some latitude on the use of non-traditional signatures. For example, the Restatement (Second) of Contracts ~Section 134, states that "the signature to a memorandum may be any symbol made or adopted with an intention, actual or apparent, to authenticate the writing as that of the signer." The accompanying comment is also states relevant:

The traditional form of signature is of course the name of the signer, handwritten in ink. But initials, thumbprint or an arbitrary code sign may also be used; and the signature may be written in pencil, typed, printed, made with a rubber stamp, or impressed into the paper. Signed copies may be made with carbon paper or by photographic process.

The published law on the use of non-traditional signatures is, as stated above, very limited in this area. From an insurance regulatory standpoint, the state of Iowa has provided us with some precedent. In Wilkens v. Iowa Insurance Commissioner, the Utah court of appeals examined whether the computer-generated signature of an insurance agent met the requirements of a signature under the applicable insurance code provision. Ultimately, the court upheld the validity of the agent's signature, ruling that:

> "The fact that the signature is computer-generated rather than hand-signed does not defeat the purpose of the act. The issue is not how the name is placed on the sheet of paper; rather, the issue is whether the person whose name is affixed intends to be bound."
>
> 457 N.W.2d 1 (Iowa Application. 1990)

Even though the issue in Wilkens pertained to an agent's signature, the court's reasoning would seem applicable to policyholders. That is, the primary question is: "Did the applicant intend, by signing -- whether by pen or other means -- to be bound by the terms of a particular contract?" Considering that the technology now exists for electronic signatures, the next question is: "What are the methods for properly securing and validating those signatures?"

Electronic Signatures: The Technology and the Law

Technology

There are two primary forms of electronic signature: (1) digital signatures and (2) stylus signatures. Digital signatures are based on "public key cryptography". Through this, the signer uses a "private key" that transforms the data into unintelligible form and the recipient uses a public key to decipher and verify the data. Digital signatures protect the security and privacy of on-line transactions. On other hand, stylus signatures work in the following manner: the signer moves the stylus (or pen) across a computer screen, which displays an image that traces the movement of the stylus. The signer sees his or her signature as it is being captured by the computer, just as a signer sees his/her signature on paper. Upon completion, the signature is encrypted and sent electronically to its destination.

Law

Several states have adopted digital signature statutes or regulations. For example, the state of California has adopted the following statute enacted California Government Code Section 16.5 which provides:

(a) In any written communication with a public entity, as defined in Section 811.2, in which a signature is required or used, any party to the communication may affix a signature by use of a digital signature that complies with the requirements of this section. The use of a digital signature shall have the same force and effect as the use of a manual signature if and only if it embodies all of the following attributes:

(1) It is unique to the person using it.
(2) It is capable of verification.
(3) It is under the sole control of the person using it.
(4) It is linked to data in such a manner that if the data are changed, the digital signature is invalidated.
(5) It conforms to regulations adopted by the Secretary of State. Initial regulations shall be adopted no later than January 1, 1997. In developing these regulations, the secretary shall seek the advice of public and private entities, including, but not limited to, the Department of Information Technology, the California Environmental Protection Agency, and the Department of General Services. Before the secretary adopts the regulations, he or she shall hold at least one public hearing to receive comments.

(b) The use or acceptance of a digital signature shall be at the option of the parties. Nothing in this section shall require a public entity to use or permit the use of a digital signature.

(c) Digital signatures employed pursuant to Section 71066 of the Public Resources Code are exempted from this section.

(d) Digital signature means an electronic identifier, created by computer, intended by the party using it to have the same force and effect as the use of a manual signature.

Under the above referenced law, the California legislature intended that the "force and effect" of the digital signature would be established by the intention of the party using the digital signature. (Utah has enacted similar legislation. See Utah Code Annotated . ~Section 46-1-3-107., et seq.)

Security of Electronic Signatures

One may ask; is digital signature technology "secure?" Can it be altered by other individuals, such as an agent or an underwriter? Is the transmission confidential?

In general, digital signatures provide at least two levels of security integrity (i.e., validation that the signature was transmitted in an unaltered state) and authenticity (i.e., validation that the signature is true and correct). These two levels of security are obtained in large measure by the use of unique "keys" which are inputted into the computer program: one by the party generating the electronic document, the other by the signing party. Changes to the underlying electronic application will render the electronic signatures invalid. Thus, the integrity of an electronic document is protected by these safeguards.

Stylus signatures offer similar safeguards, i.e., there are several encryption steps. The process uses secret keys and, to a certain extent, the process is highly resistant to alteration or unauthorized access and use. Perhaps most important for insurers, the information set forth on the application is "locked" along with the signature of the applicant (and probably agent). The fact that the application itself is more secure may reduce the possibility that information on that application will be altered.

Other Considerations for the Insurance Industry

Due to demands on commerce within the various states, state legislatures are moving forward to draft and enact legislation on electronic commerce, electronic signatures, etc. Further, banks and other financial institutions are developing business systems to fully leverage the capabilities of electronic commerce. (Apparently, even the Uniform Commercial Code is being revised to address the issue of electronic commerce -- UCC Article 2B.) These and other events may cause the insurance industry to be left "on the sidelines," watching as other industries and regulatory agencies take the initiative to create new law on electronic commerce. Given these circumstances, insurance regulators need to examine these new technologies and their application to the business of insurance now.

Advantages and Disadvantages of Insurance Sales and Service Over the Internet

Consumer Advantages

Consumers already have the ability to search the Internet for life and auto insurance quotes on the Internet via numerous home pages and other Worldwide Web Sites provided by or on behalf of insurers and agents. Some Internet sites are interactive and permit the consumer to provide certain information and allow the agent or insurer to determine eligibility for coverages.

In addition to obtaining quotes, consumers currently have the ability, from at least one auto insurer, to complete the entire transaction on-line. Another auto insurer provides consumers the opportunity to complete the application on-line and then forwards the application to an agent located near the consumer to complete the transaction.

Consumers may also browse the Internet to locate agents and insurers in their area. This provides consumers the ability to narrow their search for a particular agent, insurance company or specific type of insurance coverage. In many cases, agents advertise the names of insurers they represent and the types of coverage they most commonly provide.

A particular advantage to consumers appears to be accessibility. Often times, consumers may not have the time nor the opportunity to shop for insurance during normal work hours. The Internet increases the opportunities for these consumers to shop after hours and in most cases, a quote can be received within minutes or the next day. The quote arrives electronically, which eliminates the need to personally interact with an agent, which some consumers prefer.

Consumers using the Internet for the purchase of insurance have the ability to contact their agent or insurer 24 hours a day. Depending on the Internet site's capabilities and response time, this is likely to substantially enhance consumer service by eliminating the delays in obtaining policy information and service. While some insurers already provide 24-hour service via telephone, the Internet has the potential to increase this practice.

Consumers already have the ability from at least one company to review their account status to determine when and how much they need to pay for their existing policy. After checking how much is due, they can make a payment to the company online. This service eliminates the two step process of calling the company to find out how much is owed and then mailing a payment. Online payment could potentially prevent cancellations as this can be done at any hour of the day without the delay of the postal service.

Many major insurers have indicated they will be able to deliver insurance products and services via the Internet in a more cost effective environment. This may result in lower a overall lower cost of premiums to all consumers if a substantial number who are willing to purchase coverage and interact with an agent or insurer electronically.

Consumer Disadvantages

The most significant disadvantage to some consumers may be the lack of personal interaction with an agent. Agents are generally trained to assist consumers in determining the type and amount of coverage that should be purchased to adequately insure their needs. Some consumers may focus on how much coverage they want to purchase, rather than how much coverage they actually need. Since many consumers may not be well versed in the purchase of insurance, they may end up "ordering" insurance, rather than purchasing insurance that fits. Unfortunately, "ordering" insurance is not a practice that would be unique to Internet sales.

Many consumers are not acquainted with insurance laws and regulations. This includes, but may not be

limited to familiarity with the requirements for insurer and producer/agent licensing, producer appointment, policy form filing and approval for products sold in the admitted market, and qualifications for sales in the surplus lines and reinsurance markets. Because the location and actual identity of the producer and/or agent is not always obvious, consumers may not in all Internet transactions be able to determine whether they are doing business with regulated producers and insurers, or are purchasing insurance products that have been approved by state regulators. Or worse, could learn they purchased a fictitious policy. This could result in a variety of consumer issues where the desired level of regulatory protection may not be available to consumers.

Some consumers lack the financial ability to purchase computer hardware or software, and access the Internet. Even in today's environment where accessing the Internet is becoming increasingly more affordable, the lowest cost access can be unaffordable for some consumers. If insurers offer lower premiums to Internet access users, certain consumers will not benefit from those savings unless they have Internet access from another source such as a Public Library. Inadequacies in the telecommunications infrastructure also limits some consumers access to the Internet, especially in the rural areas of the country.

Even though Internet marketing of insurance products and services is growing at a rapid rate, there are only a limited number of insurers presently offering electronic quotes. At least for now, this may limit the number of comparisons or quotations a consumer may obtain electronically.

Regulator Advantages

Industry and consumers will have electronic accessibility to those regulators who have a presence on the Internet. This will permit regulators to respond to inquiries or consumer complaints in a quicker fashion and more efficient manner. Regulators can provide the insurance industry with electronic access to compliance information; guidelines; license applications and fees, information bulletin boards; e-mail; and, of course, faster response time to industry requests for information.

Those state regulators with Internet access will have the ability to directly monitor Internet sales and solicitation activity. There are approximately 35 state insurance regulatory agencies currently on-line, along with the National Association of Insurance Commissioners (NAIC). The NAIC has an extensive Web site at http://www.naic.org that serves as a communication link between insurance regulators, consumers and the industry. The site also provides links to all 35 of the state insurance regulatory agencies that have active Web sites, providing users with direct access to insurance regulators in each jurisdiction.

Many agent and insurer home pages currently contain a hyper-link to the NAIC and State Insurance Departments. This provides consumers with electronic access to those regulators and in turn, will provide those regulators with a better ability to respond to industry and consumer needs in a more timely and manageable manner.

The insurance industry has recently gained Internet access to the NAIC Producer Data Base (PDB) through the Insurance Regulatory Information Network (IRIN). For those states participating in PDB, industry will have electronic access to agent licensing information. This will substantially reduce the number of phone calls and written requests state insurance departments currently receive from industry for verification of good standing and/or licensing status and prior administrative actions. Time previously spent by regulators responding to these requests may instead be spent issuing licenses in a more timely manner.

In addition, the Internet has the potential to permit the electronic transmission of policy forms; thus cutting down on the cost of the application and policy issuance process.

Regulator Disadvantages

Some state regulators do not currently have adequate Internet access making it very difficult to monitor

electronic commerce or investigate consumer complaints related to Internet insurance sales and service or monitor unlicensed activity. This impairs the ability of state regulators to provide adequate consumer protections.

It may become very difficult for regulators to monitor potentially increasing unlicensed activity. This severely impairs the ability of state regulators to provide adequate consumer protections.

Someone intending to commit insurance fraud could create an Internet presence, and complete a number of sales (collecting premium) and subsequently terminate the illicit Internet presence. In these cases, regulators may have difficulty obtaining sufficient evidence that a violation of state law has occurred in order to take and/or prosecute for fraud. Unless there is a specific tie to an insurer and/or licensed agent, it may become very difficult to restore policy benefits.

Industry Advantages

The most significant advantage of the Internet to industry is the ability to communicate and transact business electronically which could substantially reduce administrative costs, and increase profits and bring more innovative and less expensive services to a wider audience.

Insurers will also have the ability to communicate and deliver marketing materials to their producers electronically, including rate manuals, underwriting guidelines, applications, company procedures and advertising guidelines. to name a few.

Consumers who commonly use the Internet or similar electronic providers for the purchase of other products and services could search for competitive insurance quotes and seek out an agent or insurer that best fits their personal needs. Consequently, the Internet could substantially enhance marketing potential for those agents and insurers willing to be on the cutting edge of this new marketing opportunity.

Automation vendors are currently designing web sites that are integrated with agency management systems. This will permit policyholders to access their agent or insurer electronically to examine their premium billing status, determine the type and amount of coverage, make changes on their policy, request quotes and obtain information about other coverages. The insurance industry views this as an opportunity to operate a "virtual" insurance agency that is accessible to policyholders and consumers 24 hours a day.

The industry will also be able to electronically access most state insurance regulators to obtain compliance information such as license applications and guidelines, applicable fees, interpretation of certain state laws, communicate by e-mail with insurance department staff and respond to consumer complaints in a more timely manner. There are those in the insurance industry who believe the Internet will enhance their ability to improve regulatory compliance and reduce exposure to potential market conduct violations.

Agent and insurer access to the NAIC Producer Data Base will allow on-line verification of the license status of agents on a state-by-state basis, as well as access to producer demographics, lines of authority, prior administrative actions taken by insurance and NASD regulators and NASD exam results. In the near future, industry will also have access to agent appointment information and will have the ability through the Producer Information Network (PIN) to electronically appoint and terminate agents or producers. This should enhance the ability of the industry to comply more efficiently with various state agent licensing and appointment requirements.

The National Council on Compensation Insurance, Inc. (NCCI) currently provides, via its Web site, carriers, agents, employers and regulators alike with worker's compensation related safety and educational materials as well as information on its products and services.

NCCI's Web site will be expanded to facilitate access to key NCCI products and services. NCCI's Web site will also provide the door through which applications and deposit premiums can be submitted to the worker's compensation residual market in NCCI plan administered jurisdictions.

In the current paper environment, agents and insurers have expressed frustration and concern regarding the binder or effective date of coverage. Those agents who choose to transmit residual market applications electronically will receive immediate notification and verification that coverage is bound per the requested effective date. The NCCI system will also facilitate electronic payment of premiums.

Industry Disadvantages

An issue for the insurance industry is remaining in compliance with insurance regulations while engaging in Internet-based sales and services. The Internet is global, and therefore insurance offerings can appear anywhere, including states or countries where the insurance company or agent may not be authorized to do business. Thus the insurance industry needs to be cognizant of state regulatory requirements in regards to licensing of agents and insurers, approval or filing of insurance products.

In most states, insurers may only issue a policy through a licensed agent. Insurers, are expressing concerns that their producers may be offering policies in states where they are not approved, Insurers, therefore, need to make particularly sure that their web sites clearly disclose where their products are intended to be offered, to insure they are only soliciting business or making representations where they have authority to transact business.

Based on recent surveys conducted by the NAIC, most states consider electronic solicitation of insurance no different from solicitation through any other media. Therefore, in most states, agents and insurers must first be authorized or licensed to transact business before soliciting insurance to consumers in that state.

In using the Internet, there may be some question as to where an insurance transaction may have occurred. When an agent or insurer solicits insurance electronically, does the transaction occur in the state in which the agent is located, or in the state in which the consumer is located? The majority of states have indicated in recent NAIC surveys that they believe the transaction occurred in the state in which the consumer resides.

Some in the insurance industry have also expressed a concern that without an agent present in a face-to-face contact with the consumer, it may become more difficult to qualify the applicant for insurance. Inadequate medical records and other sources of information about the consumer may impair an underwriter's ability to determine eligibility without actual contact and verification by the agent.

The rapid growth in development of Internet web sites for agents leaves some insurers with concerns regarding specific state advertising laws and regulations. Agents may be advertising specific insurance products and services without authority from the insurer and in violation of these laws and regulations. Furthermore, in a recent NAIC survey of state insurance departments, Internet advertising is considered subject to regulatory approval in many states.

Because agents must be licensed and in most cases appointed by insurers in those states in which the agent transacts business, licensing costs will increase for some insurers who permit their agents through the Internet to solicit business in all states.

Problems with selling insurance over the Internet

Requirement of an applicant's signature

Most state laws currently require an applicant's signature on an application for insurance. An applicant's signature is generally required to certify a sworn statement of the insured. Both the insurance industry and state regulators are expressing concerns that it may be difficult to prove misrepresentation or fraud on the part of an applicant without a sworn and properly signed statement.

At least twelve state have already enacted legislation authorizing the use of digital signatures in private communications. These statutes generally provide that a digital signature will have the same force and effect as a written signature as long as the electronic signature is unique to the signer, its authenticity can be verified, and it is valid only if the data in the document has not been altered. Once a legal framework is established and a reliable certification authority is in place, an application signed with a digital signature will be just as binding on the signer as a written signature.

Systems are currently in use (and will be design-enhanced in the future) that will allow for an electronic signature of the applicant. Sufficient security measures must be taken to assure that the applicant's electronic signature is valid and verifiable. The most serious unanswered question is what may be acceptable to courts as evidence of an electronic signature.

Requirement of blood or urine samples for life insurance

Depending on the level of coverage requested in a life insurance application, most insurers require a blood and/or urine sample for underwriting purposes. Sample Kits are currently delivered to the applicant by the agent or insurer; and the applicant is then required to visit an authorized medical provider or administrator to provide the required samples for testing purposes. The medical provider or administrator then forwards the samples to either the insurer or a medical test laboratory. Test results are then provided the insurer for underwriting purposes. These tests are essential to determine certain health conditions of the applicant, such as HIV.

In an electronic transaction, the agent would not be present to deliver the test sample kit, and therefore, the insurer would be left with no other alternative than mailing the Kit or have it delivered by a third party. Another alternative would be to schedule a visit with a healthcare provider or administrator for the applicant and advise accordingly. Regardless of whether the application was taken by an agent physically present at the point of sale or an electronic application was sent to an agent or insurer, the blood and urine test must be completed. Without the presence of an agent during the sale, the insurer will need to develop alternative procedures to ensure that the proper medical tests are performed. This change in procedure might result in some increased underwriting costs to the insurer which need to be weighed against the costs of having an agent present during the sale.

Unlicensed and unauthorized companies and producers.

The problem of providing ready access to consumers of entities which are not licensed or regulated by the states' insurance authorities is a major concern. Further, while most states provide for "direct access" by insureds to unauthorized insurers in their surplus lines, rules typically do not extend the use of surplus lines market to less sophisticated commercial or personal lines insurance buyers.

Persons, whether resident or not, acting as a producer without a license would be subject to action by most states although enforcement might be a problem for regulators.

Regulators need to, therefore, consider a strong consumer education effort encouraging people to check out Internet offers and verify that the source of an Internet insurance offer is regulated by their state insurance authorities. An NAIC model could require entities licensed in any jurisdiction to provide appropriate disclosure in solicitations that will be available to Internet users.

Fraudulent Sales

It is only a matter of time before a major Internet insurance scam appears on the evening news. The

insurance industry and insurance regulators are concerned that inadequate regulatory protections currently exist for this market. Regulating electronic commerce, especially the Internet, will require cooperation from all interested parties.

The insurance industry, interested consumer groups, insurance regulators, and others should work together in designing reasonable regulatory solutions that result in the proper protections while at the same time allowing the market to develop without unreasonable administrative burdens from industry or state insurance departments.

Insurance fraud in America already adds approximately $900.00 in additional insurance premiums each year. Thus, it is essential that investigators in state insurance departments be permitted access to the Internet and be provided training necessary to investigate and prosecute fraudulent electronic commerce.

Fraudulent sales can be expected to proliferate on the Internet because of the ease of access and difficulty of tracing the source of the fraud. Consumers should be encouraged to contact their state insurance departments to determine the authenticity of those doing the business of insurance over the Internet.

Regulatory Issues

Impact on State Insurance Departments

For the insurance industry to fully capitalize on the Internet's potential, it means changes -- some subtle, some more dramatic -- to the standard operations currently employed by the industry. Recognizing that a host of regulations already exist that: (i) are based on existing operational procedures; and (ii) may fail to recognize the Internet's borderless nature, it is likely that some adjustment to the current system is necessary to allow insurers to realize, and consumers to reap the benefits of, the Internet's full potential. It is important to note that, for these adjustments to be successful, they must come from both insurers and regulators alike.

With its ability to efficiently transfer documents with audio, video, text and hyperlinks embedded together, the World Wide Web portion of the Internet presents the best opportunities for electronic commerce on the Internet. In its December 1996 issue, "Internet World" reported that, there are currently over 10,000 Web sites dedicated to music. In fact, the music industry was among the first to explode onto the World Wide Web and utilize electronic commerce to conduct business. According to "Internet World," the top 350 music distributors sell more than 25,000 Compact Discs per day via the Internet.

Using the generally accepted estimate that there are currently 25 million Internet users worldwide, "Internet World" reported that a full 10 percent report using the Internet to shop for goods and services in place of going to their favorite local shopping mall. Attempting to capitalize on this increase in the Internet's usage, both the travel and financial services industries have recently begun using the World Wide Web to transact business as well.

With respect to insurance, current on-line sites consist mostly of static insurer sites, insurance producers, quote providers, a few ancillary services, insurance regulators and trade associations.

Insurer sites currently provide varying levels of information about their insurance products, premium levels and insurer or producer contact information for consumers interested in purchasing coverage. Some insurer sites link potential customers to a nearby agent, others ask the consumer to contact the insurer directly.

Several insurance producers are advertising their services on-line, particularly insurance brokers, to assist consumers with locating the desired coverage. Some producer sites even have on-line forms for consumers to submit basic information, assisting the agent or broker with their search producer to provide the requested or alternatively appropriate products and services to consumers. If coverage is

located, the consumer is contacted and underwriting usually proceeds via normal traditional channels.

Other sites of interest to consumers are those posted by quote providers. These sites allow consumers to compare the premiums of several insurers. Typically free to the consumer, quote providers also attempt to link potential customers with insurance carriers, usually by providing a hyperlink, telephone number. or e-mail address. For those who really want the nuts and bolts of premium calculations, there are also sites that provide insurer rates, for a fee, in a downloadable format. The rates only apply to states with prior approval requirements and, as one might expect, are usually difficult to understand. These types of rating services are typically visited only by insurance professionals, though they are available to anyone and the fees are reasonable.

Lastly, there are 35 state insurance regulatory agencies currently on-line, along with the National Association of Insurance Commissioners (NAIC). The NAIC has an extensive Web site at http://www.naic.org that serves as a communication link between insurance regulators, consumers and the industry. The site also provides links to all 35 of the state insurance regulatory agencies that have active Web sites, providing users with direct access to insurance regulators in each jurisdiction.

As an example, lets look in more detail at the California Department of Insurance's (CDI) Web site, located at http://www.insurance.ca.gov. The site, launched in April of 1996, currently contains over 860 separate documents, linked together with nearly 15,000 embedded hyperlinks, that are available to anyone with Internet access. Documents can be printed, downloaded for later use or simply read on-line. No interactivity beyond sending electronic mail to the site administrator is currently available, though extensive plans have been made to add a number of various interactive features over the next two years. In its current state, the site is similar in design to many other current state insurance regulatory agency's sites.

Even in their infancy, these regulator sites seem to be fairly popular with the insurance industry and consumers. Activity on CDI's Web site has increased virtually every month since it launched. The site registered approximately 10,000 hits during it's first month on-line (April, 1996). Just one year later, in March of 1997, the site registered over 70,000 hits per month. The number of documents downloaded has nearly tripled to over 210 per day.

Other states are developing personnel policies that define acceptable uses of the Internet as a tool to assist with job performance, just like policies developed in years past defining how to appropriately use a computer or telephone to complete job assignments. The essential elements of the policy note that:

Internet access is provided by the employer for the purpose of completing a job; Any personal use is incidental and must not interfere with job performance; and management has the right to monitor and restrict usage should the employee fail to adhere to the agency's policy.

> Agencies may require all new hires to sign a copy of the Internet usage policy for placement in a personnel file, indicating that the employee was indeed furnished with, and read, the policy. Some agencies are also incorporating Internet, electronic mail and voice mail policies into one overall communications policy.

To be used effectively, Internet access must be seen as a communication tool, just like a telephone, computer or typewriter. Very few people would seriously consider operating a business without a telephone. Today, that notion is more commonly being extended to Internet access as well.

Once a regulatory agency has access to the Internet, additional tools may be necessary to effectively participate in and monitor insurance-related activity on the Internet. For example, a regulatory agency wishing to launch its own Web site will either need the knowledge and capability to create a Web site in-house, or the resources to contract with a vendor to provide the service. Once created, the Web site will need to reside on a server that is dedicated to the Internet, and, the agency will need to create the necessary infrastructure to maintain the site, as static Internet sites quickly become on-line ghost towns.

The regulator's Internet infrastructure may be as simple as hiring or training a site administrator to periodically update the site as directed. Or, the infrastructure may be as complicated as obtaining web development software and appointing staff to maintain the content on various portions of the site, sending updates to a web administrator responsible for the technical aspects of site maintenance.

Additional items, like a system firewall and other security measures may be necessary as well, depending upon the sensitivity of information being requested from insurers, producers and consumers that is made available by the agency on-line. Tools like Web analysis software that provide automated and customized statistical reports of Web site traffic may also be necessary to determine what information is useful, what is not and what portions of a site give users the most trouble.

Applicability of Current Statutes and Regulations

Insurance regulation is based on geographic boundaries. However, the Internet, by its very nature, does not recognize geographic boundaries as traditionally viewed. This does not mean, however, that the geographic boundaries upon which state insurance regulation is based are invalid. It is this fluid portability of the Internet that makes it a desirable medium for electronic commerce, or "Internet commerce."

The threshold question of whether an Internet insurance transaction is an insurance transmission regulated by the states pursuant to the McCarran-Ferguson Act or is a commercial electronic transmission that is regulated by the federal government under the Commerce Clause has not been resolved. There is, however, no ground swell demanding that Internet insurance transactions be regulated by the federal government. Many state insurance regulators view the Internet (which consumers must "go to") only as a new communications medium, like the television, fax machines or electronic mail (which "go to" consumers). They therefore believe it would not be necessary to alter the current treatment of insurance as a business that is regulated by the various states.

Insurance regulators have not yet reacted to this new technology by mandating procedures that would be difficult (if not impossible) to enforce. Due to inconsistencies in state regulation, Internet insurance sales can not always be conducted in a uniform manner. Still, the concerns of insurers, producers, regulators and legislators are similar. For example, it is not certain that electronically transmitted insurance applications, policies and related forms are the legal equivalent (in the eyes of most regulators and the courts) of approved paper-based forms. Additional concerns include the following, which are discussed in more detail elsewhere in this paper.

Licensing

By transmitting information over the Internet, it is a simple matter to enter into potential sales situations in any and every state (and internationally) regardless of whether the insurer or insurance producer is properly licensed where the consumer is located. Accordingly, does an Internet insurance transaction occur in the state in which the consumer is located or in the location from which the electronic message originated (which may not necessarily be where the insurer or the producer is physically located and licensed)? Most likely (based on a traditional "doing business" analysis), the transaction would be deemed to occur in the state where the consumer is located.

Advertising and Disclosure

As the insurance industry becomes more comfortable with the concept of "commerce on the Internet", more Internet transactions will go beyond simple advertising and agent referral programs. However, the laws and regulations that pertain to advertising (and life insurance illustrations) would always be applicable. For example, insurance advertising rules generally prohibit deceptive or misleading statements about an insurer's or a competitor's product. Yet, with Internet advertising it will be difficult to always know who made a derogatory statement about an insurer's products or services and whether and to what degree the statement caused damage to the targeted insurer.

Insurer information transmitted over the Internet constitutes an advertisement that is regulated by state insurance laws. For example, the NAIC Model Rules Governing the Advertising of Life Insurance define "advertisement" as material designed to create public interest in life insurance or annuities or in an insurer, or an insurance producer; or to induce the public to purchase à replace or retain a policy including (a) descriptive literature of an insurer and published material, audiovisual material and descriptive literature of an insurer and; (d)] prepared sales talks, presentations and material for use by insurance producers.

An insurer's Web site should constitute an advertisement under the NAIC model because the site is likely designed to "create public interest in the" insurer and "to induce the public to purchase" insurance.

Web site marketing efforts could also trigger quote illustration regulation requirements. Marketing insurance products on the Internet involves a "presentation or depiction" that could be subject to the NAIC Insurance Illustrations Model Regulation. Thus, an Intent presentation that includes "non-guaranteed elements of life insurance over a period of years" is not excluded from the definition of "illustrations" and must satisfy all relevant regulatory requirements.

Transaction Situs

Determination of the transaction situs for an insurance sale can impact the insurance product sold. For example, common contract choice of law, premium taxation, guaranty fund applicability, insurance policy termination, continuation of coverage, cancellation and nonrenewal laws vary among the sates.

Signature Authentication

Contracts of insurance that are "bound" over the Internet require a form of signature made with the intention of authenticating the document. Because electronic signatures on their face lack the indicia of trustworthiness, procedures have been devised and are now being tested to authenticate signatures.

To date the deployment of this electronic signature technology has been hampered by different emerging technologies and a lack of consistency of laws being passed by states validating this technique.

Some states, like California, have passed laws authorizing the use of digital signatures, but regulations have not been approved to govern exactly what can be considered a valid electronic signature and when its use may not be authorized. Obstacles like the notarization of digital signatures remain to be overcome. Some states may consider abolishing "wet" signature laws, recognizing that the Internet's many security features may be sufficient substitutes to physical signatures on an application form.

Privacy

To initiate an insurance transaction, a consumer is often asked to disclose personal information. Along with a decision to divulge personal information comes a consumer expectation of privacy and secrecy. The traditional insurance sales process typically involves communication either in person or over the telephone between the insurer or its agent and the consumer, which methods of communication provide commonly accepted assurances of privacy and anonymity and should over time be extended to Internet transactions.

Collection of Premium by Credit Card

An insurer or producer marketing directly to consumers over the Internet must be willing to accept payment of the initial premium via credit card, and consumers must be willing to divulge their credit card information over the Internet. Legitimate concerns exist regarding access to credit card information on the Internet. Thus, establishing a secure "credit card environment" is vital to the success of insurance sales over the Internet.

Financial transaction safeguards should make consumers more secure when making credit card purchases over the Internet. However, it is also necessary to verify that the insurance laws of the various states do not prohibit making premium payments by credit card. States that permit insurance premium payments by credit card have varying requirements. The most common include: (i) credit card usage may not increase the premium or incur a separate fee (conversely, policyholders paying by cash or check may not be offered a discount); (ii) the credit card issuer may not cancel a policy if a cardholder fails to pay balances due that include insurance premiums; (iii) premium refunds must be made directly to the cardholder; and (iv) offers of an extension of credit for premium payments made through a particular credit card facility are prohibited.

It may be that new regulations may need to be considered, or existing ones amended or rescinded, to ensure that regulations recognize the Internet's borderless nature and work in concert to respond to operational changes that the Internet may produce. For example, if insurance agents and brokers are required to post their license number on business cards and printed advertisements, does that include advertisements posted electronically to the Internet ? Do current regulations cover that contingency?

As growth occurs in the marketing of insurance products and services over the Internet, and as the industry strives to develop innovative methods to create consumer awareness of these products, issues regarding compensation structures will need to be addressed. While some entities may find that the most efficient mechanisms for delivering products and services involve relationships with third parties and various marketing hierarchies, these efficiencies and avenues for growth will only reach full potential to the extent that regulators permit creative and flexible compensation structures. This will be fostered to the extent that compensation and licensing are only linked as necessary for the protection of the consumer, and to the extent that licensing requirements are limited to parties having contact with consumers or their funds. Regulators should consider the extent to which a benefit is derived from restrictions upon compensation to an individual or entity having neither contact with the consumer nor a role in the actual sale of the product of service, and the extent to which such restrictions might unnecessarily impede the growth of both Internet and traditional commerce. Benefits will accrue as the regulation of product and service delivery, including regulations concerning the compensation structures appurtenant to the various delivery systems, becomes more simplified and uniform.

The underlying point is that regulators need access to the on-line world before they can become familiar with, and monitor, Internet activity. Regulators must also need to be able to monitor their own Web sites so they can share meaningful information with other regulators about their own on-line experiences. It is this sharing of information across borders that will begin the process of casting a web to monitor the boundless activity of the Internet.

With or without the presence of insurance regulators, businesses from all industries will continue migrating to the on-line world as a standard means of conducting business. It is in no one's best interest for those agencies charged with regulating the insurance industry to stand idle while the rest of the world charges ahead.

Security and Privacy Issues

Security

Consumers and insurers may be hesitant to engage in insurance transactions over the Internet due to concerns about security. While numerous security safeguards are currently available for use on the Internet, they have not been widely assimilated and used. One reason is their perceived limited reliability and a general lack of insurance industry and consumer confidence in the overall security and reliability of Internet transactions, particularly with regard to using credit cards (and other payment systems) over the Internet. Current security safeguards also have a limited scope of use due to a lack of industry standards. Many of these safeguards are not currently supported by the various popular applications, servers, web browsers, and e-mail systems. However, as will be discussed below, the computer industry is quickly moving to alleviate the security problems with Internet transactions.

Because of the rapidly advancing nature of Internet security safeguards, it may be too early to think about regulation of Internet transactions with regard to security concerns in any substantive way. It is an emerging technology, and how it will develop cannot be totally predicted. Thus, it can be argued that regulation should not be unduly burdensome lest it impede the innovation and growth that has been seen thus far achieved. At the same time, however, it is important for regulators to weigh consumer protections while not impeding innovation as they consider what regulatory role needs to be played regarding security over the Internet.

There are three primary points in Internet insurance transactions in which security is an issue.

1. The privacy and confidentiality of personal information transmitted between an applicant and an insurer.

2. The alteration of information provided by the consumer/applicant by a third party such as the agent or another party with access to the file.

3. The tampering by unauthorized individuals with insurers' home pages which may affect the accuracy of information consumers receive regarding insurance sales over the Internet.

Security concerns are multi-faceted. One aspect refers to the concern that information transferred from the applicant to the company or agent could be read and misappropriated by a third party. This concern includes misappropriation of personal information and credit card (or other payment system) information. Another dimension of security is authentication, ensuring the identity of the sender and the recipient. A third aspect is data integrity, ensuring that information transmitted is not altered in the transmission process by third parties or accidentally altered by some anomaly in the transmission process.

Security concerns will likely be resolved by technical solutions from developed by the computer industry. The various players in the computer industry are cooperating to develop industry standards and protocols. Most producers of Internet products, such as servers and web browsers, are upgrading their products to be compatible with the various security standards and protocols being developed.

Security measures currently in use by the Internet community include firewalls, encryption technologies, and good management practices (passwords, digital certificates, tokens, etc.). A discussion of these topics is outside the scope of this paper, though its importance cannot be overstated. Anyone seriously considering availing themselves of the opportunities provided by electronic commerce would be well advised to learn as much as possible about these issues, and to deploy the best techniques and technologies available.

Encryption is probably the most efficient and potentially universal method of Internet security. Its purpose is to ensure privacy by keeping data from being read if it is intercepted by an unintended third party. Any message that is encrypted must be decrypted (i.e. transformed back into its original intelligible form) before it can be read. Encryption and decryption require the use of secret information shared between the parties to the message, usually referred to as a key. Most people are familiar with the method of encryption referred to as secret key or symmetric encryption. Secret key encryption involves both the sender and the receiver using the same secret key to encrypt and decrypt a message.

Public key encryption is a slightly more complex method. Both the sender and the receiver get a pair of keys, one referred to as a public key and the other referred to as a private key. Each party's public key is published while the private key is kept secret and not published. This is significant because the need for the sender and receiver to share or transmit secret information is eliminated since only the public key is ever transmitted or shared. For example, if a consumer wishes to send information to an insurer, the consumer looks up the insurer's public key and uses it to encrypt his or her private information before transmitting it to the insurer. The insurer then uses its private key to decrypt the consumer's information. Even if the consumers encrypted information is intercepted or copied, only the insurer can decrypt it. At this time, there does not appear to be an established industry-wide standard for public key encryption.

The security concerns regarding compromise of the transmittal process between the applicant and the

insurer or agent can be broken down into two elements: (1) authentication, defined as the verification of the identity of the sender and receiver and (2) data integrity or the alteration of information during the transmission process. Data integrity addresses both concerns of intentional alteration by the insurer, agent, or a third party and accidental alteration that might have an impact on the insurance application process. It should be noted that the transmission process will likely consist of information being sent and received by both parties. Thus, we are also concerned with company information sent to the consumer being altered. For example, a quote of $200 per month could be received as $20 per month, either intentionally or accidentally.

The computer industry is also developing technical solutions to address authentication and data integrity concerns. These technical solutions are referred to as "digital signatures" and "digital certificates." Used in tandem, they allow the person receiving a message to be confident of both the identity of the sender and the integrity of the message.

A ***digital signature*** is used to "sign" a transmitted message to be transmitted. To create a digital signature for a message to be transmitted on the Internet, the sender creates a message digest using a hash function. The message digest serves as a "digital fingerprint" of the message. The message digest is then encrypted using the sender's private key to become a digital signature. The digital signature is transmitted attached to the encrypted message data. The receiver can decrypt the message digest using the sender's public key and apply the same hash function to verify the message's integrity after transmission. Thus, the receiver knows that the message has not been altered in transmission and data integrity is ensured. The receiver also knows that the message was sent by someone with access to the private key that purports to be that of the sender.

To verify that the digital signature is in fact sent by the sender, and not some third party who has obtained a public-private key pair through some form of fraud or other means, the digital signature can include a digital certificate. A digital certificate irrevocably binds a person's or entity's identity to a public key or group of public keys. In effect, it becomes an electronic equivalent to a driver's license, passport, or other evidence of identification.

A digital certificate is issued by a "certificate authority." A certificate authority is a trusted third party that provides secure mathematical computations that result in unique individual digital certificates that cannot be duplicated. A certificate authority has the burden of verifying the identity of a person or entity requesting a digital certificate. Once a person's identity is verified, the certificate authority can issue a digital certificate. The typical digital certificate is issued by the certification authority and signed with its private key. The certificate will verify the owner's name, public key, expiration date of the public key, name of the issuing certification authority, serial number or register number, and the digital signature of the issuing certification authority. In any given consumer insurance transaction, the consumer would have a digital certificate, along with the insurer, the server, and a financial intermediary (if any). Thus, the identity of each of the parties that would have access to the message can be verified and authentication of the identity of the parties is ensured.

Other security concerns involve agent and industry tampering with an insurer's home pages, affecting the consumers perception of the reliability of the information presented, and subjecting the insurer to possible legal exposure should the changes be made to policy language and the like.

A separate security concern for Internet sales is that unauthorized individuals will tamper with insurers' home pages. For example, an unaffiliated third party could add a hypertext link to an insurer's homepage. When a consumer clicks on that link, he or she will leave the insurer's domain and any text or information presented will be provided solely by the unaffiliated third party. If security measures, such as those discussed above, are in place, the possibility of entering into bogus transactions with an unaffiliated third party engaging in this practice becomes unlikely. Clearly, if the practice of tampering with home pages becomes common, it will affect consumers' perception of the reliability of insurance information provided over the Internet. After discussing this problem with a number of individuals from the industry, the solution seems to rest with developing technical security measures and continuous homepage monitoring

by the person or entity maintaining the homepage.

Privacy

The first step in analyzing privacy concerns regarding personal information transmitted from an applicant to an insurer is to define the scope of the personal information that might be transmitted. Generally, the following information is requested from an applicant: (1) name; (2) address; (3) sex; (4) date of birth; (5) type of product to be purchased; and (6) payment information (i.e. credit card number or other payment source). Depending on the type of insurance being solicited, other information could include: (1) detailed health information; (2) detailed financial information; (3) type of automobile(s) applicant owns, applicant's automobile financing arrangements, and the applicant's driving record; (4) family information; and/or (5) specific information regarding property owned by the potential insured (i.e. home, boat, recreational vehicles, jewelry and other valuables).

The privacy concerns deal with how information is used once it has been received by the recipient, presumably an insurer or agent. These concerns are present with all types of insurance transactions; however, privacy concerns are heightened with Internet sales due to the aggregate dissemination of data that is facilitated by the efficient and interactive nature of the Internet. Since privacy is not limited merely to Internet sales, it will not be addressed in this section paper.

Conclusions and Recommendations

The following are conclusions and recommendations by NAIC regarding insurance marketing on the Internet:

advertising

Some jurisdictions require insurers to maintain at their home office complete files with specimen copies of each advertisement used by the insurer and its agents. To comply with this requirement, insurers typically retain "tear sheets" of print advertisements and tape recordings or a script of radio and television advertisements. However, although in "hard copy" printouts of Web site program information, advertisements displayed on Web sites may be ephemeral and capable of being altered and/or originated by unauthorized persons, making the monitoring of all advertisements difficult for both insurers and regulators.

Marketing

Marketing insurance products on the Internet involves a "presentation or depiction" that could be subject to the NAIC Life Insurance Illustrations Model Regulation. Thus, an Internet presentation that includes "non-guaranteed elements of life insurance over a period of years" is not excluded from the definition of "illustrations" and must satisfy all relevant regulatory requirements.

Privacy

To initiate an insurance transaction, a consumer is often asked to disclose personal information. Along with a decision to divulge information comes a consumer expectation of privacy and secrecy. The traditional insurance sales process typically involves communication, either in person or over the telephone between the insurer or its producer and the consumer. For the Internet methods of communication that provide accepted assurances of privacy and anonymity are yet to be fully explored.

APPENDIX

Hearing Information

On Nov. 15, 1996, the working group issued a public hearing notice. Four individuals responded that they intended to make a presentation to the working group at this meeting. In addition, written comments were submitted by Selwyn Whitehead (Economic Empowerment Foundation) for inclusion in the record of the public hearing (AttachmentáA).

The first presentation was made by Arthur J. Chartrand (Attorney representing Block Financial Corporation). Mr. Chartrand submitted a written statement for the hearing record (Attachment B). After making his presentation, Mr. Chartrand was asked by Mr. Blair if he endorsed making changes in statutes with regard to commission sharing with unlicensed agents and intermediaries. Mr. Chartrand responded that he sees this as one way to compensate technical services providers, and that regulators might consider removing impediments to companies sharing commissions with those that are participating in the sales process. He emphasized that he did not see a down side to commission sharing.

Dudley Ewen (Md.) asked Mr. Chartrand what Block Financial Corporation does on the Internet. Mr. Chartrand responded that Block Financial Corporation is a web site access provider and not an insurance company or an insurance producer. He stated that his clients' company provides a web site that can bring information together in one place and provides gateways to other companies that want to get their information on the web. Mr. Ewen asked whether the company refers potential customers to licensed agents to purchase insurance. Mr. Chartrand stated that Block Financial Corporation provides web site for licensed insurance agents to provide information and that they are compensated based on the data flow that is transacted across the web and not on the production of premiums. Mr. Ewen questioned whether these web pages provide a disclaimer. Mr. Chartrand stated that both the insurance agent and the jurisdictions where the agent is licensed are identified up front. He emphasized that disclosure of this information should be done early and often.

Richard Rogers (Ill.) asked Mr. Chartrand to explain what in his view were the regulatory issues related to insurance sales on the Internet. Mr. Chartrand stated the issues included disclosure requirements, electronic signature requirements, multi-jurisdictional and commission sharing issues, and licensure requirements. Mr. Rogers asked whether Mr. Chartrand was suggesting that the provisions against fee schedules would have to be relaxed. Mr. Chartrand stated that he believed the Internet will push this issue into the forefront because people will want to pay for services based on the results obtained. Mr. Chartrand added that many issues related to consumer protection will have to be considered and much like issues related to relaxing countersignature laws have evolved, so too will other laws related to payment of commissions and other consumer protection issues have to be reevaluated as the Internet evolves.

Troy Pritchett (Utah) stated that regulators have tried to clarify the distinction between intermediaries and producers and questioned whether Mr. Chartrand was suggesting to regulators that they need to blur the distinction between services provided by intermediaries and those provided by producers. Mr. Chartrand responded that it is likely that the distinction would need to be reconsidered, and that regulators may need to step away from the traditional approach which has been taken with regard to sharing of commissions. Mr. Pritchett then asked Mr. Chartrand if he felt that other statutes would need to be promulgated to specifically address insurance sales and marketing on the Internet. Mr. Chartrand stated that he was not in favor of more regulation, but that it will likely be an issue of adjusting the current laws to the types of activity that will occur. He added that insurance companies and technical services provider see a great potential for improvements in the distribution of services and products to consumers on the Internet, and suggested that most consumers will be able to adapt but that they would want to be able to identify the entities that that they are dealing with on the Internet. Bruce Ramge (Neb.) asked whether there would be any advantages to creating a limited lines producer license for those solely doing business on the Internet. Mr. Chartrand stated that he would not suggest such a license and that regulators should begin by evaluating the applicability of current statutes and regulations. He reiterated that disclosure is one of the most important aspects and that it should be done early and often.

J. Robert Hunter (Consumer Federation of AmericaùCFA) provided a written statement to the working group in which he identified some potential problems to insurance sales on the Internet including privacy,

security, non-licensed sales, misleading consumers, improper advertising and fraud. Mr. Hunter proposed that the NAIC establish a sales web site where qualifying insurers would be able to have their own page that meets NAIC standards for format, minimum information, solvency, etc. He stated that the requirements for coming under the NAIC umbrella could be worked out with the industry, consumers of insurance and other interested parties, with the members of the NAIC having the final say on design and other aspects. He stated that in so doing the NAIC would become the "good housekeeping seal" for insurance shopping on the Internet (Attachment C).

Don Koch (Alaska) observed that Mr. Hunters' recommendation might run into political obstacles, particularly competing against the private sector providers of such services. He asked Mr. Hunter to comment on this prospect. Mr. Hunter responded that he did not see a political conflict because under his proposal the NAIC would become a web site that consumers could access and have confidence that the companies they were doing business with were adhering to specific standards. He added that the NAIC already competes with other information providers on the sale of various types of data, including financial data, and so this would not be an entirely new undertaking for the NAIC. He added that individual state information could also be incorporated into the NAIC site and that he believed it would have a positive impact on the industry.

Mr. Rogers stated that in his comments Mr. Hunter had suggested that states require filing of a computer disk containing pricing information in order to provide a price comparison service. He stated that Illinois has struggled with such an idea and that to have a complete price comparison system is difficult. He observed that one of the problems with such a system is that it encourages people to just shop for price when other issues such as an insurer's quality of service, claims handling ability, and service quality are also important aspects that consumers may wish to consider. Mr. Hunter responded that one of the niceties about technology is that in enables consumers to look at everything: service information, company rating information and price information and then make intelligent and informed decisions with regard to purchases. Mr. Blair asked Mr. Hunter what his position was with regard to the types of disclosure that should be incorporated into web sites. Mr. Hunter stated that he believed that the name of the company, licensing information, and insurance company service levels should be provided at if at all possible.

Commissioner Kerry Barnett (Ore.) asked Mr. Hunter what he believed should be a regulators' responsibility for technology companies that have provider information on their Internet sites and then later the company is found not to be licensed in the jurisdiction where they were selling insurance. He asked Mr. Hunter whether he would agree that regulators should find ways that impose requirements on those gateway companies so that they do not host sites that are not legitimate. Mr. Hunter responded that the U.S. Federal Trade Commission (FTC) has been doing a great deal of work with regard to fraud on the Internet and that the NAIC should work closely with the FTC with regard to provider legitimacy issues. He added that the NAIC should also work with credit card companies on security issues. Commissioner Barnett questioned whether there should be an affirmative enforcement mechanism. Mr. Hunter responded that he believed such a mechanism was necessary because those companies would then be within reach and that it would not be as difficult as trying to enforce requirements upon those companies which are not within reach. Reginald Berry (D.C.) asked Mr. Hunter if he believed having such requirements would result in more informed consumers. Mr. Hunter stated he believed it would and that there are already some sites that are excellent sources of information and products on the Internet. He mentioned that, for example, there are already programs that can help you calculate your life insurance needs. Mr. Hunter added that he further believed that electronic technologies including the ability to collect information, to collect electronic signatures, and to enable instant sales of products and services will be beneficial to consumers. Mr. Ewen observed that the NAIC recently adopted model consumer information reports and asked Mr. Hunter if he believed it would be advantageous to have those reports adapted to being provided over the Internet. Mr. Hunter responded that the believed it would be a valuable source of information, but summary formatting of the report might be needed before it could be delivered over the Internet.

Ron Kuhnel (Insweb) stated that the NAIC Fall National Meeting in Anchorage, Alaska, he conducted an on-line presentation to show what types of information, products and services are available on the

Internet. He said that the question often arises as to what is Insweb. He stated that Mr. Chartrand did a good job of describing what information technology companies do. He said that there was a fine line between the types of services offered over the Internet between insurance companies and information technology provides, and that there are fine line decisions that regulators will need to deal with regarding activities of such providers on the Internet. Mr. Kuhnel then gave a detailed presentation to the working group (Attachment D). In conclusion, Mr. Kuhnel observed that the NAIC provides a great deal of data through its Internet site and suggested that while private sector web companies such as Insweb are already providing links to the NAIC home page, that the NAIC should also developing links to private sector web pages as well. Commissioner Barnett asked Mr. Kuhnel how many insurers rent space from Insweb on their cybermall. Mr. Kuhnel stated that there are more than 50 companies and tens of thousands of agents and brokers that have links through the Insweb site. Commissioner Barnett asked Mr. Kuhnel to explain how Insweb ensures that the information provided on its site meets standards and whether Insweb would allow companies to provide a side-by-side pricing comparison with a competitor on their site. Mr. Kuhnel responded that Insweb provides a secure physical space, but that companies are free to do what they want in that space. Commissioner Barnett questioned whether Insweb actively promotes its site to consumers. Mr. Kuhnel respond that active promotion is conducted. Commissioner Barnett asked whether Insweb conducts any due diligence on the companies and agents that want to get on Insweb. Mr. Kuhnel responded that he believed that certain steps are taken to ensure that a company doing business through the Insweb site is a legitimate company. Commissioner Barnett then questioned whether Internet service providers, such as Insweb, should have an affirmative duty to act as a screen to keep the bad guys off the Internet. Mr. Kuhnel responded that just like newspapers and the Yellow Pages*****, Insweb does not control the information that is provided through its site. Commissioner Barnett expressed concern and observed that if Insweb promotes its services as a beneficial location on the Internet for consumers to get valid information on insurance, then they should not have a responsibility to those consumers accessing the site to ensure that the companies or agents are legitimate. Mr. Kuhnel responded that this was a good question and that it would be a good idea to look into this issue further.

STATE SURVEY

Barbara Stewart (Stewart Economics, Inc.) stated that her company is a consulting business that specializes in insurance and insurance regulation services. She then provided a written presentation to the working group below. At the conclusion of her presentation, Mr. Rogers questioned whether Ms. Stewart was suggesting that regulators should look at a more general issue of agent licensing rather than just how those concerns apply to agents providing services over the Internet. Ms. Stewart responded in the affirmative and indicated that she was not suggesting deregulation, but rather that regulators need to rethink the purposes of agent licensing and seek ways to simplify the process. She stated that regulation should not be seen as obstructing the ability of agents to sell insurance regardless of where it is sold. She added that her consulting firm has learned a great deal about licensing and Internet marketing as a result of a study they conducted for United Services Automobile Association (USAA). She added that it is important to look at other ways of collecting licensing revenues as well as encouraging a cooperative effort by the states with regard to multi-jurisdictional licensing. In conclusion, Ms. Stewart observed that activity with regard to the Internet is moving quickly and that actually middlemen (very specialized ones) will form and that there will be an ability to distinguish the good players from the bad players.

(The survey of state insurance departments by Stewart Economics is not shown).

Citation of california's Digital Signature Statutes

California Government Code Section 16.5 (1995). On October 4, 1995, California enacted this statute which governs only electronic signatures affixed to communications with public entities. The Act provides that an electronic signature (called a "digital signature" in the statute), shall have the same force and effect as a manual signature if: (1) it is unique to the person using it; (2) it is capable of verification; (3) it is under the sole control of the person using it; (4) it is linked to data in such a manner that if the data are changed, the digital signature is invalidated; and (5) it conforms to regulations adopted by the Secretary of State.

Digital Signature Regulations. On May 23, 1997 the Secretary of State released California's proposed Digital Signature Regulations for comment. The proposed regulations provide for the following:

1. Digital signatures must be created by an acceptable technology, as specified in the regulations.

2. The criteria for determining if a digital signature technology is acceptable for use by public entities is set forth in the regulation (and essentially includes the five requirements set forth in the statute, plus a requirement that the technology must create digital signatures that are able to satisfy California's requirements for introducing writings into evidence).

3. The regulations provide that acceptable technologies are:

(a) Public key cryptography
(b) Signature dynamics

4. The regulations provide a procedure for adding new technologies to the list of acceptable technologies.

With respect to digital signatures, the regulations impose upon a person who holds a key pair a duty to exercise reasonable care to retain control of the private key and prevent its disclosure to any person not authorized to create the subscriber's digital signature. The regulation also establishes an approved list of certificate authorities authorized to issue certificates for digitally signed communications with public entities in California.

Finally, the regulations does not address liability concerns because the Secretary of State deemed that it did not have the authority to do so through California State regulations. It anticipates that some of the liability concerns can be addressed contractually with the service providers, but recognize that other issues need to be addressed by the legislature. Public hearings on the regulation were held on July 15, 1997. A final regulation has not yet been adopted.

(Statutes for other States are not shown)

Proposed UCC Article 2B

SECTION 2B-202. FORMATION IN GENERAL.

(a) A contract may be made in any manner sufficient to show agreement, including by conduct of both parties or actions of electronic agents which reflect the existence of a contract.

(b) If the parties so intend, an agreement sufficient to constitute a contract may be found even if the time when the agreement was made cannot be determined, one or more terms are left open or to be agreed upon, or the standard form records of the parties contain varying terms.

(c) Although one or more terms are left open, a contract does not fail for indefiniteness if the parties intended to make a contract and there is a reasonably certain basis for giving an appropriate remedy.

Uniform Law Source: Section 2-204, modifies (b). First Appeared: 2-203 (Prototype)

SECTION 2B-205. ELECTRONIC TRANSACTIONS: FORMATION.

(a) In an electronic transaction, if an electronic message initiated by a party or its electronic agent evokes an electronic message or other electronic response by the other or its electronic agent, a contract is created when:

(1) the response is received by the initiating party or its electronic agent, if the response consists of furnishing information or access to it and the message initiated by that party did not

preclude such a response; or

(2) the initiating party or its electronic agent receives a message signifying acceptance.

(b) A contract is created under subsection (a) even if no individual representing either party was aware of or reviewed the initial , the response, the reply, the information, or the action signifying acceptance. Electronic messages are effective when received even if no individual is aware of its receipt.

Uniform Law Source: None. First appeared: Section 2-2202 (Sept. 1994)

Selected Issues:

a. Should subsection (a)(1) require that the initial message invite performance as a response?

b. Is the exclusion of any requirement of human review appropriate?

NAIC Notes:

1. The changes in this section parallel earlier changes in that they introduce a concept of electronic agent, rather than intermediary. That concept is narrowed to clarify that the programmed activity that can bind a party is an program accepted, developed or programmed to take action by the party itself. In reviewing this, reference needs to be made to the terms of the section in part 1 dealing with attribution of messages and performances to a party.

2. An electronic transaction is as "a transaction in which the party that initiates the transaction and the other party, or their intermediaries, contemplate that the creation of an agreement will occur through the use or electronic messages or an electronic response to a message." Section 2B-102. This definition does not require that the parties also intend performance to be electronic.

3. The principal application of this section lies in the growing realm of electronic commerce. The section sets out standards for determining when and whether a pure electronic contract can be enforceable. Note that electronic-related language consistent with this section is also included in sections on offer and acceptance as well as formation rules.

4. A principal contribution is in subsection (b) which indicates that a contract exists even if no human being reviews or reacts to the electronic message of the other or the information product delivered. This represents a modern adaptation away from traditional norms of consent and agreement. In electronic transactions, preprogrammed information processing systems can send and react to messages without human intervention and, when the parties choose to do so, there is no reason not to allow contract formation. A contract principle that requires human assent would inject what might often be an inefficient and error prone element in a modern format.

5. The information industry increasingly uses electronic "intelligent agents" and database products generally available on the Internet or other electronic networks. This entirely automated means of utilizing information as a commodity creates a number of uncertain contract law issues some of which this section attempts to answer in a manner that facilitates the development of this branch of commerce.

6. Subsection (a) contains a nonexclusive statement of how a contract may be formed, giving the parties some guidance on how to structure messages to create or avoid contractual obligations. It hinges the creation of a contract on the response to an electronic message. If the response consists of furnishing the performance, the contract exists at the time that they are made available at a place and in a manner allowing the initial party (or its computer) to have access to or use the information. Notice that this response might occur without there being any decision by any individual involved

with the responding to "accept" the offer. If the response consists of creating an opportunity (or offer) to make access to the information available, the contract exists if the initial party signifies acceptance by taking advantage of the opportunity created or by indicating that it intends to do so.

7. Former subsection (c) dealing with "receipt" has been moved to the definition section.

In commentary to the September Draft, a number of people suggested that the original version did not deal well with the case of a delivery in the absence of a prior designation of a particular information system by the recipient and was not sufficiently open-ended to deal with changing technology.

SECTION 2B-310. ELECTRONIC TRANSACTIONS: TERMS.

(a) In an electronic transaction, the terms of a contract are:

(1) terms agreed to by the parties as applicable to the transaction prior to the exchange of the electronic messages;

(2) terms on which the electronic messages and electronic records of the parties do not conflict and terms on which they substantially agree;

(3) the supplemental terms incorporated under any other provisions of this article as to issues not otherwise made part of the contract by paragraphs (1) and (2).

(b) If terms included in a contract under subsections (a)(1) and (2) conflict, terms included under subsection (a)(1) control unless the electronic transaction involved review of the electronic message by an individual representing the party against whom the term is asserted and that individual manifested assent to the term contained in the message.

(c) Except as otherwise provided by terms included under subsection (a)(1) or (a)(2), if the subject matter of an electronic transaction is information content, neither party is entitled to consequential damages in the event of a breach by the other.

Uniform Law Source: None. First Appeared: Section 2-2202 (Licenses, September).

Selected Issue:

a. Should the terms of a form to which the licensee manifests accent over-ride the other form?

NAIC Note:

1. Subsection (a) creates presumptions regarding the applicable terms. Its effect parallels that of the section on conflicting standard forms and the treatment of single standard form contracts. Essentially, the negotiated terms of an agreement control areas they cover, but beyond that, the electronic transactions is treated as a standard form transaction.

2. A negotiated agreement involving individuals who represent the companies controls. Next in order of priority are terms on which the electronic messages agree. Finally, the supplemental terms of the UCC apply.

Example: A agrees to make its database available to B with charges to be computed based on the type of information requested. The contract provides that B need not pay for information that is more than one week old. Later, B's computer initiates an electronic inquiry for data on the price of cotton. Its preprogrammed terms require information require a guaranty of accuracy. It does not mention price. A's computer provides the data in a message containing no contractual terms. The contract exists when the

data are furnished to B's computer. The guaranty of accuracy does not become part of the contract, but supplemental UCC warranty rules apply. B need not pay for data more than one week old.

3. Subsection (a) provides a coordination concept between this section and the sections on standard form records (mass market and non-mass market). In essence, form provisions in an electronic transactions must comply with the terms of this section. After that step is completed, the conflict or priority resolutions sections of (b) apply.

4. Subsection (e) excludes consequential damages unless contracted for by the parties. This is based on analogy to the treatment of wire transfers in Article 4A. The electronic contracting for information and data is an industry that is growing and that thrives on efficiency and low cost of distribution. The exclusion of consequential as a basic premise here creates a base from which this low cost growth can continue. Furthermore, in most cases, the vendors of this type of data are insulated from liability for content errors under general policy standards applicable to information industry participants. See Daniel v. Dow Jones & Co., 137 Misc. 2d 94, 520 NYS2d 334 (NY Civ. Ct. 1987).

SECTION 2B-322. INTERMEDIARIES IN ELECTRONIC MESSAGES

(a) A party who engages an intermediary to transmit, make available for access, or log electronic messages or data electronically, or to perform like services is liable for damages to the other party arising directly from the intermediary's errors or omissions in the performance of such services to the extent that such errors or omissions caused reasonable reliance on the part of another party.

(b) A party who sends an electronic message through or with the assistance of an intermediary providing transmission or similar services is bound by the terms of the message as received despite errors in the transmission unless the party receiving the message should have discovered the error by the exercise of reasonable care or the receiving party failed to employ an authentication system agreed to by the parties before such transmission. Uniform Law Source: UNCITRAL Draft Model Law on EDI. Revised. First appeared: 2-213 (prototype)

Selected Issues:

a. What treatment should be given to unknown or gratuitous intermediaries such as will be involved in transactions occurring through the Internet?

NAIC Notes:

1. This section deals with one form of the issues caused by an error or mistake in a transaction involving electronic contracting. The basic issue centers on responsibility for error by a third party (intermediary) brought into the transaction. Essentially, the party bringing the intermediary into the deal has responsibility for any errors that the intermediary makes.

2. This section does not deal with the intermediary's liability, leaving that issue to other law. The Committee may wish to consider whether this is appropriate.

3. Current law makes a distinction must be made between mutual and unilateral mistakes. See Restatement (First) of Contracts ¦ 503. As a general common law principle, unilateral mistakes do not absolve compliance with a contract based, in part at least, on the assumption that each party should protect its own position in reference to the handling of errors and the like. This relatively ancient common law principle has been frequently readjusted in modern case law to hold that the unilateral mistake allows an avoidance of the contract if enforcement against the party making the mistake would be oppressive and recision of the contract would impose no substantial hardship on the other party. See 3 Corbin on Contracts ¦ 608. See also Calamari & Perillo, The Law of Contracts ¦ 9-27. 4. This formulation suggests the circumstances under which a mistake by the sender of an offer or an acceptance might avoid its mistaken consequences. Avoidance of those consequences comes most readily in cases where the receiving party had reason to

know of the error or that party did not rely to its detriment on the mistaken message. The principle is simple enough. If the mistake caused no harm and was either discovered before reliance occurred or was so egregious that the other party could not in good faith not recognize it as an error, the person making the error should not be liable for it. This element of the doctrine is incorporated here.

5. A relevant consideration deals with whether the mistake was caused by error of the sender or whether the mistake came in an error caused by the provider of a service that served as an intermediary. As between buyer and seller, in cases involving errors by telegraph companies, the majority approach is that the sender of the message is liable for errors created by the intermediary it chose to communicate the message unless the other party should have known that the message was mistaken. See discussion in Calamari & Perillo, The Law of Contracts ¦ 2-24. See also 1 Williston on Contracts ¦ 94. A minority position exists, holding that no contract exists in such a situation because the sender is not responsible for the actions of an independent contractor. Restatement (Second) of Contracts ¦ 64, Comment b.

6. In Article 4A, in contrast, the UCC defines the intermediary for this purpose as an agent. The fundamental rationale for this approach to the problem comes from the fact that neither the sender nor recipient may have been at fault in creating the problem, but that some loss occurred and must be allocated to one or the other. In such a case, the proper choice is to place the loss on the sender unless the recipient was in fact at fault in not recognizing that an error existed.

7. In computer-based systems, as between the primary parties, there does not appear to be a current common law principle requiring the adoption and compliance with a security system to detect errors or fraud. Arguably, however, the failure to electronically discern an obvious mistake in a transmitted message may cause a court to conclude that the recipient "had reason to know" of the mistake and that its reliance on the verbatim electronic terms was not reasonable or protected. More generally, engaging in transactions requires, as a matter of prudent business conduct, the creation of an effective means to discover and prevent errors and fraud in the transactions.

8. Contractually, the parties can and should deal with both how the risk of error should be allocated and what type of security or other system should be in place as a means to detect and prevent mistake. One fully appropriate contract rule is to define a commercially acceptable security procedure and to then indicate that either party's failure to conform to the procedure shifts loss to that party in compliance with the procedure would have prevented the risk from occurring. This is the result created in UCC Article 4A.

A. Offer

SECTION 2B-203. FIRM OFFERS.

An offer by a merchant to enter into a contract made in an authenticated record that by its terms gives assurance that the offer will be held open is not revocable for lack of consideration during the time stated. If no time is stated, the offer is irrevocable for a reasonable time not to exceed three months. A term of assurance in a record supplied by the offeree is ineffective unless the offeree manifests assent to the term.

Uniform Law Source: Section 2A-205; Section 2-205.

Selected Issue:

a. Should this section be limited to offers by merchants?

NAIC Notes:

1. This section follows draft Article 2 language. Issues dealing with firm offers have not been presented to the courts in reference to information contracts, but the section may be important since it applies in cases of multiple level contracts as in development agreements.

2. This section does not limit the length of the firm offer. It requires a record. If a repeal of the statute of

frauds occurs, the Drafting Committee may wish to revisit the policy rationale for requiring this type of an offer to be in a writing.

3. Article 2A requires that the term of assurance on a form supplied by the offeree be "separately signed by the offeror." The language here supplants the signature requirement with the concept of authentication and manifestation of assent.

SECTION 2B-204. OFFER AND ACCEPTANCE.

(a) Unless otherwise unambiguously indicated by the language or circumstances:

(1) An offer to make a contract invites acceptance in any manner and by any medium reasonable under the circumstances, including a definite expression of acceptance that contains standard terms varying the terms of an offer.

(2) An order or other offer to buy, license, or acquire information for prompt or current transfer invites acceptance either by a prompt promise to transfer or by prompt or current transfer. However, a transfer involving nonconforming information is not an acceptance if the transferor seasonably notifies the transferee that the transfer is offered only as an accommodation.

(3) A response by an electronic agent that signifies acceptance or that commences performance constitutes acceptance of an offer even if the response is not reviewed or expressly authorized by any individual.

(b) If the beginning of a requested performance is a reasonable mode of acceptance, an offeror who is not notified of acceptance and who has not received the relevant performance within a reasonable time may treat the offer as having lapsed before acceptance.

Uniform Law Source: Section 2A-206; Section 2-206.

Selected Issue:

a. Is the treatment of an electronic response appropriate?

NAIC Note:

1. Authentication replaces signing as the applicable expression of the party to be bound. Also, as in other sections, this section was modified to change "intermediary" to "electronic agent", a defined term, that clarifies that a party is bound by electronic preprogrammed operations only if it programmed its available system to make such responses.

2. This section generally follows draft Article 2. It adds subsection (a)(3) to deal with electronic acceptances. Otherwise, the draft assumes that the general reference to enabling a response in any form reasonable under the circumstances adequately covers the analysis of whether an electronic offer invites an electronic response.

3. Subsection (b) has been modified from existing law to expressly reflect that there is no need for notification where the party receives actual performance within a reasonable time. This is significant in electronic performance where virtually instantaneous responses are possible (e.g., electronic transfer of data). Requiring notice in such contexts is not appropriate.

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Liefer, David M. & Stevens, Marybeth G.; The Net, The Web And Other Emerging Technologies, Don't Get Caught Without Knowing The Legal Issues; American Council of Life Insurance, 1996.

THIS ENDS THE NAIC WHITE PAPER

Who's who on the Internet

The following is by no means an all inclusive list of insurance and/or related websites. Rather it is a sample of what is already in use.

www.quotesmith.com

Life insurance comparisons, company information and underwriting guidelines for a variety of life insurance products.

www.iix.com

The Insurance Information Exchange offers insurance news, resources, business tools and consumer / agent information with a heavy emphasis on Internet consulting, website planning and on line resources.

www.insurancejrnl.com

A scaled-down electronic magazine for the property-casualty industry. Insurance Journal West features regional and national insurance news. A recent article pointed to the "underinsuring" of the Nation's 43 million home based businesses.

www.irin.org

The Insurance Regulatory Information Network is a public-private partnership for the development of leading edge products and services for the insurance industry. IRIN is a non profit affiliate of the National Association of Insurance Commissioners (NAIC) offering the Producer Database (PDB) and Producer Information Network (PIN). PDB is a central depository of producer licensing information (appointments, terminations, disciplinary actions, etc). PIN is an electronic communication network that links state regulators with entities they regulate to facilitate the electronic exchange of producer information. Standards are being developed for the exchange of license applications, license renewal, appointment and termination information for faster turnaround and reduction in paperwork.

www.accord.com

Accord Software specializes in development kits that help agents generate Internet applications and more. Using agent websites, customers use Accord software to check their account balances, pay premiums by credit card and report losses. At all times, the agent logo and identity remains on the screen.

www.acord.com

Acord (differnet from above) is a well-known nonprofit insurance association dedicated to increasing the efficiency of agency distribution systems using standardized forms. The company is developing many new

electronic data exchange systems for use on the Internet.

www.4insurance.com

This company offers a ready-made method for agents to participate on the Internet even if they don't own a computer. Consumers who locate the site fill out a request for a quote and then select agents in their area. The quote requests are faxed or emailed directly to the agent within 24 hours. The agent responds with a quote which can be emailed or faxed to the consumer.

www.ibsassn.com

The Insurance Benefits Service Association offers expert advice, glosseries, AM Best ratings, lead generation and marketing services.

www.vistanet.com

Vista Net is a general agency with full Internet support for member agents. Online quotes (mostly employee benefits and 24 hour care) and free websites are two of the perks.

www.insurance.ca.gov

The California Department of Insurance Home Page is one of the shining examples of how regulators can use the Internet. This website includes newsletter type information, industry news, educational articles, agent and consumer beware notices and direct access to the entire California Insurance Code. The California Senate Home Page at www.sen.ca.gov is an excellent source for tracking new legislation. A search feature permits indexing by any topic; insurance, retirement planning, financial planning, taxes, etc.

www.iiaa.org

The Independent Insurance Agents of America site offers a multitude of services and information for agents, consumers and members. Services includes current events, an agent locator and a list of state associations.

www.insure.com

This is the Insurance News Network offering general and state-specific information about auto, home and life insurance. It is a free provider of insurance ratings from Standard and Poor's and Duff & Phelps, and also offers extensive variable annuity information and performance data from Morningstar.

www.insweb.com

InsWeb is a centralized interactive interactive resource center for the insurance industry. Services include agent listings, tax updates and other helpful directories. InsWeb also offers agencies and companies a high visibility outlet to sell policies over the Internet.

www.ircweb.org

The Insurance Research Council(IRC) offers abstracts of the Council's research studies and news releases which are oriented toward the property casualty industry.

www.inlinea.com

Insurance Inlinea is an information website targeted to the insurance industry offering on-line quotes to consumers. But, site founders say its primary purpose is to help insurance professionals integrate the Internet into their business. The service will direct clients and prospects to agent home pages through both off and online promotions and advertising.

www.insureinfo.com

The Insurance Resource Center works exclusively with the insurance industry helping both the small agent and the large insurance companies discover online solutions.

www.ambest.com

The AM Best Company website is a true resource tool where agents can find traditional rating and analysis on line (Best's Agent Guide, Best Averages, Best Company Reports, Best's Insurance Reports, Best's International Rating Guide, Best's Managed Care Report, Best's State / Line Reports). In addition, the company's new Resource Center provides Internet users a place to turn for insurance information. Examples include the World Wide Insurance Directory (a database of 7,000 insurance companies address, website, AMB and NAIC number), directories of insurance associations, government regulators, insurance news stories, stock quotes for publicly traded insurance companies and link access to search engines for locating other subjects.

www.realquote.com

Auto insurance ratings for at least a dozen companies.

www.800insureme.com

A private referral network

Miscellaneous sites

Notable company websites to visit include

- Blue Cross / www.bluecrossca.com
- Safeco / www.safeco.com
- Nationwide Insurance / www.bestofamerica.com
- Zurich Kemper / www.zurichkemper.com
- Metlife / www.metlife.com
- Prudential / www.prudential.com
- Vision Service / www.vsp.com
- Cigna / www/cigna.com
- Lifeguard Health / www/lifeguard.com

how to get connected to the Internet

In a recent article in California Broker, Bruce Salmon offers some solid advice on "getting connected".

The most practical way to get on the Internet is to contract with an Internet Service Provider (ISP). There are many generic providers like AOL or The Microsoft Network and their are industry providers, some of which are mentioned above. A major component of each of these services is e-mail. When you sign on, you receive one, two or three e-mail addresses to connect to your clients and others.

Choosing an ISP is the hardest decision. Ask and expect answers to the following questions: How many subscribers do they have? (Ask for referrals). How many modems do they have and what is the speed of the modems? You'll want to know their subscriber to modem ratio. Anything higher than 20:1 is too high and you'll likely experience connection problems. Also, if they don't have fast modems 33.6 or higher, you'll spend a lot of time waiting for data to transfer.

Ask them about the type of connection they have to the Internet. TI or ISDN are typical high-speed connections. Remember, it doesn't pay to have fast access to their system if their access to the Internet is

slow. Ask them if they monitor their usage and how often they upgrade equipment. If they are continuing to sign on new subscribers but don't upgrade regularly, their service will likely become bogged down.

Get specific details on what charges you are paying for and what is included in the fee. Companies may charge you on a monthly basis and include a certain number of hours with the basic charge. Find out what you pay when you exceed the basic hours. The current trend, however, is to offer an unlimited time for a flat fee. Ask if there are benefits to signing up for several months. Also, find out if there is a discount for multiple ID's. You may have several individuals in your office that may want an e-mail address.

What kind of software does the service provider include? They should provide you with the TCP/IP software, electronic mail package and a WWW browser. This should all be included in the monthly charge and not an extra fee.

Finally, ask about support. Who will provide support? What are the hours? Is there a local telephone number you can call if there is a problem?

Website design

There are volumes of manuals and books written on this subject and just as many companies willing to design and host sites for you. In his Weekly Guerilla Newsletter, Charles Rubin exposes six myths about website planning:

Myth #1 - You will reach millions of customers.

Having a site on the Web doesn't mean you'll automatically reach millions of customers, any more than having a book in publication means you'll automatically reach millions of readers. There may be millions of people capable of accessing Worldwide Web pages right now, but you'll have to promote your site through discussion group participation, ads, announcements, directory listings, e-mail, links on other sites, and off-line publicity before you'll attract a lot of visitors.

Myth #2 - You can set up a site and forget it.

Web sites aren't like print or broadcast ad campaigns, where you're married to a particular design and information package for months on end. When I see a site that hasn't changed in months, I wonder whether or not the company is still in business. There are too many new Web sites appearing every day for me or most Net surfers to return again to sites that never change. Your Web site had better change at least weekly. It should announce its changing features right at the top of the home page so even the most casual visitor knows he or she will see something new on the next visit. Plan for change when you plan the site, and think through the process of how it will be updated (and who will do that), and you'll end up with a site that people will visit again and again.

Myth #3 - Hits = Visits.

High hit counts contribute to the grossly inflated notions of the Web's magical ability to reach people. But your site will always get far more hits than it does actual human visitors. See my tip, "Hits Don't Equal Visits," for more information.

Myth #4 - The more graphics, the better.

When graphic designers take over a Web site, looks often triumph over accessibility. The prettiest

site on the Web is useless if visitors with non-graphical browsers can't tell what it is or how to navigate in it. Too many sites are unfathomable even to graphical browser users who view them without loading the images. And even interested visitors won't wait to see what you're offering if they have to stumble over too many minute-long downloads as images load. *Use small image files*. Offer a text-only option at the top of your home page. And let visitors know how large big image files are so they can make an informed decision about whether or not to display them.

Myth #5 - Malls make shopping more convenient.

Web mall operators say that locating on their site is a plus, because their collection of stores attracts Web surfers. But while a physical mall brings in people because it saves time, Web malls don't offer nearly the same time-saving benefit. It takes no more time for me to jump from one Web site to another than it does to jump from one mall store to another. A mall that's a hodgepodge of companies is less interesting to me than one that features businesses or resources focused around a certain topic of interest, such as the Realty Net, Book Zone, and TV Net. There's enough disorganization and chaos on the Web as it is without having to go to a generalized mall to see more of it.

Myth #6 - Sounds and video are simple.

You will hear lots of hot air about the multimedia nature of the Web, but Web sites have a long way to go before they resemble your TV set or even a CD-ROM playing on your PC. If you're expecting to point and click to listen or hear multimedia clips, you'll be disappointed. When software developers and content providers completely integrate video and sound player capabilities and overcome the lack of standards and bandwidth constraints for modem connections you might be able to use multimedia. But until then, video and sound files have to be downloaded, and they require a player utility in order to perform on your PC. Video files in particular can be multi-megabyte affairs that take many minutes to download. Further, there are different players for different PC platforms. The best Web sites that offer sounds or video also offer a selection of players you can download to ensure that you'll be able to experience the sound or movie on your PC, no matter what kind it is.

More good advice comes from the Schmidt Marketing Group (www.geoprofit.com):

Create a ***Customer-Centered Website***. Such a site creates a desire for your products and services while helping you build long term relationships. In essence, your site evolves around your customers' needs. To create one, you need to re-package your knowledge into a resource for clients to use.

Create an ***Electronic Commerce System.*** Using E-commerce, your business is transacted electronically via e-mail, fax, already paid by credit card. Customers can query your products or services online giving them instant gratification.

Create a ***Web Marketing Plan.*** Such a plan tells you what to do with available technology. In the eyes of your customers, you become an expert, a problem solver resulting in return visits to your site again and again.

Once your site is developed you will need to hyperlink to truly capture the power of the Internet. The philosophy is simple: Your potential visitors should be able to find you from many different angles. To do this, experts advise that you establish a moderate number of high quality links to related websites: Sites that share

similar subject matter. Linking to these sites can be harder than it seems since you will asking other site owners to "advertise" your website inside their domain. If customers are interested enough in your information, they can leave the host link and visit your site. Perhaps they will return, or maybe they won't.

To make your own site more of a resource tool for customers, you may also want to link your site to others. The general consensus is that you may link to other sites without asking permission provided you are not claiming their site as part of your own. However, there can be benefits to requesting permission before linking to someone's site: It is a good way to initiate a contact to ask them to hyperlink their site to your's.

Netiquette

While there are no Internet police, it is important that insurance agents using the net abide by standards of ethics and reason. In the insurance industry this is known as consumer protection; on the Internet, it is referred to as ***netiquette.***

A good foundation in netiquette can be gleaned from Arlene H. Rinaldi's book called ***THE NET: USER GUIDELINES AND NETIQUETTE***. Following are some important points presented in this work:

the 10 commandments of using the Internet

1. Thou shalt not use a computer to harm other people.
2. Thou shalt not interfere with other people's computer work.
3. Thou shalt not snoop around in other people's files.
4. Thou shalt not use a computer to steal.
5. Thou shalt not use a computer to bear false witness.
6. Thou shalt not use or copy software for which you have not paid.
7. Thou shalt not use other people's computer resources without authorization.
8. Thou shalt not appropriate other people's intellectual output.
9. Thou shalt think about the social consequences of the program you write.
10 Thou shalt use a computer in ways that show consideration and respect.

Basic Internet guidelines

It is essential for each user on the network to recognize his/her responsibility in having access to vast services, sites, systems and people. The user is ultimately responsible for his/her actions in accessing network services.

The "Internet" or "The Net", is not a single network; rather, it is a group of thousands of individual networks which have chosen to allow traffic to pass among them. The traffic sent out to the Internet may actually traverse several different networks before it reaches its destination. Therefore, users involved in this Internetworking must be aware of the load placed on other participating networks.

As a user of the network, you may be allowed to access other networks (and/or the computer systems attached to those networks). Each network or system has its own set of policies and procedures. Actions which are routinely allowed on one network/system may be controlled, or even forbidden, on other networks. It is the users responsibility to abide by the policies and procedures of these other networks/systems. Remember, the fact that a user can perform a particular action does not imply that they should take that action.

The use of the network is a privilege, not a right, which may temporarily be revoked at any time for abusive conduct. Such conduct would include, the placing of unlawful information on a system, the use of abusive or otherwise objectionable language in either public or private messages, the sending of messages that are likely to result in the loss of recipients' work or systems, the sending of "Chain letters," or "broadcast" messages to

lists or individuals, and any other types of use which would cause congestion of the networks or otherwise interfere with the work of others..

Permanent revocations can result from disciplinary actions taken by a panel judiciary board called upon to investigate network abuses.

Electronic communication do's and don'ts

Under United States law, it is unlawful "to use any telephone facsimile machine, computer, or other device to send an unsolicited advertisement" to any "equipment which has the capacity (A) to transcribe text or images (or both) from an electronic signal received over a regular telephone line onto paper." The law allows individuals to sue the sender of such illegal "junk mail" for $500 per copy. Most states will permit such actions to be filed in Small Claims Court. This activity is termed "spamming" on the Internet

Never give your userID or password to another person. System administrators that need to access your account for maintenance or to correct problems will have full privileges to your account.

Never assume your email messages are private nor that they can be read by only yourself or the recipient. Never send something that you would mind seeing on the evening news.

Keep paragraphs and messages short and to the point.

When quoting another person, edit out whatever isn't directly applicable to your reply. Don't let your mailing or Usenet software automatically quote the entire body of messages you are replying to when it's not necessary. Take the time to edit any quotations down to the minimum necessary to provide context for your reply. Nobody likes reading a long message in quotes for the third or fourth time, only to be followed by a one line response: "Yeah, me too."

Focus on one subject per message and always include a pertinent subject title for the message, that way the user can locate the message quickly.

Don't use the academic networks for commercial or proprietary work.

Include your signature at the bottom of Email messages when communicating with people who may not know you personally or broadcasting to a dynamic group of subscribers.

Your signature footer should include your name, position, affiliation and Internet and/or BITNET addresses and should not exceed more than 4 lines. Optional information could include your address and phone number.

Capitalize words only to highlight an important point or to distinguish a title or heading. Capitalizing whole words that are not titles is generally termed as SHOUTING!

Asterisks surrounding a word can be used to make a stronger point.

Use the underscore symbol before and after the title of a book, i.e. _The Wizard of Oz_

Limit line length to approximately 65-70 characters and avoid control characters.

Never send chain letters through the Internet. Sending them can cause the loss of your Internet Access.

Because of the International nature of the Internet and the fact that most of the world uses the following format for listing dates, i.e. MM DD YY, please be considerate and avoid misinterpretation of dates by listing dates including the spelled out month: Example: 24 JUN 96 or JUN 24 96

Follow chain of command procedures for corresponding with superiors. For example, don't send a complaint

via Email directly to the "top" just because you can.

Be professional and careful what you say about others. Email is easily forwarded.

Cite all quotes, references and sources and respect copyright and license agreements.

It is considered extremely rude to forward personal email to mailing lists or Usenet without the original author's permission.

Attaching return receipts to a message may be considered an invasion of privacy.

Be careful when using sarcasm and humor. Without face to face communications your joke may be viewed as criticism. When being humorous, use emotions to express humor. (tilt your head to the left to see the emotion smile) :-) = happy face for humor

Acronyms can be used to abbreviate when possible, however messages that are filled with acronyms can be confusing and annoying to the reader.

Examples: IMHO= in my humble/honest opinion
FYI = for your information
BTW = by the way
Flame = antagonistic criticism

discussion groups

When posting a question to the discussion group, request that responses be directed to you personally. Post a summary or answer to your question to the group.

When replying to a message posted to a discussion group, check the address to be certain it's going to the intended location (person or group). It can be very embarrassing if they reply incorrectly and post a personal message to the entire discussion group that was intended for an individual.

When signing up for a group it is important to save your subscription confirmation letter for reference. That way if you go on vacation you will have the subscription address for suspending mail.

Use your own personal Email account, don't subscribe using a shared office account.

Occasionally subscribers to the list who are not familiar with proper netiquette will submit requests to SUBSCRIBE or UNSUBSCRIBE directly to the list itself. Be tolerant of this activity, and possibly provide some useful advice as opposed to being critical.

Other people on the list are not interested in your desire to be added or deleted. Any requests regarding administrative tasks such as being added or removed from a list should be made to the appropriate area, not the list itself. Mail for these types of requests should be sent to the following respectively:

The world wide web

Do not include very large graphic images in your html documents. It is preferable to have postage sized images that the user can click on to "enlarge" a picture. Some users with access to the Web are viewing documents using slow speed modems and downloading these images can take a great deal of time.

It is not a requirement to ask permission to link to another's site, though out of respect for the individual and their efforts, a simple email message stating that you have made a link to their site would be appropriate.

When including video or voice files, include next to the description a file size, i.e (10KB or 2MB), so the user

has the option of knowing how long it will take to download the file.

Keep naming standards for URL's simple and not overly excessive with changes in case. Some users do not realize that sites are case sensitive or they receive URL's verbally where case sensitivity is not easily recognizable.

Infringement of copyright laws, obscene, harassing or threatening materials on Web sites can be in violation of local, state, national or international laws and can be subject to litigation by the appropriate law enforcement agency. Authors of HTML documents will ultimately be responsible for what they allow users worldwide to access.

SECTION 2 INSURANCE FRAUD

The purpose of this section is to help agents become aware of the difference between fraud and abuse, the types of fraud that occur in the insurance industry and the professional agent's responsibility to recognize and report suspected fraud.

the Role of Insurance Professionals

Fraud can occur during the application period, and it can occur when loss claims are filed. A vigilant agent should be alert for the possibility of fraud and be thorough in gathering information to support an application or a loss claim (see agent's file at right).

Beyond this responsibility, agents should understand that the intent of the Insurance Code fraud statutes is to restore legitimacy and integrity. This mission requires the cooperation of everyone--insurance professionals, employers, employees, doctors, lawyers and law enforcement.

Officials and experts suggest that the best way to start this process is to put your own "house" in order.

< Not only must agents be honest and law abiding, but they must also avoid any appearance of impropriety. Don't be guilty of what it is we are trying to eradicate. Remember that when gifts, tickets, free meals, or vacations are offered or accepted as compensation, inducement, or reward for the referral or settlement of a claim, it is a felony.

< Do not accept application or underwriting information that you know to be false as a basis for determining policy premiums or coverage. That is an unlawful act.

< Do not accept or make any material representations that you know to be false as justification to accept or deny a claim for benefits. Also, do not make knowingly false statements with regard to entitlement to benefits with the intent of discouraging an insured from claiming benefits or pursuing a claim.

You are required to report suspected fraud when you have knowledge of or a reasonable belief that a fraudulent act has been committed. The reports must be submitted simultaneously to the Department of Insurance and the local district attorney's office. This is not optional; it is state mandated. This requirement carries with it the responsibility to assure that all reports are made in good faith, without malice, and are based on facts obtained by reasonable efforts.

Until there is a conviction in a court of law, there is only suspected fraud. Use discretion and avoid accusations of fraud--or you could find yourself and your company party to a libel or slander suit. Your civil immunity protections for reporting suspected fraud are limited and only cover you when reporting to an authorized governmental agency.

THE AGENT'S FILE

In any legal action involving an insurance transaction or claim, a plaintiff's attorney will always attempt to get a copy of the ***agent's file***. It will show the agent's knowledge of the insured's intent for specific coverage, communications between the agent and client and communications between the agent and underwriting. By law, insurance companies also have access to your files including e-mail, faxes and post-it notes. Considering this exposure, agents may want to make consistent and accurate notes to their file using ***standard operating procedures***.

A final caveat: No insurance carrier, agent, self-insured employer, or third-party administrator has the right or authority to make any agreement to not report or pursue suspected fraud. For example, an agreement to not investigate or report suspected fraud, as a means of facilitating finalization of a claims case, is an illegal act. Insurance fraud is a criminal act and is in the purview of only prosecutorial agencies such as district attorneys, the State Attorney General, and the U.S. Attorney.

Insurance Fraud Overview

Trends & Statistics

In order that you may more fully comprehend the seriousness of insurance fraud and its cost to both the insurance industry and society as a whole, let us spend a little time getting an overview of insurance fraud using information from the National Insurance Crime Bureau in a recently published report.

Note the following:

- Insurance fraud ranks second only to tax evasion as the most costly white-collar crime in America.
- Property/casualty-based insurance fraud costs Americans $20 billion ANNUALLY.
- When fraud in the health, life and specialty insurance lines is added, insurance fraud costs could exceed $100 billion a year.
- NCIB estimates that 10 percent of property-casualty claims are fraudulent.
- According to NCIB estimates, the average American household pays $200 a year in additional premiums to cover the costs of fraud.

National polls on the subject of insurance fraud have yielded the following:

- The public ranks insurance fraud 8.9 on a ten-point serious crime scale.
- Seven percent of those polled reported that they had personal knowledge of a case of insurance fraud.
- Six percent of those polled had been asked by a body shop operator to falsify or exaggerate an insurance claim.
- Two percent had been asked by a health care provider to falsify or exaggerate a claim.
- Two percent had been asked by an attorney to falsify or exaggerate a claim.
- Two percent had been asked by others to falsify or exaggerate a claim.

Thus, TWELVE PERCENT of those polled had been asked to falsify or exaggerate an insurance claim. But even more alarming is the report that approximately SEVENTEEN PERCENT of adults polled feel that it is all right to cooperate with doctors, chiropractors and attorneys to falsify or exaggerate workers' compensation claims in an effort to get money from insurers.

Unfortunately, many people view insurance companies as vast, bottomless money pits, the "deep pockets" that can fork over large amounts of money and not be diminished. Such a view ignores the basic nature of insurance, which is that it is a social device which allows people to POOL a certain amount of resources to cover a certain type and amount of risk. And although an insurer's reserves might seem vast to a lay person, those reserves are carefully calculated to cover the KNOWN risks of those who have put resources into the pool.

Thus, when an automobile insurer issues a policy, the premium, which is the amount of resources the applicant is contributing to the pool, is determined by the amount of RISK this applicant represents. And this risk has been determined by the applicant's age, his or her driving record, the conditions under which the vehicle will be driven, and any other variable which might help identify risk,

When losses exceed the resources the insurer has to cover them, obviously, more resources must be found. And since by resources we mean dollars--clearly, insurance rates go up. This is why insurance fraud is considered a "social" crime--because its effects spread throughout society, forcing innocent insureds to help pay for someone else's fraudulent claim.

Further in this course we will present specific methods by which agents and insurers can help prevent insurance fraud. Now, let us say generally that insurance agents should make it a practice to instruct applicants in the insurance process, helping them to understand that it is to the benefit of themselves as well as to others to keep loss claims within legitimate limits.

Our course will follow this general outline: first, the difference between fraud and abuse; a look at the legitimate uses of insurance, covering the principle of indemnity, insurable interest, and establishing loss. We will then look at the fraudulent uses of insurance, covering personal insurance, which includes life insurance, accident and health insurance, and workers' compensation insurance, and then moving to property and casualty insurance, looking at automobile insurance, theft insurance, fire insurance, boat insurance, water damage claims and agent fraud. Finally, we will look at the costs of fraud to insurers, to consumers, and to society, as well as penalties for fraud, both legal and financial, and preventive measures the agent and the industry can take.

Fraud Vs. Abuse

What is fraud? What is abuse? What is the difference between them? Because abuse is a very broad term, it is easy to confuse the two.

Abuse Defined: Insurance abuse is any practice that uses the system in a way that is contrary to either the intended purpose of the system or the law. This includes some behavior that is not criminal and some that is, most significantly fraud.

Fraud Defined: In the simplest terms, Fraud occurs when someone knowingly lies to obtain some benefit or advantage, or to cause some benefit that is due to be denied. If there is no lie, there may be abuse but it is not fraud.

Some Forms of Abuse

Merely filing a claim that is not warranted or violating the rules of industry, in the absence of fraud (a lie) or kickbacks, may be abuse but it is not criminal. Noncompensability per se does not constitute fraud unless the specific elements of fraud are present. Similarly, overtreatment by a physician might represent only a difference in opinion; although it could appear excessive and possibly abusive, it does not necessarily constitute fraud. Typical abuses of the system also include magnification of complaints or disability that fall short of an outright lie, or an overutilization of benefits. For example, soft tissue injuries give rise to subjective complaints that cannot be either proven or disproven.

The presence or absence of a specific, provable lie is the deciding factor. To separate fraud from abuse, it is necessary to look for the lie or misrepresentation, whether written or oral.

For example, returning to work while receiving temporary disability payment might be abuse, or it might be fraud, depending upon the circumstances. As the law now stands, claimants have no legal obligation to advise anyone when they return to work, nor do they have an obligation to certify their continuing disability status. If temporary disability payments continue when the claimant has returned to work--and no one ever asks the claimant "are you working?"--there is an abuse of temporary disability benefits, but there is no lie and therefore no fraud.

However, using the same example, if someone, such as the adjuster or the doctor, specifically asks the claimant "are you currently working?"--and the claimant replies "no" and thus lies, and that lie is relied upon to determine the amount and payment of temporary disability--there is fraud.

Criminal Abuse

Though not legally a fraud, offering or accepting kickbacks for the referral or settlement of cases is a reportable and highly prosecutable crime. Kickbacks indirectly feed the problem of fraud and, as a result, cause damage to our society and our economy. Consequently, the legislature has determined that both fraud and the kickbacks that can contribute to it are punishable criminal acts; a single fraudulent transaction can be punished by up to 5 years in prison.

Fraud

In separating criminal fraud from abuse, remember these ***key elements***:

< There is always a false representation--the lie.
< The lie must be intentional or knowingly made.
< The lie must be made for the purpose of obtaining a benefit the claimant is not due, denying a benefit that is due, or obtaining insurance at less than the proper rate.
< The lie must be material, that is, it must make a difference: "If the truth had been told, would you have done anything differently?"

LEGITIMATE USES OF INSURANCE

We have already said that insurance is a social device whereby people may contribute resources to cover the risks of all members of the pool. This is a general definition, but several points in it are worthy of further discussion as we enter our study of insurance fraud.

First of all is the concept of a POOL of people. This pool is, of course, the policyholders of an insurance company. But note that APPLICATION must be made before a person can enter the pool. And note also that the application asks for certain information which the insurer deems essential if it is to accurately determine the amount of RISK the applicant adds to the pool.

Anyone in the field understands this concept: in fact, the understanding becomes taken for granted, so that filling out an application becomes almost automatic. But when we expand our understanding, and are aware of why certain information is asked for, and why it is required, we will no longer simply "fill out an application." We will understand that we are helping a person apply for admission to the pool, and that he or she is admitted, not only his or her resources will be added, but also any risks which have been specifically guaranteed by the other members of the pool.

Insurance actuarial departments spend a great deal of time, expertise, and money endeavoring to determine precisely how much premium should be attached to a particular type and amount of risk. Their purpose is to make sure that NO ONE brings more risk to the pool than resources--and also, that no one brings more resources than risk. In other words, legitimate premiums should represent, as exactly as possible, the correct proportion of resource to risk.

Yet another concept is essential for insurance to work properly. That is the concept of risk. RISK refers to future potential loss. Again, actuarial departments are responsible for determining all the various kinds of risks that may be attached to insured people, insured property, and insured legal entities, such as corporations. They do this by constantly reviewing actual losses in various classes of risks against their

projected losses, and by making adjustments accordingly.

For example, while for many years applicants for health and life insurance have been asked about smoking habits, recent research results that prove more conclusively the relationship between smoking and various life-threatening illnesses has made it possible to more accurately calculate the risk smokers add to the pool, and to make the premiums for smokers more adequate in covering that added risk.

But because risk does refer to potential future loss, it cannot be calculated with total accuracy until after a loss has occurred. Insurers can and do add a certain percentage to their loss reserves to account for this lack of total accuracy in predicting losses. But they CANNOT predict what fraudulent claims will do to those reserves, just as a bank or other financial institution cannot predict whether it will be robbed, and, if so, how much will be taken.

Crime of any sort disrupts the social fabric. While highly visible crimes such as armed robbery and murder get public attention, less visible crimes such as insurance fraud are spreading consequences across the public at large. Insurance fraud attacks the very basis of the insurance contract, which is trust between the insurer and the insured. The insurer must be able to trust that information on an application for insurance or a loss claim is true, and the insured must be able to trust that the information will be acted upon in a timely and efficient fashion. Unfortunately, one of the results of insurance fraud is to breed suspicion, so that in many instances, legitimate claims take longer to process because of added procedures to detect fraud.

PRINCIPLE OF INDEMNITY

The Principle of Indemnity is central to the effective operation of insurance. Simply put, the principle of indemnity states that ***the purpose of insurance is to restore an insured to the pre-loss condition***, insofar as that is possible. In the case of a property / casualty loss, restoration is measured in terms of the value of property lost or liability protected. In the case of life and health coverage, indemnity speaks more to the restoration of an economic loss resulting from the death or injury of the insured.

Sometimes, as in the case of the loss of an easily replaceable object, restoration is a simple matter. For example, Howard Scott has just purchased a new automobile. He drives from the dealership to his office, and parks the car in his usual spot. A building is going up next door to the lot. A crane operator is lifting a heavy load of building materials to an upper floor when the cable breaks and the load crashes down onto Howard's car. This claim will be fairly easy to determine, since there can be no question as to the present value of the car, and since there are no injuries to complicate matters.

But few claims are so easily handled. In most cases, the human factor enters into the claim process, and complicates it. There is a saying to the effect that nothing so increases the value of something like losing it. And insurance adjusters would surely agree with that. Particularly when a major disaster strikes, and emotions are high, the value people place on lost objects can escalate.

For example, when Hurricanes Erin and Opal hit the Florida panhandle in quick succession in August and October of 1995, claim adjusters found that people had family antiques and heirlooms in their beach houses, that TV sets and other lost appliances were hardly out of their boxes, and that large and expensive wardrobes had been swept out to sea.

And, faced with piles of rubble, or, in some cases, an empty lot where a house had indeed been swept away, it was difficult for adjusters to determine what actually was the value of the losses insureds had sustained.

Were these people committing deliberate fraud? In some cases, most certainly. In others the stretching of the truth--or falsification of the value of lost property--could be attributed largely to the helplessness people feel when confronted by a major disaster over which they have no control. More than physical

objects are gone when an entire home disappears, and people tend to compensate for feelings of loss and rage by trying to get something back--in the case of these hurricanes, money from insurers with which to reestablish themselves.

Such a situation, with a very large number of insureds sustaining major losses in the same period of time, represents one extreme in claim management. But out of extremes come lessons that can be applied to more ordinary circumstances. Householders who rebuild in the Florida panhandle would be well advised to maintain accurate and up-to-date documentation of the value of items put in their beach houses, because in an effort to reduce either deliberate fraud or emotional overstatement of property value, insurers will require something other than an insured's memory and word.

Let us get back to the idea of indemnity--restoring an insured to the pre-loss condition. Such restoration should occur across the entire spectrum of variables insured: physical property, and also physical injury, and mental and emotional strain. Note that each of these classes of loss presents a whole array of possible risks. Note also that insurance policies are written to either INCLUDE or EXCLUDE certain identifiable risks.

What is the premise upon which a risk is included or excluded? Primarily, the ability of the insurer to determine to a fairly accurate degree the value of possible losses. For example, a standard fire policy will insure a dwelling for a certain amount, and, if the dwelling is totally destroyed by fire, the insurer will pay the full face value of the policy after duly processing the claim. And the premium to cover this risk will be determined by, among other things, the building materials used, the availability of a fire department and fire plugs, the use of the building, and whether or not it is occupied.

If the property is insured to value, the property-owner should receive enough from the policy to rebuild, particularly when the value of the land on which the building stood is considered,

But in flood insurance, if a dwelling is totally destroyed by a flood, the insured will not receive the face value of the policy, because the damage floods do cannot be accurately predicted, and thus premiums cannot be determined that will build up sufficient reserves for an insurer to be able to pay the face value of policies in case of loss.

Property and casualty policies routinely exclude damage caused by such things as acts of war, insurrection, riots, etc., simply because it is impossible to accurately predict the possible occurrence of such things, and also because it is impossible to accurately predict the possible losses,

There are many, many examples where the principle of indemnity can serve only as a guide in settling claims. For instance, a person who has lost both legs in an accident CANNOT be restored to pre-loss condition, no matter how much money is available to settle the claim. And so a careful process of determining the dollar value of the loss is begun, using such criteria as the person's age, employment, leisure activities, family situation, and so on.

The long-time trend in this country is for juries to award very high amounts of money in personal injury cases. It is not unusual to find cases in which people working at minimum wage levels receive enormous awards from juries, not to make up for loss of lifetime earnings, but because of sympathy with what the person has endured. Nor is it unknown for the injured and those working for them to exaggerate the pain and suffering, the mental distress, and the emotional fall-out of the injury in order to play upon the sympathy of juries.

What is missing when juries vote emotionally rather than rationally? Primarily, a misunderstanding of the nature of insurance--that its purpose is to remediate, insofar as is possible, the effects of an accidental law. But the word ACCIDENTAL is also significant. The risks that insurance covers will not automatically happen. Even death, which life insurance covers, is unpredictable. It will certainly come, but whether today,

tomorrow, next year or ten years from now, is rarely known. When an ACCIDENT does occur -- a completely unexpected happening over which we have no control -- the victim certainly should not have to pay for any of the consequences of the accident -- medical expenses lost time at work, cost of future care, etc. -- but neither should the victim BENEFIT by the accident to an extent that is unreasonably above the value of the actual loss.

This is an idea juries find difficult to comprehend. And so do many policyholders when the accident or loss happens to them. Intellectually we know that no amount of money can restore a lost limb, emotionally we feel that if the victim has to be legless, if he or she lives in a somewhat luxurious manner -- this will somehow make up for the loss.

It is just this sort of thinking that creates an atmosphere in which people who would never rob a bank, escalate their claims by exaggerating their loss so as to get payment for intangible effects, A beautiful young woman who has severe facial scars as the result of a car accident will ordinarily get a much larger award from a jury than say, an elderly woman.

While insurance companies and courts cannot make people think with their heads instead of their hearts, increasing abuses in the matter of jury verdicts in personal injury cases have led to campaigns to set legal limits on such intangibles as pain and suffering. But despite the existence of, such laws, human beings are human beings, and when they suffer a loss, many of them will try to get more money than the amount that represents a reasonable and possible restoration to their pre-loss condition.

And so we have a situation in which ***there are two types of people who commit insurance fraud***. The first class, is made up of people who quite deliberately figure out ways to get more money from a claim than they should legitimately have. The second class. is made up of people who see insurance companies as "deep pockets" with endless amounts of money to be spent, and who consider the intangible suffering and emotional state of victims to be a measure of how much compensation they should receive.

But whether performed by professional crooks or by misguided or muddy-thinking individuals, insurance fraud is a serious crime, one that insurers and insureds must work to prevent.

INSURABLE INTEREST

The concept of insurable interest is not only essential to the nature of insurance, it is also an important element in fraud. Let us look at the two words which make up this phrase to better understand its meaning. First of all, what is the meaning of INSURABLE? Simply put, this means that losses that may occur from a particular risk can be identified, AND quantified BEFORE the loss occurs. By IDENTIFIED, we mean that the losses can be named: for example, a woman insures her jewelry. Each piece, with a description and an appraised value, will be listed on the jewelry schedule. It is thus. IDENTIFIABLE.

And by QUANTIFIED we mean that the possible loss may be MEASURED in TWO ways. First of all, the dollar value of the item at risk may be measured, and second, the PROBABILITY of loss maybe measured. Quantifying a risk is of vast importance determining premium.

Take the example of the jewelry. The dollar value of the item in question will be determined by a professional accepted by the insurer. The nature of the item and its use will help determine the probability of loss. For example; there is a higher risk of loss when a piece of jewelry is worn in public, at places -where jewel thieves would expect owners of expensive jewelry to go.

Does jewelry, represent an insurable risk? Certainly it does. If it is stolen, or lost, its monetary-value can be replaced, even if the particular piece of jewelry cannot.

Having looked at INSURABLE, now let us took at INTEREST. In terms of insurance, this simply means that a person or legal entity (such as a corporation) has a legal or financial connection to the item at risk, and will suffer some harm as a DIRECT result of a loss, should it occur. Thus a person who owns stock in a corporation has a legal--and, in this case also financial--connection to the corporation. A homeowner has a legal and financial connection to the property he or she owns.- should the -house be destroyed by fire, he or she would suffer a financial loss, but would also be exposed to laws regulating the removal of debris; the securing of dangerously damaged buildings, etc.

Thus an ***INSURABLE INTEREST*** refers to the legal and/or financial connection a person or legal entity has in a piece of property, either tangible or intangible, that is at risk to a possible loss which can be identified and quantified before it might occur. It is obvious why the concept of insurable interest is essential to the nature of insurance. ***Unless a person will suffer some harm as a direct result of a loss, there is no reason why they should participate*** in any instruments, such as insurance, which may be used to mitigate the effects of the loss, should it occur. Note that it is important that the harm be a direct, not indirect, result of the loss. The significance of this becomes evident in suits in which lawyers attempt to establish a connection between an event-the loss-and the problems their clients are having.

Particularly in gray areas such as pain and suffering, mental anguish and the like, demonstrating that there is a direct connection between, say, a client's depression or other emotional state and the event is essential if the plaintiff's claim is to succeed.

And, of course, the law defines certain relationships that in themselves establish insurable interests. For example, spouses, children, and parents are in the first rank of those understood to have an insurable interest in the death of a spouse, parent or child. Certain business relationships-employer to employee, for example-are also understood to establish an insurable interest, as when an employer takes out key man insurance on an employee.

Mystery writers often use this idea of insurable interest to create a motive for a crime, and, in real life, there are all too many examples where the existence of an insurable interest did motivate a crime such as arson, theft, and even murder. We shall examine such cases later in the course.

ESTABLISHING LOSS

It is when an insured is establishing loss that the opportunity for fraudulent claims arises. Many elements in the loss claim may be fraudulent, with lies being told about the extent of damage, the pre-loss condition of the damaged person or property, the value of the damaged property, and so on. Let us examine the various elements in a loss claim, and see where this process is vulnerable to fraudulent claims.

First of all is the TIME of loss. The time is important for several reasons. The policy holders have an obligation to file claims of loss in a certain time frame, or else there is a danger that the claim will not be honored, or, if honored, will not be paid at full value. When a major disaster, such as a hurricane, flood, or something of that nature, strikes, insurers normally extend the time limit for claims to be filed, knowing that the sheer number of claims and the extent of damage will prevent insureds from filing in a timely manner.

But there is another element in the time a loss occurred that is significant. For example, suppose that a homeowner has purchased the materials for a new roof, and has receipts showing that the materials were purchased before the date a hurricane struck. Suppose the insured homeowner has not yet put the new roof on when a hurricane strikes, one so severe that it blows off or damages all the roofs in the area, including the homeowner's old roof. Now suppose that the homeowner claims that he had already replaced the old roof, and uses the receipts showing the purchase of the materials as proof. He claims that he and his sons replaced the roof prior to the date the hurricane struck, and thus claims reimbursement for a new roof instead of the old one that would have depreciated in value to the point where it would bring very little

return if claimed. Insurance adjusters are all too familiar with claims that manipulate time so as to receive a greater amount when the claim is settled.

Exaggerations are also made about the pre-loss condition of the damaged item or person. As mentioned before, adjusters often find that a home consumed by fire or a hurricane or some other cause contained items of more than ordinary value, items that did not have to be listed on a separate schedule, but must still be counted in determining the amount of a claim. And, since the forms the insured fills out when claiming loss of contents of an insured property do not ask for proof, there is ample opportunity for householders to lie about the value of what they have lost.

Thus an insured who has a kitchen full of odd china may claim the loss of an almost new full set of china for twelve. A tool-box that may have held a couple of hammers and an assortment of inexpensive tools suddenly contains expensive drills and top-of-the-line items that are costly to replace. A few simple fishing poles become costly rods and reels. Such false claims are endemic in the industry, for a very good reason. Adjusters have just so much time, and insurers' claims departments are also constrained in terms of the amount of time and effort they can put in settling claims.

When a major disaster strikes, such as the double-barrel blow of two major hurricanes within two months time that struck the Florida panhandle in August and October of 1995, there are entirely too many individual claims for adjusters and claim departments to nit-pick over a set of china or a box of tools. Since householders usually stay within reason--if fraudulent claims can ever be called reasonable--insurers write off the cost of inflated claims concerning the loss of household goods as part of the cost of doing business--although the entire pool of policyholders will end up paying for this higher cost when rates are adjusted to make certain insurers have adequate loss reserves.

Unfortunately, not only insureds are guilty of inflating the size of a loss. In the aftermath of those two hurricanes, property owners could be heard bragging about the size of the check they would get when their claims were settled, amounts that could not have been received were fraud not involved. The greater part of the damage during Hurricane Opal was from a twelve foot tidal surge driven by winds of 145 miles per hour. This tidal surge pounded the beach, sucking sand from under the concrete foundations of town-homes and condos. With no foundations left, these structures toppled forward into the sand: many were reduced to rubble, and none of this type of structure stood.

But since flood insurance does not pay the face value of the policy, only a percentage which is determined by a complex formula which is applied after every such major loss, property owners who lost their beach houses because of the tidal surge stood to get far less than the amount of money it would take to rebuild. Windstorm insurance, however, does pay the full face amount of the policy. So if property owners could claim that the winds preceding the tidal surge had caused some damage before the tidal surge came in, they could get the full amount of that loss claim from their windstorm policies.

Thus, many policyholders were able to claim that their roofs had blown off before the buildings collapsed, taking the roofs with them. They claimed that the wind had blown in windows and doors, and had blown household items away. In some instances, such a scenario may well have been true. But in others, particularly where buildings built right on the beach were concerned, and especially when those buildings were on concrete foundations instead of pilings, such claims were dubious. Still, they were made.

Creative property owners found many ways of making fraudulent claims in the aftermath of Hurricane Opal. Rental units that were not indeed rented during the period of the storm and in the weeks afterward were suddenly full of tenants who had not been able to come to Navarre because their accommodations had been destroyed. And so the renter was able to claim loss of rental income for a certain period during which repairs were made.

In all too many instances, it is only the honesty of the policyholder that makes insurance work. And in a society in which personal codes of ethics seem to be increasingly rare, to depend upon the honesty of policyholders may be a mistake. People may be honest in such matters as returning lost property that they have found, or making a child go back to the store to return an item he or she has stolen. They may be honest in filing their income tax returns, or in not taking advantage of a mistake a clerk has made in giving them change.

But when it comes to filing an insurance claim, a temptation of another sort arises. After all isn't the purpose of insurance to protect the insured against loss? When the insured purchased the homeowners' policy, didn't the agent say that if anything happened to their property, the policy would pay enough to get it replaced?

Yes to all of those things. Well, then--if a hurricane blows through my home, ruining the contents, shouldn't my policy pay enough to get them replaced?

Yes to that, too. The problem comes in when policyholders don't WANT the contents replaced. They don't want a kitchen full of odd lots of pots and mismatched glasses and china. They don't want a ten year old blender on its last legs, or a toaster with only one slot that works. They want everything brand new. And, unless they paid a premium figured on the assumption that everything in the home was brand new, they cannot have that.

The value of the contents of a household is, after all, set by the householder when the policy is bought. Nor can a householder, at that time, claim a HIGHER value for the home's contents than actually exists. He or she cannot, in other words, OVERINSURE property. Actuarial departments have determined ratios that set parameters of allowable amounts of unscheduled contents insurance in relationship to the value of the house. A house that may be insured for, say, $110,000, could hardly be expected to have unscheduled contents valued at $150,000. If such an application came in, you may be sure that questions would be asked, and that proof of contents' value would have to be shown.

This is the whole purpose for having schedules attached to property insurance for such things as antiques, art work, jewelry, and other valuables. The values attached to these items must be determined by AUTHORIZED appraisers within each field, and such appraisals must be submitted to the insurer before the coverage is in force.

You can understand, then, the problems that arise when the average homeowner suffers a loss. No matter that he or she or they said, at the time they bought the coverage, that they understood the policy, and what and how it would pay. All they know is that yesterday they could cook their meals and today their stove and pots are gone. It is only human not to want to go to second-hand stores and flea markets to replace household items swept away by a storm or flood. On the other hand, it is not reasonable to expect an insurer to pay claims large enough to send the insureds off to buy brand-new items to replace what they have lost.

And so policy owners give in to temptation, inflating the value of lost items so that the amount of their check to settle the claim is sufficient to replace most of what they lost. This is what we might term emotional dishonesty, in that the emotions caused by personal loss over-ride what might be the limits policyholders would otherwise observe. But the cost to the insurers is just as great as if the dishonesty were conscious and intended.

Yet another reason policyholders are tempted to inflate the size of their loss lies in the fact that most people do not understand the concept of DEPRECIATION, and how that can affect the dollar amount they can claim. After all, not everyone deals with that concept every day--or even every month. In practical terms, which is the way most people think, an item has value as long as it can be used. And while items with working parts, sewing machines, lawn-mowers, automobiles and the like--are more obviously losing value the longer

they are used, few people stop to think that the sheets on their beds, the pots on their stove, the watch on their wrist, also are losing value with every passing day.

But when an adjuster is determining the amount of loss in terms of contents, he or she will give the policyholder a form that has places for the lost or damaged items to be fisted, described--and also a place for the approximate age. It is when filling out such a form that policyholders may become aware for the very first time that what they have lost was a house full of aging, and therefore almost valueless, items. So on top of the shock of the flood or fire or hurricane itself, they now have the shock of seeing their lost possessions in a new, and most unfavorable, light. Follow that with the realization that they will get very little for the contents of their home, and you can understand, if not condone, why such people lie. But is also in establishing loss that people other than policyholders find opportunities to gain at the insurers' expense.
For example, a great majority of medical expense claims are filed, not by the insured, but by the health care personnel/organizations who deliver the care, And there are all sorts of opportunities for fraud and abuse here. The problem has become so severe that insurers in the health care field such as TRIGON/Blue Cross Blue Shield are issuing pamphlets in their communications to policyholders asking for help in reducing these false claims.

One such example has a cover announcing: FRAUD & ABUSE ALERT! Inside, there is a plea to HELP US SAVE YOUR DOLLARS!, followed by this text:

> *Health care fraud and abuse affects everyone. Blue Cross and Blue Shield has a special unit dedicated to detecting and deterring fraudulent and abusive activity. You can help. Compare the itemized bill you receive from your provider to your explanation of benefits. Things to look for-Were insurance payments made for medical services that were not performed? Were duplicate payments made for the same medical service or treatment? Were medical insurance payments made for someone who was not an eligible Blue Cross and Blue Shield member? Was there any misuse with this medical insurance? If the answer to any of the above questions is YES, contact us on our toll-free Fraud Hotline, 24 hours a day, seven days a week. Callers may identify themselves or remain anonymous. Our voice mail will take your confidential call; please leave detailed information, If you choose not to remain anonymous, your call will be returned by our representative. Each incident uncovered and stopped saves your and all our customers' money. That is as important to us as it is to you. OTHER HELPFUL HINTS: If you are seeing the doctor for the first time, talk to someone who has seen the doctor and is satisfied with the services. Ask questions about billing practices before scheduling an appointment. Request an itemized bill before leaving the doctor's office. Insist on a receipt that shows the balance due if you are required to make a payment. Be aware of the environment and ask questions: if you are not satisfied, leave the office. We want to assure you that the vast majority of claims filed are accurate and appropriate. But inappropriate claims have a significant impact on health care costs. Statewide, such claims cost an estimated $1 million per day. (Note: this pamphlet was issued by Blue Cross Blue Shield for only one state--meaning that in JUST ONE STATE, fraudulent claims cost that insurer $365 MILLION PER YEAR!) This affects all of us in the form of higher health care costs.*

The text in this pamphlet is interesting in a number of respects, and shows a deep awareness of human nature. Note that the questions about the payments ask the insured to do things that normally, we would expect anyone to do: review a bill, and make certain that no charges were made for services not rendered. Why would an insurance company have to ASK policyholders to check their bills for accuracy? Primarily, of course, because in many cases, the policyholder makes no co-payment, and when a co-payment is made, it is relatively small. Thus, because the policyholder does not feel that the payments have come or will come from his or her pocket, little to no interest is taken in examining the bill. Only if an insurer can get the message across to policyholders that fraudulent claims DO cost them money will policyholders take an active interest in fighting abuse and fraud.

Note, too, that people who call to report fraud may remain anonymous. Relationships between physicians

and their patients vary, but usually, patients have a certain dependency on their physicians which may militate against them reporting fraud. Further, the very people who may be careless about checking bills may be the same ones who consider their physicians minor gods who can do no wrong. Insurers are left wide open to abuse and fraud from dishonest medical practitioners when these conditions exist. A further complication is that medical practitioners ARE caretakers who relieve pain, cure disease, and in general are seen as saviors alleviating human suffering, whereas insurers are money-crunchers. Patients would thus be reluctant to 'tell off ' a person who looms large in their personal welfare to a distant corporation with whom they have no contact at all. All of these factors unite to create an environment in which unethical medical practitioners may file false claims and get away. When insurers issue pamphlets such as the one just cited, however, they are pointing out, however subtly, that policyholders are colluding with fraudulent claims when they do not actively review their bills, the payments made, and report any discrepancies.

Thus, in the process of filing claims, there are several possibilities for abuse and fraud. First, a policyholder may make a fraudulent claim on his or her own. Second, the policyholder and adjuster may collude to file a fraudulent claim. And third, other parties such as medical practitioners may file fraudulent claims, depending upon the nature of their relationship with patients and the fact that most people do not pay a great deal of attention to a bill someone else has paid to help them get away.

FRAUDULENT USES OF INSURANCE

We will begin our study of fraudulent uses of insurance by examining fraud in the personal insurance field: life insurance; accident and health insurance, and workers' compensation insurance.

Life Insurance Fraud

Because of the nature of life insurance, there are limited ways in which fraud can be committed. An applicant can attempt to conceal life-threatening or even terminal conditions on an application. Second, a death can be faked. Third, proceeds from a legitimate death can be diverted to the wrong beneficiary

The first of these methods is not easy to implement, simply because even if the applicant is successful in concealing pertinent medical facts during the application process, once he or she dies, the cause of death would probably lead the insurer to investigate the client's prior medical condition. Once the concealment was discovered, the policy would be automatically void, and no monies would be paid.

Staging a death, on the other hand, has been and is being used more frequently. Before the days of computers and desktop publishing systems, staged deaths appeared more in fiction than in fact. Certainly, there were highly-publicized cases of people whose private planes went down in supposedly-impenetrable swamps or forests, people who later turned up alive long after hefty insurance claims had been paid. One case involved a scenario worthy of a Hollywood film. A young man, the rather never do well son of a prominent family, went off to Australia to make a life--and a fortune. He married there and fathered a child, gradually establishing renewed contact with his family back in the States. Then came a message from Australia: the young man had fallen overboard from a ferry crossing from the mainland to an island and had drowned. His grieving family sent plane fare to the widow and child, welcoming her into their midst and giving her a home.

Imagine their surprise when she told them that, far from being penniless, she was the beneficiary of a multimillion dollar life insurance policy which their son had only recently taken out. Since the job he had held in Australia did not pay much, his parents were impressed that he had invested so much in protection for his wife and child.

The insurer was not so impressed. At first they suspected suicide, but found that they could not prove that

to be the case. After a long investigation, they reluctantly paid the claim, but kept the case open. It was a good thing they did. The wife banked the money and settled down into life in her new home. Months passed, and then the wife told her in-laws that she wished to go back to Australia where she had been born. This seemed a natural enough wish.
But when the young woman went to the bank and asked for a transfer to a bank in Australia, the bank complied with the insurer's request that they be notified if she made such a move. An insurance investigator then tracked her. Sure enough, not long after she and the child arrived in Australia, a man appeared in her life. Although his hair was a different color and he wore a beard and mustache, and weighed more than the dead husband had, the investigator felt certain that this man and the dead man were one and the same.

This proved to be the case. When confronted alone, the wife, who had born the burden of suspicion from the start, confessed their scheme. Under his clothing, her husband had worn a survival suit that enabled him to stand the frigid waters and to breath until he could safely emerge on land. He had gone to a hide-out which they had set up, one stocked with all the provisions he would need. And there he had stayed, growing his beard and mustache, while his wife played out her part of the charade.

Both were tried and convicted for fraud, and imprisoned, as well as having return all monies the insurer had paid. So what put the insurer onto them? After all, people do fall off boats, and they do drown, several things. First of all, the size of the premium compared to the couple's income sounded an alarm. Thus, everything about the claim was gone over with a careful eye. And someone, examining the watermark on the paper the young woman used in writing the letter to tell them about her husband's death, made a discovery. That sort of paper was not sold in Australia, but only in the United States. This might not have been significant: the young man could have brought a stock of such paper with him when he went to Australia, However, there was one little fact he did not know. The paper in question had not been manufactured until AFTER the date he left the States. Thus, he could not have taken it with him, nor could he have purchased it there. This meant the young woman had to have gotten the paper in some other way.

When questioned, she admitted that they had a cohort back in the States, a lawyer who drew up the letter the young woman sent. He mailed it to her in Australia; she signed it, and mailed it in the envelope he had also addressed. The type on the letters was compared to the type on his office machine. They matched, in best detective story style. And why did they need to bring the lawyer in? Simply because the young woman pleaded that she did not have enough expertise to successfully carry the fraud through alone.

Now, schemes do not have to be so elaborate. Desktop publishing has made it possible for people wishing to stage a death to produce authentic-looking copies of death certificates. And there are officials in some Caribbean and African countries who will accept a fee for certifying that a death has occurred. In a highly transient world, it becomes increasingly difficult to use the old procedures when an insured dies.

For example, an insurance investigator was asked to check out a life insurance claim for the death of a nine year old child who was supposed to have died in a taxi accident in a West African nation, where he was staying with his grandparents while his parents established themselves in New York. The policy was new, which was the first sign that something might be wrong. When an investigator went to the grandparents' home in the West African town, the child was playing in the front yard. A local official had signed the death certificate in return for a fee.

According to a spokesman for the Coalition Against Insurance Fraud, there has been an alarming increase in the number of reports of such swindles, especially in cases where the death has happened abroad. Nor is the selling of false death certificates restricted to officials abroad. In Los Angeles County, what look like official death certificates are sold on the streets for anywhere from $500 to $1000.

While many fraudulent life insurance claims involve relatively small policies--perhaps on the theory that insurers will be less likely to use resources investigating smaller claims-there are cases where substantial

amounts were involved. In one such case, a young man used his own medical records, changing the name to one of a mythical brother, to get a life insurance policy in the fake name in the amount of $2 million. He filed a claim using a fraudulent obituary--which had appeared in the local paper--and a fraudulent proof of death, as well as a fraudulent police report. He was detected, and charged with insurance fraud.

Sometimes the very thoroughness of a claim alerts insurers that a fraud might be going on. Relatives of a deceased insured usually do not know what they need to submit to prove their claim, so when a beneficiary is quick to provide all needed documentation of the death, insurers are warned. And, of course, the absence of a body throws a red flag. That is why deaths abroad raise suspicion, as do instances of cremation when other warning signs exist.

A third form of life insurance fraud is the diversion of beneficiary funds. Consider the situation described in a 1984 court case (Crobons vs Wisconson National Life). Here, even the agent was part of a last minute fraud to replace the name of a legitimate beneficiary with an unnamed beneficiary.

The case began as an ordinary life insurance sale between agent and client. Years later, however, the client became gravely ill and lapsed into a coma. Some family members soon realized that the beneficiary of the insured's policy wasa relative whom they did not approve. The agent agreed to come to the hospital and change the beneficiary.

The agent's big mistake was agreeing to witness a change in beneficiary knowing full well that the client was in a coma. After death, the damaged beneficiary filed an action against all parties, including the agent. The beneficiary designation was eventually reversed.

In another case, an agent was dragged into a situation involving an elderly woman and her son (a bad seed). The woman purchased an annuity from the agent many years ago. The bad son eventually convinced his mother that she should surrender the contract and put the money in the bank. She was not sure about it so she asked the agent to stop by and discuss it. At the meeting, the agent could see that the son was trying to influence his mother and wanted to remain outside their conflict. Before leaving, he handed the woman a withdrawal form to sign and return to him if she decided to go ahead. Unfortunately, the agent signed the form as a witness. The bad son later found the unsigned form, forged the mother's name and sent it in. When the monies arrived, he deposited the check and as a signer on her bank account he was able to withdraw $100,000. A few months later, the good son called the agent and advised him that the signature on the withdrawal was forged. To date, there is no resolution in this matter but you can be sure that the agent is concerned about his role.

Accident And Health Insurance

Fraudulent claims in health and accident insurance are much more frequent than in the life and annuity fields. For one thing, it is obviously easier to overstate or lie about physical injury and/or illness than it is to fake a death. And it is easier to stage an accident to account for the injury than it is to create a believable death.

Do people actually fake accidents, or stage one just so they can file a claim? Look at these examples. A family in Las Vegas staged a variety of "slip and fall" and auto accidents in Illinois, Wisconsin, and Ohio. Eight family members admitted to collecting ONE MILLION DOLLARS in false claims. A man, working alone and using more than 24 false names, claimed to have staged more than 200 fake accidents across the country over a twenty year career of defrauding insurance companies with false claims. An insurance investigator assembled a paper trail of 71 slip-and-fall claims that had been paid to him by more than 50 different insurers and business, claims ranging from tripping on torn carpet to slipping on water to being bumped by cars backing out of store parking lots. Caught and charged with insurance fraud, this man could get twelve years in prison, as well as being fined $750,000 for each count of insurance fraud.

All of these are examples of bodily injury fraud, and represent several types that insurance adjusters have become all too familiar with. Slip and fall scams are favorites of those out to get insurance benefits fraudulently, and some of its users go to great lengths to stage fake falls. Some squirt the floor with water from a hidden bottle- others have put fake blood up their noses with a syringe so that their claim of a broken nose will be more believable.

The fake break is another favorite scam: it takes advantage of a new or existing injury to make a false claim. For example, a person has recently broken his or her arm, which is in a cast. An accomplice removes the cast, soaks the limb, then drives the person to the hospital for treatment, setting the stage for a false claim. Or, an old back injury might be added to a new injury to increase the size of the claim.

Some false claims come from people who have pulled items from store shelves so that they fall on top of them and cause an "injury" for which they can claim benefits. This is the ***Yank Down scam.*** Or people on the lookout for opportunities for false claims find a broken or obstructed sidewalk or stairway, and then stage a fall by tripping. And there are always those who ***Chew and Sue***, claiming they have found broken glass in their salad, bone in the soup, etc.

The National Insurance Crime Bureau advises businesses to install video surveillance equipment, to run periodic in-store safety checks daily, and to send an employee along if the injured person is taken for emergency treatment. They advise consumers who witness an accident to contact the business' manager immediately, and to report everything witnessed,

More elaborate are cases of staged auto collisions, which involve more than one person. In fact, so profitable are such collisions that rings are formed to do nothing but stage them. The National Insurance Crime Bureau describes the seven steps of a staged auto collision: first, the ringleader, who is usually a corrupt attorney or doctor, hires a "capper," the person who will actually coordinate the collision and recruit people to claim injury as a result of it. Second, the capper promises financial rewards to get passengers involved. Third, the group makes a script of the details of the collision and the injuries they will claim. Fourth, the accident occurs, Fifth, the capper sends the cooperating passengers to an unethical attorney who will represent them in their claims. Sixth, the lawyer sends the passengers to an unethical medical provider who will inflate medical expenses for injuries which may not exist. Seventh, the attorney gets the insurer to agree to an out-of-court settlement for the victims involved. The resulting payment is divided among the people involved.

The fact that the innocent driver of the other car will now have a higher auto insurance premium to pay, and will have an accident on his or her driving record, does not matter to such rings, but matters very much to the person driving the other car. Thus, drivers should be careful not to put themselves in a situation where someone can use them to stage an accident. Avoiding tailgating helps. And, if involved in an auto accident, one should always make sure the police are called. It is also helpful to keep a disposable camera in the car to take pictures of actual damages and of the passengers in the other car. It might be found that these passengers have no reasonable excuse for all being in that particular car at that particular time, which could be a signal to the insurer to carefully investigate the claim.

Auto accidents can be staged by just driving a car off the road: after such an accident, the driver can claim that another auto forced him or her off the road. A man in Pennsylvania formed a group which included his wife, his father-in-law, his sister-in-law, two close friends and his baby sitter whose sole purpose was insurance fraud. For years this group ran cars into trees and poles, slipped and fell, lost valuables, and were robbed. They took in more than TWO MILLION DOLLARS from a multitude of insurance policies, making their biggest score from a single auto accident from which they collected $495,651 from 13 insurers. The ringleader bragged to a friend that every time he went to the hospital because of his accident-caused bad back, he made $80,000.

By the time the ring was caught, the ringleader and his wife had a $400,000 house, a $300,000 duplex, investment property, $100,000 in jewelry, $40,000 in stock, a $39,000 boat, and a succession of luxury cars. He was finally convicted of mail fraud in a US. District Court in connection with faking accidents and concocting actuaries over a period of ten years and sentenced to eight years behind bars. Other members of the ring were also convicted and were given probation of their jail sentences, but were required to make restitution of the $1.4 million they had collected from 30 insurance companies for claims that were faked, staged, or enhanced.

Nor is fraud in the health and accident field restricted to patients. There is only a certain amount of money that can be made filing fraudulent individual claims, There is far greater amount to be made forming fraudulent insurance companies and other such scams.

For example, a British citizen based in Atlanta used several insurance and reinsurance operations to take in an estimated $72 million in premiums for health, disability, and business insurance from 5,500 policyholders, and then refused to pay out claims.

A man in Maryland build a complicated network of almost 50 insurance companies and sold spurious medical malpractice insurance to hundreds of doctors.

Two brothers operated hundreds of medical clinics and mobile labs in Southern California that offered free physicals to get patients to come in. They then billed insurers for thousands of dollars per patient for serious medical problems which did not exist, and may have gotten as much as ONE BILLION DOLLARS from these false claims.

A large national chain which operates psychiatric hospitals was charged with admitting thousands of patients to its institutions who did not require hospitalization, and then treating them at inflated prices.

A network of 100 in the New York metropolitan area, which included free-lance claims adjusters, employees of insurers, as well as policyholders, used staged accidents and inflated claims to defraud insurers of $43 million dollars before they were caught.

One hundred seven defendants, including medical providers, police officers, lawyers and alleged bus passengers, formed a ring which staged bus accidents and then had people hop on, claiming injuries.

A California firm set up "self-funded" health insurance plans from small businesses. It collected millions in premiums, moved the money into personal accounts, and left unpaid claims totaling $10 million.

The fact that money can be moved out of the country, and that the people who perpetrate these frauds can get out before they are caught, makes insurance fraud on this scale attractive to those with a criminal mind. Once safely abroad, particularly if the money is in accounts in countries which will not reveal ownership of accounts, the criminals enjoy a life of luxury and ease, leaving policyholder victims to deal with their losses as best they can.

But the tide has begun to turn, as Commissioners of Insurance look for signs that a company is in financial trouble, and may be using fraudulent practices to stay afloat. In a two year period, thirty-two insurance executives in Louisiana were sentenced to prison terms ranging from five to ten years. All had been involved in falsifying records to keep their companies' insolvency from being known. Many insurance companies looking for ways to make money fraudulently use alien reinsurance companies--companies that, since they are outside of the U. S., don't get a lot of attention from state insurance commissioners.
However, whether insurance fraud is done by one person claiming a back injury where none exists, a gang of people staging fake auto accidents, or insurance executives stealing millions, it is, ultimately, the insurance consumer who pays the price in higher premiums. Insurance fraud is then a crime against society, for it

threatens a device which helps take care of the unavoidable events that cause loss.

Workers' Compensation Fraud

There is one type of insurance fraud which hits society with a double blow, and that is workers' compensation fraud. The reason such fraud constitutes a double blow is that not only is the employer's workers' compensation insurance being defrauded, but the time the employee is away from the job creates a loss in productivity for the company. Another effect of workers' compensation fraud is that when it is prevalent, honest employees are suspect when they appropriately claim benefits for job-related illness or injury.

Remember that workers' compensation insurance covers injuries, illness, and death, suffered as a result of JOB-RELATED events. The injury, illness, or death must have occurred within the employee's SCOPE OF EMPLOYMENT, whether within the premises of the business, or outside of them at the employer's direction. And, because workers' compensation insurance is biased toward the workers, on the theory that if it is not, more powerful employers will be able to deny claims, a situation exists in which the employee making a claim is given every benefit of the doubt. This situation offers a temptation to easy money--in some cases, up to 66 percent of regular pay, on which no taxes have to be paid, for doing nothing.

States do not have the same workers' compensation laws, but all of the laws set up a no-fault method of paying medical expenses and wages lost due to job-related injuries, illness, or death. Some states offer job retraining, and death benefits to families. A majority of states require employers to pay 100 percent of medical expenses, and also any rehabilitation expenses incurred. Wage loss benefits are less generous, but may be as high as 66 percent.

The National Insurance Crime Bureau estimates that workers' compensation fraud costs almost $5 BILLION annually, and that in addition, it costs American businesses more billions in the form of higher premiums, and in other less obvious losses such as production delays, retraining costs, and equipment replacement costs.

Nor are fellow employees, no matter how honest they are, free from the consequences of workers' compensation fraud. Companies strapped by high premiums and loss of productivity may have to use strong measures to stay afloat: they may lay off workers, put a freeze on raises and new-hires, cut the number of hours people work, or even relocate to a state with less stringent workers' compensation laws, Some companies have filed bankruptcy or gone out of business as a result of workers' compensation costs. And, once again, it is the consumer who ultimately pays, since higher premiums for employers will result in higher prices for the goods and services offered for sale.

Workers' compensation fraud usually falls into one of three types: a worker cooperates with dishonest professionals such as medical practitioners and lawyers, to exaggerate a real injury or validate a false one, a worker takes a second job while collecting workers' compensation. benefits from someone else; a worker claims that an injury suffered off the job occurred in the scope of employment, and thus claims and collects benefits.

Unfortunately, an NICB survey revealed that IO percent of adults interviewed believe it is okay for a worker who sustains an off-the-job injury to claim that it occurred on the job, reflecting that businesses are viewed as impersonal, deep pockets whose money, apparently, comes from some source having nothing to do with consumers at all.

In such a climate, it is not surprising that instances of detected workers' compensation. fraud have been on the rise.

The NICB has developed guidelines for employers to use when trying to identify possible fraud, and has listed

ten indicators. The injured worker is disgruntled, or is about to be fired or laid off, the injured worker is a seasonal worker, and the job is about to end; the injured worker takes more time off than the injury would appear to need; the injured worker is having financial difficulties; the accident happens late on Friday afternoon, or when the worker returns to work on Monday; the accident has no witnesses; the accident happens just before workers strike, or near the end of a worker's probationary period; the diagnosis given is not consistent with the treatment the worker claims; the injured worker has a history of staying in jobs only a short time-, the accident occurs in a place where the employee making the claim usually would not be.

Any one of these indicators by itself does not mean that fraud is going on. Nor would the presence of several indicators prove fraud. But the presence of these indicators would indicate that a careful investigation should be made.

And, there are professionals, unethical doctors and lawyers, who take advantage of the fact that workers' compensation is set up so that there is no fault laid at either the employer's or the employee's door. Doctors perform tests and provide treatments that are not needed, while lawyers threaten litigation in order to get the sums their clients claim. An NICB survey showed that 17 percent of adults in this country think it is all right to work with lawyers, doctors, or chiropractors to falsify or exaggerate workers' compensation claims, making the temptation for professionals to indulge in insurance fraud that much stronger.

Nor are workers and unethical professionals alone in attempting workers' compensation. fraud. Employers are also guilty. The method they use to defraud the system if to misrepresent one or more of the variables used to set their workers' compensation. premium. They falsify the amount of their payroll, or they falsify the employee's job classification, or they falsify their loss history. When falsifying payroll, they report only a portion of it. They may cover this false record by paying some employees in cash, or by fisting the wrong compensation for employees. Employers use job classifications to defraud by fisting high risk employees as having lower risk jobs. And they falsify their loss history either by an outright lie, or by using a different owner name, a different company name, or even a different location for the company when they apply for workers' compensation. Of course, when a loss occurs, these false statements will be revealed. But in the meantime, the employer has gotten away with lower premiums.

Formerly, if an insurer had not actually loss money to insurance fraud, the perpetrators were not prosecuted. But that has changed, and across the country, the law is actively prosecuting those who even attempt insurance fraud.

Now that we have looked at fraud in the personal insurance lines, let us examine how fraud occurs in property and casualty insurance. We will study the following lines: automobile insurance, theft insurance, fire insurance, boat insurance, and water damage. We will begin with automobile insurance.

Automobile Insurance Fraud

In our study of bodily injury fraud, we learned how people stage fake automobile accidents in order to make such claims. But the same fake accidents can also result in large damage claims. How extensive is this problem? Statistics show that staged vehicle collisions are a major contributor to the $20 billion property-casualty insurance fraud problem. People who stage these collisions are inventive and thorough, even putting false witnesses on the scene to validate their story, and to contradict what the victim-driver says.

These people have favorite targets. They zero in on drivers with no passengers to dispute what they say, and go after luxury automobiles on the theory that the owners will carry a lot of coverage. And, they go to a great deal of trouble to establish false identities, renting post office boxes and even apartments to

furnish a mailing address.

Staged accidents fall into several types. There is the Swoop and Squat, in which the swoop automobile cuts in suddenly in front of the squat car, forcing it to stop quickly to avoid hitting the swoop car. But the car behind the squat vehicle usually can't stop, and hits the squat victim from the rear. Drive Down is yet another popular scheme. An innocent driver is trying to merge into traffic, and gets a signal from another driver that he or she will yield, and allows the victim of the scheme in. The innocent driver takes the signal as meant in good faith, and merges into traffic ahead of the signaler's car. That driver immediately smashes his or her car into that of the victim, and then denies that he or she ever signaled the innocent driver to merge.

Or a driver will drive a damaged car, and then claim it was damaged by someone who hit it and ran. Less effort is required by those who set up paper accidents: in these cases, a car owner whose vehicle is already damaged files an accident report with his or her insurer. The Drive Down is a scam that depends upon an opportunity presenting itself.- the driver wishing to set up an accident gets into a dual left turn lane at a high traffic intersection, and, if a driver in the inner lane drifts into the outer lane, the other driver sees to it that the two vehicles collide.

Defensive driving takes on additional meaning when drivers realize that not only are they vulnerable to legitimate accidents, but to those that are staged as well. In addition to the techniques suggested earlier for drivers to use to protect themselves against falling victim to staged accidents, here are others. Always look beyond the car in front of you to get a sense of how traffic is flowing. Keep at least one car length for every ten miles the speedometer shows. Keep careful watch when turning into a dual left turn lane. If an accident does occur, count how many passengers are in the other car, and get the names, phone numbers and addresses of all of them. Make sure the police are called. Get a copy of the police report.

When we consider the number of fraudulent claims, we realize that such warnings to drivers are seriously meant. For example, in 1994, investigations aided by the NICB discovered more than 4,200 actions by alleged insurance criminals that could be prosecuted. Among individual cases were those of 27 college students in two states who were charged with obtaining more than $500,000 in staged vehicle accident claims. In Virginia, in February of 1995, a ring of criminals who had allegedly gotten a quarter of a million dollars in false claims was found and its leaders were indicated. These leaders got people to fake accidents, and then sent them to medical clinics and law offices that were colluding in the scheme. In Texas, in that same year, two doctors and two lawyers, all practicing in Houston, along with 100 others, were charged with being part of a huge fraud operation which had gotten over one million dollars in false claims. In South Carolina fourteen people had received almost $600,000 through auto accident fraud. In Arizona, investigators looking at nearly 300 false claims amounting from $12 to $16 million found a ring that had doctors, lawyers, and chiropractic clinics involved.

The list goes on and on. There are simple cases, such as the following. A woman admitted to another driver that she had indeed backed into his car, but insisted there was no need to call the police. She gave the other driver her name, address, and phone number as well as the name of her insurer. The driver of the damaged car went home and waited for an adjuster to call. When no one did, he called the insurance agency, only to be told that the woman had reported the accident as being mutual fault, and had told her agent that the damage to her car was so slight that she would not file a claim. The man insisted that he had not been at fault, and described the type of damage to his car. The agent then called the client, who confessed that when she got home and told her husband about the accident, and said the police had not been called, he suggested that she tell her insurance agent the story she in fact did tell.

This is an example of a person giving in to temptation, but it reflects an attitude toward insurers that helps create a climate in which people deliberately plan and carry out fraud.

People almost always think of insurance companies as having a great deal of money which is not connected to THEM: an insurance company can pay out enormous sums in claims, and still, society will not suffer.

This is, of course, absolutely wrong. An insurance company is nothing more than a pool of people who have merged a certain amount of resources in order to help cover losses of members of the pool. Insurance company employees have a duty to the entire pool to make certain that no monies are paid out that do not accurately reflect the kind of coverage the individual sustaining a loss had.

But there are several things that make this concept one that is easy for the public at large to forget. In the first place, when we spend money at other businesses, we come away with something concrete. But when we pay premiums, we receive only a paper policy, which few people read. Even when an agent dutifully goes over the entire policy, few policyholders pay attention. The policy gets put in a desk drawer, or a safety deposit box, and the only time the policyholder thinks about it is when it is time to pay another premium.

Also, most people have heard from friends and relatives stories of how when they did have a loss, the company did not pay them the amount they should have received. It is human nature to exaggerate mishaps: very few people complaining of being underpaid will state that they had forgotten their policy had a large deductible, or that their claim did not actually meet the requirements in the policy they bought. Instead, it becomes the insurer's fault that the claim does not really cover the loss.

And so few people derive from possession of insurance the comfort they should. They are required by law to have automobile insurance, and, if their property is mortgaged, they are required to have insurance for that. So in these cases, they do not even have the satisfaction that they are behaving responsibly by insuring themselves against possible loss.

Further, human nature being what it is, most people expect everyone else to suffer some loss, but not themselves. We can see why many people believe buying insurance is paying something for nothing, and why they shut their eyes to--or commit--insurance fraud.

It is not the purpose of this course to solve this particular problem, which definitely creates an atmosphere in which getting money out of an insurance company is not considered all that wrong. Communication between insurers and their clients does need to be improved, however, so that an understanding of how insurance works, and why it benefits society at large to make sure all claims are legitimate and real, becomes part of the way people think.

After all, there is the risk of more than just monetary loss to the insurer in a climate where insurance fraud can exist. Take the cases we have cited of staged auto accidents. Here, those staging the accidents certainly don't expect the innocent driver and possible passengers of the other car to sustain serious injury or harm. However, since the victims are randomly picked, it is not possible for those committing the fraud to know the physical, mental, and emotional condition of the victims involved. A wreck might seem minor, but the shock of it might cause significant harm.

Theft Insurance Fraud

Less risky to the general public, but still just as fraudulent where insurers are concerned is vehicle theft fraud, in which it appears that a vehicle has been stolen, but actually has not. Just as with staged auto accidents, vehicle theft fraud has a number of ways it can be achieved. In some of these, an owner "steals" his or her own vehicle, collecting the insurance money for a theft that never really occurred. In fact, a large number of fake auto thefts are committed by the owner of the vehicle involved, usually because he or she is in need of cash. Sometimes the motivating factor is that the owner can no longer keep up payments on the vehicle, or the insurance required. Sometimes the car needs major and expensive repairs. Sometimes a fake theft is a way to make money from a car without going through the process of selling it. But in all cases, it is the

insurance company, and, ultimately, its policyholders, who pays.

There are several ways in which vehicle theft fraud is done. A popular method is to hide a vehicle and then report it stolen. When the claim is paid, often within 30 days time, the car turns up, as though it had been abandoned by the thieves. By this time, the owner has used the insurance money to buy a better car, and the insurance company is stuck with the "found" vehicle, which may be counted upon to need expensive repairs.

Yet another scam relies upon the overseas market for cars. Perpetrators rent luxury cars, make sure there is good coverage on them, and then report them stolen. The rental company gets reimbursed by the insurer, and the car joins other "stolen" vehicles aboard a ship bound for a lucrative market abroad.

Similar to the "paper accident" scam in faked auto accidents is the "phantom vehicle" scam. In this one, a person creates phony documents to prove ownership of a vehicle, often a luxury car, or a classic antique. He or she then purchases insurance for the vehicle, and later, claims it has been stolen. One example of this scam involves a man who claimed that his entire collection--nine vehicles in all--had been stolen. The nine classic cars had been in a storage facility, or so he claimed. His insurer paid him $270,000 for the claim, and he then went on to make the same claim with a second insurer. Perhaps elated by his success, he over-stated his case, claiming this time that the tools had been stolen as well as the cars. But the receipts he submitted to prove the number and value of the tools were fake--upon closer investigation, the insurer determined that some of the information on the cars was also made up.
And there are cases where a person has committed a crime involving his or her vehicle, and has abandoned it and reported it stolen so as to avoid liability for whatever damage he or she caused. People involved in hit and runs, or who damage a parked car in a parking lot, are often guilty of this.

Yet another scam involves switching drivers. This occurs when the person driving a vehicle involved in an accident either does not have a driver's license, or has a record of accidents. The legal (and premium) consequences of being responsible for an accident are worse for the true driver than for a passenger who has a driver's license and no record of accidents. Before the police arrive, the driver and passenger switch places. Even when there are witnesses, it is sometimes difficult for people to accurately remember who was driving when they are excited or upset by the accident itself. And, if the people involved in this fraud keep to their stories, it is unlikely that witnesses' reports will be believed.

How does this defraud insurers? Simply because the vehicle premium one pays is based, in part, on one's record as a driver. If a person who has been in many wrecks is able to conceal this from the insurer, he or she will not be paying a premium commensurate with the amount of risk he or she represents, and is thus cheating other members of the insurance pool.

Not all theft fraud involves automobiles. Travelers may claim to have been robbed on the street by an assailant who saw them changing money and waited for them to come out of the bank or exchange office. Or they may claim that certain items were stolen from their luggage in transit. Another popular scam is for a woman to wear a fake fur to a large party in a private home, and to call the hostess the next day claiming that when she went to retrieve her valuable mink, someone had taken it and left the fake fur in its place. Since the hostess can hardly be expected to remember exactly what each guest wore as she arrived, the hostess will not be able to prove that the guest did not in fact wear a valuable coat, and will file a claim for the lost coat's value. Meanwhile, the mink coat is safely in its owner's closet, along with the fake that makes the scam work.

These are examples of small frauds, but they add up. And worse, they add to the feeling that it is okay to cheat insurers, those companies with deep pockets full of money just waiting to be taken.

The use of schedules for jewelry, furs, and other objects of value make it more difficult for perpetrators of

fraud to invent a "lost" object, but easier for them to establish value if they claim theft. And, in a time when muggings are frequent, and of such a large number that police forces can do little to either stop them or catch the muggers, it is easier for people to claim the loss of a valuable piece of jewelry to a person who robbed them on the street. Also, when a person has been robbed, he or she may take advantage of that to report stolen objects of greater value than those actually taken.

Theoretically, all claims should be investigated so thoroughly that no possible lie would go undetected. But in reality, insurers can afford to spend just so much time investigating claims. For example, in the aftermath of Hurricane Opal, a real estate agent claimed loss of rent for a property that had been destroyed. Although the sale had not yet been closed, the property had been sold: closure took place some three days after the storm occurred. Because the agent had been the owner when the hurricane hit, she worked with the adjuster to determine the amount of loss. The monies involved would be paid to the new owner, who could then make repairs. When the new owner received a copy of the claim, she noticed that the real estate agent had included several thousand dollars in lost rent.

There were two things wrong with this claim. First, the property had not been rented, and second, even if it had, the monies would not belong to the former owner. The new owner called the insurer to tell them that this part of the claim, as well as the part that listed physical damages, were incorrect. The physical damages had been over-stated: all in all, the claim was fraudulent to the extent of about $3,000.

The insurer's response was to thank the new owner for reporting the fraud, but commented that with so many thousands of claims to settle, and so many suspected cases of much higher fraud, they could not spare people to investigate a claim of only a few thousand dollars. The real estate agent making the fraudulent claim may well have had enough experience with the pressure a disaster such as a hurricane puts on insurance adjusters and claims department, and felt confident that so small an amount would go untested. But add hundreds of other such "minor" frauds up, and the amount makes a significant contribution to the $20 billion annual bill for property and casualty fraud.

At the other end of the scale from such pedestrian frauds is a type which for most people would be pretty difficult to believe. This fraud involves the hired killing of expensive race horses who are literally worth more to their owners dead than alive.

Astonishing as it might seem, one man made a living for nearly ten years by killing animals their owners needed to get rid of in a way that would make the insurance on them pay.

His own favorite method was to electrocute horses, but at least one owner asked him to break a horse's leg so severely that the animal's veterinarian would order it killed. Nor is this killer an isolated example. Throughout the world of show horses, killing horses to get the insurance money is all part of the way things work. Such a scenario would seem to go against the public image of horse-owners having a devotion to their animals, a devotion familiar from movies sentimentalizing the relationship between owner and horse. But show horses are big business, and the animals cost a great deal of money, money that most owners cannot afford, or are not willing, to lose.

An owner might pay as much as $500,000 for a yearling of good blood-lines, with the expectation that the horse will earn back the investment and more winning prize money, and, later, with fees paid for stud services. But suppose the horse turns out not be a good runner, or to have a temperament making it impossible for it to be trained? Suppose it damages a leg, making it unfit to race? With no track record, it will not bring high fees as a stud. What is an owner to do? Some might turn the horse out to pasture, and take the loss. After all, horse raising is a risk-filled business. But others see the amount of cash they can get if the horse dies--and before too long, it does.

Sometimes investigators can detect foul play in the death of such a horse. But often enough they have not,

and some very large claims--one that totaled $36.5 MILLION--have been paid.

Fire Insurance Fraud

One of the most prevalent fraudulent activities, and one that costs insurers millions of dollars every year, is arson--the deliberate setting of a fire. Many of the acres destroyed in forest fires each year are the target of arsonists, and many buildings are destroyed by fires set by the people who own them.

There are usually two motives for arson: one, the arsonist is trying to get back at the property owner. Some forest fires are set by people with grudges against large lumber companies, and businesses may be the victims of fires set by angry employees, rival businessmen, or customers with a beef.

These, though criminal, are not an act of insurance fraud. Fraud occurs when the insured sets, or has set, a fire to destroy a building that, like the expensive horse, is worth more ruined than in good shape.

There are all sorts of reasons for burning one's own property, but, like all other instances of fraud, a need for money lies at the bottom of such acts. And, the need for money arises from the fact that the property is not producing the income it once did, or has become a drain on the owner's resources.

For example, many cities across this country now have pockets of decay and decline where once-flourishing businesses have now closed. The buildings formerly occupied by stores and offices are empty, boarded up and vulnerable to vandals and the other results of disuse. In some cases, the land under a building is more valuable than the building itself.

Arson is seen as an easy--and profitable--method of getting rid of the building while raising some cash. Arson can usually be detected by the team investigating the cause of the fire: sophisticated lab techniques make it possible to detect the use of chemicals and other fire-starters that would have escaped notice when techniques were less refined. Still, creative arsonists can set fires in ways that make it difficult to determine just how the fire started, and also, even if arson is obvious, the blame can be put on someone else. Particularly in areas noted for vagrants, an unknown arsonist can be blamed.

But there are factors that, when present, indicate that the owner might be the one who set the fire. When a property is vacant over a period of time, or has not been well-maintained, or has been on the market for a long time, or has an absentee owner, or has had many changes in ownership, and then is destroyed by fire, investigators usually interrogate the owner carefully, and look more deeply into his or her affairs.

Other signs are owners who have questionable finances, who often have difficulty meeting tax and mortgage payments, or who have a number of losses by fire or theft in the past. There may be co-owners who are in a seemingly unresolvable dispute as to how the building should be managed. Perhaps there is new business in the building, with an owner about which little is known. Or the owner might have other insurance on the building that has very high limits. Sometimes owners have criminal records. And even a simple thing like avoiding using U.S. mail could mean that the owner wants to avoid charges of using the mails to defraud--a federal offense.

These are all signals that the owner might be an arsonist, though they certainly do not constitute proof. There are also circumstances concerning the fire itself that warrant a closer look.

The fire department says that the fire has a suspicious origin. The fire policy is of recent date, or has recently been increased. The policy's face value is greater than the property's market value. The insured has had previous fire losses. The land would sell for a higher figure if there were no building on it. New building codes would force the owners to spend money for repairs and upgrading to code. The property has been condemned. Rent and payments of supplies and services, are delinquent. The business housed in

the building was doing worse than the owner claims, or the owner removed the inventory before the fire. Financial records were destroyed by the fire. When the claim is audited, there is a discrepancy between claimed losses and the merchandise on hand. No remains of furniture or fixtures are found in the ruins. The method by which the fire began and spread is like that of other fires in the neighborhood.

One would think that building owners who set fire to their own buildings would know that the risk they take will probably not pay off: as fire departments and law enforcement agencies and insurers become more aware of the way these frauds work, and as computers make complex record-keeping possible, the possibility of getting away with arson, particularly of a building, gets less.

But people who risk committing fraud are gamblers, and they are playing with the aspect of insurance that is said to be like a gamble: the policyholder gambles that he or she will sustain a loss, and thus get something back for the premium paid, and the insurer gambles that he or she will not. It is thus comprehensible that some people would want to "fix the odds", just as crooked card players do.

Fire policies of course have to factor losses by arson into the premiums charged. In fact, the problem of arson became so bad in inner cities that insurers stopped writing such coverage in the years after riots such as those that occurred in the Los Angeles neighborhood of Watts. In a typical study, the Missouri Department of Insurance found that major insurance companies made it more costly--and in some cases impossible--for low-income, minority homeowners in urban areas to purchase policies. Even when policies were sold, they were far more likely to be limited fire insurance policies rather than the comprehensive homeowners' coverage available in other areas. Still, inner city policyholders paid more per $1,000 in coverage--due, of course, to the loss records when these neighborhoods first began to decline.

Insurers have to look at loss records when determining rates. When vandalism and arson caused severe property loss in certain areas, it is understandable that properties in these areas were defined as being high risk. And, like floods, riots and other criminal acts are not predictable: all one can do is look at the past record, and establish a probable incidence of property crime.

However, when insurance regulators in California found that nearly half the homes and businesses that had been damaged in the riots in Los Angeles were not insured, either because of prohibitively high rates or refusal of companies to issue policies in these areas, the situation began to change.

State Farm, which insures nearly one out of every four homes in the U.S., no longer considers the age and value of a home when issuing policies. Other large insurers have followed suit, making insurance for people living in inner cities available again. And, in an effort to educate homeowners as to what they can do to reduce incidents of arson and vandalism, some insurers are offering discounts to homeowners who attend a safety seminar and install security devices, much as automobile insurers reward safe drivers with lower premiums.

Still, insurers may experience higher loss rates in inner cities, making these policies less profitable. However, a vice president and senior lawyer for State Farm said, "The private sector cannot get away with purely economic considerations. You're certainly trying to make as much profit as you can. But the political and community pressure is on you to invest part of your assets and capital in less than promising markets. This is a major consideration." (NEW YORK TIMES, October 30, 1996, p. C6).

When the owner of a property burns that property, the criminal act will have effects on others, but not as directly as when arson is committed during a riot. Here, the victims are often neighbors of the rioters, and are caught in a disaster to which they have contributed nothing. When insurers take steps to see to it that these victims still have access to insurance for their property, they are acting in a socially-responsible way.

Boat Insurance Fraud

One of the most creative types of fraud is maritime fraud--after all, a ship is a large object to hide! Indeed, one case is a hallmark of maritime fraud, involving as it did a supertanker named SALEM. Here is a quote from a story in the March 21, l993 edition of TIME magazine about this super-sized fraud.

"It took three years, but the South African public has finally learned. . . last week how its government lost $30.5 million in what has been called the biggest maritime fraud in history. The disclosures were made during a parliamentary debate. . . after which the government. . . tried to prevent both its critics and the press from discussing the matter any further. It's grounds: all information concerning South African purchase of oil, which are in contravention of world embargo to block such sales, is a state secret.

"The case involved the supertanker SALEM. . . which off loaded 180,000 metric tons of Kuwaiti oil at the South African port of Durban in late December l979. In Parliament last week, the South African government acknowledged that it had paid $45 million for the oil, The ship then sailed for Europe, but sank mysteriously in the Atlantic off the coast of Senegal on January l7, 1980. The trouble was that the cargo. . .left in Durban had actually been owned all along by the Shell International trading company, and the SALEM was supposed to have been carrying it to the Italian port of Genoa. As soon as it became known that the SALEM's cargo had in effect been sold twice, there were allegations that the tanker had been scuttled to hide that fact. The South African government revealed. . . that it has subsequently paid an additional $30.5 million to Shell in partial compensation for the loss. . . "

Such huge frauds are the exception, of course, but there are plenty of small operators who manage to cost marine insurers money with their inventive scams. There are three general classification of marine fraud--The Rust Bucket or Scuttling Fraud, Documentary Fraud, and Charter Boat Fraud.

In the first type of fraud, an older boat, perhaps one that is becoming "a hole that sits in the water and eats money," is loaded with cargo and sets out to deliver it to the cargo owner. Cargo and boat are both insured for amounts above actual value. Then, the ship sinks. Many times, weather conditions are fine, and offer no solution to what caused the ship to sink. Normally, the crew is able to leave the ship and get into life-boats so that there is no loss of life. Both of these circumstances are, of course, signals that the sinking may be a fraud. There are cases where the cargo was never loaded at all, and is sitting high and dry while the ship supposedly carrying it is scuttled, or abandoned in a place where it will not be found.

Documentary Fraud involves the use of forged or altered documents which cover the fact that a cargo has been stolen. One such example is a case in which 38,526 metric tons of crude oil with a value of $15 million dollars were siphoned off at sea and sold to another buyer. Forged documents covered the shortage. Another example is when marine crooks switched a $30 million cargo of coffee for sand, gravel and broken glass.

Charter Party Fraud uses a variation of Documentary Fraud. In this scam, a fraudulent operator charters a small tonnage vessel, paying the smallest amount necessary to hire it. He then sells the cargo space, and gets the freight charge from the shipper. Once the ship is loaded, and has left for its destination, he disappears. When the ship owner tries to collect the payments due for the use of the ship, he is left empty-handed. And, if the scam is detected before the cargo is delivered, the shipper may well have to pay freight charges again.

Registering boats that do not exist, insuring them and then reporting them stolen or lost at sea is a simple process. The Insurance Crime Prevention Institute has many such cases, including one involving one person who forged NINETEEN Manufacture's Statements of Origin for nineteen boats that existed only on paper. There is no requirement that boats be inspected before they are registered, so the "owner" of these ghost vessels was able to get insurance on them. Of course, all nineteen were eventually "stolen," and the owner

reaped a small fortune in insurance claims.

But there are others who often share in the bounty from illegal claims, and these, unfortunately, are insurance adjusters themselves. Property-casualty insurance industry figures show that approximately TEN PERCENT of the $200 billion annual claim payments made are for false claims, and that the adjusters have colluded with property-owners to file them. We have already touched on this subject in prior sections; let us examine instances of adjuster fraud a little more closely here.

Water Damage Fraud

Certain types of fraudulent claims are popular with corrupt adjusters. Water damage claims are easy to stage: in one example, a public adjuster from New York had a plumber install a urinal in such a way that employees of the business could break the pipes connecting it to the water pipes. In another case, an adjuster suggested to a Florida company that it make a claim based on a ladder slipping in a warehouse, hitting and breaking and sprinkler head, and causing a $1.7 million inventory loss. Other scams involve "damaged goods" which are moved into a building for photographs to support the claim.

Public adjusters, who are usually paid 10% of whatever the insurer pays the claimant, obviously have a solid motive for fabricating or exaggerating claims--the more their client gets, the higher their fee. And, in the case of fraudulent claims, they may charge up to 33 1/3% of the yield. Such corrupt adjusters rely on the fact that the claims-adjusting process is highly vulnerable to corruption. Because time and personnel are limited, most claims under $50,000 are settled with little oversight by the insurer. Furthermore, the distant insurer has to take the word of people on the scene--salvers, adjusters, accountants and so on--that the claim on paper accurately and truthfully reflects the claim in reality.

For the individual paying the premium, it probably seems inconceivable that so many fake claims get paid. But when we consider that an insurer with one million insureds may have only one hundred people servicing claims, it is easier to understand how fake claims slip through. And, were more personnel added, there would be higher administrative costs which would also show up in higher rates. That cut-off line of $50,000 represents the amount of loss insurers can absorb when measured against the costs of investigating claims under that limit. As we have seen, one way or another, insurance fraud is a costly business.

Agent fraud

A discussion about insurance fraud would not be complete without mentioning the misdeeds of agents. Consider the following types of agent fraud:

Misrepresentation of Value

An agent sold annuity policies to mostly retired clients where the average purchase was about $20,000. The agent typically represented that the principal was available at anytime and the accumulation value of the contracts were guaranteed to grow to certain levels. Both representations were so false so as to prove a fraudulent scheme for which the agent was liable.

Paid-Up Policies

An agent sold whole life policies under the assumption that coverage would be “fully paid” in six years. After six years it became apparent that the policies would not come close to being paid up. The courts determined that the agent’s actions constituted fraud.

False Statements by Agent

An agent sold disability policies to his clients on the basis that coverage could be extended for life for an additional premium, when in fact, the policy and rider required a higher level of disability occur before life benefits could be awarded. The court was clear to point out that any agent who does not understand the differences between two products he is selling is subject to liability for fraud.

Agent Mistatements on Application

An agent helped a client fill out an application for homeowner's coverage. The client supplied information that he had previous claims ad was canceled by another carrier. A loss resulted and the insurance company refused the claim upon learning that the agent intentionally omitted the client's claim experience. The agent was accused of fraud.

Agent Back-Dating

An agent received an initial premium from a client three months prior to a fire that damaged the client's home. Upon learning of the fire, the agent scurried to obtain insurance he had neglected to purchase by altering his postage meter to give the appearance that he processed the application two days prior to the fire. The insurance company received the application three days after the fire and uncovered the fraud.

Signature Fraud

A policy was sold with $100,000 in uninsured motorist coverage. When the client submitted a claim, the insurance company produced a "Reduction Agreement" which reduced coverage down to only $25,000. The agreement purported to bear the signature of the client although he denied signing them. Eventually, the courts determined that the agent had signed the client's name thereby committing fraud.

COSTS OF FRAUD

Let us review the costs of fraud to insurers, to consumers, and to society. There is a dollar cost to insurers--$20 billion a year to the property-casualty industry alone.

That adds up to an enormous amount of money, all of it passed on to the consumer in the form of higher rates. As we have noted, it is estimated that insureds pay on the average $200 more per year in premiums to pay for insurance fraud. Nor does society as a whole escape the results of insurance fraud. An industry that has the purpose of protecting members of society from losses resulting from identifiable and quantifiable risks has to spend an inordinate amount of time and money investigating fake claims, or being more thorough when processing applications, leaving less time and money for fine-tuning the instruments it uses to protect policyholders. And, when cases of fraud become publicly known, a certain erosion in the faith of the public in insurers begins. Further, a climate in which people think it is all right to defraud insurance companies develops. After all, if the fellow down the block and the woman across the street got away with padding a claim, why shouldn't I?

It is this erosion of public trust that is perhaps the most serious consequence of insurance fraud. Trust is the essential element in the contract between insurer and insured. The insurer must be able to trust that the insured is accurate, thorough and truthful when applying for insurance and also when filing a claim, and the insured must be able to trust that the insurer is overseeing both applications and claims effectively so as to detect false statements and fake claims.

Penalties for Fraud

Unfortunately, for a long time, people attempting insurance fraud and failing were not prosecuted: the only cases that went to court were those that succeeded and were later found out. Now, federal statutes making it a crime to send documents intended to defraud through the U.S. mail are used to prosecute those who attempt insurance fraud, even when they do not succeed. An expanded mail fraud statute includes materials sent or delivered by any private or commercial interstate carrier, meaning that people who did not use the U.S. mails so as to avoid charges of mail fraud do not have that out. Also, sections of the federal crime bill apply directly to insurance fraud. These sections address false entries of a material (important) fact in the books, records, and statements of an insurer if the entry is meant to deceive interested parties about the solvency of the company; as well as making it a crime to use, or even attempt to use, force or threats to corruptly influence, impede or obstruct any insurance regulatory proceedings or any insurance regulator or examiner. Further, the bill defines most proceedings before state insurance regulators as official proceedings, a definition that protects witnesses who attend or testify at said proceedings. Another important section of the crime bill prohibits ex-convicts whose felony crimes involved dishonesty or breach of trust from being in the insurance business, unless written exceptions are made by the appropriate state official. Persons convicted of charges under this bill usually get up to 10 years in prison, although they can get as much as 15 years behind bars. And, civil actions and injunctions can also be used against those who violate these new criminal insurance fraud statutes. The maximum penalty in a civil action is either the amount the person received or offered for the prohibited conduct, or $50,000, whichever sum is higher. Admittedly, however, it is only the largest and most significant cases that get to court, the cost of litigation in both time and money militating against taking "minor" cases that far.

The staging of automobile accidents is specifically addressed in new legislation on the heels of victim motorists who have been injured and killed.

In California, under existing law, it is unlawful to knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim. Existing law imposes a 2-year sentence enhancement for each prior felony conviction for any person who violates this provision and who has a prior felony conviction for any specified offense against insured property or insurers.

A new bill (SB 334) would impose a 5-year sentence enhancement for any person who violates this provision and who has 2 prior felony convictions for violating this provision. The bill also would impose a 2-year sentence enhancement for each person other than an accomplice who suffers serious bodily injury resulting from the vehicular collision or accident in a violation of this provision. By creating new sentence enhancements, the bill would impose a state-mandated local program.

Current laws on the books also impose penalties for the following:

It is unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do any of the following:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss or injury, including payment of a loss or injury under a contract of insurance.

(2) Knowingly present multiple claims for the same loss or injury, including presentation of multiple claims to more than one insurer,
with an intent to defraud.

(3) Knowingly cause or participate in a vehicular collision, or any other vehicular accident, for the purpose of presenting any false or fraudulent claim.

(4) Knowingly present a false or fraudulent claim for the payments of a loss for theft, destruction, damage, or conversion of a motor
vehicle, a motor vehicle part, or contents of a motor vehicle.

(5) Knowingly prepare, make, or subscribe any writing, with the intent to present or use it, or to allow it to be presented in support of any false or fraudulent claim.

(6) Knowingly make or cause to be made any false or fraudulent claim for payment of a health care benefit.

(7) Knowingly submit a claim for a health care benefit which was not used by, or on behalf of, the claimant.

(8) Knowingly present multiple claims for payment of the same health care benefit with an intent to defraud.

(9) Knowingly present for payment any undercharges for health care benefits on behalf of a specific claimant unless any known overcharges for health care benefits for that claimant are presented for reconciliation at that same time.

It is unlawful to do, or to knowingly assist or conspire with any person to do, any of the following:

(1) Present or cause to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information concerning any material fact.

(2) Prepare or make any written or oral statement that is intended to be presented to any insurer or any insurance claimant in connection with, or in support of or opposition to, any claim or payment or other benefit pursuant to an insurance policy, knowing that the statement contains any false or misleading information
concerning any material fact.

(3) Conceal or knowingly fail to disclose the occurrence of an event that affects any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.

(4) Prepare or make any written or oral statement, intended to be presented to any insurer or producer for the purpose of obtaining a motor vehicle insurance policy, that the person to be the insured resides or is domiciled in this state when, in fact, that person resides or is domiciled in a state other than this state.

Every person who violates the above rules is guilty of a felony punishable by imprisonment in the state prison for two, three, or five years, and
by a fine not exceeding fifty thousand dollars ($50,000), unless the value of the fraud exceeds fifty thousand dollars ($50,000), in which event the fine may not exceed double of the value of the fraud.

There is another factor in insurance fraud which makes it increasingly difficult for insurers to determine how much risk is attached to each policy they write. That factor is the amount of money juries award when claimants sue an insurer on the grounds that the insurer did not fairly settle a claim. When a claimant takes an insurer to court in such a case, the insurer is vulnerable to two types of damages--tort damages and punitive damages. The tort damages will be awarded if the insurer is found guilty of not honoring the contract. Punitive damages may also be awarded. And these costs are impossible to predict.

For example, there is the case of a young woman who claimed that a burglar had taken all her jewelry, along with other valuable personal property. The adjuster learned, during the course of his investigation, that she had lost property in three previous burglaries. He also noticed that some of the property in her apartment

seemed very like that on one of these previous claims. And when the young woman commented that she had received a certain object from a friend whose name seemed familiar, the adjuster went back and looked at the prior claims. One of them was in the name of the friend she had mentioned and this claim, for stolen jewelry, had ten items that exactly matched items on the young woman's present claim. In two cases, items were wristwatches with exactly the same serial numbers.

The adjuster went back and told the claimant what he had found, expecting her to retract what was clearly a false claim. Instead, she hired a lawyer, who threatened to sue the insurer if the claim were not paid. On its side, the insurer had written proof. On the lawyer's side was an attractive young woman with a decidedly innocent air. There are all too many such threats, and all too many cases in which insurers pay fraudulent claims rather than run the risk of high damage awards in court.

A more equitable way to deal with disputes between insurers and insureds is to apply contract damages only: that is, to require insurers only to pay the benefits defined in the contract should they lose a dispute with an insured.

Only the removal of the temptation to "strike it rich" with punitive damages will correct a situation in which people think of insurers as golden geese with an unlimited supply of golden eggs.

When individuals are convicted of insurance fraud, they are subject to both jail sentences and financial penalties. The severity of the sentences and the penalties depends, of course, on the severity of the crimes with which they are charged. Insurance fraud can bring charges of conspiracy, extortion, theft, violations of federal securities laws, obstruction of justice, and bank, wire and mail fraud. These are often known as "white collar" crimes, because they are committed by people of education and, usually, executive position. Although violence may not be involved, and no one is murdered during the commission of these crimes, still, when one considers the social cost of such crimes, it is clear that the individuals committing them deserve penalties as severe as the consequences of their acts.

PREVENTIVE MEASURES

Insurance fraud is a problem of large proportions, and the insurance industry is taking steps to solve it. Some of the steps can be taken by agents and adjusters. Others are being taken industry-wide. And others are being written into laws, as we have seen.

Let us look at some of the things individual agents and adjusters can do to stop insurance fraud.

First of all, agents should personally inspect any property covered by a policy they sell. In the case of valuable property, or in instances when there are multiple risk factors, photos are useful in later establishing the validity of claims. Proof of a property's value should also be asked for: there are varying factors which change a property's value, and these should be identified and known. Agents should also be wary of "walk-in" business that results in a large policy being sold. Most people who buy sizable insurance policies are in a position to have an agent on call; this is one instance when one should definitely look the gift horse in the month. A more thorough than usual investigation of the potential client's background--credit reports, for example--might reveal information that would allow the policy to be declined. Agents should also talk about risk reduction to clients whose property is vulnerable to risk. Material relevant to their particular property and its safety should be made available. All too often, agents fail to educate clients in maintaining and protecting their property. Doing so might give the agent a feeling for the client's attitude toward the property--very often, it is intuition rather than concrete knowledge that points the way later to a suspicious claim.

An industry association has developed a Suspicious Claim Profile to help adjusters determine whether or not

a particular claim should be closely investigated. Automobile insurance claims, for example, have a number of indicators that fraud may be present. The policy is relatively new, with a short time period between the time it was bought and the time the claim was filed; the policy was for comprehensive and collision only; the agent didn't know the applicant, and did not personally inspect the property/vehicle. The driver's license is new, is temporary, or is a duplicate. It is an out-of-state license. Does the age of the insured/spouse match the car? For example, a teen-aged couple driving an expensive car might be a tip-off to fraud. How long has the insured lived at his/her current address, and how long at the previous address? If the answer is six months or less, a warning flag goes up. P O Boxes and relative's addresses are also flags, as are transient residences, such as hotels, motels, trailer courts and the like. If the home telephone number is an answering service/device, or if a friend or relative's phone number is used, the claim is possibly fake. People who are self-employed, recently employed, or vaguely employed, should be looked at, particularly when the business isn't in the phone book or with information. If the car has been recently bought, if the seller's identity isn't provided, if it is an out-of-state vehicle, a gift, or had a really high or really low purchase price, if it was rebuilt from salvage, or has been upgraded with expensive accessories or equipment--all of these are signals of fraud. Also, if there are no receipts for additions to the vehicle, or if it was stolen before, or if the claimant is vague about financing or has recently refinanced the car, look out! Other signals are current financial problems, or a vehicle recently repossessed. If the claimant services the vehicle himself/herself, if the vehicle has recently been for sale, or if the insured was not the last driver of the vehicle before it was stolen--again, this may be a case of fraud.

Adjusters should also beware if the claimant can't provide the identity of a prior insurance carrier, or a prior policy number. When the premium is paid in cash, or when it has to be financed despite the fact that the insurance is on an expensive car, the claimant may be a fraud. Further, look at the report of the theft. If the handwriting is illegible, if the report is incomplete, if there is a delay, check further. The insured's story may differ from the police report, or perhaps the insured did not report the theft to the police. Sometimes fraud is indicated if an insured goes home to call the police rather than reporting the theft at the scene. The vehicle may not be registered with the Department of Vehicles for the current year, or it is registered or titled in a name not that of the insured, and the individual on the title can't be located. Sometimes fraudulent claimants are too cooperative and too knowledgeable, other times they are pushy and hostile, and may make references to "my attorney" when there is no reason to think they will need a lawyer. Again, when thefts happen far from home, and a friend or relative jut happens to be present, the claim may be a set-up. Sometimes the claimant doesn't seem concerned for the loss, and this may mean the loss is a fraud.

Many of these indicators that a claim may be fraudulent seem to describe people of low income, unstable employment, and transient life styles. But remember that among the frauds perpetrated are thousands staged by people who appear to be perfectly respectable. These are the homeowners' who lie about the value of contents lost when a beach was destroyed, or business people who arrange fires to cover business losses, or professionals such as doctors and lawyers who work with others to file false or exaggerated medical claims. Fraud knows no social class, no sex, no age. It is prevalent at all levels of society.

Fortunately, the insurance industry has responded to this situation with a number of powerful groups. One of these is the ***Insurance Committee for Arson Control (ICAC)***, founded in 1978 by major property and casualty insurers with various trade associations. Now its membership of 2,000 plus companies writes approximately 85 percent of p/c polices.

Because of an effort by ICAC, arson was elevated to permanent Part I status in the FBI's Uniform Crime Report with the passage of the Anti-Arson Act of l982. Further, ICAC worked with the NAIC to form a model reporting immunity law to encourage the exchange of information about suspected arson cases between insurers and law enforcement agencies. ICAC cooperates with local anti-arson committees, and offers information about arson control through brochures, a toll-free number, and a speakers program. With the Ford Foundation, it began a neighborhood program titled AIMS (Arson Information Management Systems) in five cities; the purpose of AIMS is to identify the presence of factors that might make arson likely.

Such things as vacant buildings, violations of building codes and the like alert a neighborhood to the possibility of arson before it occurs.

Another industry-wide association preventing and detecting insurance fraud goes back to I912. This is the ***National Automobile Theft Bureau (NATB)***, which represents 580 property casualty companies which do about 95 percent of auto theft insurance nationally. Maintaining 188 million automobile manufacturer's assembly and shipping records through a sophisticated computer system, it also has a data system that can automatically check auto theft reports to see if there are records of pervious recovery and theft, salvage, impoundment, police inquiries, and, in the state of New York, derelict towing. NATB works with law enforcement agencies in detecting auto insurance fraud, and in preventing auto theft.

According to NATB, about 15 percent of all theft reports are false. Headway has been made in reducing the number of auto thefts, but the figures for recovery have also gone down, largely because professional thieves know how to keep cars from being found, and because of a growing number of shops that take cars apart for their parts.

The ***Insurance Crime Prevention Institute (ICPI)*** is involved in criminal investigations of auto insurance claims that are suspect, and also other types of property casualty fraud. It is supported by about 400 insurers writing 80 percent of the property casualty insurance in this country. ICPI comes into an investigation when a member-insurer or a law enforcement agency requests that it do so. Any evidence of fraud it finds will be turned over to the proper law enforcement agency for further action.

The ***Coalition Against Insurance Fraud (CAIF)*** encompasses national and international organizations representing consumers, regulators, state legislators, prosecutors, attorneys general and insurance companies. Its purpose is to combat all forms of insurance fraud through public information and advocacy. The coalition has drafted model insurance fraud laws and works to enact them in state legislatures. The coalition also initiates public outreach programs to raise awareness about fraud and encourage consumers to support fraud-fighting efforts.

The ***Insurance Information Institute (III)*** has been one of the property-casualty's primary sources of information and analysis on insurance subjects, including insurance fraud.

The ***National Insurance Crime Bureau (NICB)*** is a public communication program supported y 1,000 insurers and self-insured private businesses. The NICB maintains a toll-free fraud hotline (1-800-TEL-NICB) and a Crime Net (on line resource offering statistics and news about insurance fraud).

The ***Property Insurance Loss Register (PILR)*** is concerned with residential property fraud; its computer base has 1.4 million property loss claims, including fire claims, and burglary and theft claims in excess of $1,000, entered by the 827 insurers who belong to the group.

These insurers represent 95 percent of the nation's property insurance premiums. When investigating a fire claim, PILR is able to look for undisclosed additional insurance; look for previous similar claims by an insured--and in this search, the computer pulls up phonetic spellings of surnames listed on the report so that an insured trying to disguise or conceal his or her identity can be found; look for the loss history of the location and at the insured's previous address; and last, look at reports for histories of similar name combinations, all through data in its computer system. When a claim is made for a theft or burglary, two searches, one the loss history of the individual, and the other a search for undisclosed other insurance, are made. Results are sent to insurers, who decide what action to take.

The ***Property Loss Research Bureau (PLRB)*** is a specialized resource organization for insurance companies, with regional anti-fraud programs on arson, theft, and the legal aspects of fraud defense one area of service. It also offers education, legal research, and consultation on property loss matters, as well as

providing individualized guidance and practical advice on the proper handling of claims and avoidance of common pitfalls. Companies belonging to PLRB can send claims to it for help with questions about coverage, proceedings, and the availability of specialists who might be required.

PLRB has developed two Cause/Origin Research and Evaluation Kits which, with films, are available to member companies. These kits and films show how to efficiently and effectively interview the insured, work with the fire department, inspect the scene, conduct a financial analysis, and examine any other factors that might be relevant to the loss, whether commercial or residential. Students also learn techniques which, when used in interviews and investigations, can help them tell legitimate claims from those which are not.

Also available from PLRB are a series of forms which individual insurers can send to policyholders who have filed a theft claim. The series has a notice of loss which both the insured and his/her spouse (if any) must sign, and also a form on which the stolen goods are listed, and their value put. If the stolen goods were gifts from another person, that person must sign an affidavit of donor which states that the goods were actually given, and that they do have the value claimed. A release of purchase information, when signed, permits the insurer to get in touch with merchants and credit card companies whose records can substantiate the client's claim.

Such forms not only gather accurate information, but they also put pressure on those making fraudulent claims. These forms, when used with the systematized claim handling procedures developed by PLRB, give insurers a much better chance of detecting fraud.

Industry-wide, insurers are adopting procedures like those of PLRB's, and they are using Special Investigative Units (SIUs) to reduce instances of fraud. An All-Industry Research Advisory Council survey showed that property casualty insurers using SUIs saved $7.39 for each dollar invested in these special teams. The SUIs cost $1.38 million industry wide, and produced a savings of approximately $10.2 million, the amount companies would have paid out in 1500 fraudulent claims including arson, bodily injury, collision, auto and property theft. The SUIs handled 2,358 claims for 19 companies, and were able to determine that 65 percent of these were fraudulent. In the other 35 percent classified as non-fraudulent, there were cases where fraud was suspected, but could not be conclusively proved.

The cases of fraudulent claims ranged from highly sophisticated professional rings down to the usually honest policyholder trying to get the best of a bad car deal. Insurers' claim personnel and also their underwriters work with SIUs in anti-fraud efforts. The ***Racketeer Influenced and Corrupt Practices Act (RICO)*** is now used in cases of insurance fraud. The act allows treble damages to be awarded, and also the forfeiture of a criminal's assets. Plus, the insurer may collect damages and take over the assets of ANYONE involved in the conspiracy to commit fraud, not only the named insured. For example, when 21 companies and individuals were convicted of conspiracy to commit fraud by falsifying auto accident and theft claims, a U.S. court awarded the insurer plaintiff $1.7 million in treble damages.

Other less dramatic means of combating fraud involve making sure that boats, like vehicles, are subject to a uniform identification system. Prior to the Federal Boat Safety Act of l971, boat registration and identification was haphazard. After the act passed, and enforced since August l, l972, each recreational boat built or brought into the U.S. is subject to its provisions.

The main sections that relate to insurance is that all recreational vessels must have a 12 character hull ID number, or HIN, which is permanently attached to the boat's hull. The number may be made up with the calendar year, or the model year method.

State Fraud Bureaus are also cropping up with a fury. These government organizations, with which insurance companies cooperate, complement the industry's efforts to communicate the ramifications of insurance fraud. The New York Fraud Bureau, for example, recently entered into an agreement with the NICB to produce a series of advertisements offering rewards to callers who report suspected fraud. The

California Department of Insurance Fraud recently initiated an out-reach program to aggressively reach and train local law enforcement to become more aware of staged automobile collisions and the growing problem they are causing on street and highways. During the training, officers are taught to spot certain red flags which could indicate whether the accident they've responded to is staged, and they are also given pointers on how to proceed with their investigation once they believe they may have come across a staged collision. A positive effect of this program is how it has assisted officers in uncovering additional cases and suspects that have been tied into cases already under investigation.

Perhaps one of the fastest-growing areas in the fight to reduce insurance fraud is occurring among the commissioners who are the watchdogs for the industry. There is a connection between the threatened insolvency of an insurance company, and the possibility that its executives are committing fraud. And although companies that become insolvent are not always rife with fraud, in 41% of fraud allegations from l976 to l991, the insurers involved were inadequately pricing their products and overstating their assets--a sure road to insolvency, and very definitely--fraud.

The ***National Association of Insurance Commissioners (NAIC)*** not only pushed hard for the insurance provisions in the federal crime bill, but also has initiatives which help state regulators seek out insurance executive fraud. Further, the insurance industry has a Coalition Against Insurer Fraud (CAIF), one of whose activities was drawing up a model insurance fraud law addressing both claims fraud and insurer fraud. Such laws help stop fraudulent individuals by giving prosecutors and courts clear guidelines under which they may proceed.

Nor is there really such a thing as a "small" case of insurer fraud. When Louisiana regulators seized an insurance holding company in l991, it was $200 million in debt--and its executives had taken most of that sum. Yet another Louisiana insurer was seized in l989 with a $150 million debt--and the executives responsible for falsifying the records that kept that information hidden.

Because of the connection between insolvency and fraud, insurance commissioners such as Jim Brown of Louisiana are stepping up efforts to keep informed about the financial condition of insurers doing business in their states. Brown added nineteen employees to his department's financial analysis staff soon after he took office, bringing the complement up to 20 full-time employees. Armed with this increased staff, Brown has been able to exam the finances of insurers doing business in Louisiana every year, instead of once in every three years as had been done previously. His office also cross-references quarterly financial reports with other data to detect early signs of fraud. His fraud detection team's members include staff from the legal, audit, and consumer complaints divisions of the Commissioner's office; they share evidence of possible fraud with the U.S. attorney's office. Brown also requires insurers doing business in Louisiana to use reinsurers his office has approved, and also to get his department's approval before entering into reinsurance treaties. Thus he nips in the bud one way in which insurers commit fraud, that of using alien reinsurers who escape official notice.

Regulations in Louisiana now require that financial reports from insurers be sent via US mail, keeping perpetrators of fraud from avoiding charges of mail fraud by hand-delivering their false documents. Other laws allow the prosecution of third parties who may have helped insurers conduct fraudulent operations. Rental assets are also outlawed. When a parent company transfers holdings from its books to an insurer's books, but lists only assets. Naturally, this makes the insurer's balance sheet look strong.

Efforts such as these are turning the tide against insurer fraud.

The Justice Department has a program titled National Level Insurance Fraud Working Group which uses FBI investigators as well as those from the Department of Labor and the Department of Treasury, the U S Postal Service and the Securities and Exchange Commission (SEC), to share information about instances of insurance fraud, and to get information from state regulators, as well as from insurers.

A top contender in the fight against insurance fraud is, as we have already stated, the federal crime bill. This bill makes it a federal crime to misappropriate funds from an insurer, file false financial reports, obstruct insurance regulation and attempt to deceive regulators about the insolvency of an insurer. Conviction under the bill carries sentences of up to 15 years in a federal prison, as well as penalties and fines.

All of these measures are helping and will continue to help reduce insurance fraud. ultimately, however, it is the insurance industry itself which is in the best position to combat fraud. Over the years, insurance executives and employees have accumulated a great deal of experience and expertise that can not only help devise anti-fraud procedures, but can also lead to industry wide standards concerning the conduct of everyone in the field, and also the accountability of every executive and employee in maintaining a fraud-free operation. When used as expert witnesses in court cases, members of the insurance community can help judges and jurors understand the difference between what the industry as a whole accepts as standard practice, and the way the defendant behaved.

All anti-crime programs have several steps. Prevention comes first, and efforts like those of PRLB are helping make this step successful. As both consumers and those in the insurance field learn more about fraud, and about its costly effects, those who are neutral now will become advocates of anti-fraud campaigns. Detection is a second important step, and again, the systematized claims process and the series of forms issued by PRLB help insurers more accurately detect fraud. Prosecution is the next step, one made more effective by the presence of laws which more clearly define insurance fraud, and which make it possible for prosecutors to take everyone involved in a conspiracy to court.

Enforcement is the final step. This step, too, has becoming increasingly effective as even those whose frauds did not succeed are tried, convicted, and punished.

And, with the advanced computer systems the insurance industry now has, keeping track of a large amount of data, cross-referencing claims and other information, and doing sophisticated financial analyses is possible. All of these help detect fraud.

On a more personal level, it is essential that all policyholders become fully aware of how much fraud costs each of them. Agents must do a thorough job in educating their clients, helping them understand the precise nature of the policies they buy, and just what the policies will cover if a loss occurs.

As we stated at the beginning of this course, insurance is a social device which allows people to pool a certain amount of resources to cover a certain type and amount of risk. Loss reserves are calculated according to known risks, and there is no way an insurer can calculate fraud. ALL members of the pool should take responsibility for developing an active climate against insurance fraud. Only when the general public loses the vision of insurers as deep pockets who can pour out enormous sums and never feel it will the attitude that it is okay to defraud insurers change.

The Sub Rosa Investigation

For special fraud cases insurance companies will launch a ***sub rosa investigation*.**

According to the dictionary, sub rosa is an old Latin term meaning "under the rose," the rose being an ancient symbol of secrecy or privacy. In modern terms, it refers to the surreptitious filming or still photographing of a subject who is under investigation, what law enforcement calls surveillance video.

A sub rosa investigation is potentially one of the most valuable tools a claims handler can employ. It is often true that "A picture is worth a thousand words." Film or video evidence can be very useful in criminal court.

But there's also another saying: "Don't believe everything you hear--and only half of what you see." Sub rosa evidence, like all forms of evidence, may be open to interpretation. An effective sub rosa investigation takes time, planning, and preparation.

It is important to remember that not every suspected fraud case will be a good candidate for sub rosa investigation. Once again, the basic elements of fraud are: The lie; knowingly told; for the purpose of obtaining benefits not due; and the lie is material.

The Lie

The lie need not be either written or verbal--it can also be assertive behavior. For example, if a patient arrives at the doctor's office wearing a neck brace and using a walker, the doctor would assume the patient was using these devices because of an injury. But if it could be shown that the patient did not use these devices either before or after the office visit, there would be a strong suspicion that the patient was trying to fool the doctor. And trying to fool a doctor is a form of lying that can be prosecuted. Further, this is an instance where visual evidence could prove the lie.

On the other hand, there is a vast difference between a claimant saying "My back really hurts when I lift things" and "I can't lift things." You might suspect lying when you're told that the claimant's back hurts, but you won't be able to use sub rosa to prove the lie. Sub rosa is a visual tool, and can only be used to uncover lies that can be disproven visually.

Good sub rosa cases are where the claimant makes specific statement of things that can or cannot be done. Remember that the district attorney can't prosecute a claimant for not following the doctor's orders. If the doctor gives a work restriction and the patient does the activity anyway, you haven't necessarily established fraud. Video of the activity might help reduce the eventual permanent disability award, but it will be of no use in proving suspected fraud. The activity being filmed must be the subject of a statement (or assertive behavior) of the claimant, not someone else's opinion of what the claimant can or cannot do.

Also, consider whether the lie is material to the claim. Will disproving the statement change the benefits being provided to the claimant? People will sometimes lie in an attempt to obtain workers' comp benefits, but the lies are irrelevant to their eligibility and they would have had the same outcome if they'd told the truth. If that's the situation, the case is not a good candidate for a sub rosa, because unless you can establish that, by virtue of the lie told, the applicant gained some benefit that wouldn't have been obtained without that misrepresentation, you're not going to meet the element of materiality needed to establish a fraud case.

In some cases insurers might want to conduct an activity check before considering a sub rosa investigation. For example, an employer calls and says that the claimant is working at another company while telling the doctor it's not possible to work. An activity check would be an inexpensive way of determining if that person is working and if the physical activity is different from what the person claims is impossible to do. Once this groundwork is completed, then they might consider running a sub rosa--if necessary.

Identifying the Subject

One of the most important elements of planning a sub rosa operation is obtaining good, solid identification of the subject. The best sub rosa in the world is useless if it's of the wrong person. A photograph of the claimant is the best identification, and there are several ways to obtain one:

* A claims handler or investigator should check with the employer to see if there is a photo in the personnel file that could be verified.

* Obtain a photocopy of the DMV photo from either the personnel file or the medical file. Doctors and

clinics frequently keep a copy of this photo, as proof of who they saw.

* If there are no photos on file, the investigator might have to find the claimant, take a still photo, and show it to the employer to confirm identity. This might cost extra, but it would save time and money in the long run.

Another tactic is to arrange for the sub rosa to be done when a doctor's appointment is scheduled. The investigator can spot the claimant before the appointment, follow the claimant to the doctor's office, call the office to confirm that the patient is there, then follow the patient away from the office.

One of the excuses for refuting sub rosa evidence is to say that the suspect statement and the sub rosa were so far apart in time that the medical condition changed between the two events. If the claimant makes a statement, and then two months later there is a video taken that "disproves" the statement, can one prove that the medical factors or other conditions didn't change or improve in the intervening two months? Putting the sub rosa in context takes away one more excuse the claimant might try to use.

In many cases, the best possible time to conduct a sub rosa would just before and just after a medical appointment or deposition. These are the times when the claimant will make statements that you suspect of being false. Further, having the sub rosa done on the day of the office visit or deposition--as well as the day before and the day after--could make the sub rosa evidence so strong that it cannot be "excused away." If your film from before and after the deposition shows activity that is contrary to what the claimant said in deposition, then you have evidence that the claimant knowing lied under oath. It might sound like "trapping" the claimant, but it really isn't. We are asking questions and giving the claimant the opportunity to tell the truth. If the claimant lies, it is by choice.

The Time Element

A thorough sub rosa will include footage shot at all hours and on different days. Not everyone works or plays during the daytime. Not all jobs operate on a 9-to-5, Monday-Friday basis. Has the claimant ordinarily done the kind of work that is performed on a swing shift and/or graveyard shift in addition to the day shift? Has the claimant been involved with sports groups or other activities that meet in the evening? On weekends? If your lead comes from an informant, such as the employer, you or the investigator might want to conduct an in-depth interview. The more information you have to begin with, the better the sub rosa will be.

Getting Maximum Coverage

One of the things most stressed in a sub rosa investigation is the need for sufficient video--enough footage to show context. A few seconds or a few minutes will not be sufficient. Insurers will want to show not only that the claimant performed the activity in question, but also that the person suffered no ill effects afterwards. You are looking to establish a pattern of activity, so you want film before the individual is actually engaged in the relevant activity; you want film during the activity; and you want lots of film afterwards.

Investigators should be cautioned about "turning on the camera only when the subject is doing something interesting." Footage like that allows the subject's attorney to argue that if the camera had not been turned off so quickly, you would have seen that the subject suffered pain and had to stop the activity. Take that argument away from the claimant by getting plenty of film before, during, and after the "something interesting."

The investigator needs to get as much film as possible over several days to show a pattern of behavior that is not a one-time event. It might sound like overkill, and it certainly can be expensive, but this is one situation where you definitely get what you pay for. Remember, the burden of proof is on the accuser, and the proof

must be "beyond a reasonable doubt" in criminal cases. We must be able to remove any reasonable doubt that the subject is knowingly lying. Absent sufficient evidence, the district attorney might not be able to prosecute.

Also, experts in this area advise investigators to get good, clear, still photographs of the claimant at the time the sub rosa is taken. Stills have a sharper image than video and sometimes furnish better identity of the subject. Additionally, they can be enlarged for use in court and you can use them to capture a split second of time showing a particular activity or some other precise detail.

Evaluating the Sub Rosa

When insurers get the sub rosa material from the investigator, the first thing they try to do is to find reasonable explanations for the suspect behavior. Look at it the way the suspect's attorney will. Go over it with a fine-tooth comb. Are you sure the person in the film is the claimant? Is the activity different from what the claimant said could or couldn't be done? Are sure you it isn't exactly the same? Could the subject have suffered any ill effects from the activity that do not show up on film?

If you find any holes in the evidence, you must either plug them--with more sub rosa, witnesses, or some other strong evidence--or you might have to conclude that you haven't the necessary evidence for a fraud referral.

A Successful Sub Rosa

One of the best examples of a sub rosa that was done quite well was a case prosecuted in Riverside County. Quite a bit of sub rosa tape had been taken of a particular claimant performing all sorts of chores at her church. She was sweeping, bending over, and picking up things. She was shaking out the vacuum cleaner bag and cleaning it out. She was even engaged in a few instances of horseplay with children in the parking lot. The day of the insurer's appointment, she was filmed lifting and lowering the hood of her truck and checking the water and oil. She did all of this despite having claimed that she had some neck problems, some back problems, and severely restricted movement. The interesting part of this video is that when she was driven to the doctor's office by her pastor, she got into the car unaided, then proceeded to put on her neck brace. When they arrived, the pastor handed her a pair of crutches, and she employed guarded motions and exhibited pain behavior as she walked into the doctor's office. She was found guilty of workers' comp fraud.

Sub rosa can be an effective fraud-fighting tool, but it is an expensive one. Cases need to be carefully chosen and planned to get maximum benefit.

Other Insurer Efforts to fight fraud

Insurance companies use a variety of means to fight fraud: sub-rosa investigations (see above) special investigative units, home office claims departments, and the National Insurance Crime Bureau are used most often to train employees in recognizing potential fraud. Overall, about 10 percent of insurers' total corporate training efforts are spent on means detecting insurance fraud.

Most insurers have also put automated claims index systems into place to uncover potential fraud. These systems are basically sophisticated data bases used to spot unscrupulous claimants and/or applicants. The NICB database, for example, is a huge, cross-referencing claims database providing access to some 400 million records. About three-fourths of insurers have put these systems into operation.

Great care is taken to insure that information supplied in this text is accurate and current. However, many

of the general principles and conclusions are subject to interpretation and court case revisions. The reader is urged to consult legal counsel regarding points of law. This publication should not be used as a substitute for competent legal counsel.

WHO SHOULD REPORT SUSPECTED FRAUD

Insurance Code Section 1877.3(d) requires all insurance carriers, agents, self-insured employers, and all third-party administrators to report suspected fraud to the Fraud Division and the district attorney's office within 30 days after the duty arises. This means that if you, utilizing the various "red flags"and other warnings presented throughout this course, have come across some aspect of a fraudulent claim, and you believe it needs to be reported, and you are doing so without malice, then your duty is to make an initial report to your company's ***Special Investigative Unit***. If your company is not required to maintain an SIU function, then the report must be filed simultaneously with the Fraud Division and the office of the district attorney in whose jurisdiction the fraudulent act was committed. And these filing must be made within 30 days of knowledge. The Fraud Division and the district attorney hold a joint responsibility to take your fraud report and act upon it accordingly. At this point it cannot hurt to put forth this reminder: The referral of a case to the Fraud Division or the district attorney's office does not mean a specific person or facility is guilty of fraud.

A preliminary evaluation by the Fraud Division will determine whether your particular case merits a criminal investigation and, ultimately, criminal prosecution. The cases that receive the highest priority are the most egregious in nature--the larger criminal conspiracies that are more likely to be prosecutable.

The Forms to Use

All suspected fraudulent activity is to be reported on CDI Forms FB1/FB2: Suspected Fraudulent Claim (SFC) forms. Take care in providing accurate, detailed answers to all the questions. Keep copies of the FB1/FB2 for your records (either by SIU or in separate records). Be sure to indicate on the form whether additional follow-up will be completed. The originals are sent to the Fraud Division in Sacramento, and a copy is to be sent to the appropriate district attorney's office. Specify to which district attorney the case has been sent. The SIU is your conduit to the Fraud Division, and its regulations cover moving the referral through channels.

Retaining All Case Files

All the Fraud Division requires to begin its evaluation is the FB1/FB2. You will not be asked to submit your claims files unless the Fraud Division's evaluation shows that the case is a candidate for further investigation. In the meantime, of course, it is important to keep the files updated if your investigation is ongoing.

The Immunity Provision

The Insurance Code provides you with immunity from civil suit when referring suspected fraud to the Fraud Division and the district attorney's office. This immunity covers not only the insurance carriers, the self-insured employers, and the third-party administrators, but also those agents, such as private investigators, retained by you to seek out additional information, and the government agencies involved in the investigation process. However, as broad as it is, the immunity protects you only as long as the fraud referral is done without malice and it is consistent, that is, it applies to everyone in the same manner. This means that a specific doctor or attorney cannot be targeted for investigation simply because they receive the lion's share of payouts on your claims processing.

After the FB1/FB2 Is Filed

Do not advise the suspect party that the claim has been referred to either the Fraud Division or the district

attorney's office.

The referral to the Fraud Division or the district attorney's office is handled separately from the proceedings.

If you have evidence to defeat a case within the jurisdiction, utilize it, regardless of the status of the Fraud Division or district attorney's case.

If a party is found guilty of fraud, restitution or incarceration can be imposed. A petition and Order of Restitution can also be filed.

The Agent's Role

To the extent that you have heard the defendant say or do certain things, or to the extent that you are familiar with and are bringing to court or have presented to the court various documents, you may be called as a witness. You may be a source of information in that you can provide foundation for various documents.

Under previous law, only the custodian of the records could qualify business records. But to the extent that you have files that are under your control during the claims process, you may be the custodian of records for those files. You will be asked for information on how a claim file is prepared and how the documents are received and maintained, in order to satisfy the court that these records are reliable and should be admitted into evidence.

It is important that you know how your company's system works, because you will be called upon to not only describe the documents for what they are but also relate to the court the underlying system and show that the system is a reliable one.

Some Things to Remember as a Witness

* You are not an advocate in the criminal courts environment. You are there to tell what you know, what you recall, and to lay the foundation for the documents.

* Listen very carefully to the questions and answer only those questions. Don't give what you think the person should know, just give what has been asked.

* Don't guess. Don't draw conclusions unless you're asked to do so.

SECTION 3 INSURANCE AS A SOCIAL INSTRUMENT

The purpose of this section is to help you understand the nature of insurance. By "nature," we mean its essential quality—what it essentially IS. To do this, we will examine insurance as a social instrument. The word "social" of course refers to the interaction of human beings. An "instrument" is a thing by means of which something is done. Thus, we are looking at insurance as a thing by means of which something is done, and the arena in which insurance acts, is one of interaction between human beings.

Whatever we discover about the nature of insurance will be applicable to all fields of insurance, not just one. This knowledge will form a basis on which to build specialized knowledge having to do with the various fields—life and health, property and casualty—within the broad term.

And, we believe, having an understanding of how the insurance industry came about, and how it has responded and still responds to the changes in the ways in which human beings interact with one another will give you a perspective through which you can view any and all information related to your particular field. This understanding is particularly important in establishing a truly professional approach to the work of soliciting, placing, and servicing insurance policies. In an increasingly sophisticated market, with a population that is increasingly knowledgeable, simply knowing the contents of a policy is often not enough. As any agent with even minimal experience knows, motivating a prospect to buy is the key to a successful and productive career. When a prospect understands, at a level that works for him or her, the true nature of insurance, and how it functions to put protections into place that he or she cannot put into place alone, the task of placing the policy becomes much easier. The agent becomes the provider of an important service, and the insurance policy is seen for what it is: an instrument which serves to safeguard the insured from the hazards and risks endemic to the human condition.

The course is divided into four major sections: I. An Historical Perspective, in which we will discuss the history of insurance; II. Identifying Risks, in which we will investigate how risks are selected and defined; III. Classifying Risks, in which we will examine the thinking that leads to a ranking of risks; and IV. Assessing Risks, in which we will learn how risks are evaluated in terms of their probable frequency and severity of occurrence, and their probable cost. You will find frequent review questions which are designed to reinforce the information presented in the text, and to highlight the more significant information. And now, to the body of the course.

HISTORICAL PERSPECTIVE

Insurance as a concept could not exist were it not for two factors: first, the invention of money; and second, the acquisition of property that may be kept/maintained over a period of time. Property, in other words, that is not consumed within a relatively short time after it is acquired Let us look at these two factors and see why they are both essential to the concept of insurance.

In the first place, unless the value of property can be quantified with terms that may be applied throughout a society, it is not possible to accurately determine the cost of the loss if it is damaged or destroyed. And second, only when a person possesses property which may be kept/maintained over a period of time does the risk of losing it become a threat. For example, if a primitive man caught, killed, and ate a fish, he would have no reason to protect this "property," for it has been consumed immediately. But if this same primitive man has killed a number of animals, and has a large pile of animal skins and furs which will be used to shield himself and his family against the cold of the coming winter, he now has property the loss of which would cause him a harm.

Property, its acquisition, maintenance and disposition, is one of the most significant bases for most legal systems, and as is attested by every kind of human record, disputes over property are the cause for many of mankind's

worst ills. Even so personal a social institution as marriage had as its original purpose the orderly descent of property from one generation to the next, establishing legality for children, who would then be legitimate heirs, and naming others illegitimate, thus depriving them of any inherent claim to a parent's property. And certainly, the disputes over property during the course of a divorce give rise to some of the most hostile encounters two people could have.

On a larger level, disputes over property rights have started wars, everything from the range disputes between sheep ranchers and cattlemen in the west, to the German desire for "lebensraum," (living space) that was a primary motive for this century's two world wars.

There is still a third factor which led to the rise of insurance. This factor was the change in the way man lived, so that it was no longer possible for an owner to personally protect or defend all the property he or she had. Let us examine this idea. Early man lived off the land, gathering food that grew wild, catching fish from nearby waters. And, these early humans followed their food sources, moving from place to place. In such a situation, clearly anything they had in their possession they could protect themselves. Later, when humans became more domestic, creating shelters in which to live, fashioning tools with which to hunt animals and make clothing, they now had something to protect that did not move when they moved, but stayed in one place.

Out of the simple need to protect their homes, tribes came together, and hierarchies of work evolved. Some members hunted for food. Others gathered what was nearby. Others fashioned vessels in which to store food. Others made weapons to keep animal predators and hostile humans away.

The above discussion is of course a much-abbreviated and simplified version of how man's relationship to property developed and changed. But as we think about it, we realize that such development was inevitable, giving the way human needs are organized.

A psychologist named Abraham Maslow developed what he called a Hierarchy of Needs, which we will describe here. At the lowest level are the physical needs, which early man satisfied in a happenstance way.

Next come the security needs, which demand that we have certainty that our future as well as our present physical needs will be gratified. Early man met security needs with the establishments of places in which to live, and with systems by which to gather and store food and other necessities for future use. The next level of needs deal with man's need for companionship with his own kind—what is called the herd instinct. The formation of tribes answered this need. The homogeneity of these early tribes helped make the needs of one the needs of all: thus, the concept of a common defense against predators took shape.

As did also the concept of using force to take from another tribe what this tribe lacks and that one has. Whether the disputes were over food supplies, water, materials for shelter, essentially, property was the issue at hand. As war was added to the ways in which human beings could obtain property, defenses for property became more elaborate. Tribes joined together to make larger groups. In Europe, the feudal system emerged, with a castle at the center of a walled town. Serfs living and working outside the walls came into the town during times of danger: like the inanimate objects the lord of the castle owned, they, too, were property to be protected. And, when the lord had to be away, heavily armed men were left to secure what he owned.

But not all human interchanges dealing with property used violence and war. Barter as a system of trade emerged very early in the history of man, and proved itself a viable method for people to exchange useful goods. Still, the value of goods exchanged remained subjective: that is, the value was determined by how much the item was in demand. Only with the invention of money could a more universal standard of determining value be used. People in Mesopotamia appear to have been the first to use measures of silver in recording accounts of goods: this before 2000 B.C., but not until late in the third millennium that a true metal currency emerged, the silver ingots used in Cappodocia. By the seventh century B.C., coins came into use, though they were not widely used. The Phoenicians, the legendary traders who roamed the known seas, began using coins a century later, and the Egyptians, representing a highly civilized culture, did not use coins as currency until 400 B.C.

And, also during this period, the parameters of trade had been extended, primarily through the use of boats. Land travel, after all, was mostly by foot. Though the invention of the wheel made carts and carriages possible, the primitive nature of the axle design and the almost non-existent roads made trade by land impractical. Boats were another matter, and anthropologists have long established the wide-ranging routes the ships of early traders took.

Now the three factors necessary for a social instrument such as insurance to exist are present. Man had property which could be contained, and could be maintained or held over a period of time without losing its utility or value. Money had been invented, which meant that a more uniform standard of exchange could be devised. And, trade between far-flung entities was possible through the use of ships.

And so, devices very much like insurance rose up in these ancient times. One such device closely resembled BOTTOMRY, a concept in maritime law which means the act of borrowing money with the ship used as the security for the debt. If the ship is lost, the debt is canceled. Babylonian traders in ancient times assumed the risks inherent in caravan trade through loans which would be repaid, with interest, when the goods in the caravan had arrived at their destination. This practice was given legal authority by inclusion in the Code of Hammurabi, 2100 B.C. Sea-going traders such as the Phoenicians and the Greeks used a practice resembling bottomry to protect themselves against the loss of their ships, and the practice was also widespread throughout the Roman Empire.

The Romans also had an early form of life insurance through burial clubs, which paid the funeral expenses of members, and also made payments to survivors. And by the year 220 A.D., a Roman jurist had constructed a primitive mortality table. After that, practices which operated very much like insurance flourished throughout the civilized world. As towns grew up across Europe, and as trade increased, medieval guilds, organized around a particular craft, offered protection to guild members from property losses caused by shipwreck or fire, provided ransom money in case a member was captured by pirates, and also provided support during times of illness or poverty. These guilds also paid for members' burials.

A marine insurance contract dated 1347, and formed in Genoa, Italy, offers evidence that marine insurance had, by that time, gained usage throughout Europe's maritime countries. When the concept of insurance reached England, brought there by traders from Lombardy and the Low Countries, it moved a step nearer to the form it takes today. And, as is generally known, marine insurance flourished under the auspices of Lloyd's of London, arguably one of the most famous names in the insurance field, even today. Lloyd's had its start in the 17th century at Lloyd's Coffee House, from which it took its name. There merchants, shipowners and underwriters met to conduct their business. The term "underwriter" comes from the way insurance was written in these early days. Since in the beginning, individuals, not companies, insured against loss, the following method was used: the value of the shipment or property being determined, each of the individuals willing to insure the loss wrote down his name, putting next to it the amount of loss he was willing to assume.

Other forms of insurance were also developing into meaningful ways to protect people against certain kinds of loss. Fire insurance had been offered to members by their guilds, as we have already noted. But in 15th Germany, fire insurance was offered as by communities who formed a pool from which losses were paid.

Life insurance lagged behind because it involved both usury—the payment of interest—and betting, and there were laws that prohibited both. Still, there is evidence that in 1583, a life insurance policy was issued in England, but until 1693, premiums were level, and did not vary according to the age of the insured. But in 1693, the astronomer for whom Halley's Comet is named, Edmund Halley, developed a mortality table that he based on the laws of compound interest and mortality. Some sixty years later, in 1756, a man named Joseph Dodson improved Halley's mortality table.

Then, as trade and commerce flourished in the 17th and 18th centuries, so, too did insurance. And, by the 19h century, the many risks inherent in civilization helped the field of insurance grow as it addressed these risks and

insured them. As we have already noted, early insurance policies were underwritten by groups of individuals, not by companies. Then, in 1720, stock companies were issued charters in England: the sole purpose of these companies was to write insurance. Fifteen years later, an insurance company was chartered to do business in Charleston, South Carolina, followed in 1759 by the founding of a life insurance corporation by the Presbyterian Synod of Philadelphia. This corporation paid benefits to Presbyterian ministers and their dependents. As the prejudice against insurance—prejudice based on laws against usury and betting—diminished, insurance as a concept became more widely accepted, and by 1840, the life insurance business was well established.

Fire insurance companies were first founded in New York in 1787, followed by the establishment of one in Philadelphia in 1794. Not only did these companies provide fire insurance, they were also engaged in preventing and putting out fires. Two disastrous fires, one in New York city in 1835 and in Chicago in 1871 demonstrated, first, that fire insurance companies needed to have large reserves in the case of such disasters, and, second, that the risk of large-scale fire damage increased as populations became more concentrated in cities. Thus, states, beginning with Massachusetts in 1837, began to require companies to maintain reserves sufficient to cover the potential risks they insured. Yet another facet of modern insurance developed as a result of these two fires, that of reinsurance, whereby the insured risk is spread among a number of companies to prevent any one insurer having to absorb the entire risk.

The nineteenth century saw the initiation of a number of other forms of insurance. For example, accidental injury insurance was first offered in 1845, and insurance for travelers against the hazards they encountered was begun in 1864. As a reflection of the risks posed by the Industrial Revolution in the 19th century, the English parliament passed a Workmen's Compensation Act in 1897, whereby employees would be compensated for work-related injuries. The first public liability insurance also came into being in the late nineteenth century, with early legislation being passed in the 1880's. Later, with the arrival of the automobile and its attendant hazards, liability insurance became more important. Even before that, England had laws requiring public conveyances to have liability insurance, and collision insurance was also first offered there.

America, however, was the birthplace of burglary insurance: it had its inception in 1885. Corporations had used fidelity bonds as early as 1840, and by the 1890's, risks attached to property titles and to credit transactions could be insured. Notably, one major field of insurance was a late-comer: the field of what is termed social insurance, which takes care of losses from sickness, accident, disability, and/or old age.

Thus, by the end of the nineteenth century, most major forms of insurance had been developed, and were well in place. In the twentieth century, these forms became more complex and sophisticated to meet the changing nature and number of risks to be insured. Marine insurance, which formerly covered cargoes at sea, now had a new branch called inland marine coverage, which insures everything from the baggage of tourists to goods in transit on trucks. Fire insurance was expanded to cover damages from lightning, and other losses caused by nature, such as those resulting from hail, flood, drought, and tornadoes, could also be insured against. And, special risks ranging from Marlene Dietrich's legs, which were insured by Lloyd's of London for one million dollars, to rain insurance, could be covered by policies designed for unusual risks.

Life insurance in particular has undergone many changes in the twentieth century. While a life insurance policy can be set up so that it pays lump sum benefits to survivors at the insured's death, most policies are much more versatile than that, offering a whole menu of benefit plans that can meet the particular needs of an insured.

Further, in the twentieth century, state and national governments became more involved in regulating insurance, everything from permitting a company to do business in a state to setting required liability limits for automobile insurance. A prime example of governmental action in insurance is the Social Security Act of 1935, which was passed as part of President Franklin D. Roosevelt" New Deal, the legislative package he used as a tool against the effects of the Great Depression which began in October, 1929, and lasted until the Second World War began. Yet another law passed as part of the New Deal was the Federal Crop Insurance Act of 1938, which sought to protect the nation's farmers against the devastating losses so many of them suffered when the wheat belt of the mid-west became a Dust Bowl that ruined many.

The federal government got into the life insurance business when it offered life insurance for those serving in the military in the Second World War: it also began providing pensions and other benefits for both veterans and government employees. And, in 1944, the commerce clause of the U.S. Constitution was interpreted to mean that the U.S. Congress had a duty to regulate insurance. Until then, such regulation had been the duty of the various states.

Throughout the twentieth century, there have been many changes in the field of insurance which reflect changes in the society it serves. For example, after the riots that occurred during the sixties, a practice known as "redlining" began, whereby property insurers either refused to write insurance in certain neighborhoods, or sold the policies at a higher rate. Later, laws were passed forbidding this practice. Certain recreational activities, such as sky-diving, led insurers to exclude these hazards from coverage. The development of alarm systems for residential use became a factor in setting premiums for homeowners' insurance, with many companies giving credit to those who have alarm systems which are monitored, and which can bring police or firemen to handle a potential loss. Insurers began to offer business owners a wide range of coverage, including business interruption insurance, which helps replace income lost if a business is temporarily disrupted by a covered risk.

But perhaps the most dramatic changes in the field of insurance are those associated with the changes in health insurance. These changes are directly tied to technological advances in the field of medicine, and in society's attitude toward health care. Before the highly sophisticated diagnostic procedures which are available today came into being, physicians relied on their own knowledge, experience, and, often, intuition, to diagnose a patient's problem. Obviously, it costs a great deal less to be diagnosed by one human being than it does to be diagnosed by an array of tests and equipment, all of which involve technicians and assistants of various kinds. And, because of the rise in malpractice charges brought against medical personnel, many physicians who might otherwise rely on their knowledge, experience, and intuition order diagnostic procedures as a safeguard.

Further, the treatments available to physicians are also sophisticated—and expensive. And, as patients become more aware of diagnostic and treatment options available to them, they are far more likely to have input into their care. The days when physicians reigned as minor gods, able to make decisions about a patient's care without giving the patient much information are long gone. Now, again because of malpractice risks, physicians routinely discuss with a patient all the possible outcomes of a particular treatment, even when, in the physician's opinion, the patient not only does not need to know all this, but may well indeed be harmed. Highly susceptible people can develop the negative symptoms attached to a certain procedure simply because they have been told that there is a possibility they will occur.

The cost of hospitalization has also sky-rocketed, resulting in a health care system where insurers determine how many days a patient may be hospitalized after a particular surgical procedure or care for a particular condition. Personnel working in modern hospitals are both more numerous and more specialized than those in earlier times. There are respitory therapists, nutritionists, physical therapists, occupational therapists, social workers, and a host of other specialists involved in the care of patients—which results in more effective care, but also in higher costs. As we know, the development of Health Management Organizations (HMO's) and Preferred Physician Plans (PPP's) are now dominant in the health care field. Managed care are the buzz words as we look toward the twenty first century, and the debate as to the concepts effects on patient care and health care-givers alike is far from over.

And, because adequate health care is now seen as a right that all citizens have, efforts to provide this care to the indigent have complicated an already complex issue. Efforts to mandate health care insurance for all children in this country have resulted in Congressional action, and concern for workers who lose their jobs because of a nationwide trend toward downsizing companies has led to legislation requiring the new employer to provide health coverage equal to that the worker previously had, and, usually, without the limitation that pre-existing conditions are not paid for.

Thus, the insurance industry is caught in the middle. On one side, society increasingly requires adequate health care for all, even for those who cannot pay anything toward it. On the other side is the health care profession, which, because of the increasing costs of both diagnosis and treatment, is finding itself in the position of having outsiders determine how much care will be paid for, and the length of time the care will be allowed. As usual, the large number of abuses of such systems as Medicare and Medicaid have put honest health care professionals in a position where they will suffer from prohibitions put into place because of the illegal acts of a few.

Yet another recent development in health care is tied to the fact that more and more Americans are living longer, to ages where they must have long-term care. And so long-term care insurance has come into being, with policies designed to cover both at-home and nursing home care.

Probably the one single factor in our society that makes the health care problem so severe is an increasing tendency for people to believe that every problem has a solution, and that someone else should provide solutions for our problems. Obstetricians, for example, can be sued in many states for malpractice until a child they delivered is TWENTY-ONE years of age. Common sense tells us that any number of factors other than a trauma at birth could cause a condition not identified until a person is twenty-one years old, but in today's world, common sense does not prevail. Medical malpractice insurance for obstetricians has become so high that many physicians are avoiding that specialty, going instead into one that has a lower rate of risk. And at the other end of life, physicians and hospitals are using extraordinary measures to keep alive some person who cannot recover, simply because they fear lawsuits from the family if they do not do everything possible to prolong life.

Yet another problem that is a direct result of the direction in which our economy is going is the trend of corporations and businesses to hire part-time or contract workers for whom they provide no health insurance plan. Because these people are not part of a group, getting health insurance can be an expensive proposition, so expensive that many do without. Some managed care plans accept individual members who do not have to be part of any group, and so in this manner take care of workers without access to an employer's plan.

Because so many of the factors affecting health care came into being in, essentially, the same stretch of time, it is no wonder that workable solutions are still being sought. But in a democratic society such as ours, the pendulum usually swings from one extreme to the other, with a period of equilibrium in between. The present emphasis on managed care is a reaction to spiraling health care costs, and a climate in which physicians worked under the threat of malpractice, using techniques which helped drive costs up. Because insurance is a social instrument, it is affected by these swings. However, because its particular function is to identify risks, classify them, and assess the probability of their occurrence, and the probable severity of the loss they inflict, insurance can offer solutions to current health care problems, solutions based on a vast array of statistics and evidence gathered by insurers in the field.

IDENTIFYING RISKS

The section just concluded presented a brief survey of the history of insurance as a social instrument, showing how various forms of insurance came into being as a response to a felt societal need. Beginning with marine insurance, which responded to the hazards posed by maritime trade, and with burial clubs which recognized the economic loss death imposes, insurance progressed until it offered protection against economic losses associated with illness and injuries, against fire and burglary, and against the losses caused by harm caused to others or to their property for which a person is legally liable. Specialized concepts such as worker's compensation and crop insurance were a later development, coming during the New Deal of the 1930's. In the decades since, insurance has become highly refined, as it addresses the changing needs and requirements of our society. But its essence remains the same—its function is to reduce insofar as it is possible the losses suffered as the consequence of a certain known hazard, or risk.

In order to fulfill this function, a number of factors must be addressed. First of all, the risks must be identified. In other words, before an insurer can provide protection against a risk, the risk must be known. This section

will discuss the process by which insurable risks are identified. But before going on, let us examine that term, "insurable." Essentially, the term refers to possible/probable losses which can be protected. And, taken broadly, we might conclude that every material good is insurable, and that all risks to which human beings are subject can also be protected by insurance. In reality, as we all know, this is not the case.

A major factor in determining whether or not a risk is insurable is economic: how much money will an insurer have to charge to cover its costs if it undertakes to provide protection against a certain risk? And, conversely, how much can an insured reasonably be expected to pay for this protection? In a later section, we will study the classification of risks, and we will see that certain risks are termed "catastrophic," and require premiums that reflect the loss potential of the risk. And, some risks will never be insured by any company, for the possibility of ruin is too great. This sort of risk is found in policy exclusions: common risks which are excluded are riots, vandalism, war, and the like.

In identifying risks, we will divide them first into three broad areas—risks which affect human beings directly; risks which affect property; and risks arising from liability in regard to others and to their property.

Risks which affect human beings directly are those which cause bodily harm, either through illness or injury, and death. Such harm may be temporary and partial, permanent and partial, or permanent and total. For example, the loss of a limb through injury is a partial, permanent loss—partial, because the person still has the use of one arm, or one leg. The loss of eyesight in both eyes is a permanent and total loss; the person has no vision at all.

Insurance providing protection against risks which pose a threat of harm to human beings is divided into four basic types: 1) Life insurance, which can provide a replacement of income should the insured die during his/her productive years or live years past them; 2)health insurance, which pays for medically-related expenses; 3)workers' compensation insurance, which provides protection for loss of income through injury or illness sustained on the job; and 4)accident insurance, which provides protection against losses from injuries/death while traveling on common carriers as well as in private passenger vehicles.

As we examine these various risks, we will also comment on the social usefulness of the insurance which provides protection against them, reinforcing the concept that insurance is a social instrument.

Life insurance provides protection against two particular risks: dying too soon and living too long. In the first instance, the insured himself/herself receives no tangible benefit from the policy. But the intangible benefit, of providing for beneficiaries dependent upon the insurance funds for their security, is the motivating factor for the purchase of most life insurance. When an insured lives too long, he/she of course is a primary beneficiary of the cash values in the policy. One difficulty attaching itself to the sales process is that most young people have an optimistic view of their longevity, and thus may be resistant to purchasing protection at the very time of their lives when they will, normally, pay the lowest premium. And yet, if they wait until they do have a life-threatening condition, insurance will either be denied to them, or, if it is sold, will be sold at a premium that reflects the increased risk of death the condition imposes.

The fact that premiums are directly tied to the overall health and lifestyle of a prospective insured makes life insurance (and health insurance) seem more like a gamble to many laypeople. It is almost impossible for laypeople to understand the actuarial processes by which the risks to health and life are identified, and, since it is human nature to think that ills will befall other people, but not ourselves, when policies are rated above the standard premium because of some risk the insurer identifies, insureds are often resistant, and may even refuse to purchase a policy which they very clearly need.

Beyond such factors as the health history of a prospect's parents, siblings, and grandparents, or the medical records of the prospect, there are now environmental and lifestyle hazards to be considered in identifying the risks that might cause a fatal accident or illness. Such distinctions as those made between premiums charged to smokers and to non-smokers are one example. Yet another is the fact that if life insurance is issued to people who indulge in high risk activities such as sky-diving, car racing, and the like, they will pay a very high price.

The vast accumulation of medical records now available to the actuarial departments of insurers has made risk identification in terms of life-threatening conditions much easier, and it allows insurers to fine-tune premiums to reflect very closely the amount of risk an insured runs. Thus, where formerly the health risks of people making up insurance pools might have varied widely, making the overall prediction of losses difficult, today, insurers can place people in much more precisely defined pools. Those who present the lowest risk of loss to the insurer will benefit with lower premiums, while those who present the highest risk of loss are in a high premium pool.

Let us now look a little more closely at life insurance as a protective devise against the losses occurring should the insured die too soon or live too long. As we have said, the main purpose of life insurance is to provide funds which can replace income for a family whose breadwinners die before the every member of the family can be self-supporting, or to provide income for people after they are retired from their jobs. Remember that the earliest forms of life insurance were burial clubs, which paid the expenses associated with death, and, in some cases, provided some funds for the survivors. Now, life insurance policies are tailored to the various situations and groupings of individuals in our society, and the instruments delivering protection reflect this variety.

The simplest form of life insurance is term insurance, which builds up no cash value, and which may be of three types: decreasing term, level term, increasing term. Because the policyholder does not have equity in the policy, and because term insurance is written for a specific period of time, the premiums are lower than those for other forms of life insurance. However, unless a term policy actually provides protection against the insured's particular risk, the lower premiums should not be the final factor in deciding to purchase it.

Let us look at these various types of term insurance. Decreasing term is an effective instrument in protecting the risks associated with a long-term mortgage on a piece of property. It can be tailored so that as the principal on the mortgage decreases, the face amount of the term policy decreases, also. At every step of the way, if the mortgagee dies, the mortgage will be paid off by the policy, since the amount the policy pays keeps pace with the amount owed. Level term provides protection in cases where the lower premium is a definite consideration because of the age or physical condition of the proposed insured. In a level term policy, the premiums stay the same for the specific period. After that, they will rise, perhaps astronomically. The premise, however, is that by that time, the insured will have fewer other economic obligations and can pay the higher premiums. For example, the parents of a family of young children each take out a fifteen year term policy. The premiums will stay level during the fifteen years in which the children present the most expense. By the time the premiums go up, the parents should have the income to meet them. Increasing term is yet another form of term insurance, in which the face value of the policy goes up to meet anticipated expenses which would have to be paid for, even in the event of the death of the insured. For example, a parent wishes to make sure that a child's education will be paid for. The anticipated cost of educating the child is projected, and an increasing term policy issued that will pay for these rising costs.

There are five other types of life insurance: whole life, which offers protection for life at a fixed premium—it has a fixed death benefit, and a cash value that can be borrowed against and that increases over the years; universal life insurance, which has permanent protection, death benefits, flexible premiums, and a cash value which is based on current interest rates and on the amount of premiums paid to date; express interest whole life insurance, which has permanent protection, a fixed death benefit, a premium which is fixed, but which may be adjusted by the insurer after issuance of the policy depending on the investment yield which is tied to the cash value; variable life, with either fixed or flexible premiums, permanent protection, variable death benefits, cash value tied to the performance of the investment, over which the policyholder has control; and adjustable life insurance, with permanent protection that can, if the insured wishes, be reduced—the death benefit and premiums can also be increased or decreased. In each of these cases, the intention is to replace income lost through the death or retirement of the insured. Endowments are yet another form of life insurance: such policies are normally written to provide funds to certain institutions or causes the insured wishes to support. Because of an increasing awareness on the part of the public that pensions and other provisions for retirement can prove inadequate to address the needs of a population that is getting older, the use of annuities has also

increased. In their simplest forms, annuities are instruments which either pay out a specified sum of money over a specified period of time, or which are open-ended, and pay varying sums of money over an unspecified length of time. Two broad types of annuities are annuities immediate, in which payments are made as soon as the annuity is in place—this category includes instruments called annuities certain, life of one person, joint life, survivorship, reversionary, guaranteed minimum, and combination. Annuities deferred are those in which payments are delayed. This class includes certain, life, and guarantee.

The most immediate benefit of any life insurance policy is, of course, to the insured's beneficiaries, or, in the case of annuities, to the insured first, and then, depending on the form of the annuity, to his/her survivors. Life insurance benefits can be paid in a variety of ways—beneficiaries can take a lump sum payment, or they can take incremental payments that are increased by interest paid. Life insurance policies can be set up so that they are not considered part of a deceased's estate, and are therefore not subject to estate taxes. Policies with cash value can be borrowed against, and the interest charged is, in most cases, well below what another lending institution would charge. In extreme cases of need, policies with cash value can be cashed in, and there are many examples of insureds who, during an economic slump, used the cash value in their policies to save their businesses or their homes.

Obviously, when a prospect purchases insurance, his/her first concern is to protect himself/herself and his/her beneficiaries/family against the negative effects loss of his/her income would produce. The insured hopes to keep his/her family in their home with the purchase of a mortgage cancellation policy, which will pay off the amount owed on the home at the insured's death. An annuity purchased at a baby's birth can provide funds for his/her college education. Couples in retirement can use the cash value in a policy to purchase an annuity that will supplement their other retirement income. In all of these cases, the first benefit is to the insured and those he/she seeks to protect.

But there is a larger benefit to society that should not be overlooked. There has probably never been a time since the beginning of mankind where the economic stability of one segment of society, or one section of the globe, has so much effect on the entire planet. Even we were not becoming a global society, not just in economic terms, but in social terms as well, any instrument which contributes to the stability of individuals and families is making a huge contribution to the welfare of the whole. For example, if a breadwinner dies and there is no insurance, in almost every instance, the economic status of the family immediately goes down.

Studies have demonstrated the negative effects of economic stress on both individuals and families, and we need only turn to the daily news to see what happens when children are not properly provided for, or when the adults responsible for them provide for them only at the sacrifice of any possibility of family coherence.

Each family that is stabilized by a life insurance policy adequate to its needs is part of the mortar holding a strong society together, just as every family which is thrust into economic chaos helps weaken the society in which they live.

When life insurance provides sums for the education of children, once again, it is a social instrument providing a needed and most desirable good, for we are already in an age where the inadequately educated will be hard put to survive.

Every time a life insurance policy pays off a mortgage on a home or business, the economic fiber of society is strengthened. And in many, many instances, a condition attached to a loan is that it be protected by the purchase of life insurance.

Even in cases where an individual or family seems to have sufficient wealth from other sources to provide income in the event of the death of a major figure in a family business, life insurance policies can pay estate taxes, thus very often preventing the sell-off of valuable assets to pay that inevitable bill.

Life insurance funds buy-and-sell agreements between partners in a firm. It can protect a business against the

untimely death of a key man/woman. And it can be used to fund trusts which will provide for minor beneficiaries while at the same time providing oversight of the funds' use.

Further, insurance companies are major investors in every sector of our economy, using the reserves built up against anticipated losses to earn money for the company while at the same time providing a source of capital for enterprises as various as real estate, public utilities, railroads, and industrial bonds.

And, as more and more people have become interested in investing in the stock and bond markets, insurance companies have developed policies which allow them to do just that, without having the burden of handling the funds they invest.
Non-profit organizations and other institutions such as universities and museums encourage donors to make them the beneficiary of life insurance policies. In this way, donors can spread out tax-deductible payments for premiums over a period of years, and the beneficiaries can expect a known sum at the donor's death.

Clearly, life insurance can be considered a valuable social instrument, contributing as it does to the economic stability of individuals and families, and thus, to that of the whole society.

Health insurance, as we have noted, is experiencing vast changes as conditions and attitudes in our society also change. And, given the history of the field of health care, these changes are not difficult to understand. After all, it is not so very long since a time when there was very little physicians and hospitals could do to cure patients of many of the diseases afflicting them, nor has it been all that long since deaths as a result of childbirth or surgery were common.

Several factors other than the paucity of effective medications and surgical procedures contributed to the high mortality rates that persisted into this century, even in so-called civilized countries, and which still exist in those nations not yet blessed with modern medical care.

A major factor was wide-spread ignorance of the causes, and thus the prevention, of disease. Until it was recognized that certain diseases such as smallpox, tuberculosis, typhoid and the like could be spread from one person to another by contact with bacteria either on the skin or through the air, epidemics were common, and physicians often were guilty of carrying a disease from one patient to another.

When Dr. Joseph Lister, building on Louis Pasteur's theory that bacteria were the cause of infections, and brought antisepsis into the operating room in 1865, a major step forward was made in medical care. Until that time, many perfectly healthy women contracted an infection termed "childbed fever," and died. Lister saw a direct connection between these deaths and practices common in hospitals of the time. For example, it was, unfortunately, not uncommon for a physician performing an autopsy in the hospital morgue, or one using a cadaver to teach students biology, to leave and deliver a baby without washing his hands. The simple introduction of requirements which would inhibit the careless spread of bacteria thus saved many lives.

Yet another factor in the high mortality rates of earlier times was the lack of medications that could actually cure a disease. Though current research into the use of a variety of "natural" medicines—those made from herbs and other vegetation--demonstrates that many of these natural remedies possess chemical properties similar to those in medications developed in laboratories, still, the use of these medications was neither as reliable or as widespread as are medications used today.

Thus, until the discovery of the modern "miracle" drugs, in many cases the patient's own sturdy constitution was as much the instrument of recovery as were the remedies a physician could provide. And, the modern "miracle" drugs have not been around that long. Sulfa, one of the first of these, was introduced in the United States in 1936, and penicillin, though it was discovered in 1929 by Sir Alexander Fleming, was not ready for medical use until 1941. Widely used in military hospitals during World War II, it was not until March, 1945, that the War Production Board released it for civilian use. Wars have often proved to be testing grounds for new drugs and new procedures--it was the MASH units of the Korean War that did much to innovate surgical

procedures that are now commonly used. The development of diagnostic equipment that includes CAT-scans and MRI's, as well as a host of laboratory tests, has made pinpointing a patient's problem more precise—but also, much more costly as well.

Thus, ignorance of the causes of certain diseases and how they were spread, as well as the lack of tools with which to accurately diagnose and treat them, cost many lives.

Yet another factor complicating early medical care was geographic—people simply did not have access to a trained physician, and thus had to rely on whoever happened to be at hand. Midwives commonly delivered babies, and it was usual for people who became familiar with the medicinal properties of herbs to act as doctors in the area in which they lived. Distance from medical care certainly meant that more people who suffered heart attacks and strokes would die before a doctor reached them, and all too many people died of infected wounds because none of the available and accessible remedies could kill the bacteria infecting the wound.

Nor were the effects of diet, alcohol, nicotine and the like on health recognized. A memorable example of such ignorance is demonstrated in the motion picture, CHARIOTS OF FIRE, in which one of the athletes on the English track team training for the Olympics is seen practicing running the hurdles with a glass of champagne awaiting him after every successful jump. Members of the team were also shown smoking on the boat crossing the Channel to France, nor was the use of tobacco at all unusual among athletes of the first decades of this century.

One ameliorating factor that might have counteracted some of the health hazards our forerunners encountered is a possible lower level of stress. Many of the conditions of modern life which increase daily stress did not exist: although telephones and fax machines, computers and other technological devices make our lives more efficient, they can also be the source of a great deal of stress. Recent studies are emphasizing what common sense has told many of us: stress can be a greater killer than many factors formerly considered the cause of heart attacks, strokes, and a whole range of other modern ills.

Finally, preventive medicine was almost unheard of until relatively recent times. Inoculations against diseases ranging from diphtheria—which used to kill thousands of people every year—to polio have greatly reduced mortality rates, and as medical science more closely identifies the causes of various ailments and conditions, people can change their diets, their level of exercise, and other life factors to help prevent some of these hazards from occurring, at best, and, at the least, to minimize their effects if they do occur.

Health insurance thus operates in a climate far different from that in which it began. Since there are measures that may be taken to prevent many diseases and accidents from occurring—the widespread use of helmets for those riding motorcycles and bicycles is an example of one such preventive measure—health insurers are as concerned with the active participation of the insured in preventing a known risk from occurring as they are with providing funds to cover losses. Much of the responsibility for maintaining a healthy life style is put on the insured. This is a drastic change from the time when illness and disease were seen as random occurrences over which an insured had little control.

Now, again because of sophisticated computer programs which give health insurance actuarial departments a much greater model of all the things that can go wrong with the health of a particular human being, insurers are able to divide insureds into more precise groupings, and loss prediction is more accurate than it has ever been before.

These same computer models have provided information concerning the type of treatment and the length of treatment for a whole range of human ills, from the time an insurer will pay for a patient to remain in the hospital after a particular procedure to the type of treatment it will cover. Insurers are now actively engaged with the health care professions in attempting to offer the widest coverage to the greatest number of people. As with any major change, those who formerly paid for their own health insurance plans, or who received them through employers, and who were and are satisfied with the generous terms many of these plans provided—it

was not unusual for executives to be provided with major medical plans which paid 100% for a long list of conditions, after deductions that could be as small as $250.00 per plan—are highly resistant to the changes "managed care" is bringing about.

The change in health care insurance is a reflection of a societal tendency to consider the population as a whole, and to extend to as many members of our society as possible the safeguards formerly provided only to certain sectors. All of this is to the good. How our society can afford to pay the price for these improvements is a question that is still being debated. The formation of Health Management Organizations and Preferred Physician Plans is an innovation that is expected to meet at least some of the consequences of the changes in the health care scene. Such plans are far distant from early health insurance policies, which reflected in their scope the health care situation at the time. There have been major changes from societal attitudes at the time when health insurance first began in the United States in the 1850's. These early plans were offered primarily by cooperative mutual benefit and fraternal beneficiary associations, though some insurance was available from commercial carriers. From 1920 until recent changes in health insurance plans, emphasis was on medical and hospital expenses. Until rather recently, illness, accident, and death were accepted as part of the human condition. Parents in the earlier part of this century did not expect all of their children to reach maturity, and their grim acceptance of this possibility is supported by a visit to any cemetery dating back more than seventy-five or so years.

Accidents occurred because the machinery developed during the Industrial Revolution of the 19th century was designed to make work more efficient: the additional hazards presented to those who used these machines was not a consideration, and the health and safety of workers from factories to coal mines did not enter into the corporate thinking of the time. Again, social conditions permitted such risks to exist. The flood of immigrants to this country in the forty years between 1880 and 1920 provided an endless source of workers who were more concerned about income than they were about their safety or health. In such a climate, it is no wonder that little or nothing was done to see to it that accidents and illnesses resulting from workplace conditions were addressed.

Not until May 3, 1911, with the passage and institution of the first Workmen's Compensation Act in the state of Wisconsin, was official notice taken in the United States of the responsibility of employers to provide safe and healthy working conditions for their employees, and to offer assistance if work-related accident or illness should occur. Forms of workers' compensation were established in Germany, Austria, and England in the late 1800's—by 1920, all but six states in this country had workers' compensation laws. Now, all fifty states have workers' compensation laws. While specific requirements vary from state to state, in many states, employers must have workers' compensation insurance if they have as few as one worker. In the years since then, numerous laws, some on the state level, and some, such as the law establishing the Occupational Safety and Health Administration in 1970, on the federal level, have been enacted which mandate certain preventive measures as well as benefits to employees which companies must provide.

It was only a matter of time before health benefits offered to workers were seen as a necessary benefit for a worker's dependents as well, and so health insurance plans which covered a whole family appeared on the scene. Still, until the cost of medical care rose to the point where one illness or accident could indeed impoverish a family, many people not covered by an employer's group plan considered individual health insurance policies luxuries they could not afford. That attitude of necessity changed when the sophisticated techniques we have already described came into being, and when a simple office visit to a physician can result in a bill of several hundred dollars or more.

How our society will address all the factors in caring for the health of its citizens is a question that will be studied for years to come. However, the primary goal of health insurance—to pay for costs associated with a covered illness or accident—is a fixed concept. As with life insurance, health insurance pays a double benefit. First of all, it benefits the insured, who has the security of knowing that he/she has a plan which will pay for losses caused by illness or accident. Second, it benefits society as a whole by maintaining the productivity of its workers, and by preventing sudden and disastrous economic loss from undermining the stability of an individual's

or a family's life.

Workers' Compensation Insurance, as we have already stated, began in this country with the passage of a bill in the state of Wisconsin in 1911. Though other attempts at such legislation had been made, this bill was the first to be considered constitutional, and thus enforceable by a court of law. The debate over the constitutionality of workers' compensation bills lay in the fact that under this legislation, a worker injured on the job would not have to prove that his/her employer had been negligent in order to have the economic loss he/she suffered paid for. In British Common Law, on which the laws of all but one state, Louisiana, are based, many cases rested on whether or not a particular individual demonstrated negligence in an incident causing harm to another. If negligence could not be established, the defendant did not have to pay.

Thus, this first workers' compensation law was a dramatic departure from the usual rules of law. Those who fought for such legislation based their arguments on the premise that the employer, not the employee, provided the workplace and the conditions therein, and that should illness and accident result from a work-related incident, or in an employee's scope of employment, the employer, who controlled the conditions under which the employee worked, had liability.

Obviously, arguments can be devised against this premise, but increasingly, the rights of workers for compensation for work-related injuries or illnesses prevailed, and worker's compensation laws are now universal in this country.

Workers' compensation insurance generally provides several types of benefits. First, these plans cover medical expenses associated with a covered illness or accident. Second, they pay for rehabilitation and retraining, should the worker's condition require either or both. Third, they provide disability income in instances where an employee's illness or injury means that he/she can not work. Disability income may be paid for the period of time that it takes for an employee to be judged ready to work by the company's medical review board, or for life, should the injury or illness be of such a nature that the employee's ability to work is forever affected.

Classes of disability recognized by workers' compensation plans include partial and temporary; partial and permanent; and total and permanent. Determination as to the severity of the disability and its length are made by medical review boards associated with the employers' workers' compensation plan. Employees who do not accept the judgment of these boards may take their employers to court, and, in an effort to avoid costly litigation, employers may find themselves in the position of making or negotiating settlements in cases which they believe to be based on false claims.

Just as prevention is an important component in health care plans, so too is prevention a watchword with employers mandated to carry workers' compensation insurance. Thus safety manuals and training procedures are significant parts of an employers' efforts to prevent illnesses and injuries from occurring. There are notable court cases, however, in which the refusal of employees to adopt required safety practices has resulted in harm. For example, a class action case was filed against a number of shipyards by shipyard workers who claimed that over the course of many years of employment in these yards, their hearing was so affected by the intense level of noise associated with the work that they have deafness to some degree. Lawyers for the defendants pointed out that the shipyards had indeed provided all workers in areas where there were high levels of noise with ear-plugs which would have effectively reduced the decibel levels their ears perceived, and would have, if used, prevented any deafness from occurring. Investigators learned that the ear-plugs were seen as something "sissies" would wear, and so were not used by the greater majority of workers involved in the suit.

The prevalence of drugs in our culture, and the fear employers have as to how an employee under the influence of drugs will behave on the job, has led to random drug-testing in company after company, with the consequent complaints that such testing is a violation of employees' privacy rights.

When research stated that people inhaling second-hand smoke ran almost as much risk of developing cancers associated with the use of tobacco, no-smoking rules were established in everything from restaurants to public

buildings to workplaces, another example of where the health of one group is considered primary over the personal choices of another.

The bottom line on any decision affecting the health of employees is cost. Studies can tell employers just how much productivity—and thus, corporate income—they lose with each manhour lost to injury or sickness, thus giving them impelling reasons to institute practices that not only prevent injuries, but help employees maintain their health as well. It is not unusual to find on-site fitness centers, or for company cafeterias to provide health-conscious meal choices.

Workers' compensation insurance is perhaps a model of what we call "social" insurance is intended to do, for it not only covers the economic loss a worker suffers from medical expenses, but it also pays for his/her rehabilitation to make him/her fit to work again, and, in cases where the worker's condition does not permit a return to the former job, retraining for something else. And, it provides a continuing income should a partial or permanent injury/illness reduce the employee's capability to work, either temporarily, or for life.

Employers may choose several ways of providing this benefit. They may purchase workers' compensation insurance through a commercial, private carrier. They may choose to enroll in a state-sponsored plan. Or, in some cases, they may self-insure, meaning that they put aside reserves to cover anticipated loss. All plans require that each position has a well-defined job description, listing the exact duties the employee is expected to perform. Further, employers are made aware that if they give an employee a task not listed in the job description, and if the employee is injured in pursuing that task, while the employer has liability for the injury, the insurance will not pay.

The rationale for this is simple. There is a vast difference in the physical strength required of a person hired to load inventory and that of a person hired to stay at a computer. If a person hired to run a computer is asked to move heavy objects from one place to another, and injures himself/herself, clearly, the employer/supervisor/manager has ordered him/her to do something for which there is no proof he/she can do.

The lucrative field of personal injury law attests to our present legal climate, where an accident can appear to be a gift of Fate, one that, if followed zealously, can lead to a jury trial, and a large judgment against the defendant in the case. Still, there is little question that employers must assume responsibility for the conditions under which their employees work, and although there are certainly numerous cases of workers' compensation fraud, insurers in the field are growing more knowledgeable about how to detect it, and thus avoid paying spurious claims while at the same time providing benefits to those who are truly in need.

Accident or travel insurance is yet another category of insurance that provides protection against risks to human beings. Such insurance routinely provides payment for accidental injury and death, as well as payments for partial or total losses of such things as vision and the use of limbs. Some policies pay only hospital cost. These policies are often sold through credit card companies, with the premium automatically charged to the card. As with travel insurance, which covers one particular journey—for example, a flight from Washington to London—accident polices usually have a list of exclusions, and the circumstances under which coverage is provided are limited. Thus, these should be considered as supplemental policies.

While Social Security is a government program, its benefits often serve as a foundation for private insurance to build on. Broadly speaking, Social Security provides an income to covered workers when their earnings stop because of unemployment, old age, or death. This is the more significant feature, although Social Security also has programs which give aid to dependent children, to impoverished blind people, and to impoverished elderly people. Since its passage by the Congress, and subsequent approval by President Franklin D. Roosevelt on August 14, 1935, the Social Security Act has undergone many changes beginning with amendments in August of 1939.

Seen as the first of a number of legislative acts which, grouped together, are called "entitlement programs," Social Security was the forerunner of wide-reaching government programs, including everything from Head Start

programs to Medicaid. As we know, legislation regulating welfare in this country was passed in 1996, and states are developing various methods of dealing with a federal mandate that includes lifetime limits on benefits and insistence that able-bodied recipients work, while at the same time adjusting to a concept that delivers funds for programs in block grants to the individual states. Yet another program that reflects a societal attitude that the benefits of insurance should not be withheld from those who cannot afford to pay for them is the one that provides health coverage for children whose families live at or below the poverty line. Realization that a cut-and-dried figure determined to be the poverty line does not adequately reflect individual circumstances, adjustments have been made so that families technically living above the poverty line can participate in certain social programs relating to health and education.

Changes in present day societies are dispersed much more quickly throughout the society than in days before communication became both rapid and global. The ability to more clearly identify risks that might cause harm to a particular group of people with similar characteristics is enhanced by technological advances in gathering, sorting, and interpreting data. If we compare the simple instruments that formed life insurance and health insurance contracts in the early 1900's, we would find fewer forms, and fewer choices. But the underlying principle of these policies, as well as those providing workers' compensation and benefits for losses caused by accidents on commercial carriers, has not changed. Life insurance policies still provide funds to cover needs arising when the insured dies too soon or lives too long. Health plans still provide protection against economic loss arising from covered illnesses and injuries. Workers' compensation plans still protect the worker against the economic consequences of job-related injuries and illnesses. Accident policies add protection for travelers over and above what they may already carry. Together, they provide the best possible cushion against the risks every human being faces—illness, injury, and death.

Property

The next class of risks we shall identify are those relating to property. First of all, let us list the classes of property which may be owned, and are therefore subject to risk. Real property is the term given to real estate, the buildings and structures on it, and this forms one class of insurable property. Yet another class is personal property, which can include everything from furnishings to furs, sports equipment to fine art. Business property is another class: this class includes not only items such as desks and other furnishings, computers and other equipment, but also includes the cost of blank recording or storage media, and of pre-recorded computer programs (software) available on the retail market. And, there are also miscellaneous forms of property insurance which include surety and fidelity bonds, title insurance, and credit insurance.

Property insurance covers risks associated with the ownership of property in two ways: first, it protects the insured against losses resulting from the damage to or destruction of property—this is terms direct loss insurance. Second, property insurance in the form of liability insurance protects the insured against losses caused by damages for which the insured is legally liable as a consequence of negligence which caused harm to third parties.

Obviously, the risks to property are many and varied: the insurance covering them has been divided into three main groups: marine, fire, and casualty insurance.

As we have already seen, marine insurance has the longest history. In the beginning, coverage was provided to protect vessels and their cargoes from "perils of the sea," which included such things as storms and other natural catastrophes, and also dangers such as piracy. And, at first, policies covered the ships and their property and cargo while said property and cargo was actually on the ship. Later, cargo/property coverage was extended until it also covered perils encountered while cargo/property was being transported across land to the dock, while it waited at the dock to be put aboard the vessel, and while it was being transported across land to its final destination. Thus, sea-going cargo was covered from its point of origin on land to its point of destination, and the dangers of land transport were added to the perils of the sea as covered risks.

A natural consequence of this additional coverage was insurance that covered cargo/property transported on land only, and thus, inland marine insurance began. While the term implies that cargo is transported over inland waters, such as lakes, canals, and rivers, this is not the case. Any cargo, freight, and the vessels that carry it over water are covered by ocean marine insurance, even if the water is Lake Superior or the Intercostal Canal. Cargo/freight shipped by train, truck, parcel post, etc., is covered by inland marine insurance.

Fire insurance also covers a wider range of perils than the one for which it is named. For one thing, while originally fire insurance covered only those losses which could be directly attributed to a fire, it now covers loss of use and loss of business, losses which are consequential to a fire. Further, since a number of other perils may lead to a fire, fire insurance policies may also be written with coverage for damage sustained as a result of explosion, earthquake, windstorm, riots, and other such disasters. Logically, it would be difficult to ascertain what damage in a building was caused by the explosion itself, for example, and what damage was caused by the resulting fire. It is therefore understandable that fire policies be written to include perils which might lead to a fire, and also cover the loss of use of a home or business.

Both marine and fire insurance are relatively simple in both the type of risks they cover, and the coverage they provide. Less clear is casualty insurance, for over the years, this class of insurance had developed past its initial reason for being, which was to pay losses caused by an accident, usually violent: such an accident was called a casualty. (While current usage of the term "casualty" often means the victim of the accident, and while this definition is indeed the first listed in Webster's, the third definition listed is the accident itself.) What then, does casualty insurance cover? Essentially, those risks not covered by marine, fire, or life/health insurance.

The following definition, taken from a policy description, demonstrates the types of coverage casualty insurance provides, and the losses for which it will pay.

Coverage on the health of persons, and for injury, disablement, or death that results from traveling, or from general accidents on land or water, and also for any liability the insured may have for injuries suffered by employees or other persons; (2) Coverage for the lives of domestic animals; (3)Coverage for damage caused by plate glass breakage; (4)Coverage on boilers against explosion and also for loss or damage to life/property such explosion causes as well as losses resulting from breakage of machinery; (5)Coverage for losses from burglary/theft; (6)Coverage to guarantee and indemnify merchants, traders, or any persons who engage in business and who give credit, against losses/damages caused by giving credit to customers and to others with whom they deal; (7)Coverage to guarantee titles to real property; (8)Coverage that insures any other risk which is legally insurable, the insurance of which is not against public policy with the condition that this section not be interpreted as prohibiting other solvent companies from issuing contracts of fidelity/surety.

Note: casualty companies routinely write fidelity/surety policies, although there are other companies that specialize in this field.

Throughout this section, we have been identifying COVERAGES rather than risks themselves. The reason for this is simple: not all of the causes of loss to human beings and to property can be insured. For example, no life insurance policy will pay if the insured commits suicide within a prescribed period of time, because while the underlying causes of suicide—extreme depression, mental illness, etc.—may be identifiable, the decision to commit suicide is not an accident as the term is understood. War causes severe losses to both life and property, but again, the extent of these losses is not predictable, nor can statistics relevant to the occurrence of wars be used in any valid way to predict when they might break out.

Actually, the dividing line between those risks insurers will cover and those they will not rests upon the control they or the insured have over the risk. For example, using the Law of Large Numbers, the actuarial departments of insurance companies can study the risk factors in a pool of similar things—people in the same age group with the same degree of health, houses constructed with similar materials, automobiles used for certain purposes in certain driving areas—and predict with a fair degree of accuracy the amount of loss the insurer stands to bear when the identified risks occur. Further, they can identify those risks which seem to be

more likely to create a loss—smoking, poor driving record, history of past serious health problems—and thus recommend rates that will compensate for the increased risk of loss. And, realizing that drivers do have control over the way they drive, even if they have no control over the driving habits of other drivers they encounter on the road, insurers can encourage drivers to maintain sound driving practices by giving lower premiums to drivers with good records, and also by giving a premium break for such things as refresher driving courses. Homeowners cannot control the decision of someone to break into their homes—but they can make it more difficult by having well-secured doors and windows, and by installing alarm systems. Again, insurers usually reward policy owners who have alarm systems which are tied in to police and fire stations with a premium break.

The suicide exclusion in life insurance policy which prevents any payment being made for death by suicide within a set period of time after the policy is issued—usually, three years—recognizes the lack of control the insurer has over the insured's decision to take his or her own life. Other acts of willed violence, such as civil insurrection and war, are excluded from policies, again on the grounds that neither the insured nor the insurer has any degree of control over these risks, and also the unpredictability of the severity of the losses such risks create.

Flood policies are an interesting example of how control over the risk is a major factor in identifying which risks may be reasonably be insured. Certainly, if structures are built in a flood zone, it may be possible to predict that a flood will probably occur. However, when the flood will occur, how high it will rise, and what damage it will cause is not easily predicted. When floods are the result of tidal surges associated with hurricanes, the losses can be astronomical, as with Hurricanes Andrew and Opal in the state of Florida. Flood insurance policies are thus subsidized by the government; further, when flood losses do occur, the insureds suffering damage may find that their flood policies do not pay the face value of the policy, but only a portion, depending on the resources in the insurer's pool.

Acts that are deliberate, and that result in harm to another person and/or to his/her property are never covered by an insurer, because the will of the insured is not controllable by the insurer. It is, of course, sometimes difficult to determine whether an act was intentional or not, particularly in cases like auto insurance fraud, where "accidents" are rigged. Nor is it always possible to detect when a reported loss, say of a heavily-insured piece of jewelry, is the truth or not—the owner may have sold the jewelry or disposed of it in some other way, and is claiming a loss where none exists. Insurance fraud costs the industry millions of dollars every year, and this is one reason why the general ethics of an insured are of interest to insurers.

In identifying insurable risks, then, the process goes something like this: first, an insurer looks at all the possible ways the human body can be harmed, either through illness or injury, and all the ways property can be damaged, and then determines the probability of their occurrence. For example, people who report that close relatives on both sides of their parentage have had diabetes run a higher risk of contracting this disease than do people whose families have never had diabetes. People who drive in high traffic areas continually are more likely to be involved in automobile accidents than those driving in sparsely populated rural areas. People who play body contact sports are more likely to suffer injuries than those who do not. Once the probability of occurrence is determined, the possible degree of harm suffered is predicted—for example, if a house is located in a fire district with a high rating for its fire department, the probability of a homeowner suffering a total loss is less than for a homeowner living in a fire district with a poor rating—or living where there is no fire protection at all.

At the end of the process, the insurer will have three broad classes of risks: those which it will never insure, such as losses caused by war; those which may be insured when certain conditions are met, and those which are always insured. The first and third classes will be smaller than the middle class, because most of the risks to person and property can be insured, though the premiums may vary quite widely as they reflect the many permutations in both human life and the maintenance and use of property. In the next section, we will examine more closely the process of classifying risks once they have been identified.

CLASSIFYING RISKS

The discussion concerning classification of risks will be divided into two general areas: those risks which threaten human health and life, and those risks which threaten property. We will begin by examining risks which threaten human health and life.

ALL human beings are subject to the common hazards of illness, injuries, and death. Thus, life insurance companies know that at some point in time, all of their insureds will die. What they do not know is when. Thus, when life insurance companies classify risks, they examine those factors which have been found to have direct bearing on human longevity. These include age, gender, physical condition, personal and family history, body physique, occupation, alcohol and drug use, morals, economic status, and special hazards.

Before looking at this factors individually, let us discuss briefly the nature of an insurance pool. As we know, an insurance pool is made up of members all of who are exposed to a common hazard/risk. Thus, in the case of life insurance, the pool is made up of insureds, all of whom are exposed to the common risk of death. However, the amount of risk various members of the pool represent varies—an insured who is fifty years old and who has a heart condition clearly presents more risk of loss to the insurer than an insured who is fifty years old and has never had a serious illness in his/her life. Why then wouldn't insurers put all of the fifty year olds who have had a heart problem in one pool, and all fifty year olds who have perfect health records in another? Wouldn't this homogeneity of risks make the process simpler? Perhaps. But it would also create a situation in which all the high-risk insureds would have to pay extremely high premiums because the insurer would be almost certain to sustain frequent losses among this high-risk group. Thus, an insurance pool will be made up of risks who share one factor—age—in common. Then, the pool is distributed along a normal curve, with each point on the curve representing a different degree of risk. Anticipated losses are then calculated, and the amount of premium that will cover the losses is distributed along the curve, so that each insured pays a premium proportionate to the risk he/she represents.

Using a normal curve to represent distributions of samples in a pool is a common device. Let us review briefly how a normal curve is arrived at. Let us assume that there are one thousand samples in an insurance pool of 50 year olds. Among those thousand samples, there will be small number—perhaps 100—who present a serious risk of loss to the insurer, because they have several negative factors which predict a relatively early death. At the other end of the spectrum is another small number of sample—perhaps 100—who are in perfect health, and thus present little risk of loss to the insurer because of early deaths. The remaining 800 samples show various degrees of risk. Some—perhaps another 100—are in almost perfect health except for one factor which increases their risk of early death. Some—perhaps another 100—have almost as many things wrong with them as the 100 who are almost certain to die early. Of the remaining 600, 300 will have some health hazards, but still, can be expected to live to an age very close to the norm for this group. The remaining 300 have an increasing number of health hazards, but still may live longer than those who are at the extreme right end of the curve.

Now the insurer has the predictable risks, and also the number of members in the pool presenting each risk. These figures are then drawn as points along the curve. A normal curve looks like this:

Note that the number of pool members at both the left end and right end of the curve is lower than the numbers in the central part of the curve. The theory behind a normal curve distribution is that the members who present little risk of early loss to the insurer will pay enough premiums over their lifetimes to build reserves against the losses from members who present a greater risk of early loss. However, those presenting little risk will pay premiums that are much lower than those presenting greater risk. Even so, the actuarial department of an insurer can calculate exactly how much premium each member of the pool should pay in so that all members of the pool are covered against loss, and so that the insurer has adequate funds for administration costs, sales and servicing costs, and loss reserves.

Why should insurers use age as the most significant factor in assigning members to a pool? Primarily because of the fact that each day that a person lives brings him/her closer to the date of death. Further, although there will be individual differences in the life experiences of insureds of the same age, still, certain societal trends can have affected them in common. For example, over the years pediatricians have changed the advice they give to parents concerning how infants should be fed. There was a time in this country when breast-feeding was not in favor, and when bottle-feeding infants was the norm. Then, breast-feeding came back into vogue for a number of reasons, most of which concern the health of the infant being fed. The natural immunities of the mother are passed onto the child when it is breast-fed. Being held by the mother in its early weeks and months of life helps reduce the trauma of being out of the womb. Therefore, fifty years olds who were breast-fed may have a different health picture than those who were not. Still other trends, such as the vegetarian habits of the hippies of the 1970's, affect people's health, and children born to hippies may well have experienced a diet quite different from other children born at the same time.

Before the relationship between smoking and a number of life-threatening conditions was determined, smoking was viewed as a harmless activity, and smokers did not pay a higher premium to reflect the greater risk of loss they presented. Before the relationship between alcohol and drug use during pregnancy and serious health problems in the babies these women delivered was established, women were not cautioned to avoid these substances. Now, such warnings are highly visible in establishments which sell alcoholic beverages.

Yet another example is the kind of protective gear now worn routinely by players in a variety of sports. Small children wear knee pads while skating and helmets while riding their bikes. Football players wear face guards and helmets designed to minimize the effect of falls and blows to the head. Runners wear shoes specially designed to support their feet and reduce the shock to their knees. Not too many years ago, men who had played body contact sports for a long period of time might demonstrate the cumulative effects of a series of concussions. Today's helmets are designed to minimize that risk.

All of these things we have been discussing are societal—that is, they are part of trends that developed at certain periods of time over an entire society. And since all human beings are born into a particular society at a particular point in time, these trends can and do affect overall health. Certainly, the number of Americans who run, walk, and work out is larger now that the relationship between aerobic exercise and healthy hearts is known.

Thus, age is the most significant factor in assigning risks to a pool for two reasons: one, all human beings age every day; two, societal trends are associated with time periods, and thus people born at a certain time will, generally speaking, be exposed to and affected by these broad trends.

What are some other factors which affect how the risk a particular human being poses to the general pool to which he /she belongs is weighed?

Physical condition is of course important. Physical condition as used here refers to the function of the vital organs of the body, primarily the heart, lungs, and kidneys of the applicant. Thus, life insurance applications contain a long list of questions designed to elicit information about the applicant's physical condition. Should an applicant answer a question or questions falsely, the insurer will have grounds for canceling the policy, based on regulations against misrepresenting significant information. When large amounts of insurance are applied for, the insurer will usually have a medical examination done by an approved source. These examinations include measuring blood pressure, administering an electrocardiogram, and urinalysis. Should an examination show the possibility of some disorder, the insurer may order a more in-depth examination be made. Or, the insured may be assigned to that part of the pool representing a higher risk, and thus will pay a higher premium to compensate for the condition.

Personal and family history are closely tied to physical condition, and thus an application for life insurance contains many questions designed to elicit information about the applicant's health since birth. Questions about surgeries, allergic conditions, impairment of vision and hearing, and the like, give the insurer a clearer idea of

how much risk the applicant poses to the pool. Family medical history is important, because many conditions/diseases are genetic. For example, a high incidence of cancer, diabetes, heart diseases and strokes in an applicant's family can indicate that he/she, too, will succumb to one of these conditions. One problem with obtaining accurate family histories, however, is that many people do not know what caused the death of relatives other than those in the immediate family—and sometimes, not even then—and also, family members have a human tendency to report the health of their family members as good unless they are, at that time, suffering from some illness or medical condition. And, while the applicant's answers to personal medical history questions can be confirmed by medical reports provided by the applicant's physician, this is not feasible in the case of other family members.

Body physique means the relationship between an applicant's height, weight, and measurements, particularly the chest and abdominal measurements. Over the years, charts designed to show the "ideal" relationship as well as all the variations have changed as medical science better understands the effects these relationships have. Generally speaking, people who, when they gain weight, distribute it over their limbs as well as their torsos, have a better physique than those who, when they gain weight, gain it mostly in the abdominal area. (We are not speaking here of people who are very obese.) The reason for this is that when extra fat is distributed over the entire body, the entire skeletal and muscular structure is supporting it, and thus the strain on the heart is somewhat reduced. When most of the weight is in the abdominal area, those muscles must work harder to support the weight, and thus the strain on the heart is greater. Calipers can be used to determine the relationship of fat to muscle, and this measurement is a useful indicator of whether or not the relationship between height, weight, and girth is within a normal range.

Occupation is also considered when an insurer assigns an applicant to a place within his/her pool. Because of an increasing awareness of hazards associated with certain occupations, such as those in which industrial pollutants present a health hazard, and legislation regulating the remedying of these hazards, the list of occupations which are considered to present additional risk of loss is dwindling. Still, certain occupations still present a higher risk than others. Obviously, people who work with heavy machinery are more subject to accident than those with sedentary occupations. Some occupations open people to increased risk of being the victim of a crime—for example, bartenders and those who work night shifts at 24-hour quick-stop markets. It is interesting that an occupation such as being a steward or stewardess on an airline which allowed passenger smoking was determined hazardous after the relationship between inhaling second-hand smoke and health problems normally associated with being a smoker was revealed. Though American airlines no longer allow smoking on any flight, there have been lawsuits against them brought by stewards and stewardesses who claim to have been adversely affected by the amount of second-hand smoke they inhaled before smoking bans went into effect.

Also, studies which demonstrate the effect of breathing "second-hand" air, such as that found in offices where the air is recirculated, thus carrying bacteria and viruses from one office to another, show that some occupations considered relatively risk-free may not be. And, as the relationship between stress and heart attacks, stress and strokes, stress and health in general, becomes clearer, people in very high-stress occupations may find themselves paying higher premiums than those in low stress jobs.

Alcohol and drug use are obviously important factors in assigning a particular member to a place in an insurance pool, since both affect health seriously. Confinement to a clinic or other facility designed to help a person overcome an alcohol or drug problem is a warning sign to an insurer that this person has a real problem, and that, while he or she may be in recovery now, still, the chance that he/she will return to former habits must be considered. People who are addicted to drugs are considered worse risks than those who abuse alcohol, and therefore, even if they have conquered the addiction, may be refused insurance altogether or required to pay high premiums because of the great possibility that they will go back to using drugs.

At first glance, it would seem that the morals of an applicant would not be of valid concern to an insurer. However, an insurance contract rests on mutual trust between the insured and the insurer that each party is dealing honestly with the other. If an applicant is found to indulge in unethical business practices, if an applicant's

credit report shows a dubious record, then the insurer will have difficulty in trusting such a person to answer questions on the application honestly, and to keep the policy in force. While it is true that an insurer may invalidate a contract if it learns that an applicant has misrepresented one or more vital facts on the application, some misrepresentations may be difficult to detect. Even when the insurer does detect the misrepresentation, and cancels the policy, it will have sustained a loss, since the administrative costs of putting a policy into force are higher than the costs of maintaining it.

The economic status of an applicant is important for two reasons: first of all, is the amount of insurance applied for appropriate in terms of that
person's economic status, and second, can the person afford to keep the insurance in force? For example, if a person making $30,000 a year applied for a multi-million dollar policy with an annual premium of $10,000 or more, several questions would immediately arise, the first and most important being how the applicant intends to pay this premium? Yet another question would be whether or not the insured has some scheme in mind. For example, there are many, many cases on record where one spouse took out a large insurance policy on the other spouse, and after a short time, the insured spouse met with an untimely, often violent, death. A recent case demonstrating this is that of a young man who worked as a mechanic at an automobile dealer. He had begun gambling heavily, and was seriously in debt. Afraid to face his wife with the fact that he had mortgaged their home and anything else of value, he took out a $100,000 policy on her life. Not six weeks later, while sitting in their car outside a movie theater waiting for her husband to come out, the wife was killed by two men who fired a shot-gun through the car's open window. The grieving widower put on a good show—but it was not too long before one of the hired gunmen turned himself in. Life insurance fraud is on the rise, and so delving into the economic status of an applicant can reveal hidden risks.

Finally, there are special hazards which may mean higher premiums for applicants. People who indulge in recreational activities that, while challenging and adventurous are still dangerous, may expect to pay a higher premium for life insurance than those members of the pool whose leisure time is spent in less hazardous ways. For example, such activities as sky diving, hang gliding, skin diving, and mountain climbing obviously have a greater potential for harm than such activities as tennis, golf, or bridge.

ASSESSING RISKS

Once risks have been identified and classified, the final step is to assess them in terms of the potential frequency and severity of the loss experience. This assessment process is carried out by the underwriting departments of insurers. Until the 1970's, underwriting departments were not regulated by either the states or the federal government. However, during the seventies, a period of dramatic social change in this country, the ways in which premiums were developed and assigned were challenged by a number of groups, and by individuals. These challenges focused on certain practices which underwriters used in determining loss experience, and thus, rates. Individuals and groups saw some of these practices as discriminatory, and laws were passed affecting them. Thus a trend began that forced underwriters to adapt to a new way of doing things, and to use statistical proof rather than experience as the primary factor in determining rates. Statistical proof in itself may be a valid way to arrive at a conclusion, but only if sufficient samples are available to create the statistical base. As we shall see later, such is not always the case.

Before looking at the methods used to assess risks at the present time, let us briefly review traditional underwriting practices.

The foundation of traditional underwriting practice is to assess loss experiences, and then to determine what factors seem common to certain types of loss. For example, automobile insurance underwriters could see, from loss records, that male drivers under age 25 are responsible for a greater number of accidents than are female drivers under age 25. Thus, male drivers under age 25 represent a higher risk of loss to the insurer than do female drivers under age 25, and so pay a higher premium.

Over time, underwriters could see that some risk factors almost ALWAYS produced a high loss experience. For example, drivers who had been involved in a number of vehicular accidents in which they were at fault were far more likely to continue to have such accidents than those drivers who had never been the cause of an accident. Such high risk drivers are refused insurance by normal means, and are put in a pool of their own. Then, each auto insurer doing business in that particular states takes a proportion of this high-risk pool that is equal to the proportion of business the insurer does in the state.

Underwriters in the auto insurance field looked at loss experience in terms of the accident record of an applicant, as well as accident rates by number of accidents in a set prior period. Liability for the accident was also considered, though a study of cases where a driver found not at fault could have prevented the accident by taking defensive measures led to the concepts of contributory negligence and comparative negligence The number and types of traffic violations were also considered, with certain violations, such as drunk driving, being considered much more serious indicators that this person would cause severe loss to the insurer. Moving violations, such as running a stop sign, are always seen as more serious indicators of a possible loss than non-moving violations, such as letting a parking meter expire. Using the Motor Vehicle Records departments, underwriters can learn the driving record of an applicant, and make a determination as to the probable risk of loss the applicant presents.

Determining probable loss for property insurance proved more difficult, since the risks to property, while real, are less predictable than those to vehicles. A vehicle is, after all, operated by a human being, and his/her driving habits have a very definite effect on the amount of risk. But risks to property are not so clear-cut. For example, the fact that all of the residences insured by standard fire policies have electrical wiring systems does not help the underwriters to predict when and if these systems will cause a fire. Of course, in obvious situations, where, for example, a building's electrical system has been found not up to code, the insurer will have specific information. Otherwise, there is little real evidence to help underwriters assess the risk of an electrically-started fire.

How, then, did underwriting departments assess property risks? Primarily, using their own property loss records as a WHOLE, without particular regard to individual risks. And, property insurers often exchanged information so that the base of information could be broader. Of course, underwriters did have some factual material which helped them assess the possible loss a certain property posed. Residences made of masonry with little wood in their construction could be expected to suffer less structural damage than those built entirely of wood. The contents of a residence or building could be assigned a value based on what they had originally cost, and what the replacement cost would be. But essentially, the professional experience of underwriters was the major determinant when property insurance rates were set. Thus, a combination of verifiable facts and the intuitive experience of underwriters produced rates for both residential and commercial exposures.

Out of this combination, certain factors became indicators of the acceptability or non-acceptability of a particular risk. First among these is the condition of property. Buildings, whether residential or commercial, that are well-maintained and cared for testify to an owner who is concerned with his/her property, and an insurer can then anticipate that losses due to neglect will not be a problem. Buildings become more subject to certain risks as they age: traditional underwriting practices normally insured buildings over 25 years of age with great caution, and were even more reluctant when dealing with buildings over 50 years of age. The reasons for this caution and reluctance were varied. One, as buildings age, their electrical and mechanical systems also age, and may develop faults which can lead to a loss. Or, the usefulness of the building might be limited because it is not up to modern technological requirements for its particular function. The desirability of the location of the building can change, as neighborhoods change. For example, in many cities, residences near the down-town area have lost value as commercial establishments grew up around them, and as other residences were turned into offices and shops.

Yet another factor underwriters formerly considered was the value assigned to a building. However, since most dwelling and homeowners policies are written on a replacement cost basis, a problem arose. Older structures may have an actual value—what they would bring on the open market—far less than their replacement value.

Although insurers could require policyholders to insure a structure to at least 80% of its replacement cost, if, for example, a house would bring only $60,000 on the open market, but would cost $120,000 to replace, the difference between the two amounts was seen as a negative factor to insurers. Why? Simply because even if the house is insured to 80% of its replacement cost, this is $96,000--$36,000 more than the insured could get if he/she sold the house. Insurers felt that a moral hazard now existed-—nsureds could very well be tempted to set fire to their own houses in order to collect the insurance, and pocket the $36,000 difference between what they would have gotten if they had sold the house, and what the insurance on it paid. Thus, traditional underwriting practice was to refuse to issue polices which seemed to over-insure the buildings covered.

Whether or not a structure is occupied, and how it is occupied, was another condition of interest to underwriters. The ideal condition for residences was for the owners to occupy them. Residences that were occupied by tenants were considered to be at higher risk for loss, while those totally vacant were seen as highly undesirable, for obvious reasons. Commercial exposures also had to meet occupancy guidelines under traditional underwriting practices. An office building occupied by workers twenty-four hours a day, three hundred and sixty-five days a year, as some are in large urban areas, was clearly a more desirable risk than a warehouse occupied by an occasional visit from a security guard. And, at that time, underwriters often ignored the many factors that could reduce risk of loss, regardless of occupancy, such as fire and burglar alarms, sprinkler systems, fences, etc.

The neighborhood where a particular property was located was also a factor in determining risk, with some neighborhoods seen as being unacceptable, and others seen as being most desirable. Certain neighborhoods have higher crime rates than others, or contain businesses with a greater potential for accidental fires.

And just as age is a factor in driving, property insurers found that older homeowners often are not able to maintain their property as well as younger ones, because of disability or lack of income. Further, older homeowners are more likely to leave a stove burner or iron on, thus increasing the risk of fire.

Marital status, under traditional underwriting practices, was a guide to the stability of the environment in which the property was housed. The ideal situation, for an insurer, was a married couple with a family. People of opposite sexes who lived together were deemed unacceptable, on the grounds that the relationship was not stable, and that even if an acceptable partner lived with an insured at the time the insurance was written, a less acceptable one might move in later. The rise of communes presented an even more difficult situation, with commonly owned property used by a number of people, the identities of which could fluctuate over time. Traditional underwriting practices also looked upon single, separated, widowed and divorced homeowners as higher insurance risks, because people in these categories lead lives in which a number of factors can contribute to instability. One factor is economic—these people often have less income at their disposal than do married couples. Another factor is emotional, particularly in the case of separated and divorced women, who may not be able to adequately maintain their property. Widows and widowers are, as a rule, more stable than others in this group, but that, too, is an individual situation which requires a judgment call on the part of the underwriter.

Certain occupations, under traditional underwriting practices, were considered more hazardous than others, in terms of potential loss. For example, people whose occupations require a great deal of travel could be exposed to more possibility of theft because of the items they carry with them, both personal items, and items related to their business, such as samples. Underwriters translated frequent travel into enhanced risk, and thus put limits on people who traveled a great deal in their line of work, or, more specifically, might give a certain number of weeks as the limit of travel allowed. And, if persons sustaining a loss of some valuable while traveling had not followed the insurer's requirements to protect the item against loss, the insurer would not pay.

Traditional underwriting practices also penalized people who could be considered transient. Transience was equated with instability in the insurers' minds, and so many occupations were on the unacceptable list, including such occupations as barbers, beauticians, house painters, bartenders, taxi drivers, and others who can pick up their skills and move. Also, traditional underwriters looked upon entertainers, especially those performing in

night clubs, as high risk, because of the environment in which they worked, and the possible exposure to alcohol and drugs, as well as a possibly higher risk of theft. And, surprising as it may seem, underwriters found that the loss experience of clergy in terms of automobile accidents was higher than the norm, whether because members of the clergy tend to live in their heads more than other people, and thus be less aware of driving conditions around them, or because of a blind trust that a higher power will watch over them.

The main factor which all of these considerations had bearing on was stability, both economic and personal. Stable people are more likely to take care of themselves and their property, to observe the laws, to protect themselves against foreseeable risks, and to handle financial matters efficiently. They therefore pose less risk to the insurer than people whose lives are chaotic at the worst, and, at the best, disorganized. Questions concerning length of residence and length of time at one job give insurers information that leads to judgments about the stability of an applicant.

Other factors that made an applicant less acceptable under traditional underwriting practices were such things as having a criminal record, mental incompetency, physical impairments, and alcohol and drug use. Also, applicants whose use of English indicated that they would have a difficult time reading traffic signs or communicating with the insurer were considered a higher risk. Thus, the ability to speak English was a factor in obtaining insurance.

Often, an applicant for a policy had a better chance of obtaining it if he/she had related insurance with the insurer, because much of the information regarding a policy already in force would pertain to the policy being applied for, thus reducing costs of investigating the desirability of the risk. Further, since some insurance lines produce more profit than others, underwriters might require the higher profit line as a condition to issuing the lower profit line.

And, the insurance history of the applicant was a consideration under traditional underwriting practices. If an applicant for insurance had never had that type of insurance before, a logical question would be why? And, if the applicant had had insurance, but it had been canceled, that, too would give the underwriter valuable information.

As we stated at the beginning of this section, after the 1970's, traditional underwriting practices came under attack, and in the decades since then, many changes have been made. Even loss history, which is by far one of the most significant predictors of the possibility and probability of loss, has been examined, and changes have been recommended. While the actual loss experience, for example, the accident record of a particular applicant, is still considered a valid factor in setting a premium for that person's insurance, several aspects relative to that accident record have been challenged.

One of these is the concept of fault. The general view now is that insured drivers should not be penalized with an increase in premium when they are involved in an accident in which they were no way at fault. Conversely, if a driver involved in an accident essentially caused by someone else could have avoided the accident, but did not, the general view is that he/she should be found liable for contributory or comparative negligence, thus reducing the total liability of the other driver.

Again, some insureds drive commercial vehicles and also their own personal automobiles. If their accident record, or traffic violation record, from both these vehicles is used as one record, the record from one vehicle may adversely affect the premiums on the other. For example, someone driving a commercial vehicle does not have the same control over hours driven and routes driven as someone driving a personal automobile. Current thinking is that only the accident and traffic record of the vehicle to be insured should be considered for rating purposes.

The use of past loss records in regard to such lines as homeowners' insurance also came under attack, because some losses might have been caused by perils over which the homeowner had absolutely no control, such as hurricanes, tornadoes, and the like. Further, the tradition of putting higher rates or refusing insurance

altogether on structures in undesirable areas has been attacked on the grounds that if the property under consideration meets all safety and structural codes, the neighborhood surrounding it should not be a factor in determining the premium for insurance on it.

Traffic violation records are still an important indicator of a driver's loss potential to the insurer, but there is a difference in being cited (given a ticket) for a traffic violation, and being convicted of it. Thus, insurers are warned not to consider citations in determining premiums, but only convictions for traffic violations.

In terms of the condition of property, critics of traditional underwriting practices emphasize that only those conditions which are directly relevant to a particular risk be considered. For example, lack of lighting in stairwells used by employees might well be a negative factor that would make a certain building an unacceptable risk, but the fact that the carpet covering the stairs is worn and stained should not be considered.

Those underwriting practices which treated the age of a building as a primary reason for rejecting coverage or raising premiums came under particular attack, since the age of a building is not necessarily an indication of its risk potential. Many older homes and commercial structures have been carefully restored/renovated, with all systems brought up to code. Critics of this practice felt that certain neighborhoods where almost all of the residences or commercial structures dated from a certain period were actually the target of the practice. They pointed out that such a practice kept home and business owners in the urban core of many cities from being able to purchase insurance.

In answer to these critics, the National Association of Insurance Commission developed the Property Insurance Declination, Termination and Disclosure Model Act. This model gives seven acceptable reasons for canceling property insurance policies on dwellings of not more than four residential units and/or on the personal property contained therein. The seven reasons are: nonpayment of premiums, fraud or material misrepresentation by the named insured in obtaining, continuing, or presenting a claim under the policy, willful/reckless acts or omissions which increase any hazard insured against, a change in risk which increases the insured hazard substantially after coverage has been issued/renewed, violation of local fire, health, safety, building or construction regulation/ordinance with respect to insured property or the occupancy thereof which increases an insured hazard substantially, determination by the state's Commissioner of Insurance that to continue the policy would mean that the insurer violated the insurance of the state, and finally, if real property taxes on the insured property have been delinquent for two or more years and continue to be delinquent when the notice of cancellation is issued, the policy may be terminated.

State FAIR Plans came into being in the late 1960's, addressing the problems critics saw in the requirement that insurance be sufficient to cover 80% of the replacement cost of the structure. As we noted earlier, this requirement meant that many people whose homes would bring, say, $60,000 on the open market would then be forced to purchase insurance that would pay 80% of the cost of replacing the home, which could be $120,000, meaning that the owner of a house worth only $60,000 on the market would carry $96,000 worth of insurance, with the commensurate premiums. The core provision of FAIR Plans is that insurers may not verify property values and establish insurance-to-value rules in the areas to which the plans apply. However, it is because of this provision that the loss ratios of insurance under FAIR Plans has been higher than those ratios on insurance written according to underwriting guidelines.

Another change brought about by critics of traditional underwriting practices is that the use of devices which protect a building from certain insured hazards can compensate for the fact that the building is unoccupied for stretches of time. Smoke alarms and burglar alarms, particularly when tied to a monitoring system that sends firefighters or police, are seen to lower the risk of fire and theft in unoccupied or occasionally occupied buildings. Burglar bars, fences, the use of guard dogs—all of these are now recognized as lowering the risk unoccupied buildings pose.

The criticism that received the most widespread publicity at the time it was made was the one directed toward an underwriting practice that made the location of a piece of property a primary consideration in determining

whether to underwrite the risk. The term "redlining" was used to summarize this practice, which, essentially, refused insurance on properties within a certain boundary. (The term originated in the mortgage loan business, when a red line was drawn around an area within which mortgages would not be made.) When insurers adopted the practice in the aftermath of urban riots and conditions known as "urban blight," one effect was that an individual property-owner no longer had the option of purchasing insurance on that property, even if the property were in great condition, and was protected from hazards insured against. A secondary effect was that individual property owners were thus discouraged from improving their property, for, unless the entire "redlined" area was rehabilitated, they could not purchase insurance. And, in areas where redlining was practiced, a vicious circle was set up. Since property owners could not insure their properties, those who could left the area. Those who could not stayed, but, since they usually had low incomes, the properties in which they lived deteriorated further, making them even less acceptable insurance risks. Now, geographic location cannot be used as a sole criteria for denying or rating insurance.

The use of age as a factor in assigning people to automobile insurance pools has come under increasing attack, as drivers at both ends of the age spectrum rebel against being put into a higher risk category when their own driving records are good. These drivers believe that an individual's driving record is a far better indicator of potential risk of loss to the insurer than is age, and statistics have borne this belief out. Thus, there are now state laws and regulations which prohibit an insurer from considering the age of applicants for automobile insurance as a factor.

As with age, sex as a factor in underwriting has been criticized, and the NAIC formed a Sex Discrimination Task Force to investigate charges that using gender was discriminatory. Even assigning males under age 25 to a higher risk pool because loss experience has shown them to be involved in more accidents than females in that age group has been criticized. Critics use the rationale that for many years, young males drove more frequently and for longer distances than did young females, and that the higher accident rate was a consequence of more miles driven, not a more reckless attitude. If this proves to be the case, then putting a higher rate on a male driver just because he is under age 25 could be termed discrimination. Similarly, while women normally live longer than men, and so are better risks for life insurance companies, they make use of health insurance to a greater degree, and so in the past, some insurers have put restrictions on the type and amount of health/disability insurance they sold to women. Along with all the other changes in health insurance, this situation, too, has changed.

A major change in underwriting practices is one regarding using marital status as a factor in issuing or rating insurance. Socioeconomic changes in the past fifty years have been dramatic, and rules that used an applicant's marital status as an indicator of risk are now looked upon as intrusive into a person's private life. Underwriters now are commonly prohibited from using marital status in their determinations.

Yet another societal change that has compelled changes in underwriting practices is the trend toward two-income families, or households headed by a single, working parent. In such circumstances, the residence is unoccupied during the day, a situation that many underwriters formerly used as a reason to deny or put a higher rate on insurance. In the face of a society where working women/mothers are the norm rather than the exception, such a practice is seen as discriminatory and unfair.

The guidelines regarding travel have also changed, with underwriters no longer being allowed to lump all business people who travel a certain number of miles per year, or a certain number of weeks per year, in the same pool. Individual risk factors must be assessed and considered, such as the value of merchandise carried, the mode of transportation, safety precautions taken, etc. The same changes have occurred in regard to insurance for people in occupations formerly termed "transient". Individual situations are to be examined, and determinations concerning the acceptability of the risk are to made on an individual basis, not on the basis of assignment to a broad occupational class.

It is highly important to insurance companies that their insureds be stable individuals who can be counted upon to pay their bills, take care of their health, and maintain and protect their property. But some of the subtle,

almost intangible, cues underwriters formerly used to determine the "stability" of a prospective insured can no longer be used. They must now be careful to avoid arbitrary decisions, and to use guidelines which can be statistically supported.

A factor related to stability, but perhaps easier to substantiate, is the factor of social adjustment. Such conditions as a criminal record, mental incompetency, physical impairments, and alcohol and drug use are easier to determine, and insurers are on firmer ground when they refuse or put a higher rate on insurance when one or more of these factors is seen as increasing a risk, or presenting an unacceptable hazard. However, underwriters must be prepared to demonstrate that there is a clear relationship between the condition and the risk, and that their decision is not made arbitrarily.

Using knowledge and use of English as a factor in underwriting a risk is no longer allowed. The determining factor is whether an individual has been issued a driver's license by the state in which he/she lives. If so, then insurance must be made available to that person, and must be issued if all other criteria are met.

With the rise of public interest in the rights of individuals, such practices as requiring an applicant to purchase a higher profit policy with the insurer before the lower profit policy will be issued are no longer permitted.

And, as provisions in the NAIC Property Insurance Declination, Termination and Disclosure Model Act make clear, insurers may not decline or terminate a policy because the applicant has previously been denied coverage by another insurer, or had a policy terminated by another insurer. Further, the fact that the applicant formerly had insurance in a residual market insurance mechanism cannot be used to decline or terminate coverage.

All of these changes reflect the susceptibility of insurance of all types to societal trends. As we said in the beginning, insurance is a social instrument, working in the context of a society to offer protection to individuals as well as to society as a whole from identifiable and insurable risks. Societal attitudes have a way of swinging from one extreme to the other, as even a cursory survey of our nation's history will show. At the present time, rights of individuals are being stressed, even to the point of naming as a "right" something which in former times was considered a reward for effort. But because the insurance field is composed, not just of the insurers themselves, but also of the agents selling and servicing polices, and the policyholders who purchase insurance in all its forms because of its value to them, there is a built-in flexibility in the interaction among these various segments of the industry that, ultimately, achieve the goals of insurance in ways that suit the greatest numbers of those affected by it.

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