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MARKET CONDITIONS

There is a four letter word that most agents use to describe the recent and near-term P&C market. . . soft. The late 90’s have seen a significant decrease in general pricing (premiums) while underlying claims, in most cases, have gradually increased. Many say that the two conditions actually crossed and the result is finally beginning to show up on company balance sheets.

Industry experts point to the fact that the soft P&C market is nothing new. In fact, the last “hard” market was in 1985. The exception has only been in a few geographic marketplaces and certain types of P&C business. For example, homeowner lines tightened considerable after the Northridge, California earthquake where large direct writers decided they didn’t want to write anymore earthquake coverage.

If there is one bright spot on the horizon, it is the fact that new carriers are not showing up as quickly as they used to. In addition, the old players are becoming more restrictive in their underwriting requirements. While these facts have not produced a clear hardening trends or any significant price firming, experts are happy to declare that it is not getting any softer.

In the meantime, insurers and agents alike need to find areas where they can serve the insuring public better and do a better job for them.

MERGERS & ACQUISITIONS

Mergers and acquisitions continue to sweep the industry as carriers look for ways to consolidate overhead and remain competitive. For instance, half of the personal lines auto market is in the hands of seven giant carriers. The remaining 300 or so companies have less than 1 percent of the market each. All are now staking out strategies for their survival.

Financial deregulation is another force that is driving acquisitions. Carriers may need to align themselves with stronger rivals to compete against banks who are marketing a host of insurance lines.

Also, any potential downturn in the investment market, which has remained strong for years, could force smaller carriers to form strategic alliances.

Multi-line insurers, in particular, are finding it difficult to efficiently write both commercial lines and personal lines. Many are in need of streamlining their operations by selling a portion of their business.

PERSONAL LINES

For the personal lines industry, the last several years have been a blur of disappointments. The homeowners market has suffered unprecedented catastrophe losses placing many insurers in an unsteady position. It began with Hurricane Hugo in 1992. Then came the Northridge earthquake and more recently Hurricanes George and Floyd. Industry sources quote national losses to be $10 billion in 1998 compared with just 2.6 billion in 1997. This is an increase of

A “soft” P&C market is nothing new. The last hard market was 1985.
300 percent. Premium growth, on the other hand, rose only 7 percent in 1998. And, the growth in homeowners is described as strong compared to other lines.

For personal auto lines, major mergers have resulted in almost half the business being controlled by seven giants. These major players wrote 53% of the premium in 1998 while the remaining 300 or so carriers did less than 1 percent each. Even with a few companies in charge, price competition has put the squeeze on profits.

In this type of market, securing a niche has become more important. Small companies, for example, who simply can't compete with the giants, have begun to specialize. The non-standard auto market, for example, is a specialty area that insures risks for drivers who don't meet standard criteria because of poor driving records or other problems. Over the past several years, this market has seen above-average growth rates and favorable loss ratios. It has also been a large part of the mergers and acquisitions taking place.

One reason that the non-standard market has grown so rapidly is its ability to draw from state-assigned risk pools. Given a choice, drivers would much prefer to do business through voluntary carriers.

Direct-response auto writers have also making major growth inroads. Here, drivers are responding to reduced premiums and other discounts above all other concerns.

**COMMERCIAL LINES**

In response to extremely soft market conditions, commercial property and casualty insurers, who have been eager to maintain and grow premiums, are taking more chances by writing risks that were formerly written by surplus carriers. That, in turn, has made things difficult for the surplus lines sector which has again started new price competition.

Another major issue effecting the commercial market is *deregulation*. There is a deregulation trend that is gaining support state by state. The lines most impact include commercial auto, general liability and commercial multi-peril – a combination of general liability and property coverage. Workers’ compensation is excluded in most states as is medical malpractice.

In addition to general soft market conditions, the impetus for deregulation is the departure of large commercial risks from the admitted markets to self-insurance and other alternative risk-transfer markets.

Deregulation would save money for carriers by eliminating the need to address special regulatory requirements across state lines. Policies that had to reflect multi-state jurisdictions would go from “bible thick” documents that are very costly to produce to more tradition arrangements. The real cost savings, however, would go to the insured businesses because they would finally be able to purchase the coverages they specifically need.

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*Deregulation and new legal interpretations of CGL policies top the concerns of all commercial line carriers and agents.*

Some in the industry worry that deregulation would exempt insureds from the protection of state guaranty funds that cover when an insurer fails. Others argue that the protection offered by the funds is only the “top layer” of coverage that most corporations could write off as a deductible or retention.

In other casualty matters, recent court decisions have and will greatly effect CGL policies. In the past two decades, a precedent case (International Surplus Lines vs Devonshire) held that CGLs cover only those liabilities arising from torts. New cases (Vanderberg vs Superior Court of California) now say that CGLs cover BOTH tort and contractual liability. The underlying reason that courts ruled against insurers is the CGL phrase “legally obligated to pay as damages’ describes liability based on
breach of duty imposed by law, i.e. tort rather than contract”.

The courts rejected the distinction between tort and contract liability saying “A reasonable layperson would certainly understand ‘legally obligated to pay’ to refer to any obligation which is binding and enforceable under the law”. Experts feel that this decision could have far-reaching negative effects on insurers across the country, just as the International case had positive effects when it was decided in 1979.

MULTILINE INSURERS

Multi-line insurers are finding it increasingly difficult to efficiently write both commercial lines and personal lines and still remain competitive. The pressures of low premium growth and high claims are the main culprits. Added competition from financial service deregulation players like banks is also a factor. As discussed below, these market conditions in the multi-line arena has and will likely lead to “sell-offs” or consolidation of entire divisions.

SURPLUS LINES

Surplus lines coverage is insurance coverage not available from an admitted company in the regular market. Recent times have been tough for the surplus lines market with new competition coming from admitted insurers who are writing higher risks than before to bolster profits. Many predict that this will lead to a consolidation of specialty insurers and wholesale brokers since there are better economics where two small companies, with two sets of overhead, combine into one operation.

Surplus lines carriers are also worried about deregulation in the commercial marketplace. Deregulation would simplify the writing of new risks or unpredictable markets for admitted companies. These are the very same markets where the surplus lines industry has made their mark. For example, surplus carriers insure gene-splicing and batteries for heart pacemakers. There were also the first to cover communications satellites and day-care centers. Because they take these risks there are not subject to rate-and form-filing requirements. Deregulation could eliminate many of these same obstacles for admitted carriers making the market highly competitive.

Many in the surplus lines industry believe that deregulation will lead many surplus carriers to become admitted. While this could be seen as a bonus for consumers, who will not be doing business with someone who is regulated and examined by the state, it will add to the operating costs of these same carriers who had previously made their mark through innovation and price. As an admitted carrier, they won’t be so light on their feet.

WORKERS’ COMPENSATION

The statistics are gloomy if not frightening for worker compensation lines. Written premium is down and underwriting results are dismal. Extreme price competition and the severity of claims are to blame. Some are predicting an “underwriting blood bath” on the horizon with considerable damage to insurers and their stockholders.

Another problem, say industry experts, is the fact that high employment rates have resulted in a lot of unskilled workers being assigned to skilled jobs. This ultimately leads to more accidents and workers who are more prone to lingering injuries.

ALTERNATIVE MARKETS

As a means to retain market share and remain competitive, agents and brokers are exploring many alternative markets including:
Risk purchasing groups. These associations are formed by members of a homogenous group seeking purchase cost- and coverage-effective liability insurance.

Risk retention groups. Two or more entities that combine to form and charter a licensed liability insurance company under the auspices of the 1986 Risk Retention Act for purposes of sharing the liability risk of its members.

Captives. An insurance or reinsurance company formed and owned by a noninsurance company, a group of insureds or others wishing to insure or reinsure the risk of owners, their affiliates, or the third-party profit center risks stemming from the owner’s activities.

Rent-a-captive. These companies “rent” their capacity, certificate of authority and reinsurance arrangements. They are typically located offshore to enable them to write third-party business without restrictions.

Agents competing against direct sellers or direct response companies are retaining major portions of their business by packaging and transferring known risks among their client base to rent-a-captives. Premiums are more competitive here and agents can exchange a percentage of risk for share of any ultimate underwriting profit.

Self-insured trusts. Two or more entities can form a self-insurance trust under special state and/or federal enabling laws allowing true risk-sharing or pooling. These arrangements are commonly used to self-fund medical and employee benefit plans.

Self-insured pools. Similar to self-insured trusts, two or more entities can combine to form a self-insurance pool under special laws allowing risk-sharing or pooling.

Self-insured retention plans or SIRs. Here the insured purchases excess insurance through a primary insurance company or E&S carrier over a deductible or a self-insured retention.

Special capacity facilities. These companies are typically organized offshore captive domiciles. They are designed to offer substantial excess insurance capacity over the working layers that standard group captives write.

THE INTERNET

In all areas of sales, customers are getting used to going “online” to learn more about products and services. Internet purchases are expected to rise from 123 million in 1996 to 600 billion in 2000. The growth is so rapid that consumer expectations in this area are changing about every 12 months: a cycle that is much quicker than the insurance industry is accustomed to.

Some feel that agents and insurers are well behind the times in keeping up with the technology changes. Others are fighting the change, electing to stay on a paper-based system in hopes that their clients still value the “personal relationship” enough to bypass use of the Internet.

While this may work for some, the fact is that new market groups are entering the system. People who are in their 20’s – the “Nintendo generation” -- are becoming agents as well as day-to-day consumers. To them, computers and the Internet are just another tool. These people will be thinking about creative and expanding ways to use the Internet for faster, effective consumption of goods and services. As their numbers, and the generations behind them, become major players as consumers and competitors, it will be harder to ignore an Internet presence.

The biggest fear of agents is the prospect that the selling of insurance online could increasingly cut out the middleman.
out the middleman. Direct sellers are already surfacing and competing with agents at reduced rates. Agents and brokers are fighting back by finding ways to “add value” to the equation. For example, one major broker is developing a “global brokering system” so its agents and offices around the world can trade placements electronically with carriers. Another is building its technological services and capabilities simply to expand its level of customer service.

The Internet is also a means of point-to-point contact with insurers and their representatives. Companies are discovering they can cut down on everything from office supplies to phone calls to wasted time with online forms and e-mail. Agents are also connecting to their clients using their websites as newsletters and sources of other information. Some customers use e-mail to request policy changes and upgrades. Others are reaching out to market areas beyond their own city or state.

Still others are using the Internet to find a special niche in the market, e.g., the sale of term life insurance using instant quotes from multiple carriers. The non-standard automobile market is another area where drivers with multiple accidents can go online to research their options. Some companies already boast the ability to upload information, get a policy number and billing information, bind coverage and let the customer know they’re protected, all within minutes!

Despite the successes, there are still many obstacles to full-scale online selling of insurance. To begin with, there are still many concerns about security. People are still not used to sending their credit card number out into cyberspace even though the experts say that a secured site is safer than using a cordless phone to place an order with a live sales agent. The internet is also lacking in areas such as electronic signatures, specimen collection and the benefit of face-to-face contact that is sometimes crucial to underwriting.

**DISTRIBUTION CHANNELS**

Insurance companies are still not sure how they want to deliver their products and services. The agent and broker network is still extensive and the most palatable. But, direct marketing is substantially on the rise with companies using telephone, mail and media to generate qualified leads. Others are experimenting with electronic media, using commercial online services and the Internet, selling policies through kiosks and interactive video facilities in non-traditional settings such as post offices, banks and travel agencies.

In making the choice between the use of agents or direct marketing, the most basic trade-off is cost vs. service. Although start-up and initial acquisition costs can be high, direct marketing can significantly reduce costs over time, while agents and brokers typically offer a greater degree of service based on person-to-person contact.

For the meantime, the experts believe there is no single distribution channel that is right for every market or product. There could be a need for both and possibly some opportunities for synergism between the two. For example, could direct marketing be used to generate sales numbers while agents are introduced to improve retention?

Already, more than one-third of the top property / casualty insurers writing personal lines are using multiple distribution channels that may include some combination of independent agents, captive agents, the Internet and banks. Multiple distribution channels for commercial lines are also on the rise using a combination of agents / brokers / managing general agents, exclusive agents and direct access.

Some doom-and-gloomers believe that this massive shift in thinking has started an erosion of the
independent agent system. Certain agents are responding by mass marketing their products and services or segmenting the population into those who value their service and are willing to pay more as a result. Associations like the IIAA are also helping agents by providing guidance in how to partner with banks.

Through all the changes in distribution it is interesting to note that the bulk of personal lines market share that national agency companies have lost in the past few years has been picked up not by direct writers but by regional agency and captive agency insurers. This reinforces the notion that, for the meantime, that customers still value the role of the insurance advisor.

AGENT SERVICES

Clients are looking to agents to provide services that were once handled internally, i.e., loss prevention, claims services, risk analysis, etc. A good example of requested new consulting services is injury management in the workers' compensation area or working with clients to analyze, assess and decide how they can reduce or transfer risk in the broad sense. Ten or 15 years ago, these were conversations that had to be referred to the insurer or an outside consulting firm.

The general “business mix” is also requiring a shift in services and consulting. The middle and alternative market areas are special areas of opportunity where agents can bring their existing client base. In many cases, agents are moving clients into these markets simply to be able to compete against direct sellers who are offering lower premiums and discounts.

The “geographic mix” is also changing as the Internet allows businesses to reach out to distant cities, states and countries. Some major agencies, for example, are finding more growth potential in places like Latin America and Asia Pacific. Even places like Japan, where regulations have restricted outside participation, are changing and creating opportunities for brokers to deliver new services.

REINSURANCE

The reinsurance marketing has taken some heavy blows in recent years. The demand for traditional reinsurance products is falling as buyers look for new approaches that bring together reinsurance and investment banking techniques to manage both capital and risk. In addition, record losses from hurricane and earthquake catastrophes have shaken reinsurance capacity. The reinsurance catastrophe market has become so soft that experts believe that future capital needs may need to hinge on alternative risk transfer techniques (ARTs) that harness the capacity of the securities market.

Another major dent in the reinsurance industry is the Unicover Pool fiasco. The players here included primary insurers who were ceding away significant amounts of their potential losses while only retaining a relatively small exposure; managing general agents who were given too much writing authority without adequate controls, and the Unicover pool who was packaging blocks of business for reinsurers where premiums received did not cover the risks assumed – primarily workers’ comp business. High levels of losses have resulted and shaken the entire industry to the core.

Industry people believe that the sum total of this problem is that reinsurance and workers’ comp are going to be harder to come by and more expensive when you can. In essence, this is a huge wake-up call for the industry. Agents who were not fully aware of their company’s reinsurance arrangements should be more alert in the future.
TORT REFORM & LAWSUITS

Recent years have seen some legal caps on non-economic and punitive damage awards. This fact, combined with improved loss control should be encouraging to the insurance industry as a whole. However, the disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits.

Lawyers say the industry should expect new cases to attract massive numbers of complaintants and have a wider scope, reaching beyond manufacturers and sellers, to building owners, landlords, contractors and public housing authorities.

Technology is also playing a role here. A case in point: Two Illinois residents recently filed a class action lawsuit against State Farm concerning the use of non-factory authorized parts to repair their vehicles. Their lawyers established a website to recruit additional litigants Other lawyers say they use the Internet to look for opportunities in class action insurance claims.

In essence, people today are not waiting for something to happen to sue, they’re out looking for vulnerabilities. Some of the emerging legal battles include Y2K computer problems, Fen-Phen and Redux diet drugs, latex, construction product defects (plastic pipes), intellectual property rights (copyrights, inventions, trademarks, etc), tobacco, asbestos, lead and carbon monoxide.

In some cases, the insurers themselves are taking pro-active roles in mounting multi-million-dollar lawsuits against their own policyholders as in the case of manufacturers of polybutylene pipes for residential and commercial construction projects.

THE BUSINESS OF INSURANCE

Although procedures and techniques change over time, the underlying goal of any property / casualty insurance company is solvency and growth. Staying focused on this goal is often complicated by the ebb and flow of intense issues like premium rate wars, politically inspired regulatory compliance and even government mandates. Still, insurers must carry on with the business of insurance -- collecting premiums, paying claims and investing capital. Beyond pure financial planning, the business of insurance must contend with the nature of the business itself. Property-casualty insurance, for instance, is a highly cyclical business that does not necessarily coincide with the general economy. The reasons involve factors of competition, fluctuating investment performance, regulatory delays, rate restrictions and, of course, unexpected catastrophes courtesy of mother nature. Life insurance companies too, are experiencing wider swings in business than in years past due to pressures of competition (insurance and non-insurance based), investment troubles and regulatory restrictions. The most significant shift in the way insurers do business, however, involves regulatory and rating agency concentration on operational performance and reinsurance. In essence, how companies make money and how much money they owe is becoming more meaningful indicator of solvency over the singular magnitude of what they own.

HOW INSURANCE COMPANIES MAKE MONEY

Overview

When laymen think of an insurance company, it is easy to conjure a world of actuarial precision--the uncanny ability to project the future through sophisticated formulas and mathematical prophecy. Few purchasers of insurance, for instance, are knowledgeable on the subjects of mortality tables, experience ratings, the law of large numbers and probability analysis. Given the vast resources and long histories of insurance companies, it is no wonder the average insurance consumer believes that ALL insurers represent “mega-business” conglomerates with unlimited profit potential.

Students of how insurance company's make money, however, are more likely to see the industry from
a much different perspective -- where uncertainty runs high and where profitability can be wiped out in a blink of an eye. They consider mortality to be an evolving concept and experience rating levels something to be shattered by new, more spectacular catastrophes that bend our imagination beyond all belief. For example, the increased mortality of the flu epidemic of 1918 caused insurance companies of that era to lose an equivalent of one year's annual profit and render some company's temporarily insolvent. One can only imagine how modern day diseases such as AID's will affect the "bottom line" as the fatalities compound and companies are required to take "all comers" regardless of pre-existing conditions. In another instance, property and casualty claims filed from Hurricane Andrew amounted to almost 20 times the annual premium collected by all insurers in the State of Florida combined. This is also equivalent to the amount of premium collected by all property/casualty insurers nationwide for one full year! Other examples include the Midwest Floods, the California earthquakes. Add to this the day to day struggle insurers confront concerning fraud, groundless lawsuits, growing compliance laws and the ups and downs of stock and bond portfolios and it is easy to see that the business of making money is a constant challenge for insurers large and small.

**Basic Money Making**

For all forms of insurance, the *primary source of income* is still the premium. Since most accounting considers insurance contracts to be annual in nature, a company tracks its *written premium* (an annual figure) versus its *earned premium* (1/12th the total written premium if collected monthly, 1/2 if semi-annual, etc). Losses for insurance companies include *incurred losses* as well as loss adjustments and there are operating expenses (commissions, overhead, taxes, etc). What remains, if anything, is the *underwriting gain*. Determining profit at any one point in time is difficult because each insurer has thousands of policies with varying maturities. So, companies use estimated "ratios" to measure ongoing performance. There are *loss ratios* -- the ratio of actual losses and loss adjustments compared to earned premiums -- and there are *expense ratios* -- the ratio of expenses to written premium.

In addition to their "book of business", insurance companies make money from *investment profits*. In the past, an acceptable investment strategy for insurance companies involved moderate mixing of well diversified risks like real estate and some higher risk bonds. Because premium income was predictable, longer maturity investments, with corresponding higher yields, were common in most portfolios. In recent years, however, the need to improve profitability caused insurers to seek the same high yields in shorter term or more liquid investments (junk bonds). Ultimately, these holdings became the subject of regulatory action and in some cases policyowner panic. Needless to say, insurers will have a tough time producing high investment yields in the years ahead.

Another consideration affecting profitability is competition. Sometimes, insurers sacrifice their own profits to build business. In the mid 1980's, for example, major price wars between insurers were launched in an attempt to build volume. At times, insurance was so cheap that premiums did not cover claim payments. But for years, such losses hardly mattered because the growing volume of premium dollars coming in to the company were plowed into investments that brought bigger dividends and interest payments. Also, the losses from operations turned out to be great tax shelters to offset high yielding investments. This is because insurers were able to take a percentage of their losses as a tax credit. Companies at the time were racking up millions in tax credits or so-called "paper profits". In fact, a survey among insurance companies in 1984 found that about 40 percent of all property and casualty companies attributed 68 percent of their operating income to tax credits.

**Measuring Profitability**

It is apparent, that there are several source of income for insurance companies. And, insurer profitability can be measured through a variety of financial tests. A few used by A.M. Best are as follows:

**PROFITABILITY RATIOS FOR CASUALTY COMPANIES**

*Combined Ratio After Policyholder Dividends* : The sum of the loss ratio, expense ratio and
dividend ratio. This ratio measures a company's underwriting profitability. This ratio does not reflect investment income or income taxes. For companies underwriting predominantly property risks, the normal range for this test is from 95 to 105. For companies underwriting predominantly long-tailed liability risks, the normal range is from 100 to 110. A higher than 105 for property insurers and 110 for liability insurers is considered above the accepted norm for this test.

**Loss Ratio**: The ratio of incurred losses and loss adjustment expense to net premiums earned expressed as a percent.

**Expenses Ratio**: The ratio of underwriting expenses (including commissions) to net premiums written expressed as a percent

**Operating Ratio (IRIS)**: The combined ratio less the Net Investment Income Ratio. The Net Investment Income Ratio is the ratio of net investment income to net premiums earned, expressed as a percent. This ratio measures a company's operational profitability. The operating ratio does not reflect realized and unrealized capital gains or income taxes. The normal range for this test for all types of insurers is currently from 85 to 95. Above 95 is considered normal. This is also one of the IRIS tests (Insurance Regulatory Information System), developed by the National Association of Insurance Commissioners in 1974.

**NOI to NPE Before Taxes**: The percent of net operating income to net premiums earned before taxes. The normal range is from 3 percent to 6 percent. A ratio below 3 percent is considered poor profitability.

**Yield on Invested Assets (IRIS)**: Net investment income as a percent of cash and invested assets plus investment income minus borrowed money. This ratio does not reflect realized and unrealized gains or income taxes. The normal range for this test is 6 percent to 8 percent. A poor rating is under 6 percent. This is another IRIS test adopted by the National Association of Insurance Commissioners.

**Change in PHS (IRIS)**: The change in policyholders surplus from the prior year. Lower than 5 percent is considered poor. The normal rage is from 5 percent to 10 percent.

**Return on PHS**: The ratio of all operating income, after taxes and realized gains and unrealized investment gains, to the prior year policyholders surplus. Under 5 percent is considered unacceptable. Normal ranges run from 5 percent to 15 percent.

**Property-Casualty Profits**

In the early days, property-casualty companies wrote only property insurance, beginning with marine type insurance and later expanding into fire insurance. Liability insurance was not written until the last half of the 1800's. Today, liability insurance constitutes an increasing proportion of the industry's premium. The shift from property to liability is significant because liability insurance requires higher loss and unearned premium reserves. More reserves, in turn, means more funds to invest and reserves are the industry's largest sources of investment capital. In taking this one step further, the profit and capital gains from investments is an important component of insurer profitability. Another major source of investment earnings comes from policyholder surplus. Surplus is the second largest source of investment capital. Surplus is also critical in determining an insurer's capacity to write insurance and collect premiums. Many states, for instance, require property-casualty carriers to have $1 of surplus for every $2 of net premium written. The National Association of Insurance Commissioners allows $3 premium for every $1 of surplus. It stands to reason then, that having a large surplus permits a higher volume of business to be written, which can mean more profits as well as greater potential earnings from investments.

**PROFITABILITY RATIOS FOR LIFE COMPANIES**

**Benefits Paid to NPW**: This ratio takes total benefits paid as a percentage of net premiums written. A range of 45 percent to 70 percent is average.
Commissions & Expenses to NPW: Here, commissions and expenses are compared to net premiums written. The average is from 30 percent to 55 percent.

Net Operating Gain to Total Assets: This ratio is the net operating gain (after taxes) as a percentage of the prior year admitted assets. A range from 0.5 percent to 1.5 percent is normal.

Return on Equity: This is net operating gain (after taxes) as a percentage of prior year capital and surplus. Companies should average from 8 percent to 14 percent.

Net Operating Gain to Net Premiums Written: This test measures earnings (net operating gain after taxes) in relation to a company's current net premiums written. A range of from 3 percent to 7 percent is considered normal.

Change in Capital & Surplus: A change in capital and surplus is important to track from year to year. A change lower than 5 percent is below average. Most companies average 5 percent to 15 percent.

Life Company Profits

Until the 1970’s, low inflation and level interest rates helped to stabilize cycles in the life insurance industry. The primary product was whole life insurance. **Premiums were predictable** and, yielding a steady cash flow. Insurers needed only to invest to keep ahead of the relatively low 3 percent to 5 percent being paid credited to cash values. Higher interest rates, rampant inflation and a more competitive playing field changed all that. Beginning in the late 1970’s, new insurance products had to be developed and insurance company managers had to find higher yielding investments. With money market accounts yielding more than 10 percent, it was easy to see why many policyowners "cashed-in" their policies to invest elsewhere. Deregulation in other financial areas, namely banking, caused serious problems for life companies since they could market variable interest accounts that automatically increased when t-bills or other indicators rose. The life industry did not acquire this privilege of "interest sensitive" accounts until 1980 when the National Association of Insurance Commissioners created the Model Standard Valuation and Nonforfeiture Law. This opened the door for universal-type policies which skyrocketed to popularity in the early to mid 1980’s -- universal's share of total industry premium during this period went from a low 2 percent to almost 40 percent. Then came variable life, universal-variable life, single premium whole life, a resurgence in annuities and guaranteed investment contracts (GIC's).

All of these policy derivatives **changed** how life companies made money. For one thing, policyowners have become quite a bit more transient than when whole life was the dominant choice. If another, more competitive rate appears, they may surrender and move. So, company managers have lost the predictability of their premium income. Therefore, they are not able to commit to long term investments as they did in the past. In addition, they now assume greater interest rate risks. A swing in interest rates, for example, may require a life company to sell a portion of their bond portfolio at a bad time. In both instances, investment yields can be significantly lower.

**WHAT INSURANCE COMPANIES OWN AND INVEST IN**

**Assets**

A major restructuring of insurance companies during the late 1980’s and early 1990’s has put an entirely new face on insurer balance sheets. Equally significant is the trends sought by regulators and industry groups concerning how insurer assets are valued and the type and ratio of investments allowed. The story begins with assets. Insurers have **admitted assets** (investments, real estate owned and data processing equipment) and **nonadmitted assets** (unsecured loans, prepaid expenses, agent advances, furniture, supplies, office equipment, etc). A solvency analysis of a company would focus
on admitted assets which are more easily converted to cash. Nonadmitted assets might take considerably longer to liquidate or they may be entirely unmarketable. An investment analysis would delve into the company's risk/return profile including the desired bond duration, the mix between stocks and bonds, the mix between taxable and tax-exempt bonds, international diversification and real estate (loans and real estate owned). The combination of solvency and investment analysis is the most difficult task now before asset/liability managers. In essence, they walk the fine line between satisfying regulatory requirements and meeting stockholder expectations.

The most common tests involving insurer ownership and liquidity include the following A.M. Best formulas and ratios:

**Quick Liquidity**: Quick assets (cash, short term investments, short term bonds, government bonds of five years or less, and 80 percent of common stocks) divided by net liabilities (total liabilities less conditional reserves plus real estate encumbrances less any negative liabilities) PLUS ceded reinsurance balances owed. This ratio measures the proportion of net liabilities covered by cash and investments which can be quickly converted to cash. A normal range for casualty companies is considered to be from 30 percent to 50 percent. Life companies operate at 75 percent to 90 percent levels.

**Current Liquidity (IRIS)**: Cash plus invested assets and encumbrances on other properties compared to net liabilities plus ceded reinsurance owed. This ratio measures the proportion of liabilities covered by cash and investments. A number less than 100 percent means that a company's solvency is dependent on the collectability or premiums and sale of investments. A ratio lower than 120 percent is considered poor for property insurers. Liability companies, however, can operate at levels between 100 and 120 with normal results. Life companies test in the 95 percent to 110 percent range.

**Operating Cash Flow**: The ratio of funds generated from an insurer's operations, excluding dividends, capital injection, unrealized stock gains/losses and non-insurance gains/losses. This test would measure a company's ability to meet its obligations internally. Any negative balances would be considered poor.

**Investments**

As a general rule, insurance companies invest only after they have met their surplus and reserve requirements (discussed below). Investments outside reserve and surplus funds lean toward interest bearing or income producing investments that are non-speculative in nature. While most states do not specify where excess funds must be invested the undertone is conservative. The State of New York, for instance, provides a listing, they call Section 1405, of appropriate choices. They include: Government obligations issued by the United States, the District of Columbia, any territory of the United States; obligations and preferred shares of U.S. institutions (corporation, association, trust company, partnership, joint venture); obligations secured by liens on real property located within the United States; investments in real property located in the United States; and personal property located or used in the United States which is held directly or evidenced by partnership interest, stock, trust, etc.; common shares of United States institutions and certain Canadian and other foreign investments. New York also allows some leeway in this scenario, sometimes referred to as the *basket provision* whereby an insurance company may invest a certain percentage (no more than 3 percent of admitted assets) in investments that do not quite fit Section 1405 classification.

In addition to this, many states have special provisions relating to the amount of investment an insurer may make in a subsidiary or other insurance company. New York Insurance Code 1701 directly prohibits a life insurance company from organizing or acquiring a bank, trust company, savings and loan, credit union, sales finance company or any other company engaged in the business of financing or accepting deposits that may be insurable by any federal or state insuring agency. Further, New York insurers may not invest in any subsidiary where its total aggregate investment would exceed 10 percent of admitted assets. Investments in other insurance companies or insurance subsidiaries are exempt from this limitation. Beyond this, some states restrict insurance company investment by the type of investment. Examples include preferred and common stock, where
investments in a single company must not exceed 4 percent of admitted assets. And, not more than a total of 20 percent of all admitted assets can be invested in common stocks (New York).

**Surplus**

Before insurers can write business or make investments, they must meet minimum capital and surplus. Far and away, the most important measure of an insurer's capacity to function is surplus. *Policyholders' surplus* is the difference between an insurer's total admitted assets and liabilities -- i.e., net worth. It is also the principal measure of an insurer's financial cushion for policyholders when insurance company results turn sour. Increases in policyholder surplus reflect an insurer's ability to provide security. Each state is different as to the levels of surplus required. Surplus requirements also vary depending on the line or lines of business an insurer is authorized to write. Even once established, regulators strictly control the type of cash or cash equivalents that make up surplus. Typically, these investments are limited to investments in cash, U.S. Government securities, or securities (bonds) of the state in which the insurer is domiciled. In New York State, insurance companies must keep not less than 60 percent of the amount required as capital and surplus in cash or cash equivalents similar to those described above. Once capital and surplus requirements are met, an insurer is permitted to invest its funds in a broader range of securities and investment products. These options range from corporate bonds and preferred and common stocks to real estate and mortgage loans, as well as to the more speculative investments like junk bonds, financial futures and put and call options.

Overall, the trend in policyholders surplus is still increasing, but at a very slow pace. For example, the rise in surplus during the year 1992 was only 2.7%—about one-fifth the previous year. For the most part, this decline was due to unprecedented losses suffered by casualty companies (Hurricane Andrew, etc). So great were these catastrophes that in the same year, the industry suffered its first operating losses in over seven years. The fact that surplus increased is directly attributed to the actions that management has vigorously pursued during 1992 and 1993. To offset losses, insurers have sought capital contributions from their parent companies, sold real estate holdings and liquidated a large part of their bond portfolios, which prospered well in the late 1980's and early 1990's. The gains on these sales have, for now, "shored-up" company surplus. Of course, this is nothing new. Insurer's have often fallen back on their investments to recover from major underwriting losses. In past situations, however, inflation kept real estate prices and bond yields high. This time around, as the industry recovers from its losses, subsequent profits will be reinvested at lower rates. Further, it may take many years for the real estate market to recover before insurers will again consider it an option. So, there will be fewer investment gains in the years ahead to offset future surplus problems. In essence companies will have to contend with weakened balance sheets.

**Reserves**

Reserves come in several different flavors. Property and casualty companies maintain *unearned premium reserves, loss reserves and voluntary reserves*. Life companies maintain *policy reserves*. The basic premise of a reserve is to "stock-up" capital to cover anticipated losses. Property and casualty companies need unearned premium reserves to provide for the return of premium or pro-rata share thereof when a policyholder cancels. Reserving for unearned premiums is particularly hard on insurers because they are usually required to show the full amount of the liability and the amount allowed for expenses is usually spread over the term of the policy when, in fat, it is all paid within the first year. For these reasons, unearned premium reserves are generally an overstated. Loss reserves, on the other hand, are a little more practical in application. They cover claims that have been reported, both adjusted and unadjusted, and claims that have happened but not reported. The size of the loss reserve is relative to the type of coverage and experience. Some insurers, are even required to use projections and estimates to reflect the many contingencies that can affect loss
reserves. Health insurance companies, for example, estimate claims that might occur after the policy expires. Worker compensation insurers budget on-going litigation. And life insurers generally use discount factors to reflect the time value of money and changing mortality concerning policies of potentially long duration. Insurance companies are constantly modifying their loss reserves to meet minimum regulatory requirements yet not exceed IRS guidelines for maximum deductibility. A high level of reserves also depresses profit which highly concerns shareholders.

**Policy reserves** are used primarily by life insurers to insure that policy obligations will be available when they are due. **Policy reserves are measured** by calculating net premiums received over the life of the policy (total premiums received less expenses) and the assumed interest that will help build cash value to pay death benefits. Mortality rates and reserve requirements change over the space of time which permit these figures to be modified. Policy reserves are usually grouped by block of business. In other words, policies issued in the same year, with similar face amounts, interest assumptions, age and risk level of insured. Uniformity makes it easier to group and calculate policy reserves. Over the years, the size of the policy reserves builds until the mortality cost for the particular block of business is covered. Then, the holding of reserves decreases until reaching zero when final claims are paid.

Specific A.M. Best formulas to calculate surplus and reserves include the following:

**CASUALTY COMPANIES**

**Non-Investment Grade Bonds to Policyholders' Surplus**: This test is vastly more popular due to the junk bond rush of the late 1980's. This ratio measure's a company's exposure to non-investment grade bonds as percentage of policyholder's surplus. Typically, bonds rated less than BBB are consider non-investment grade. The normal range for companies is from 0 percent to 10 percent. Above 10 percent is considered risky.

**Loss Reserves to Policyholder Surplus**: This ratio measures the potential impact that deficiencies in loss reserves have against surplus. The higher the ratio, the more reserves should be scrutinized. Casualty companies typically score from 50 percent to 150 percent.

**Development Reserves to Policyholder Surplus**: This reflects the change in loss reserve, as a percentage of surplus, from one period to another. The normal range is from 0 percent to 25 percent.

**Developed Reserves to Net Premiums Earned**: This test measures whether or not a company's loss reserves are keeping pace with premium growth. For the industry as a whole, the ratio is rising.

**LIFE COMPANIES**

**Non-Investment Grade Bonds to Capital Surplus** For purposes of this test, Class three bonds are considered below investment grade. The usual range for this category is 20 percent to 70 percent.

**Mortgages & Real Estate to Capital & Surplus**: The usual range for this test is 150 percent to 350 percent.

**Delinquent & Foreclosed Mortgages to Capital & Surplus**: Delinquent mortgages are those over three months past due. Normal operating ranges for this test are between 5 percent and 35 percent.

**Affiliated Investments To Capital & Surplus**: A ratio higher than 35 percent is considered risky.

**WHO INSURANCE COMPANIES OWE**

Reinsurance plays a vital role in the support of new companies and new policies. However, the high cost of reinsurance and the safety of the reinsurers themselves are new issues of concern to regulators.
If there is anything the industry can learn from recent insurer liquidations it is that financial statements can be misleading. As we have just discovered, a company's earnings and surplus can appear to look good even when insurance sales are poor. Capital contributions or the sale of investments can easily make the bottom line seem profitable. Now, another factor must be considered -- who insurer's owe -- leverage. In the insurance industry, leverage is typically incurred through the process of reinsurance. Insurers often find it necessary or at least advantageous to reinsure risks that they insure. For the most part, reinsurance remains as negotiated contracts between a reinsurer and the ceding company (original insurer). Reinsurance is important in that it contributes strength to an insurer by taking over part of its financial burden. This added strength, however, does not come without a price tag. The high cost of reinsurance and the safety and strength of the reinsurers themselves are now issues of concern to regulators and the industry.

Reinsurance plays a particularly vital role in the support of new companies and new policies. For new insurance companies, reinsurance is necessary to "selling" financial stability. After all, who wants to do business with a new company with no track record. Put a large established company guaranteeing the claims against the new company, however, and customers are more easily convinced. Leverage, or reinsurance, is also needed by many established companies who have had big spurts in business.

A specific problem that all insurers have is the need to bolster their surplus during high volume periods. This is particularly troublesome during the first policy year. Accounting valuation of the policy and high costs to issue the policy (commissions, etc) in the first policy year post a loss and a reduction in company surplus. A strain on surplus can create problems with regulators and lenders, so insurers go to great lengths to "shore up" their surplus from first year losses. In some cases this is accomplished using additional capital contributions, but more often, the company will buy surplus relief reinsurance. This has the same affect to the balance sheet as adding capital and surplus is not reduced. In the process, however, a liability to the reinsurer is created. One test to determine if the amount of leverage is within accepted norms is as follows:

\[
\text{Ceded Reinsurance Leverage} = \frac{\text{Reinsurance premiums ceded plus net reinsurance balances owed to policyholders}}{\text{Policyholders surplus}}
\]

The normal range for this test is from 0.5 to 1.3. Companies with higher ratios are considered to be too dependent on reinsurers.

REASONS WHY INSURANCE COMPANIES FAIL

Whenever a major financial institution is known to be underperforming or worse, "seized" by a regulator, there are accusations leveled about how and why this could happen. Investigations first seem to focus on "who" was at fault and the many sorted details on innocent customers who will be affected. Almost always, someone is next presenting a case on the "incompetence" of regulators, the greedy industry without compassion for its customers and some kind of comparison on how this same kind of problem happened somewhere else with devastating results. That is why, the current problems in the insurance industry are compared, ad nauseam, to recent calamities in the savings and loan industry. Some have gone so far as to label the insurance industry a savings and loan debacle waiting to happen. Regulators of both industries are being chastised for their lack of controls and need for faster response and early warning systems to alert the consumer.

Lack of Confidence

No one could say that these charges are entirely false. Every industry has its rogues and less than ethical players. What is often forgotten, however, is the fact that consumers create many of their own problems by choosing to ignore risks, even when they are told (or supposed to know) what could go wrong. It was fairly common knowledge, for example, that Executive Life was able to pay higher rates on annuities because they invested in higher risk investments. Basic economics tell us that the demand for a product or service is a "derived demand" -- derived, that is from the customers demand for those goods and services. Clients for Executive Life demanded higher rates. This does not excuse any alleged wrongdoing that may have been perpetrated by Executive Life, but policyholders who want higher than market returns should share in the risk of loss. Another interesting point about consumers is their sometimes unrealistic expectations. What consumers expect and anticipate may be the very
thing that creates the problem. For example, when bond rating agencies dropped the portfolio ratio of Mutual Benefit Life, policyholders anticipated a faltering company. The eventual "run on the bank" actually created or accelerated the liquidation. Also, every casualty agent can attest to client demands for cheap coverage -- any coverage -- to meet some licensing or contract requirement. When something goes wrong and a non-admitted insurer is not capable of fulfilling its promises, one can only imagine how these clients will steam over the incompetence and lack of due care exercised by the agent.

**Free Market Failures**

Sometimes, the reason companies or insurers fail can only be explained as a consequence of free-market forces. They result in cases where large survives small, a new concept makes an old one unattractive, an unexpected event is just too large to recoup losses, lower prices prevail over benefits, higher interest rates win over lower rates or the economic climate is simply not conducive to making a profit. It is suggested that a combination of ALL these factors are responsible for reasons why some insurance companies fail in a free market.

**Slim Profits**

Declining profits are still another explanation for insurance failures. Premium wars and unusual natural disasters have whittled profits in property-casualty companies to levels lower than most other industries, while risk remains high. Life insurers have suffered from thinning margins of profits and greater exposure to interest rate cycles. In severe situations, either of these problems could cause a company to operate below accepted levels or force a conservatorship.

**Management Mistakes**

In 1990, the Government Accounting Office compared the failures in the insurance industry with 20 of the largest savings and loan institution failures. Of the eleven root causes identified for the failures, ten were the same for both the insurance companies and the thrift institutions. These included multiple regulators and infrequent examinations, rapid growth in risky business areas, poor underwriting, extensive underpricing, excessive reinsurance or loan participations, **bad management**, and inadequate loss reserves. Only time will tell if there were, indeed, intentional or negligent abuses in the insurance industry similar to those found in the savings and loan shakeout. An ongoing investigation into insurance fraud is underway by the Justice Department and the Senate has held at least two different investigations of insurance fraud since 1990. Certainly, violations will be found, but it is not likely to be as widespread a problem as the savings and loan fiasco since insurance companies are, by design, better able to "pay" for their mistakes since they are financially diversified, more liquid and quite a bit larger (most insurance companies are national in scope). Critics will point out, however, that while these differences may be true, insurance companies **DO NOT** have any federal backing, such as Federal Deposit Insurance as a backup. This would suggest that a failure by an insurer could be a greater downside for policyholders -- especially if the state guaranty funds backing insurers failed to function as promised. A discussion of state guaranty funds can be found in a later section.

The savings and loan debacle will probably outshine the "fallen angels" of the insurance industry for another reason -- people. Many prominent savings and loan executives took big falls in the thrift shakeout, including civil and criminal charges. The spotlight was intense and involved some of the nation's most prominent figures -- Charles Keating, Gerald Ford's son, etc. Similar actions are now being pursued against insurance executives without as much fanfare. As case in point is the suit by the State of New Jersey against former officers and directors of failed Mutual Benefit Life. Charges allege negligence by these individuals that permitted Mutual Benefit to pursue shaky real estate investments and leveraged buyouts. Some of the investments, as charged, involved conflicts of interest for top officers who purportedly profited from the deals. A list of the parties named is like a Who's Who in America, including a U.S. Senator, a top official of American Express, the owner of a pro football team and more. A similar drama is being played out in a suit filed by the State of California regarding Executive Life. This action (Garamendi v. Carr, etal) names Fred Carr, several corporate offices, former auditors Deloitte & Touche, ratings services A.M. Best Co., Moody's and Standard &
Poors. The liquidator may also sue the insurer's managing general agents and reinsurers who were believed to have inside information on mismanagement within the company.

**Junk Bond Investments**

The search for higher yields seemed to dominate investment manager thinking in the 1980's. In part, it was driven by consumer demands for higher earnings. At one time, for example, single premium deferred annuities were yielding as much as 14 and 15 percent (tax deferred). Then came single premium life, structured settlement annuities and guaranteed investment contracts (GIC's). Once a company offered high rates, others followed suit in an effort to remain competitive. In order to pay these higher rates, insurers needed to invest at higher rates. At about the same time, brokers like Drexel Burnham were heavily involved in funding major corporate takeovers and mergers. Insurance companies were the perfect entity to finance these transactions through the purchase of bonds. A single transaction, such as the 1986 Maxxom takeover of Pacific Lumber Company, could involve as much as $900 million. It wasn't until Michael Milken took a fall that bond issues such as these became a sore issue in the financial dealings of insurance companies. Companies with more than 20 percent invested "junk bonds" were under heavy criticism, by agents, regulators and consumers alike. Executive Life of New York and Executive Life of California were over 60 percent invested in junk issues. And, it took even longer for regulators to take action because for years, these bonds were held on the books at their purchase cost, not market value. So, insurer's financial statements still looked reasonable. In addition, regulators were not as harsh in classifying what is a "low grade" bond as were the rating services like Moody's and Standard and Poors.

In 1990, standards were laid down by the National Association of Insurance Commissioners ranking the quality of issues. A numeric classification is assigned to all bond holdings as follows: Class 1 (highest quality), Class 2 (high quality), Class 3 (medium quality), Class 4 (low quality), Class 5 (lower quality) and Class 6 (poor quality). Investment grade securities now may only qualify as Class 1 or Class 2 bonds. Classes 3 through 6 are categorized as non-investment grade or "junk" bonds. Obviously, companies that maintain a high concentration of non-investment grade bonds will be scrutinized more closely than in the past. Further, regulators and rating agencies alike are also giving attention to the types of investments made and the ability to "match" assets and liabilities (the concern is that where assets are not linked to liabilities, fluctuations in interest rates can negatively impact cash flow and surplus. With these precautions in place and with promise of stepped-up regulatory monitoring, a decline in non-investment grade securities has occurred during the early 1990's. Much of this through a "controlled liquidation" to help shore up and clean up insurer balance sheets. Industry wide holdings in 1993 were estimated at only 3.8 percent of invested assets compared to 7.2 percent in 1990.

**Real Estate Investment Losses**

Without a doubt, another contributor in the insurance insolvency war is real estate. Specifically, nonperforming and underperforming commercial real estate. Most insurer's hold over 90 percent of their real estate mortgages in commercial properties. It is the nature of these loans, not delinquencies that has caused problems. Delinquent real estate loans reached a peak of only 7 percent of the industry's total 1993 loan portfolio -- mostly commercial projects that started unwinding around 1990. Problems with insurer real estate and loans took root in purchases and loaning in the "oil patch" areas (before the oil industry buckled under) and the building boom of the 1980's. During this latter, banks and thrifts maintained their role as construction lenders while insurers competed more heavily in the "mini-perm" market. Mini-perms are loans of from five to seven years designed to fill the gap between construction financing and long-term financing. As longer, permanent loans became harder to get in the 1980's so grew the mini-perm market. And, as luck would have it, many of these same loans are coming due in the early 1990 recession at the same time that the demand for commercial space is down and the ability to refinance or replace these maturing loans is practically nonexistent. Specifically, this is the reason why public rating services have downgraded so many life insurers with large mortgage loan portfolios. Concurrently, commercial property owners have encountered great difficulty in generating sufficient operating revenues, on the heels of major rental rate deals and
other tenant concessions, to keep mortgage loans current. Thus, a rise in loan delinquencies has also occurred, again, mostly among office and commercial real estate.

To date, the effects of loan delinquencies on insurer balance sheets has been minimal since real estate owned and mortgages typically represents less than 3 percent of the industry's assets (about 19 percent for life companies). However, with the advent of new Risked Based Capital requirements, "down rating" by major services for insurers with large real estate portfolios and poor public perception about insurer real estate owned, the negative impact of delinquent real estate has intensified. The threat of "bad press" has prompted many insurers to "sell short" or restructure underperforming real estate and real estate loans--sometimes prematurely--to avoid rating writedowns. Further, a company with slightly higher than normal mortgage delinquencies or an above average volume of real estate loans could now be subject to regulatory control or corrective action under new National Organization of Insurance Commissioners guidelines. Under these standards, regulators could force companies with a low risk capital base to raise capital and take other steps to avoid failures. In more severe cases, reserves for expected real estate losses could be mandated.

Also, an insurer must calculate whether capital deficiencies under the NAIC rules, based on the mix of their real estate portfolios and real estate owned. When deficiencies are present, the insurer may be forced to consider changing its asset mix--selling nonperforming real estate in exchange for bonds. As of 1993, nonperforming real estate mortgages has declined from a peak of about 8 percent in 1992 to just under 6 percent. However, this does NOT account for money raised through guaranteed investment contracts which are essentially mortgage backed bonds. A major inventory of these contracts will be maturing in the mid 1990's which will exert added pressure for performance.

Reductions of nonperforming mortgages have also been attained by restructuring or refinancing troubled loans or providing new loans for new buyers on foreclosed real estate. With a stroke of the pen, these new loans or newly structured loans are no longer nonperforming. Yet, the real estate tied to these loans is the same. Further, insurance companies may own problem real estate through partnerships. Again, this nonperformance is not reflected in industry wide statistics. Another significant trend of the early 1990's is the "bulk-sale" of real estate owned. An appetite for non-performing real estate developed as a result of the banking industry fallout. Agencies like the Resolution Trust Corporation found plenty of buyers for foreclosed real estate and underperforming mortgage loans. At a time when the Resolution Trust was running out of investor, insurance companies were in the mood or required to let go of some large, but less than spectacular real estate properties. Sales prices like $634 million (Travelers) and $1 billion (Prudential) have been commonplace. While some these properties were sold at somewhat competitive prices, the hardest financial pill to swallow was the time period between the default of payment and actual foreclosure. Liberal tort laws allowed owners lengthy bankruptcy protection which cost insurers dearly or forced them to restructure loans at the last minute. In many cases, insurers had to be involved and stand the cost for managing these properties until an agreement could be reached.

Not all of the "moves" to reduce nonperforming real estate have been accomplished voluntarily by insurers. Even before NAIC risked based capital ratios, insurers were feeling regulatory heat to restructure or move nonperforming or newly structured loans off the books to avoid capital deficiencies or substantial write-downs under generally accepted accounting principles (GAAP). An insurer typically carries real estate assets at historical costs. Under GAAP guidelines, however, collateral received as a result of a foreclosure is returned to the insurer at its fair market value. Because commercial property values have declined so rapidly, fair market values on foreclosed properties could be substantially less than the historical value. This can result in substantial GAAP write-downs at foreclosure. Owning and managing foreclosed real estate can also drain an insurer resources. A decision must be made whether to continue holding the asset until the economy rebounds or risk further deterioration if the economy goes the other way. Holding on may also involve setting aside reserves under NAIC rules. Selling foreclosed real estate may also be difficult to accomplish in today's depressed market. With many other lenders and insurers selling nonperforming real estate, a deep discount may be required to unload a problem property. This can result in further write-downs from the value carried on the books. In either case, holding or selling depressed real estate, the process can adversely affect earnings, capital requirements, dividends and ratings. An option for an insurer may be to package multiple properties and mortgages as collateral for a new securities offering to raise new capital. This will aid an insurers liquidity, but the original real estate asset or loan would remain on the books, perhaps at a deep discount. Again, the need for additional reserves exists and the condition still
"muddies" the balance sheet. A more creative approach involves "spinning off" or selling problem real estate and loans to a new entity (created by the insurer). The new entity sells bonds or stock to the public to buy the problem assets. Since this is considered a sale, the asset gets off the books, the need for reserves can be eliminated and the insurer's balance sheet is cleaned up. This helps the company meet GAAP, statutory capital requirements and improves the "rating picture". In addition, the real estate assets are, in a manner of speaking, retained to take advantage of any real estate turnaround. As with any strategy, there are pitfalls to the "spin-off" including deep discounts, the cash drain to start a new entity and the possibility that the transfer may be a taxable event.

By all standards, the handling of problem real estate and mortgage loans is part of doing business in today's insurance world. Realistically, this has been the cycle of real estate and most investing for as many years as insurers have been around. One must wonder, however, if the popularity of 'real estate bashing' has promoted a widespread purging of real estate assets beyond reason. Real estate has been a traditional sound and profitable investment for insurance companies since their inception. It has been the policy of insurance companies to invest in real estate for income and hold these assets to maturity. Therefore, the industry feels that only an assessment of how these assets perform over time is important – not a temporary drop in book value reflecting some current market condition. While this may be a sound investment practice it is unfortunate that regulatory measures and rating standards related to real estate are so closely influenced by public perception of the moment.

Fortunately, and, for the meantime, most mortgage loan delinquencies and problem real estate have settled with the large insurers. Analysts do not expect this to create an industry crisis similar to the savings and loan debacle. Moreover, most insurers have substantial cushions against real estate losses and/or have raised new capital offsets.

**Regulatory Guidelines**

The outcry to limit insurer's holding of junk bonds and real estate has forced many companies to restructure their portfolios by **divesting these assets**. In the case of bonds, a very low interest rate cycle during the early 1990's greatly favored the sale of bonds, and, in fact, created large capital gains for many companies to offset losses elsewhere. In the case of real estate and commercial loans, divesture has NOT been as easy considering difficult market conditions. In response, the rating agencies and regulators are fast developing new criteria to assess the **ratio of junk bonds or high risk issues** and less favored assets like real estate, common stocks and real estate owned by the insurer. Examples include the WAR (Weighted Asset Risk) Formula developed by Townsend and Schupp, Risked Based Capital and Bond Classification developed by the National Association of Insurance Commissioners. The details of these programs are best left to later sections, but the importance of these tools is that each analyzes insurer assets by breaking down the various levels of risk they present. In essence, B rated bonds are assigned a higher risk than AAA bonds. Using historical simulations, formulas such as these may have raised "red flags" years before the downfall of companies like Executive Life, First Capital Life, Fidelity Bankers Life and Mutual Benefit Life.

Insurers can be classified in many ways. For the purposes of preparing for the licensing examination, we have classified the insurers into four groups: domicile, admission status, legal form of organization, and by classes of insurance written.

**THE STRUCTURE OF INSURANCE COMPANIES**

**DOMICILE**

Insurers may be domestic, foreign, or alien.

A **domestic insurer** is organized under the laws of each state, whether or not admitted to do business in that state.

A **foreign insurer** is an insurer not organized under the laws of a specific state, but in one of the other states within the United States, whether or not it is admitted to do business in that state.
An alien insurer is an insurer organized under the laws of any jurisdiction other than a State of the United States, whether or not admitted to do business in that state.

ADMISSION STATUS

An admitted insurer is one which has received a certificate of authority from the Insurance Commissioner permitting it to transact specified classes of insurance business in the state. All other insurers are nonadmitted insurers and not entitled to transact insurance in that state. An admitted insurer may be either a domestic, foreign or alien insurer.

LEGAL FORM OF ORGANIZATION

Insurers have two classes of organization. First, private enterprises that are corporations organized on a capital stock basis known as stock insurers. Second, those private enterprises organized as cooperative enterprises, including mutual insurers, reciprocal (interinsurance exchanges), fraternal benefit societies, and county mutual fire insurers.

Stock Insurer: is a corporation owned by individuals who contribute capital through the purchase of stock. The stockholders elect the board of directors who, in turn, appoint the executive officers. The gains or losses from the operation are shared with the stockholders through dividends declared by the board of directors and through the increases or declines in the market value of their shares of stock. Most stock insurers issue nonparticipating policies which do not entitle the insured to participate in the profits or earnings of the insurer. A few stock insurers are doing business on the "mix plan" where they issue both nonparticipating and participating policies.

Mutual Insurer: is a corporation owned by its policyholders. These policyholders elect the board of directors who, in turn, appoint the executive officers. The policyholders are entitled to share in any profits earned by the insurer. The earnings, if any, are returned to the policyholders in the form of a refund on their premiums, commonly called a "dividend". Those policies that entitle the insured to a dividend are called participating policies.

Reciprocal or Interinsurance Exchange: is an unincorporated association that enables individuals, and business firms, to insure one another. The policy-holders are both the insured and the insurer. Each policyholder agrees to insure all of the other policyholders in the association and, in turn, is insured by each of the other policyholders. These associations are managed by an attorney-in-fact, appointed by the policyholders and empowered on their behalf to bind them to one another.

Fraternal Benefit Societies: are authorized under special sections of the state insurance code to conduct the business of insurance providing benefits to members and their families in the event of accident, sickness or death. Fraternal societies usually are incorporated without capital stock. Membership is required in the society to purchase insurance from the society.

County Mutual Fire: Two hundred and fifty or more persons residing in one county of a certain state may incorporate for the purposes of forming a mutual fire insurer. The policies issued, by a county mutual fire insurer, shall have a minimum amount of $1,500,000 aggregate coverage with a minimum premium of $15,000.

CLASSES OF INSURANCE WRITTEN

An insurer may not transact any class of insurance which is not authorized by its Articles of Incorporation or its charter, nor can an insurer transact any class of insurance in the state without first being admitted. An insurer can become an admitted insurer by securing a Certificate of Authority from the Insurance Commissioner to transact a class or classes of insurance. Therefore, insurers can be classified according to the classes of insurance for which they are admitted in a particular state.

Life Insurer - an insurer issuing policies in one or more of the classes of life, disability, liability, workers' compensation, common carrier liability, and no others. Few life insurers transact other than...
life or life and disability insurance.

**Multi-Line Insurers** - an insurer doing business covering several insurance classes, such as fire, marine, and general casualty lines. This insurer cannot transact life, title, mortgage, or mortgage guaranty insurance.

**Title Insurer** - an insurer that is limited to transacting title insurance.

**Mortgage Insurer** - an insurer that is limited to transacting mortgage insurance.

**Mortgage Guaranty Insurer** - an insurer that is limited to transacting mortgage guaranty insurance.

**MARKETING SYSTEMS USED BY INSURERS**

In insurance, “marketing” is the method used by insurers to inform potential buyers about the various contracts that are available. Three types of marketing systems are used by insurers: (1) the independent agency system, (2) the exclusive agency system, (3) the direct mail system. Most admitted insurers in are marketing their contracts under one of these three systems. The role of the broker in marketing will also be discussed at the end of this section.

1) The **independent agent** is a person who enters into agency agreements with more than one insurer. This agreement gives the agent ownership of the business written by the agent. This ownership allows the agent to place the insurance with any insurer he/she represents, he/she can transfer the insurance from one insurer to another if he/she or the insured becomes dissatisfied with an insurer. The agent is also able to transfer the insurance if the insurer is unhappy with the insured. The independent agent generally receives a higher rate of commission than the exclusive agent, but the agent must finance his/her own agency. The cost of office space, secretarial help to prepare contracts and send out renewal notices will be paid by the agent.

2) The **exclusive agent** is a person who enters an agency agreement to represent one insurer, or a group of insurers who have common ownership. This agreement generally prohibits the agent from representing any other insurer and gives ownership of the business to the insurer. If the agent should leave the insurer to work for another insurer, the book of business is kept by the insurer and given to another agent to service. The exclusive agent cannot give the insureds a choice among insurers. Technically, exclusive agents are not employees of the insurer, but independent contractors paid a commission for contracts written. The insurers provide services to their exclusive agents, such as providing office space, clerical support, preparing the contracts, sending out renewal premium notices and handling most, if not all, claims.

**NOTE:** The Insurance Code makes not distinction between an independent agent and exclusive agent when a license is being issued to a person. The authority granted under the agents license is the same in either case, but the agency contact entered into by the agent with an insurer will determine whether the agent is independent or exclusive.

3) The **direct mail** systems does not depend on an agent. The insurers market their contracts from the home office. These insurers offer their contracts to the public through direct mail campaigns, newspaper and magazine advertising. The person who is interested in these contracts normally will write for information, which the insurer returns with an application to be filled out and returned. Presently, this system accounts for a very small percentage of insurance being written in most states.

These three methods of marketing are used by the insurers and their authorized agents. One other method of marketing that should be mentioned is the broker. The broker is the representative of the insured who, in effect, does the insured's insurance shopping. Brokers have no agency contracts with the insurers, but place business with those admitted insurers which will accept the offer by the broker. A person may be licensed as both an agent and broker. When a person is licensed as an insurance
agent and broker, that person is required to act as an agent for those companies for which that person is appointed as an agent. He or she may act as a broker only with those insurers for which that person is not appointed as their agent.

**INSURANCE COMPANY SAFETY**

**OVERVIEW**

At one time, the topic of insurance company safety was discussed among a tight circle of professional industry groups and regulators. Today, however, potential trouble spots and ideas for constructing new regulations to protect consumers are being unveiled at a fast and furious pace. The suggestions hail from consumer coalitions, industry groups, auditors, state regulators and some members of Congress who continue to press for some form of uniform federal supervision of the entire insurance industry. So great has the call been, that at the outset of the final decade of the twentieth century, an industry that has flourished in this century is now struggling to redefine itself. At the center of attention are the issues of safety, solvency and agent due care: how to regulate, who will regulate, what the consumer will be promised and whose going to pay if something goes wrong. Clearly, the insurance professional is at risk to know as much about his product and company than ever before.

Recent problems are complex and visible and not limited to insurance companies. Most financial markets and many industries have changed dramatically especially through the 1980s. Changes in financial institutions have resulted from events like information and communication technologies -- making the world smaller and competition greater within a chosen financial services industry -- to spectacular financial disasters, e.g., the '87 stock collapse, the junk bond fiasco, the Executive Life / Mutual Benefit Life debacles, national catastrophes (Hurricanes Andrew Hugo, the midwest floods and California earthquakes). Geographic and product boundaries for financial markets... traditionally, not a factor for insurance companies... have faded, and new products and services have blurred the distinctions between bank or thrift institutions, security brokers and insurance agents. A place once reserved to buy groceries, for example, may now be a convenient spot to deposit or cash a pay check. And who would have thought banks and insurance agent would market and control "managed asset" mutual fund accounts? Further, with news of innovations like the "Information Superhighway" beaming financial and educational services to anyone who owns a telephone, there is no indication that this era of change is over. On the contrary, financial markets and institutions will continue to evolve.

The need to adapt to the increasingly competitive environment, new products, financial "heart attacks" and more has presented problems for many types of financial institutions... commercial banks, savings and loans, securities firms... and insurance companies. As always, when things change or require restructuring, there is a period of adjustment accompanied by trial and error, financial stress and an increased likelihood of less than top performance or the threat of complete collapse. It happens to many kinds of companies... including property/casualty and life/health insurers. It is a fact of doing business and part of any free-market system.

Multiple and prolonged insolvencies, however, take their toll. The insurance industry becomes tarnished, and new consumer/political pressures expound. This, in turn, expands the burden on regulators, industry groups and the insurance professionals to correct the potential effects a major insurance failure may have against the public and the economy. In some cases, over-regulation and speculation result in panic or perhaps a "light trigger" that could catapult a seemingly secure company into the solvency spotlight. During the 1980s, solvency paranoia was focused on the banking industry. Volumes of information documented faulty and fraudulent investments by banks and savings and loans. Managers were branded as criminals and regulators clamped down like a proverbial ton of bricks. Of course, the insurance industry has had its bout with solvency wars. In fact, just the cast or suspicion of problems or a drop in bond ratings has put companies at bay or, in some cases, out of business.

With rare exception, the insurance industry has enjoyed the comfort of consumer and regulator confidence throughout its history. Conservative marketing and investment practices in the industry scored high marks with a remarkably low rate of failure. Performance has periodically fallen below
adequate levels, but generally not to a point that would jeopardize solvency. In the few episodes that varied this trend . . . the dangerous securities practices after the turn of the century and the substandard writers in automobile insurance markets of the 1960s . . . insurance regulators, aligning insurance companies and industry groups like the National Association of Insurance Commissioners have appeared to provide appropriate regulatory responses. Recent episodes are no exception. Most of the major insurers that went insolvent are in the process of being rehabilitated by state regulators or private investors. It is doubtful that policy owners will incur material losses.

THE FAILURE RATE

It is true that the decade of the 1980s and the early 1990s subjected the industry to higher levels of financial and market trauma than ever before. This period was marked by new records in sales and innovations. Fierce competition and increasing cost pressures became new problems in addition to outside influences like federal deregulation of financial services, higher interest rates, new financial instruments, expansion of tort liability, soaring medical costs, catastrophic claims, the entry of some inexperienced, small insurers and relatively poor investment results. In a rather short time frame, the industry evolved from a conservative, mature business with stable elements and generous profit margins, to a business marked by higher risks and narrowing profit margins.

A combination of these factors has also brought media and political attention and a definite erosion in consumer confidence. As this confidence declined, redemptions increased dramatically. At the same time, a major recession created financial havoc via junk bonds and plummeting commercial real estate values. The result: insurer failures. The additional toll of many years of "rate wars" and dramatic natural disasters created even greater pressures on the property/casualty side of the industry.

Just how bad is it out there? The answer depends on the source. The federal government has published volumes on insurance industry abuses and made scathing comparisons of insurer problems and the huge banking debacle of the late 1980s. Actual statistics, however, tell a somewhat different story. For example, in 1989, the peak of the bank and thrift controversy, failures in that industry numbered over 500 institutions involving some $130 BILLION in assisted mergers or closures. In the same year, which coincidentally seems to be the peak year for insurance company problems, the number of failed companies numbered about 40 property-casualty insurers and about 40 life companies with a combined total bailout of less than $1 BILLION. While no one should be happy with these results, it is clear that insurance industry failures have and will not likely become another savings and loan fiasco -- especially, since recent information seems to indicate a cycle of declining failures. This is indeed good news. But, this should not diminish the severity of recent failures -- more than the industry has seen since the great depression. These failures have given the industry a "black eye" which will take many years to heal. In a like manner, agents will bear the brunt of new client doubts and increased responsibility, both ethical and legal, to present financially secure companies.

INDUSTRY TROUBLESPOTS

In addition to enduring some of the greatest natural disasters of modern times, property/casualty insurers are still paying the price for some heavy price competition during the 1990's. At the same time, liberal tort liability concepts have expanded and claim costs related to environmental issues (asbestos, toxic, etc) have soared beyond all previous levels. In order to remain "head above water", property and casualty companies, who had previously limited themselves to more conservative lines of liability insurance, entered markets with higher risks and greater underwriting uncertainty. In some cases, these changes were made with inadequate expertise, utilizing marketing techniques that inappropriately relinquished underwriting authority. Some insurers severely underestimated their reserves and underpriced their policies with disastrous consequences.

Far and away, the casualty losses of mega events like recent Florida Hurricanes the Midwest floods and the California earthquakes, one right after another, will prove to be the losses hardest to recoup. Hurricane Andrew alone amounted to losses almost 20 times greater than the premiums paid by all Florida homeowners in that year and approximately equal to all homeowner premiums written countrywide for the same period. Unfortunately, rate regulations prohibit setting off losses in one state
with gains from another. So, raising rates in all states to cover extraordinary costs resulting from
problems in one state is not possible. Allowable rate increases are also inadequate. It is estimated,
for example, that Florida insurers would have to increase their premiums by 25 percent, each year for
the next 15 years to recover recent hurricane losses! Obviously, the State of Florida will not allow such
an increase.

Since many property/casualty companies are reinsured, the reinsurance industry has felt the brunt of
the impact. As a result, **reinsurers have substantially withdrawn from the marketplace.** Industry
experts worry that this could create a capacity shortage. For the meantime, however, things appear
stabilized for property/casualty insurers simply because they have been able to reap major capital
gains from recent bond sales and the stock market has been very supportive in raising capital as
investors needed higher paying issues. As mentioned, these two events have softened the blow of
reinsurance withdrawals. The bad news is that the industry and reinsurers alike are now reinvested
at much lower yields than before so there will be less net income available to relieve future underwriting
losses. Further, if major catastrophes continue in a period where interest rates are rising, it is doubtful,
that the insurers/reinsurers will be able to turn to bond sales to offset losses since rising interest rates
cause bond portfolios to lose value. In addition, it is not sure how much help the securities industry
could be during a period of rising rates since investors may lean toward more conservative "insured"
issues like municipals. The bottom line of these events could mean that the property/casualty business
will have less access to reinsurers and could experience more insolvencies in the years ahead when
major claim events occur.

A 1992 survey of the top 100 casualty companies by A.M. Best documents recent financial changes.
"Assets for these 100 insurers, which totaled $533.8 billion in 1992, collectively represent nearly 85
percent of the property/casualty industry's assets. In line with the industry's growth, admitted assets
of the top 100 grew 5.8 percent in 1992, slowing from 7.9 percent growth in 1991. The diminished
growth occurred because of reduced growth of invested assets. In three of the past five years, the top
100 groups increased their invested assets by about $35 billion, dipping to the $20 billion level in 1990
and 1992 when the industry was hit by heavy catastrophe losses. Operating cash flow declined 35
percent to $14.5 billion in 1992. This reflects continued growth in negative underwriting cash flows,
which culminated in substantial Hurricane Andrew claims payments and a decline in cash flow from
investment income -- the first decline in 50 years for the property/casualty industry. Declining
investment yields and diminishing cash flows reinvested in the industry's portfolio combined in 1992
to cause a decline in net investment income. Consistent with A.M. Best Co's earlier projection, the
industry's investment yield declined an additional 55 basis points to 5.95 percent as of September 30,
1993. Had it not been for additional funds from significant realized capital gains and capital
contributed, growth in invested assets would have been a meager 2.5 percent instead of 4.4 percent
for the top 100 groups".

**What Do the Problems Mean**

Many of the pressures described above have already "vented" in the form of a rise, in the latter half
of the 1980s, in a number of insurance companies failing, at least by certain regulatory standards, and
those requiring formal action. Most of the underperforming activity, until only recently, was confined
to companies writing between $6 million and $12 million in premiums per year and assets of between
$20 and $40 million . . . small companies in the world of insurance. According to many industry
professionals, however, the typical American insurance company, is in no way facing the kinds of risks
faced by major company breakdowns like Executive Life, Mutual Benefit Life and others. In their
opinion, the bulk of the industry has pulled through a tough economic environment and remains
financially responsible. Most insurers are generally well capitalized, relative to other financial
institutions, and are restructuring assets to meet new solvency standards, merging with stronger
insurance and non-insurance companies and still conservative. Whether these measures are enough
to weather the economic storms and other natural disasters of the 1990s remains to be seen.

As between property casualty companies and life/health companies, it appears that the casualty
carriers continue to maintain greater liquidity -- about 77 percent of their assets are liquid vs. 56
percent for life companies (A.M. Best 1992 Survey). The life industry's affliction to real estate,
mortgages and non investment grade bonds account for its low liquidity ratio. In contrast,
property/casualty carriers have invested primarily in stocks, a trend they have maintained for the past five years. One must wonder, however, if the potential for loss in the casualty industry greatly offsets this liquidity edge. On the other hand, it has been principally life companies that have experienced the most serious failures.

Despite these statistics, the industry is, nonetheless optimistic. The independent agent, however, continues to walk a tightrope between clients who demand a "close to perfect" recommendation, an industry that is reeling from some major restructuring, aggressive competition and regulators who seem to have their own agenda. Through it all, no one has decided on a uniform system to determine safety and solvency and what role the agent will play. Any practicing agent should obviously stay close to this developing arena.

COMPANY SAFETY IN THE YEARS AHEAD

During the last half of the 1980s industry failures filled the spotlight. During the 90's, poor profitability due to severe price competition and continued underwriting losses became the problem. Other problems in the industry were brought to surface like deceptive sales practices, misleading illustrations, national health care, asset risks, the adequacy of the state guaranty system, private rating service deficiencies and certain industry tactics used to "shore up" balance sheets. This negative exposure accelerated political investigations which have and will continue to result in new regulatory pressures. In addition, new troubles from major growth in class-action filings are disturbing. For the meantime, most insurers have been fairly successful in stabilizing their financials -- particularly capital surplus -- through aggressive cost containments and the "bulk sale" of selected assets.

Some experts believe that company managers are overcompensating, building surplus beyond reasonable levels in response to new or proposed risk-based capital rules. While this will help companies meet new regulatory quotas, future earnings will decline, as potentially profitable acquisitions are by passed and the development of new product lines is placed on the back burner. This, in combination with proposals like the model investment law, render industry managers some complex limitations. Some believe, in the long run, insurers will be legislated out of their ability to make any investment risks. Since investment profits play a major role in surplus, this could leave the industry at a major disadvantage to cover future liquidity problems. A major turn of events or more catastrophic hurricanes or floods could again push many insurers over the brink. Further, the insurance industry position as a major source of capital for real estate and bond markets will be diminished or lost.

FUTURE OPERATIONAL CHANGES

The biggest challenge facing insurance companies is how to balance profits and solvency. The industry is entering a period of higher regulatory action and reaction. But what standards will they have to meet and who will regulate them? Further, will complying with new surplus and investment standards jeopardize an insurer's ability to satisfy shareholders and meet its own financial goals? These questions will probably NOT be answered for many years. In the meantime, insurance companies will likely be taking a "double books" approach of testing for regulatory reporting on one side, while the other side is testing for investment strategies and new products. Blending the two together will not be easy.

While insurers have improved their monitoring of cash flows and asset/liability matching, the danger of interest rate fluctuations is now a substantial risk. If rates edge upward, carriers risk disintermediation, or a major outflow of funds, if they are unable to keep pace with consumer demands for higher rates. A concern shared by industry groups is that this condition, or additional casualty catastrophes (hurricanes, floods, earthquakes) might strain carriers beyond their resources. And, even though their liquidity level may be higher, under new risk based capital rules where future investment returns might be less, there will not be large "profit pools" to draw on for contingencies and as emergency claim funds. As a result, insurers may be forced to raise mortality and/or premium rates at a time when the forces of competition, regulatory pressures and
consumer demand can least tolerate it. Aside from slim profit margins, other factors which could influence future solvency include changing demographics which have reduced the demand for life insurance; increased competition for savings dollars / insurance products from the banking and mutual fund industry and the ever present threat of potential loss of insurance tax advantaged status. On the casualty side, the industry is still suffering from past baggage in the form of liability suits and environmental claims (asbestos, toxic, etc). And, of course, no one knows what mother nature is likely to dish out.

POSSIBLE REGULATORY CHANGES

In recent years, the industry has experienced a small taste of the new regulatory "bite". Despite huge insurer losses from hurricane and Midwest flood claims, regulators in these states prohibited major rate hikes and required companies to continue providing coverage. In Florida, consumer outcries prompted the state legislature to initiate a moratorium on "non-renewals" and limit annual rate increases to five percent when an increase of 20 percent is needed to recoup from hurricane losses. The liquidity problems of life insurers are also a definite target for regulators. So great is the pressure and so many are the proposals that life companies are totally consumed with restructuring for regulatory solvency to the detriment, some say, of passing on investment opportunities that could mean substantial earnings in years ahead. The management of profitability under these conditions runs a clear second to solvency issues. This could place life companies at a competitive disadvantage to banks and other financial services industries, where solvency issues have improved and profitability is again the first priority. The end result is still anybody's guess. What is certain is that new regulatory laws and proposals will proliferate. Here are a few that are already on the books or in motion:

Risked Based Capital

*Risk Based Capital* is the "brainchild" of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a "national regulatory system" by the passage of "*model acts*," or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners. While the jury is still out on the effectiveness of Risk Based Capital, no one can argue that any attempt to establish a universal form of solvency regulation is attractive, and quite possibly mandatory in light of recent pressure by Congress and consumers. The National Association of Insurance Commissioners can be considered a logical conduit for national regulation, since its members are the insurance commissioners of each state and at present, the authority of states to regulate the insurance industry is allocated to the states under the 1945 McCarran-Ferguson Act.

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

Insurers reporting Risk Based Capital levels of say less than 70 percent to 100 percent may be subject to strict regulatory control. Scores from 100 percent to 150 percent might be issued regulatory orders requiring specific action to cure deficiencies. Higher scores might receive regulatory warnings and corrective action stipulations. Attaining 250 percent or more, would relieve an insurer from any further Risk Based Capital requirements in a given year.
It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an *asset-default test* under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the **C-1 surplus requirements** alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Salomon Brothers Inc study of almost 500 insurance companies clarifies the problem. Financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective risked based capital levels. Even though, a majority of companies exceeded the 150 percent threshold--thus, not requiring regulatory correction--the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when risked based capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.

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

Risked based capital also scores low among insurers for another very important reason--Risk Based Capital Reports can be disclosed and misunderstood by the public, despite National Association of Insurance Commissioners' confidentiality promises. It is easy to realize that disclosure concerning a low scoring company could damage or cause a "run" on the insurer. The National Association of Insurance Commissioners feels it has adequately provided for confidentiality within the Risk Based Capital Act. Specifically, the Model prohibits anyone in the insurance industry from using Risk Based Capital data and analysis in any public statement. There is even a provision recommending that state legislatures **exempt Risk Based Capital** information received from the National Association of Insurance Commissioners from state "freedom of information" laws. Insurers doubt that any such exemption from disclosure will suffice, since few states have adopted any exemption legislation, and there is history that pressure from public, political and judicial arenas ultimately lead to access by anyone for any reason.

In fact, there may be reason for insurance company concern about disclosure of Risk Based Capital data. Recently, there has been attempts to retrieve information similar to Risk Based Capital data by an insurance journalist/analyst using "freedom of information" statutes. Many states denied these requests for reports, called IRIS ratios (Insurance Regulatory Information System reports) since this data is considered confidential by state financial examiners. Yet, in some states, the same requests for information had mixed success via direct court action. In response, the National Association of Insurance Commissioners adopted a policy to withhold IRIS report information from states that could not assure confidentiality. Under court order, however, they later agreed to disclose the actual IRIS ratio themselves but not the analysis of their examiners that usually accompany IRIS reports. The court argued that even though the National Association of Insurance Commissioners is considered to be a private organization of government officials, rather than a government agency, IRIS ratios eventually became the exclusive property of state insurance departments and thus subject to public access under freedom of information. In another state, the courts rendered a different decision and granted an exemption under freedom statutes thus asserting the state regulator’s right to withhold IRIS reports. They concluded that the privacy rights of the insurance company outweighed the merits of public disclosure.
Indeed, insurance companies have reason to remain uncomfortable about disclosure of confidential information like IRIS and Risk Based Capital reports. In fact, they might be uneasy to learn that efforts to win access to even more sensitive information, like minutes of insurance company board meetings, has been met with some success. Once information is demanded and then delivered to state regulators it becomes potentially fair game under freedom of information statutes. In a similar vein, there is concern that federal political pressure to subpoena confidential records of an insurer would allow even greater access since federal "freedom of information" statutes are typically more liberal that individual states. Safeguards proposed by the National Association of Insurance Commissioners and state regulators may help forestall public access, but it may be optimistic to think that a foolproof method to avoid disclosure is possible. Troubled insurers, may well brace themselves for the likelihood that data on their Risk Based Capital could make national news or influence their ratings.

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

**Solvency & Financial Enforcement Trust (Safe-T)**

In the search for a solvency "cure", it is possible that simple is better. Nothing could be simpler than a proposal called "**Solvency & Financial Enforcement Trust**" or SAFE-T for short. SAFE-T is considered a simple, straightforward solution because it eliminates the complex formulas proposed by many other plans, such as the National Association of Insurance Commissioners "Risk Based Capital" plan.

Developed years ago by State Farm for use by property/casualty companies, the SAFE-T method would require each insurer to fund a **custodial account** at an institution that is not related or affiliated with the insurer. The funding of this account would be accomplished using real, liquid assets. The amount of assets in the account would be sufficient to cover loss reserves and loss adjustment expenses. To facilitate claim payments from an insolvent insurer, the guaranty fund for a particular state has, in essence, a lien against the SAFE-T trust account. The value of assets in the custodial account would be verified annually by a Certified Public Accountant along with a certification of loss reserves. More recent amendments to the proposal allow the insurer to retain all ownership rights to the assets in the custodial account, as well as the rights to sell and trade them, so long as any securities meet qualifying standards under the act. Only cash, cash equivalents, publicly traded securities classified by the National Association of Insurance Commissioners as medium or high quality would be accepted. Also, an insurer could submit an approved letter of credit to meet assets requirements. The amount of this letter of credit, however, could not exceed 15 percent of the amount required to be on deposit in the SAFE-T account. Further, an insurer would be provided some leeway if the value of the assets in the account dropped during the year. So long as assets maintained 80 percent of the required value, the insurer would not be required to add more assets in the middle of the year. If, however, the value drops below 80 percent of the required amount, the insurer must immediately respond with additional asset deposits or risk a "cease and desist" order restricting the company from writing any new business. Custodians of the SAFE-T accounts would be responsible for reporting to the respective insurance commissioners the activity and value of the insurer's account. In the event an insolvency was eminent, the SAFE-T account would be available to make prompt claims or to reimburse the state guaranty fund.

The advantages of the Solvency & Financial Enforcement Trust are many. First, many of the standards, such as the use of Certified Public Accountants and certification of loss reserves, are already in place. This will enable easier set up and enforcement. Second, SAFE-T is based on the use of assets considered by many, including the National Association of Insurance Commissioners, to be the most valuable to an insurer's ability to meet its obligations to its policy holders. Third, the
requirements of SAFE-T seem to align with the needs of state regulators looking for an improved "early warning" system that could be enforced without the need to apply complicated formulas and legal hoops. And, fourth, the number of insolvencies may be minimized, since liquid assets of the company will be "marshalled" by the custodian. In past cases, by the time an insurer faced insolvency, most of the liquid assets had already been sold, leaving less valuable and illiquid ones to the liquidator, state guaranty fund and policy owners.

The Compact Approach

Another approach to solvency regulation is to improve the existing state guaranty system. One proposal by the National Conference of Insurance Legislators seeks to provide a uniform set of standards for all state guaranty fund regulators. This would be accomplished by creating an interstate "compact" or agreement among all states to standardize the protection provided by guaranty funds, as well as procedures to rehabilitate and/or liquidate an insolvent insurer. The idea of a "compact" between states is nothing new. Article 10 of the Constitution provides for a mechanism for states to make agreements among themselves in order that fair treatment of the citizens be served. This has resulted in over 100 interstate compacts over the years on issues like taxes, vehicle laws and crime. There is no reason this wouldn't work to overhaul the current state guaranty systems which are riddled with loopholes, exclusions and diverse protection limits. It is common knowledge in the industry and among regulators that improvements to the system are needed, especially in the aftermath of public hearings presented to members of Congress in the early 90's. Significant weaknesses in the guaranty fund system were discussed, and the fear among industry leaders and regulators alike is that a lack of action to respond with corrective action may result in efforts to replace the state guaranty system with a federal mandate.

State fund problems aired in the public hearings include guaranty limits, insurer and policyowner residency and specific product exclusions. Guaranty fund limits vary widely between states. In Kansas, life and health benefits are covered up to $100,000. The limits are $500,000 in New York. Utah includes a $500 deductible others do not. Michigan guarantees 1/20 of one percent of all property/casualty premiums while New York stands behind a whopping $1 million. Some funds will only cover residents of their state, others will back anyone insured by a company that is domiciled in the state. Additional variations include service and product coverage. Some funds guarantee all annuities written by domiciled companies while others exclude variable type policies. Some cover HMOs and Blue Cross/Shield plans, while others do not.

The National Association of Insurance Commissioners developed "model acts" which it hoped most states would follow -- The Post-Assessment Property and Liability Insurance Guaranty Association Model Act (1969) and the Life and Health Insurance Guaranty Association Model Act (1970). The property/casualty model sets maximum limits at $300,000 for any claim with unlimited coverage for workers' compensation. The life/health model includes maximum benefits of $100,000 in cash values of life, annuity and health contracts and $300,000 in death benefits. To date, not all states have followed these guidelines. On the property/casualty side, about 14 states meet or exceed the NAIC limits. The remaining follow some, but not all standards. In life/health, only 15 states limit guaranty funds in line with the Model Act.

The interstate "compact" proposed by the National Conference of Insurance Legislators could potentially smooth out the differences among states and bring about a set procedure for handling insurance company insolvencies. The proposal suggests this could be accomplished by creating a commission, called the Insurance Claimant Protection Commission, to coordinate the activities of all state funds participating in the compact and act as the receiver of insurers placed in rehabilitation or liquidation. The commission would be comprised of the commissioner of each state. Each state would have one "member vote", as well as a designated number of "premium votes", based on the state's total premium volume. Any decision by the commission would require a majority of BOTH member and premium votes. Commission meetings would be public, unless a majority of members agreed that subjects discussed would reveal trade secrets or confidential information. Funding of the commission would be through assessments of insurance companies doing business in the compact states. Reports would be made annually to the governor and legislature of each state as well as the National Conference of Insurance Legislators. Regulations and statutes approved by the commission
would be binding on all state funds in the compact. As an escape measure, each state's legislature could vote to reject a commission statute. If a majority of states follow suit, the specific regulation would have no force and effect on any compact participant.

Under the threat of federal intervention, it is likely that the interstate compact should attract major attention. Already, insurance departments of several states are amenable to working on a compact plan and the National Conference of Insurance Legislators is in process of contacting state legislators, policymakers and industry trade groups. The fact that the interstate compact was conceived by state legislators with technical assistance from one of the nation's top insurance law firms give it a greater chance of success than many other solvency proposals.

**Federal/State Co-Regulation**

On the heels of several large insolvencies, a flood of regulatory initiatives have emerged. Critics of the new proposals say there is no panacea for the problem of insolvencies. Even federal intervention will not bring an end to insolvencies, since they are inevitable in a free market. Then, too, the federal government does not have a stellar record in the area of efficiency and regulatory success. Others, however, believe that federal involvement in the regulation of insurance is necessary to industry stability and the centralization of authority. While there is cause to doubt this last proclamation, it is possible that some form of federal and state system of regulation will be attempted. The *Federal Insurance Solvency Act of 1992* is one such form. Under this act, a solvency commission is established to regulate all insurers. Insurance companies and reinsurers receive the equivalent of a "solvency certificate" which would permit them to do business anywhere in the United States. The bill also creates a protection or guaranty fund to cover any insolvency losses. As good as all this sounds, it would undoubtedly come with a hefty price tag and since it leaves rate regulation with each state, it establishes a system of "dual control". One can only imagine the regulatory hurdles and snafus that could surface under this proposal.

Some believe that a slightly different "two-tiered" system can work. Federally licensed companies could do business alongside state licensed insurers much like they do in the banking industry where some institutions are federally chartered while others operate solely under the jurisdiction of the state. Insurers, both large and small, could have the choice to be federal or state licensed and limits on guaranty funds could be standardized. Additionally, an insurer could and should be totally regulated by either the federal or state system, not partially regulated by both. The advantages of such a system key on uniformity for the insurer wishing to do business on a nationwide scale. Policy owners would also know that guaranty fund limits are the same from state to state. One would wonder, however, if such a system would favor federally licensed companies where policy owners might feel a federally backed guaranty fund is safer than a state fund. It is suggested, then, that for a successful federal-state system to exist, competition must be eliminated: This could be difficult, if not impossible to accomplish. That is why many industry regulators and players believe that a new, untried federal system is not practical. They argue that in place of scrapping state systems of regulation, a major restructuring of existing state guaranty funds and universal solvency rules would have greater value. Thus, proposals like Risk Based Capital, SAFE-T and the Interstate Compact must be seriously considered to "head off" federal intervention.

**Model Investment Laws**

The National Association of Insurance Commissioners has also made headlines for its Model Investment Laws. The purpose of these regulations is to prevent insurance companies from concentrating too much cash in too few types of assets. Critics feel the National Association of Insurance Commissioners' guidelines rely too heavily on classifying by type of investment and risk and setting percentage maximums. This, they say, will leave regulators with little opportunity to use their own judgement.

**National Catastrophe Fund**

Although it may be years in the making, a National Catastrophe Fund is also being considered. During
hearings before the Senate Commerce, Science and Transportation Committee, details indicate that this fund would reinsure existing companies to ease the impact of major disasters. A company with losses that exceeded 20 percent of its surplus would qualify for assistance. Because only regional and small companies are likely to collect from such a federal fund, the current thinking is that the amount of losses would not be large enough to seriously strain the fund.

**State Catastrophe Funds**

Regulators have and will be influential in convincing state legislatures to establish catastrophe funds. These funds may start out to be permanent solutions only to fizzle out within months or years after the disaster has struck--like the earthquake fund in California. Current efforts include Hawaii and Florida, where major hurricanes have hit in the 1990s. In Hawaii, the state hurricane fund is the exclusive provider of hurricane insurance. The programs is financed through a variety of real estate fees, premium taxes and assessments. The systems functions as a reinsurer to companies writing within the catastrophe zone. Florida's hurricane trust fund will reimburse insurers for 75 percent of their losses once claims surpass two times the amount of the company's annual premium. Financing of the program will be through surcharges on policies, a percentage of premiums written, emergency assessments and state guaranteed bonds.

**RATING CHANGES**

For now, while interest rates and mother nature is lying low, insolvencies are down. Agents should, however, be prepared for the very minimum expectation -- the new regulatory environment coupled with diminished profits and the need for rating agencies to clamp down will affect ratings. The major rating services expect downgrades to outpace upgrades for many years to come. As case in point, A.M. Best recently issued life companies 172 downgrades and only 56 upgrades. While this is not the same as widescale insolvencies, it is a deteriorating condition that could affect client confidence. Marketing products and services in the face of reduced ratings will test agent due diligence and company selection skills beyond any previous limits.

In a period following major company failures it is logical that the rating agencies will emerge with new, tighter criteria. They must also adapt to changing regulatory laws and formulas. Needless to say, major changes are going to occur. A preview of the intensity and breadth of change possible took place in July 1993 when A.M. Best shocked the insurance world by downgrading over half of the life companies who previously held A+ or A++ ratings to A. Before this, in late 1992, Best added six new letter ratings (A++, B++, C++, D, E and F). This increased the ratings of this firm from 9 to 15. It also brought to light the huge differentiation the company anticipates in company ratings. Further, it could be a indication that the company will no longer be timid in swiftly downgrading a company . . . perhaps to as low as D and F (liquidation). In a recent article, Best explains its rating modifications . . . "The purpose of these changes was to enhance the usefulness and clarity of our rating system . . . More important than the structural changes to Best's rating classification has been the continuing evolution of our analytical review. Specifically, qualitative considerations have become increasingly important in Best's rating system". Some feel that the Best downgrades are tied to size of company. One company's analysis showed that 77 percent of the 71 companies adjusted downward had assets less than $600 million. Best contends that its rating framework is the same for all companies, regardless of size. They do admit, however, that there are advantages to size in certain lines of business. According to the company . . . "Administrative capabilities, technological advantages, lower unit costs and management depth can provide competitive strengths that contribute to market penetration and presence difficult to achieve in highly competitive businesses on a relatively small scale. Though such advantages may be reflected in rating assignments, smaller companies that remain highly focused and maintain sustainable and defensible strengths also fare favorably in Best's rating assignments".

Other rating services will also recognize the need to adapt their solvency formulas. In the past, some of these companies, namely Standard & Poors and Weiss, have based their analyses primarily on quantitative issues such as the insurer's claims-paying ability based on statistics generated from statutory filings with individual state insurance departments or the National Association of Insurance Commissioners. With new risks of regulatory violations, competition from new entrants, banks, thrifts, etc, and the delicate line insurers must walk between solvency and profit, it is likely these agencies will add fresh information to modify their approach. Few raters, with the exception of Moody's, have
focused on the breadth of such issues. This is likely to change in the years ahead with the inevitable result being lower ratings.

POLICY CONSTRUCTION

INSURANCE CONTRACTS IN GENERAL

The definition of insurance as given in the most insurance codes has not been substantially changed since over time. Most define insurance as “a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.” It is important that a licensee understand the meaning of this definition. In order to obtain a good understanding, it is necessary to be able to identify and know the meaning of following terms in this definition:

**Contract:** an agreement to do or not to do a certain thing that is enforceable by law.

**Indemnify:** to make payment in money or property, to compensate for a loss.

**Contingent:** the peril that might occur and cause damage or liability against a person.

**Unknown event:** Perils could include fire, windstorm, hail, explosion, flood, theft, riot, vandalism, negligence, failure to satisfy and obligation to another person.

"Insurance" generally may be defined as an agreement by which one person for a consideration promises to pay money or its equivalent, or to perform some act of value, to another on the destruction, death, loss, or injury of someone or something by specified perils.

Insurance policies are contracts, therefore they must meet the requirements of other legal contracts. The essential elements needed to make contracts enforceable are:

1) **Capable parties** - all persons are capable of contracting except minors, persons of unsound mind, and persons deprived of civil rights. The exception in making a contract of insurance is that a person under the age of 18 is competent to contract for life or disability insurance or an annuity contract on his/her own life for the benefit of himself/herself or members of his/her immediate family. A person under 16 years of age nearest birthday must have the written consent of parent or guardian to enter into an insurance contract (see examples under insurable interests).

2) **Consent** - must be given freely, mutually and communicated by each party to the other. Consent is given between two parties when a proposal or offer by one of the parties is made and the other party accepts.

3) **Lawful subject** - agreement shall not call for the violation of any laws. In insurance, lawful subject is any contingent or unknown event, whether past or future, which may cause damage to or create a liability against a person having an insurable interest. Most insurance codes expressly prohibit insurance on a lottery or the outcome of a lottery, and policies executed by way of gaming or wagering.

4) **Consideration** - any benefit given to a party by the other party which was not lawfully due the party. In insurance, the consideration is the monies which are given as premiums.

While these elements are essential to contracts in general, there is one more requirement that is necessary to contracts of insurance. In insurance, the insured must have an **insurable interest** in the lawful subject of the contract.

Most insurance codes define insurable interest in property insurance as "every interest in property, or any relation thereto, or liability in respect thereof, of such a nature that a contemplated peril might directly indemnify the insured." Lack of insurable interest causes the contract to be void. In fire and
casualty insurance, the requirement of an insurable interest in property must exist when the insurance takes effect and when the loss occurs, but need not exist in the meantime. The measure of insurable interest in property is the extent to which the insured might suffer financial loss by damage to or loss of the property.

Most insurance codes define insurable interest in life and disability insurance as "every person has an insurable interest in the life and health of (1) himself/herself (2) any person on whom he/she depends wholly or in part for education or support (3) any legal obligation to him/her for the payment of money or respecting property or services of which death or illness might delay or prevent payment (4) any person upon whose life any estate or interest vested in him/her depends."

1) **Himself/Herself** - every person 18-years or older that is capable of entering into a contract may apply for insurance on his/her own life in any amount. The amount of life insurance in force on any one life is not limited by law, but is normally a negotiable term limited by underwriting requirements of a company. These requirements may vary from company to company, while one company's limit of insurance in force on any one life may be $100,000 another's limit might be unlimited.

When a person, 18-year or older, purchases a policy of life insurance on his/her own life, the law does not require that the beneficiary have an insurable interest.

A person under age 18 is competent to contract for life or disability insurance or an annuity contract on his/her own life for the benefit of himself/herself or the benefit of the father, mother, husband, wife, child, brother or sister.

A person under 16-years of age, nearest birthday, must have written consent of parent or guardian to enter into an insurance contract. If assessments are involved in the insurance of any minor, the liability for assessment must be assumed by the parent or guardian by a written agreement.

2) Any person on whom he/she **depends wholly or in part for education or support** - A wife has an insurable interest in her husband. The husband has an insurable interest in his wife. The children have an insurable interest in their parents.

3) Any person under legal obligation to him/her for the payment of money or respecting property or services, of which death or illness might delay or prevent the performance - A creditor has an insurable interest in the life of a debtor. When a person owes money or property to another person, the person to whom the debt is owed has an insurable interest in the life of the person owing that debt to the extent of the amount owed.

**APPLICATION**

Except in a few specialized types of insurance, the selection of risks is based upon comprehensive applications signed by the insured in which he/she is required to answer searching questions from which the company determines insurability. In many cases, life insurance applications are supplemented with medical examinations. These are subject to being supplemented or checked by a report to the company by the soliciting agent and by the inspections made for the company by other than the agent.

No contract exists between an applicant for insurance and an insurance company until the application for insurance is accepted. An application for insurance is a proposal which does not become an enforceable contract until it is accepted by the insurer on the terms in which the proposal was made. If the insurer alters any terms of the proposal, then the applicant must accept the alterations before the contract is effective.

Company requirements for applications vary depending on the type of insurance and the authority given to the agent by the company. For some types of insurance, a written application may not be required. For these coverages, an applicant may request coverage orally and the agent may create
an oral contract by immediately binding the requested coverages. When the agent has this authority, the agent should understand what makes an oral contract of insurance valid and enforceable. It is necessary that both the agent and the applicant agree to the company providing coverage, subject matter, risk, premium, duration of risk and amount of insurance. Specifying the company providing coverage at this time is important to an agent if he/she represents more than one company. Failure to do so can result in each company that the agent represents paying a pro rata share of a loss that might occur before a written binder or policy is issued, and possibly the agent may be held responsible for the loss. Whenever the parties enter into an oral contract before the policy has been issued, the policy should be backdated to the date of the oral contract. An agent should use extreme caution when using his/her authority to enter into an oral contract. The difficulty of providing the terms of an oral contract or its existence makes it advisable to confine contractual agreements to those that are written whenever possible.

Other types of insurance that are more complex require a written application, even though an agent may have issued a binder to provide temporary coverage. In these cases, the company wishes to know about particular details, which allows it to determine if the risk meets its underwriting standards. If the risk meets the underwriting standards, the company may issue the policy, or inform the agent to issue the policy depending upon the method used for issuing policies by that particular company. When the risk does not meet the underwriting standards, the company must cancel any temporary binder that was issued in the same manner it would cancel a policy that has been in force.

NOTE: When the agent prepares the application for the insured, the agent is doing so as the agent of the insurance company, and not the agent of the insured.

BINDERS (COVER NOTES)

Binders may be issued to bind insurance temporarily pending the issuance of the policy. Within 90 days after issue of a cover note, a policy shall be issued, including terms and premiums identical to those bound by the cover note. An insurer may extend a cover note beyond 90 days with the written approval of the commissioner for a period which, when added to the original 90-day period, will not extend coverage beyond 150 days. A risk must fall into one of the following categories to be eligible for extension without written approval from the commissioner.

1) The property insured is in five or more separate locations.

2) The premium is estimated to be:

   A) $400 or more annually in the case of fire insurance.
   B) $250 or more annually in the case of insurance other than fire.
   C) The risk is one which requires an inspection and is located in excess of 100 miles from a city with a population of 100,000 or more.

Cover notes and all extensions must be in writing. The insurer must maintain a permanent record of the original covering note and all extensions. The cover note must contain the following:

1) Name of the insured,
2) The property or liability insured,
3) The amount of insurance,
4) The perils insured against,
5) The effective and termination dates,
6) The basis or rates upon which the premium is to be determined and paid,
7) If cover note is extended, the extension must identify the original note.

A policy must be issued covering the insured, after a risk has been bound by a cover note, with the same effective date which was provided in the cover note. When the policy is issued for a period of time that extends beyond the period of coverage in the cover note, the earned premium may be
included in the premium charged under the policy. When the period of coverage provided by a cover note does not extend beyond that provided by the cover note, a policy shall be issued showing the time coverage was in force and premium charged for the insurance.

MORE ON POLICIES

In most states a policy is either open or valued. An "open policy" is one in which the value of the subject matter is not agreed upon, but is left to be determined in case of a loss. Under an open policy, the measure of indemnity is the expense to the insured of replacing the thing lost or injured in its condition at the time of its loss or injury. A "valued policy" is one which expressed, on its face, an agreement that the thing insured shall be valued at a specified sum. Whenever the insured desires to have a valuation named in a policy insuring any property, the insured may require such property to be examined by the insurer and the value shall be fixed at that time by insured and insurer. The cost of this examination shall be paid by the insured. A clause shall be inserted in such a valued policy, stating that the value of the insured's property has been fixed by such an examination. In those valued policies that do not make the stipulation "not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality", the insurer shall pay losses as follows:

1) In case of a total loss, the amount stated in the policy.
2) In case of a partial loss, the full amount of the partial loss.

In various classes of insurance, different policies or contract provisions are used. However, a degree of uniformity exists in the basic provisions of the policies issued by a majority of insurers. There are certain provisions which are common to many lines. In general, these policies usually contain five parts known as "declarations", "insuring agreement", "exclusions", "conditions", and "miscellaneous provisions". Only the definition of these parts is given this portion; they will be reviewed in more detail in the portion of this manual dealing with the specific policies.

Declaration: is a term applied to underwriting information identifying the insurer and insured, subject matter, premium or how the premium will be determined, policy limits, policy term, and a list of forms that make up the body of the contract. In some policies, the perils will be listed in the declaration, but in most policies, other than the standard fire policy, the perils are listed in the body of the contract. The declaration normally appears on the first page of the contract.

Insuring Agreement - states what it is the insurer agrees to cover under the terms of the contract. It will refer to the subject matter of the insurance. In the standard fire policy, the declaration and insuring agreement will appear together on the first page of the contract. In those policies that have more than one subject matter, such as homeowner policies, there will be an insuring agreement for each subject matter.

Exclusions - These provisions in a policy will fix the limits on the promises of coverage stated in the insuring agreements. These provisions serve one or more purposes, including elimination for coverage of (1) coverage for losses caused by certain perils, (2) coverage provided by other insurance, (3) coverage of uninsurable losses. Basically, exclusions are those portions of the insurance contract which limit the scope of the coverage and/or list causes and conditions which are not covered.

Conditions - Those provisions in a policy which call for the insured to do something, or not to do something, either before or after a loss has occurred. The insurer's obligation to pay for losses or to provide services is based on the insured's obligation to perform certain duties, or prevent certain things from happening. One of the duties of the insured, before a loss, is to have been truthful in applying for the insurance coverage. Concealment or fraud by the insured will make the policy void. One of the duties of the insured, after a loss, is to protect the property from further loss. Failure to do so could relieve the insurer of the obligation to pay the claim.

Miscellaneous Provisions - Those provisions which, along with the declaration, insuring agreement, exclusions and conditions complete the insurance policy. These provisions help to establish working procedures for carrying out the terms of an insurance policy.
ENDORSEMENTS

An endorsement is an agreement not contained in the original policy. It may be written on or attached to the policy, thus becoming a part of the policy. Historically, when written on a separate piece of paper and physically attached to the policy, it was originally called a "rider" and, when written on the policy itself, it was originally called an "endorsement". These terms are now used interchangeably.

When a policy has conflicting provisions between a policy and endorsement (rider) the following will normally apply. A contract will be interpreted, if at all possible, so as to give effect to the intent of the parties who executed it. If the conflicting provisions can be reconciled, they will be so interpreted as to give effect to every part of the contract. If they cannot, the following rules, considering only typography, are a generally applied:

1. An endorsement (rider) added after the execution of the policy will prevail over the original policy terms whether they are printed or written.
2. The terms of a printed rider attached at the time the policy was issued will generally prevail over the printed part of the policy, but the assumption is not as strong as in (1) above.
3. A written part of the policy, having been especially chosen to express the agreement of the parties to the contract, will prevail over the more general printed portion or printed endorsement (rider).

Where a policy and its endorsement disagree, the courts will interpret the intent of the parties involved. If this does not resolve the conflict, then the written endorsement usually prevails.

FIRE INSURANCE

Fire insurance companies admitted in most states are permitted (subject to their charter limitations and their certificates of authority) to write all lines of insurance excepting life, title, mortgage and mortgage guaranty insurance. Most fire insurance companies in addition to fire are writing such classes as riot and civil commotion, explosion, windstorm, hail, earthquake and sprinkler leakage. While forms of policies are generally standardized in these classes, a statutory form of fire policy is prescribed by most Insurance Codes for the writing of fire insurance and must be used by all fire insurers as follows:

1. Mutuals must print thereon such by-laws and mutual conditions as will define the liability of the policyholder.
2. Reciprocals may insert such provisions not in conflict with law as are made necessary by the transacting of business on the reciprocal plan.
3. County mutuals have a standard form of their own containing additional clauses pertaining to the policy application, the policyholder’s liability for assessment, if any, cancellation and assignment.

The standard fire policy is an "interest" policy, i.e., it insures the interest of the insured in the property described but does not require that such interest be that of sole and unconditional ownership. The agent, broker, and solicitor must be thoroughly familiar with the risk to be insured and with all the terms and conditions of the standard policy in order to know what changes are necessary to be made by endorsement to give the insured proper coverage.

The standard fire policy is composed of five basic parts: declarations, insuring agreements, exclusions, conditions, and miscellaneous provisions. In the standard fire policy, there is no clear distinction made to set off these five basic parts. In order for the new licensee to understand the standard fire policy, we have grouped together the different provisions into these five basic parts.
DECLARATIONS

The "declaration" appears on the first page of the standard fire policy. Generally, it will contain the following information:

1. The name of the insurer, the policy number, insured's name and mailing address, inception and expiration dates;

2. A space for listing amounts of insurance, rates and premiums for the coverages insured.

3. The number of items or locations, amount of insurance for each item or location, a description and location of the property covered. The description will normally include the type of construction, type of roof and occupancy of the building covered or containing the property covered;

4. The identifying number of the endorsements being added, a space for identifying a mortgage, and the signature of the agent, if necessary.

INSURING AGREEMENTS

The "insuring agreement" will read: "In consideration of the provisions and stipulations herein or added hereto and of (the above specified) dollars premium, this company, for the term of this policy at the location involved, to an amount not exceeding (the above specified) dollars, does insure (named insured) and legal representatives, to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair, and without compensation for loss resulting from interruption of business, or manufacture, nor in any event for more than the interest of the insured, against all loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy, except as hereafter provided, to the property described herein while located or contained as described in this policy, or pro rata for five days at each proper place to which any of the property shall necessarily be removed for preservation from the perils insured against in this policy, but not elsewhere." The insuring agreement is the heart of the contract. It states what the insurer is legally obligated to do under the contract. To better understand the insurer's obligation, we should know the meaning of the following phrases which make up the insuring agreement:

1. **In consideration of the provisions and stipulations herein or added hereto.**

   - **Herein** - those provisions and stipulations in the standard fire policy.

   - **Added hereto** - those provisions and stipulations contained in the endorsements that are added to the standard fire policy to increase the scope of the policy. It is important to remember that when the conditions in an endorsement conflict with the provision in the policy, the conditions of the endorsement prevail over those stated in the policy.

2. **Does insure (the named insured) and legal representatives.**

   - **Named insured** - will be all persons named in the policy as having an insurable interest in the property. This would include all loss payees and mortgagees named in the policy.

   - **Legal representatives** - any executor or administrator of an insured who dies during the policy term, or the person appointed by law to supervise the affairs of a minor or of an insane or incompetent person.

3. **To the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality**
Actual cash value - actual cash value means replacement cost less depreciation. If part of a 20-year old building is destroyed by fire, the company will pay what it would cost to restore the building to the condition it was in before the loss. The company is not required to pay to restore the building to the condition it was in when new, simply because the building wasn't new.

But not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality. If a 10 year old couch which costs $900 was destroyed by a fire, the company will pay enough to buy a used couch comparable in make and quality in today's market. Recovery may be limited to $300 because the insured had the use of the couch for ten years.

NOTE: While the definition of "actual cash value" given above is still the most accepted definition, there have been various court rulings over the years that equate "actual cash with "fair market value". In arriving at this interpretation, courts note that the insuring agreement was to indemnify up to "the extent of actual cash value . . . but not exceeding the cost of repair or replacement". If actual cash value is synonymous with "replacement cost less depreciation", then paraphrasing of the insuring agreement would be: "to pay replacement cost less depreciation but not exceeding the cost of . . . replacement". Obviously, replacement cost less depreciation can never exceed the cost of replacement. Therefore, actual cash value has to be subject to a different interpretation. The court interpretation of "actual cash value" as being synonymous with "fair market value" should be of concern when there is a wide variance between "fair market value" and "replacement cost". When the replacement cost exceeds the fair market value the insured would be wise in comparing the difference between open and value policies.

4. Without allowance for any increased cost of repair or reconstruction by reason of any ordinance or law regulating construction or repair - if the property did not meet specific building code requirements before the loss, the insurer would not be required to pay for making it meet the building code requirements during the repairs after a loss.

5. Without compensation for loss resulting from interruption of business or manufacture - the standard fire policy is intended to cover property against all direct loss by fire and lightning. There is no coverage for indirect or consequential losses. These consequential losses can be insured under a separate policy.

6. Nor in any event for more than the interest of the insured - the insurer is not required to pay more than the extent to which the insured might suffer financially. The insured should never make a profit from a loss, but should be restored to the same position financially that was held before the loss.

7. Against all loss by fire, lightning and by removal from premises endangered by the perils insured against in this policy-

All loss by fire - fire is combustion sufficient enough to produce a flame or glow. Fire is classified as either friendly or hostile. A friendly fire is one intended to serve a useful purpose such as in a stove or fireplace, even though the heat or flame from it may become excessive and extend beyond the place where the fire was created. Loss by a friendly fire is not covered under the standard fire policy. A fire becomes hostile when it extends beyond the place where the fire was created. Loss by a hostile fire is covered by the standard fire policy.

Lightning - is a discharge of atmospheric electricity, which may cause damage to the property.

Removal from premises endangered by the perils insured against - One of the duties of the insured is to protect the property from further damage during a loss, the insurer extends the protection from the location stated in the policy to the new location to which the property was necessarily removed to protect the undamaged property. This coverage is extended for five days.

8. Except as hereinafter provided - this phrase in the insuring agreement allows the policy to be changed by adding endorsements to change perils insured against, conditions and exclusions.
EXCLUSIONS

The "exclusions" in the standard fire policy will normally appear on the second page, or exclusions may also be included in any endorsements being added to the standard fire policy. At this point we will review only those in the standard fire policy. There are two types of exclusions in the standard fire policy: (1) eliminating coverage of uninsurable and excepted property; (2) eliminating coverages for losses caused by certain perils.

Uninsurable and excepted property - The policy shall not cover accounts, bills, currency, deeds, evidences of debts, money or securities; nor, unless specifically named hereon in writing, bullion or manuscripts. The reasons for excluding these properties are the ease with which they can be concealed and removed, lending them to fraud. Also, it would be hard to prove the amount of money destroyed in a fire. These properties can be insured in some cases by using endorsements or property forms.

Perils not included - This policy shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: Enemy attack or action taken in resisting enemy attack; invasion; insurrection; rebellion; revolution; civil war; usurped power; preventing the spread of fire, provided the fire did not originate from any of the perils excluded by the policy; neglect of the insured to use all reasonable means to save and preserve the property at and after a loss or when the property is endangered by fire in neighboring premises; order of civil authority, except acts of destruction at the time of and for the purpose of preventing the spread of fire, provided the fire did not originate from any of the perils excluded by the policy; loss by theft.

CONDITIONS

The “conditions”, appear on pages one and two of the standard fire policy. Conditions are those provisions of a policy which call for the insured to perform certain duties. If the insured fails in the performance of these duties, it may relieve the insurer from liability under the policy. These duties can be required before a loss, after a loss, or both before and after a loss.

Duties of the insured before a loss:

Pay the premium in the first sentence of the insuring agreement "In consideration of the provisions and stipulations herein or added hereto and of the above specified dollars premium", it should be noted if the insured does not pay the premium, no contract exists.

Conditions suspending or restricting insurance; cannot increase the hazard, within the insured's control or knowledge. If the insured secured a fire policy covering a dwelling, and then converted the dwelling to a storage shed for explosives without the consent of the insurer, the coverage would be suspended; the described building, whether intended for occupancy by owner or tenant, cannot be vacant or unoccupied beyond a period of 60 consecutive days; there is no liability upon the part of the company as a result of explosion or riot, unless fire ensues, and in that event for loss by fire only.

Under these duties, the contract is suspended. A suspended policy is automatically reinstated when the conditions causing the suspension no longer exist. However, the suspension does not extend the term of the policy nor create any right for refund of any portion of the premium.

Duties required of the insured after a loss:

1. Give notice in writing to the insurer without unnecessary delay.
2. Protect the property from further damage.
3. Separate damaged from undamaged property and put it in the best possible order.
4. Furnish a complete inventory of destroyed, damaged and undamaged property showing in detail quantities, costs, actual cash value and amount of loss claimed.
5. Within 60 days after the loss, unless such time is extended in writing, render-proof of loss sworn...
to and containing specified particulars.

In addition, the insurer may require the insured to perform the following duties after a loss:

1. Furnish verified plans and specifications, if obtainable, of any building, fixtures or machinery destroyed or damaged.
2. Exhibit remains of property.
3. Submit to examination under oath and sign the statement.
4. Produce for examination all books of account, bills, invoices, and other vouchers, or certified copies thereof if originals are lost.

Duty of the insured before and after a loss occurs.

The entire policy shall be void if the insured before or after a loss has willfully concealed or misrepresented any material fact concerning the insurance, the subject of the insurance, the interest of the insured, or swears falsely. The insured is required to furnish the truth to the insurer.

To better understand this duty, it is necessary to know the following definitions:

Concealment - the neglect to communicate that which a party knows, and ought to communicate. With reference to insurance generally, a material concealment, whether intentional or unintentional entitles the injured party to rescind the insurance contract.

Representation - is a statement made as part of the negotiation leading up to a contract and may be oral or written. A representation is false when the facts fail to correspond with its assertions or stipulations.

Material fact - materiality is determined by the probable and reasonable influence upon the other party in forming an estimate of the disadvantages of the proposed contract.

The "miscellaneous provisions" of the standard fire policy would be all the remaining provisions not included in the first four basic parts:

Assignment - This provision states that the policy cannot be assigned except with the written consent of the insurer. An assignment is the transfer of the legal right or interest in a policy to another, generally in connection with the sale of property. If the benefits of a contract are used as collateral to secure an indebtedness, the person being assigned the benefits receives only a stipulated amount not to exceed his/her interest as it may appear.

Other insurance - This provision states that other insurance may be prohibited or the amount of insurance may be limited by endorsement.

Other perils or subjects - allows the standard fire policy to be endorsed to provide coverage for other perils and other subjects of insurance.

Added provisions - permits additional provisions regarding extent of insurance and contribution of company (e.g. co-insurance).

Waiver provisions - prohibits waiver of conditions except as authorized in the policy and then only in writing.

Cancellation of Policy - This provision allows the insured to cancel the policy at any time. When the insured terminates the policy, the refund of paid premium is based on short-rate cancellation. If the insurer wishes to cancel, it too may cancel at any time, but must give the insured (5) days written notice. When the insurer terminates the policy, the refund of paid premium is based on pro rata cancellation. In addition, if the refund is not included with the cancellation notice, the insurer is required to include a statement that refund will be made on demand.
Pro rata cancellation - is one in which the earned premium is proportioned to the time the coverage has been in effect.

Short rate cancellation - is one in which the earned premium is calculated according to an established short rate table which includes an extra charge to the insured over the pro rata premium. This change is made to absorb part of the expense incurred by the company in the issuance of the policy which would otherwise have been absorbed throughout the policy period had it remained in force to its normal expiration date.

Flat cancellation - is the cancellation of a policy without any premium charge. Such cancellation nullifies the contract from its inception. This usually occurs when the policy is returned to the company prior to the effective date or when no liability existed under the contract either because of no exposure or because coverage was afforded under another policy.

Mortgagee interest and obligation - in the standard fire policy the mortgage clause recognizes the existence of a mortgage on property and provides that the mortgagee named in the policy shall:

1. Be given ten days written notice of cancellation.
2. Submit proof of loss within 60 days after notice is given to the mortgagee that the insured has failed to submit a proof following loss.
3. Be subject to the provisions relating to appraisal, time of payment and of bringing suit.
4. Subrogate to the insurer all rights of the mortgagee to the extent of payment made to the mortgagee, when no liability existed as to the mortgagor or owner. An example of when no liability existed to the owner might be if a loss occurs after the owner increased the hazards within a building and the policy was suspended at the time of the loss. The suspension coverage would not affect the mortgagee.

The mortgage provisions of the standard fire policy may be changed by endorsement.

Pro rata Liability - this provision states that the insurer shall not be liable for a greater proportion of any loss than the amount insured shall bear to the whole insurance covering the property against the peril involved, whether collectible or not.

Example 1 - "In proportion that the amount of each policy bears to the whole insurance covering the property"... An insured's property is insured for $10,000 in four companies, each company's policy is in the amount of $2,500. A fire damages the property to the extent of $800. Each company's liability will be computed by the following method:

\[
\text{Coverage of 2500} \div \text{Total insurance 10000} = \frac{1}{4} \text{ of $800 or $200 each.}
\]

Total recovery of $800, four times the $200.

Example 2 - "In proportion that the amount of each policy bears to the whole insurance covering the property, whether collectible or not"... It now develops that one of the four companies involved is insolvent. The three solvent companies will use the same method.

\[
\text{Coverage of 2500} \div \text{Total Insurance 10000} = \frac{1}{4} \text{ of 800 or $200 each.}
\]

In this case the total recovery is $600, three times the $200. Since the three solvent companies had no control over who the insured was doing business with, they are not responsible for more than their proportion to the total. In this case the insured must bear the $200 which was uncollectable from the insolvent company.

NOTE: If two or more insurers cover the same property the written portions of all policies, including all endorsements or riders, should be identical. This is known as "concurrent or uniform" policy coverage. If they are not identical, the variance in the policies may result in impairment of the insured's ability to collect the full loss.
Example 3 - An insured's property is insured for $10,000 in four companies, each company's policy is in the amount of $2,500. The insured had extended coverage endorsed on two of the four policies. A windstorm caused damages to the property to the extent of $1,000. Each company's liability will be computed using the same method as shown in the examples of pro rata liability.

Coverage of 2500 / Total insurance 10000 = 1/4 of $1000 or $250 each.

Since the endorsement adding extended coverages was attached to two policies, only those two companies are liable for their portion of the loss or two times $250 equals $500.

Appraisal - in the event the insurer and the insured cannot agree as to the actual cash value or the amount of loss each on the written demand of the other, shall select a competent and disinterested appraiser. The appraisers select a competent and disinterested umpire. The agreement of any two filed with the company determines the amount of the actual cash value and the amount of loss. The insured and insurer each pay the appraiser appointed by them and equally divide the payment to the umpire.

Company's Option - the insurer may take all or any part of the property at its agreed or appraised value; may repair, rebuild or replace the property destroyed or damaged with other of like kind and quality, if it gives notice to insured within 30 days after receipt of proof of loss.

Abandonment - the insured may not abandon damaged property to the insurer.

When Loss Payable - within 60 days after proof of loss is received by the insurer and an agreement to the value of the loss has been reached.

Suits or Action Against Company - provisions in a policy which state that no suit or action can be made against the insurer unless the insured has complied with all the requirements of the contract. Generally, it will make reference to some period of time before a suit maybe brought.

Subrogation - provisions which allow the insurer to require from the insured an assignment of all right of recovery against any third party for a loss which the insurer paid under its policy. If the insured had a loss caused by the negligence of a neighbor, the insurer, after it has paid the loss, may sue the negligent neighbor to recover the amount paid. The insurer is "subrogated" to stand in the place of the insured.

ENDORSEMENTS

Endorsements frequently attached to the standard fire policy are the extended coverage endorsement, the vandalism and malicious mischief endorsement, the fire department service clause, and the coinsurance clause. The first two increase the number of perils insured against. The third provides for payment by the insurer of a service fee to fire departments. The latter is a condition added that the insured must carry a certain amount of insurance.

The Extended Coverage endorsement is designed for use with the standard fire policy. It extends the perils under the policy to include insurance against loss by windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles and smoke. It is important to remember that this endorsement does not increase the amount of insurance provided in the basic fire insurance policy. The policy and the extended coverage endorsement together constitute a single indivisible contract. If the extended coverage endorsement is attached to one policy it should be endorsed to all other fire policies on the same property. The extended coverage endorsement limits the liability of the company to that portion of the loss which the amount of insurance under the policy bears to the total amount of all fire insurance on the same property.

By attaching the vandalism and malicious mischief endorsement to a fire insurance policy to which is already attached an extended coverage endorsement, the scope of the extended coverage endorsement is broadened to include "willful and malicious damage to or destruction of the property insured", excluding glass and provided the building has not been vacant for a period of more than 30 days preceding the loss. The term vandalism and malicious mischief, as used in the endorsement, is
restricted to and includes only, willful and malicious damage to and destruction of the property described in the basic policy.

The fire department service clause is used on policies covering property outside fire protection to reimburse the insured for the cost of a fire department run. The coverage should be added to all policies on property in rural areas when a service charge would be made for fire department runs.

Coinsurance clause grants the insured a reduction in premiums for accepting a condition that the insured maintain the insurance at a specified percentage (usually 80%) of the actual value of the property covered. The insured becomes a co-insurer to a partial loss if he or she fails to maintain the insurance at the required level. The clause does not operate in event of a total loss. This provision provides that the insurer's liability for any loss is limited to the proportion of the loss that the amount of its policy bears to the amount obtained by applying the specified percentage in the coinsurance clause to the value of the property at the time of loss, not exceeding the face amount of its policy. If the insured fails to carry an amount of insurance equal to the specified percentage of the value of the property, the insured cannot recover the full loss.

The formula for coinsurance is
\[(A/B) \times C = D.\]

"A" is the amount of insurance covering the property;

"B" is the amount of insurance there must be on the property to insure it up to the required percentage of value of the property (e.g., an 80% coinsurance clause would require the insured to have at least $16,000 insurance covering his $20,000 building);

"C" is the amount of the loss;

"D" is the amount the insurance company will be required to pay.

Example: The operation of the 80% coinsurance clause.

Value of property is $20,000
Amt of insurance carried (A) $12,000
Amt insured should carry (B) $16,000
Amount of the loss (C) $5,000
Amt of co liability is - - (D) $3,750

\[\frac{12000(A)}{16000(B)} \times 5,000(C) = 3,750(D)\]

It should be noted in the application of the formula that the insurance company will pay the face amount of its policy whenever the amount of loss is equal to or exceeds the amount obtained by applying the specified percentage in the coinsurance clause to the value of the property at the time of loss.

Example: The operation of the 80% coinsurance clause, when the amount exceeds the amount of the specified percentage.

Value of property is $20,000
Amt of insurance carried (A) $12,000
Amt insured should carry (B) $16,000
Amount of loss is total (C) $20,000
Amount of co's liability (D) $12,000

\[\frac{12000(A)}{16000(B)} \times 20000(C) = 15000(D)\]
In no case will the insurance company pay more than the face amount of the policy. Therefore, (D) $15,000 is reduced to the same amount as (A) $12,000.

The purpose of coinsurance is to require the insured to maintain adequate insurance, since the majority of fire losses are partial losses equaling only a small percentage of the value of the property involved. Because of this, many policyholders would carry a low percentage of insurance to value, thereby obtaining an unfair advantage in premium cost over other policyholders since premiums collected from all must be sufficient to pay the losses of all.

Another endorsement used with the standard fire policy is the pro rata distribution clause. The clause is not used as frequently as the others previously mentioned, but must be used when the insurance provides coverage at more than one location under a single policy.

Pro rata distribution clause - When the policy, under one amount of insurance, covers several buildings or the contents of several buildings, this clause operates to distribute the insurance over the buildings, or contents of each, in the proportion that the value of each bears to the whole value.

The pro-rata distro formula is \( \frac{A}{B} \times C = D \).

- \( A \) is the value of the individual property.
- \( B \) is the value of all property covered.
- \( C \) is the total amount of insurance covering all property.
- \( D \) is the maximum amount of insurance covering the individual property.

Example:

- Value at Location 1 = $5,000
- Value at Location 2 = $10,000
- Value at Location 3 = $15,000

If the insured carries 50% insurance to value, he is 50% underinsured at each location that the policy covers. In this example the insured's total insurance carried is $15,000 on the three locations valued at $30,000.

**AMOUNT OF INSURANCE AT LOCATION 1**

\[
\begin{align*}
(A) & \quad $5,000 \text{ (Value at Location 1)} / \\
(B) & \quad $30,000 \text{ (Value at all locations)} \times \\
(C) & \quad $15,000 \text{ (Total insurance)} = \\
(D) & \quad $2,500
\end{align*}
\]

**AMOUNT OF INSURANCE AT LOCATION 2**

\[
\begin{align*}
(A) & \quad $10,000 \text{ (Value at Location 2)} / \\
(B) & \quad $30,000 \text{ (Value at all locations)} \times \\
(C) & \quad $15,000 \text{ (Total insurance)} = \\
(D) & \quad $5,000
\end{align*}
\]

**AMOUNT OF INSURANCE AT LOCATION 3**

\[
\begin{align*}
(A) & \quad $15,000 \text{ (Value at Location 3)} / \\
(B) & \quad $30,000 \text{ (Value at all locations)} \times \\
(C) & \quad $15,000 \text{ (Total insurance)} = \\
(D) & \quad $7,500
\end{align*}
\]

**RATES & PREMIUMS**
Fire rates are generally established by the Insurance Services Office, an organization funded by the insurance companies for the compilation of statistics and gathering of information to establish rates. The methods of rating are based upon four elements: construction of the building, occupancy, protection (i.e., available water supply, response of fire departments, etc.,) and exposure (i.e., distances from other occupancies which may contribute to a more hazardous condition such as a dress shop next to a dynamite factory). Credits may be given for protective devises, maintenance, and superior construction. Charges are made for any substandard conditions that may exist.

Dwelling rates are published in rate tables according to town classifications which are established with data on water supply, fire and police protection, geographic location, and pumping capacity of hydrants being among the factors considered.

Mercantile risks are class rated (similar to dwellings) if they are not excluded from such class rates by reason of occupancy (restaurant) or by size of area (over 5,000 square feet). Risks of over 5,000 square feet, or of certain occupancies (restaurants) are subject to specific rates as established by the Insurance Services Office. These rates are normally published for 80% coinsurance, but rate adjustments are available for higher or lower percentages.

Farm rates are published in separate schedules.

It should be noted that most Insurance Codes provide that rates are to be adequate, not unfairly discriminatory, and not excessive.

**EARTHQUAKE INSURANCE**

Certain states such as California have enacted special earthquake insurance legislation and/or state supervised authorities to resolve the crisis in insurance availability. In California, the California Earthquake Authority represents a unique partnership between government and private sector. The CEA uses funds from premiums, insurance companies and reinsurers to make available a “pot of money” to pay earthquake claims. Insurers must still offer earthquake insurance to California homeowners but may elect to sell private coverage or CEA insurance.

Residents in high risk area, which have been delineated throughout the state, pay more. Pools, spas, detached garages, fences, patios and other outbuildings are not covered. Personal property is covered up to $5,000 and an allowance of $1,500 is provided for emergency living expenses. A CEA policy deductible is 15 percent. Renter policies are also available.

**MULTI-PERIL POLICIES**

The fire and casualty-insurance industry has been rather rigidly divided, until recent years, by corporate restrictions and insurance regulatory laws into two main underwriting groups. The fire-marine group specialized in fire and allied lines, ocean marine and inland marine, automobile physical damage, and, in general, physical loss insurance. The casualty-surety group specialized in liability, worker’s compensation insurance, fidelity and surety bonds, and other casualty lines.

Changes in their underwriting powers by revision of the insurance laws of the states and of the articles of incorporation or corporate charters of the insurance carriers have brought a new era wherein fire insurance companies may write casualty insurance and casualty insurance companies may write fire insurance. Such practice is known as “multiple line underwriting.” Most admitted fire and casualty insurers, upon complying with applicable requirements of law, can now transact all classes of insurance except life, title, mortgage and mortgage guaranty.

Multiple line underwriting permits an insurer to offer package policies whereby many different perils are
covered in one policy. Such "multiple peril" insurance makes it possible to broaden the protection given by a standard form fire policy.

All fire policies typically require a standard form. The law, however, provides that any policy which, in addition to providing coverage against the peril of fire, includes substantial coverage against other perils on an unspecified basis need not comply with the provisions of the standard form fire insurance policy. Such policy, however, must include provisions which are the substantial equivalent of the provisions of the standard form policy with regards to the peril of fire insurance.

**DWELLING & CONTENTS**

Three forms are used with the standard policy in insuring dwellings and contents: the Basic form, the Broad form, and the Special form. A fourth form is used when household contents only is the subject of insurance.

**Coverage A**
- Basic Form: Dwelling
- Broad Form: Dwelling
- Special Form: Dwelling
- Basic Contents: Not Available

**Coverage B**
- Basic Form: Appurt Structure
- Broad Form: Appurt Structure
- Special Form: Appurt Structure
- Basic Contents: Not Available

**Coverage C**
- Basic Form: HH & Pers Property
- Broad Form: HH & Pers Property
- Special Form: HH & Pers Property
- Basic Contents: HH & Pers Property

**Coverage D**
- Basic Form: Rental Value
- Broad Form: Rental Value
- Special Form: Rental Value
- Basic Contents: Not Available

**Coverage E**
- Basic Form: By Endorsement
- Broad Form: Add Living Expenses
- Special Form: Add Living Expenses
- Basic Contents: Not Available

The Basic, Broad and Special Forms are identical in their insuring agreements for Coverage A, B, C and D. These Coverages are divisible, it is permissible to insure the dwelling under Coverage A while not scheduling any amount for household and personal property under Coverage C. When household and personal property, but not the dwelling, is to be insured the Basic Contents form can be used, but if Broad form coverage is desired and the amount of insurance is $4,000 or more, the Broad form is used with a scheduled amount for Coverage C and none for Coverage A.

The Broad form and Special form provide the protection of Coverage E for additional living expenses. Under supplemental coverage 10% of the amount of insurance on the dwelling can be applied to rental value and additional living expense, collectively, but in this event no more than the total value insured on the declaration page will be paid in the event of a loss. This extension applies to all forms. However, this amount may be increased by endorsement and be paid in addition to the insured value of the dwelling. Additional living expense insurance may be added to the basic form by endorsement.
INSURING AGREEMENTS

There are five insuring agreements: Coverage A, dwelling; Coverage B, appurtenant structures; Coverage C, household and personal property; Coverage D, rental value; and Coverage E, additional living expense. As shown the Basic form does not include Coverage E and the Basic Contents form deals only with Coverage C.

Coverage A -- applies to the dwelling described in the policy, any additions in contact with the dwelling, building equipment, fixtures and outdoor equipment when owned by the owner of the dwelling and not otherwise covered. Building equipment, fixtures and outdoor equipment must pertain to the service of the premises and be located on the premises.

Coverage B -- appurtenant structures are attached to the premises and passing in possession with it. This does not include any buildings in contact with the dwelling.

Coverage C -- household and personal property usual or incidental to the occupancy of the premises as a dwelling, with specific exclusions of animals, birds or fish, aircraft, motor vehicles and boats.

Coverage D -- if scheduled, insures the fair rental value of the buildings insured, including parts of them, as furnished and equipped by owner. The time element begins with loss to the building or to equipment on it or on the premises and runs for as long as would be required with the exercise of due diligence and dispatch to restore the property to a tenantable condition.

Coverage E -- additional living expenses, may be scheduled only under the Broad form or Special form. It applies to the necessary increase in living expenses incurred by the insured in order to continue as nearly as practicable the normal standard of living of the household following loss by a covered peril.

COVERED PERILS

Basic Form and Basic Contents Form

These forms cover the basic perils of fire and lightning, removal and inherent explosion. The insured has the option of including the perils of Extended Coverage and Vandalism and Malicious Mischief. Since these perils are in the printed form a premium charge on the Declaration page indicates when either or both of these additional coverages are included.

Broad Form and Special Form

The protection under the Broad form is an extended list of named perils, while the Special form provides protection on an all risks basis.

The Broad form named perils are the same as those in the Basic form with the Extended Coverage and Vandalism and Malicious Mischief. In addition these named perils are included in the Broad form:

Damage caused by burglars.
Glass breakage.
Falling objects.
Weight of ice, snow or sleet.
Collapse.
Sudden and accidental tearing asunder, cracking, burning or bulging of a steam or hot water heating system.
Freezing of plumbing, heating and cooling systems and domestic appliances.
Water escape.
Removal.
Sudden and accidental injury from artificially generated electrical appliances, devices, fixtures and
wiring.

EXCLUSIONS

The exclusions that apply to all of the forms are:

- War risk.
- Nuclear exclusion.
- Flood, sewer and drain back-up and subsurface water.
- Coverages for loss brought about by the operation of building or zoning laws.
- Earth movement.
- Wear and tear, deterioration.

Other exclusions or conditions which may eliminate coverage are related to the specific perils named in the policy forms. We will not review those conditions under this section, but agents should become familiar with these exclusions and conditions in order to properly explain the coverages to their clients.

Example: Under the perils of smoke damage - accidental smoke damage from agricultural smudging and industrial operation is excluded.

ELIGIBILITY

Insurance using the dwelling forms may be applied to any dwelling, owner occupied or otherwise, whether finished or under construction. A dwelling is any structure used for that purpose so long as it contains not more than four apartments and houses not more than five roomers or boarders. Town houses or row houses are eligible. Personal property of tenants in apartment structures, larger than four families, may be insured under the dwelling forms, but not the structure itself.

Trailer homes and mobile homes are eligible if they are used exclusively for dwelling purposes and are at a fixed location. Town houses, row houses, trailer homes and mobile homes, generally may not be written for a period exceeding one year and coverage is limited to the Basic Form.

INCIDENTAL OCCUPANCIES

The dwelling or owner may carry on incidental service or professional operation. Permissible incidental occupancies are small service operations such as a beauty parlor, shoe repair (handwork), dressmaker types. No more than two persons may be at work in the operation at one time. Private schools, studios and offices are also permitted and storage of merchandise is allowed if the value of the merchandise does not exceed $5,000. Merchandise and property pertaining to incidental occupancies must be separately scheduled, and the premium charged according to the class of business.

DEDUCTIBLES

These forms of dwelling and contents policies will generally be subject to $100 deductibles. It is permissible to reduce or eliminate the deductible for some perils by paying additional premiums.

HOMEOWNERS INSURANCE

A basic document is used as a standard skeleton policy for the homeowners policies. This skeleton is used with one of six standard forms that have identical coverages for Comprehensive Personal Liability (Section II), but are different in the Property coverages (Section I).

The skeleton homeowners policy consists of four pages. The first page contains the customary spaces for the insured’s name and mailing address, the location of the insured premises, a schedule of limits
of liability and premium information, mortgage information and specific identification of other residence premises maintained by the insured or his spouse for Section II (Liability) coverage. This page will contain information about construction, occupancy and fire protection and spaces for stating whether or not the dwelling is seasonal, used to conduct a business, or has full time residence employees. Another space is provided for an indication of how Deductible provisions apply.

The remainder of the first page corresponds to the first page of the standard fire policy. The second page is identical with the second page of the standard fire policy. Most states follow the New York Standard Fire form provisions and contain 165 lines. Space for attaching forms and endorsements is at the top of page three. The balance of pages three and four contain provisions and conditions that are common to all homeowners risks.

FORMS - PERILS INSURED AGAINST

HO 1. The Basic Form - insures the dwelling building, private structures and personal property against fire, lightning, removal, the perils of extended coverage, vandalism and malicious mischief, glass breakage and theft. Additional living expense coverage is included.

HO 2. The Broad Form - insures the dwelling building, private structures and personal property against the same perils named in the HO 1, except that there is broadened coverage for explosion, aircraft, vehicle, smoke, glass breakage and theft. Also, additional perils are included: falling objects; weight of ice, snow or sleet; collapse of all or part of a building; sudden and accidental tearing asunder, cracking, burning or bulging of a steam or hot water heating system or of a water heater; accidental discharge, leakage or overflow of water or steam from plumbing, heating or cooling systems or from domestic appliances; freezing of these systems or appliances; and sudden and accidental injury from electrical currents artificially generated.

HO 3. The Special Form - insures the dwelling building, appurtenant private structures, and additional living expenses against all risks. The unscheduled personal property is covered for the named perils of the Broad form.

HO 4. The Contents Broad Form - insures the contents unscheduled personal property including limited Improvement and Betterment coverage against the named perils of the Broad form. Additional living expense is written on the same named perils basis.

HO 5. The Comprehensive Form - insures the dwelling building appurtenant private structures, personal property and additional living expenses against all risks.

HO 6. Condominium Unit - Owners Form - insures the unscheduled personal property against named perils of the Broad form. The policy is made suitable for the condominium unit-owner with optional coverages which may be added by endorsement.

The homeowners policy is intended to cover all the exposures common to owning a home, excluding those connected with the ownership and operations of an automobile. The policy has two main sections. Section I pertains to real and personal property. Section II pertains to personal liability and medical payments. The premiums for the policy are basically indivisible. Homeowner policies provide the following coverages.

**Section I:**

Coverage A. Dwelling Building (HO1, HO2, HO3 and HO5).

Coverage B. Private Structures = 10% of Coverage A (HO1, HO2, HO3 and HO5).

Coverage C.

(1) Personal Property = 50% of Coverage A (HO1, HO2, HO3 and HO5).

(2) Personal Property away from premises = 10% of Coverage C with a minimum of $1,000 (HO1, HO2, HO3, HO4 and HO6). This coverage is omitted in HO 5 since Coverage C is worldwide for that policy. (In July 1982 Insurance Services Office introduced homeowners plus policy. Coverage C limit for such property will be increased to 100% under the new forms.)
NOTE: HO 4 and HO 6 are contents policies.

Coverage D. Additional Living Expense = 10% of Coverage A in HO 1 and 20% in HO 2, HO 3, HO 4 and HO 5. HO 6 is 40% of Coverage C.

Section II:

Coverage E. Comprehensive Personal Liability. The minimum is typically $25,000 and may be increased in all policies.

Coverage F. Medical Payments. The minimum is about $500 per person and $25,000 per accident and may be increased in all policies.

NOTE: Worker's Compensation coverage for private residence employees is also provided under most Homeowner's Policies.

INSURING AGREEMENTS

There are six insuring agreements:

Coverage A -- Dwelling.

This policy covers the described dwelling building, including additions in contact with it, occupied principally as a private residence. This coverage also includes:

1) if the property of the Insured and when not otherwise covered, building equipment, fixtures and outdoor equipment all pertaining to the service of the premises and while located on it or temporarily elsewhere; and

2) materials and supplies located on the premises or adjacent to it, intended for use in construction, alteration or repair of such dwelling.

Coverage B -- Appurtenant Structures

This policy covers structures (other than the described dwelling building, including additions in contact with it) appertaining to the premises and located on it. This coverage also includes materials and supplies located on the premises or adjacent to it, intended for use in construction, alteration or repair of such structures.

This coverage excludes:

1) structures used in whole or in part for business purposes; or

2) structures rented or leased in whole or in part or held for such rental or lease (except Structures used exclusively for private garage purposes) to other than a tenant of the described dwelling.

Coverage C -- Unscheduled Personal Property

This policy covers unscheduled personal property usual or incidental to the occupancy of the premises as a dwelling and owned or used by an Insured, while on the described premises and, at the option of the Named Insured, owned by others while on the portion of the premises occupied exclusively by the Insured.

This coverage also includes such unscheduled personal property while elsewhere than on the described premises, anywhere in the world:

1) owned or used by an Insured, or
2) at the option of the Named Insured,
   (a) owned by a guest while in a residence occupied by an Insured; or
   (b) owned by a residence employee while actually engaged in the service of an Insured and while
       such property is in the physical custody of such residence employee or in a residence
       occupied by an Insured;
3) but the limit of this Company’s liability for the unscheduled personal property away from the
   premises shall be an additional amount of insurance equal to 10% of the amount specified for
   Coverage C, but in no event less than $1,000.

This coverage excludes:

1) animals, birds or fish;
2) motorized vehicles, except such vehicles pertaining to the service of the premises and not licensed
   for road use;
3) aircraft;
4) property of roomers and boarders not related to the Insured;
5) property carried or held as samples or for sale or for delivery after sale;
6) property rented or held for rental to others by the Insured, except property contained in that portion
   of the described premises customarily occupied exclusively by the Insured and occasionally rented
   to others or property of the Insured in that portion of the described dwelling occupied by roomers
   or boarders; business property while away from the described premises;
8) any device or instrument for the recording, reproduction or recording and reproduction of sound
   which may be operated by power from the electrical system of a motor vehicle, or any tape, wire,
   record disc or other medium for use with any such device or instrument while any of said property
   is in or upon a motor vehicle; or
9) property which is separately described and specifically insured in whole or in part by this or any
   other insurance.

**Coverage D -- Additional Living Expense**

If a property loss covered under this policy renders the premises untenantable, this policy covers the
necessary increase in living expense incurred by the Named Insured to continue as nearly as
practicable the normal standard of living of the Named Insured’s household for not exceeding the
period of time required:

1) to repair or replace such damaged or destroyed property as soon as possible; or
2) for the Named Insured’s household to become settled in permanent quarters; whichever is less.

This coverage also includes:

1) the fair rental value of any portion of the described dwelling or appurtenant structures covered
   under this policy, as furnished or equipped by the Named Insured, which is rented or held for rental
   by the Named Insured. The fair rental value shall not include charges and expenses that do not
   continue during the period of untenantability. Coverage shall be limited to the period of time
   required to restore, as soon as possible, the rented portion to the same tenantable condition;
2) the period of time, not exceeding two weeks, while access to the premises is prohibited by order of
civil authority, as a direct result of damage to neighboring premises by a- peril not otherwise
excluded.

The periods described above shall not be limited by the expiration of this policy.

This coverage excludes expense due to cancellation of lease, or any written or oral agreement.

**Coverage E -- Personal Liability**

The Company agrees to pay on behalf of the Insured all sums which the Insured shall become legally
obligated to pay as damages because of bodily injury or property damage, to which this insurance
applies, caused by an occurrence. The Company shall have the right and duty, at its own expense, to defend any suit against the Insured seeking damages on account of such bodily injury or property damage, even if any of the allegations of the suit are groundless, false or fraudulent, but may make such investigation and settlement of any claim or suit as it deems expedient. The Company shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of this Company’s liability has been exhausted by payment of judgments or settlements.

Coverage F -- Medical Payments to Others

This Company agrees to pay all reasonable medical expenses, incurred within one year from the date of the accident, to or for each person who sustains bodily injury to which this insurance applies caused by an accident, while such person is:

1) on an insured premises with the permission of any Insured, or
2) elsewhere, if such bodily injury
   a) arises out of a condition in the insured premises or the ways immediately adjoining,
   b) is caused by the activities of any insured, or by a residence employee in the course of his employment by any Insured,
   c) is caused by an animal owned by or in the care of any Insured, or
   d) is sustained by any residence employee and arises out of and in the course of his employment by any Insured.

GENERAL EXCLUSIONS

All Homeowners policies have certain exclusions in common. Two are located in the Homeowner’s policy jacket and are usual in all property insurance policies.

1) War risks - called government action in the Homeowners policies.
2) Nuclear exposures.

Other exclusions are contained in the form themselves; some of these clauses are:

1) Excluding loss occasioned directly or indirectly by enforcement of any law or ordinance regulating the construction or repairs of buildings or structures.
2) Earth movement - including earthquake, volcanic eruption, landslide, mud slide.
3) Flood, surface water, waves, tidal water or tidal waves, backing up of sewer or drains, water below the surface that flows, seeps or leaks through walls, floors or walks.
4) Losses by power, heating or cooling failure unless the failure originates on the premises from an insured peril.

ELIGIBILITY

The homeowners package policies are designed for owner occupied dwellings, the exceptions being the HO4 designed for tenants and the HO6 designed for condominium unit owners. An eligible dwelling may contain no more than two families and not more than two roomers or boarders per family. In addition the homeowners’ forms cannot be used for a dwelling located on a farm if the dwelling is within 200 feet of a farm building.

INCIDENTAL OCCUPANCY

Incidental office, professional, private school or studio occupancy is permitted if the fire rating organization permits incidental occupancy without additional changes under its rules; the premises are occupied principally as a dwelling; no other business is conducted on the premises.

DEDUCTIBLE CLAUSES

The most common deductible clause in use is the $250 deductible with "buy back privileges." Most insurers allow the insured to select larger deductibles with an appropriate premium reduction.
FARMOWNERS POLICIES

The Farmowners - Ranchowners policy is the basic policy to which are attached various forms that are available under the Farm owners - Ranch owners program. The first page of the jacket presents the policy declarations, the insuring agreement and limits of liability for both Property and Liability coverages for dwellings and personal property and farm buildings and scheduled or unscheduled farm personal property. The second page of the basic policy jacket contains the provisions of the standard fire policy, while the third, fourth and fifth pages contain general conditions of the insurance and definitions applicable to the forms to be attached.

FORMS - PERILS INSURED AGAINST

The program gives a choice from four forms providing mandatory Section I coverages and a choice from two forms providing mandatory Section II coverages. Three other forms provide optional coverages under Section I.

FR00-O1 -- Basic Form - Provides coverage against fire, the perils of Extended Coverage, vandalism, malicious mischief, and theft applicable to the farm dwelling (Coverage A), unscheduled personal property other than farm property (Coverage B), and the usual combined Additional Living Expenses - Rent Coverage (Coverage C).

FR00-02 -- Broad Form - The same coverages as FR00-O1 but on a broad named perils basis.

FR00-03 -- Special Form - The same coverages as the FR00-O1 and FR00-02, but all risks coverage under Coverage A and C.

FR00-04 -- Farm Tenants Broad Form - Broad named perils coverage on unscheduled personal property other than farm property and Additional Living Expense.

The above-listed forms provide coverage on the residential property, i.e., dwelling and unscheduled personal property, not farm property. The coverage for the farm property is provided by adding the following forms.

FR00-06 -- Scheduled Farm Personal Property (Coverage D).

FR00-07 -- Unscheduled Farm Personal Property

These forms are used to provide coverage on livestock; machinery, vehicles and equipment; grain and hay; farm records (Coverage E).

FR00-08 -- Barns-, Buildings, Structures and Additional Dwellings. The Farm owners - Ranch owners policy does not provide automatic coverage on other structures on the insured premises. This form allows coverage for farm barns and other buildings on the premises on a scheduled basis against fire, extended coverage perils, and vandalism and malicious mischief (Coverage F).

The combination of residential and business exposure require that the liability insurance be more complex than for a residential exposure. The two forms providing mandatory Section II coverages are:

FR00-O9 -- Personal Liability Form - provides Personal Liability (Coverage G) and Medical Payments to Others (Coverage H) insurance with a modified Business Pursuits exclusion that does not apply to farming.

FR00-10 -- is used to cover corporately owned farms or ranches and contains Comprehensive General Liability coverage rather than Personal Liability.

The coverages provided by the Farmowners - Ranchowners policy are based on the Homeowners
program and most coverages are parallel. The difference is that the Farm owners - Ranch owners policy may include coverage on the farm personal property and barns.

Section I:

Coverage A - Farm Dwelling
Coverage B - Unscheduled Personal Property (Household)
Coverage C - Additional Living Expense
Coverage D - Scheduled Farm Personal Property
Coverage E - Unscheduled Farm Personal Property
Coverage F - Farm Barns, Buildings and Structures

Section II:

Coverage G - Personal Liability
Coverage H - Medical Payments to Others

Other differences between a Farmowner - Ranchowner policy and the Homeowners program:

1) No automatic coverage for other than the dwelling must be specifically scheduled and a separate premium listed.
2) The Homeowner’s Comprehensive form is not duplicated in the Farmowners - Ranchowners program.
3) Owner - occupancy is not required.
4) Coverage of unscheduled personal property must be omitted if the policy is written for owner-nonoccupant.
5) Additional Living expense limit is 10% of the farm dwelling, or 10% of the limit specified for unscheduled personal property under the Tenants form.
6) Trees, shrubs, plants and lawns are specifically excluded in the Farmowner - Ranchowner forms.

ELIGIBILITY

The Farm owners - Ranch owners policy is not restricted to owner occupied, but must be a one or two family dwelling used exclusively for residential purposes.

There may be up to two roomers or boarders per family. Incidental occupancies similar to those of the homeowners policy, is allowed.

EXCLUSION

The general exclusions contained in the forms are the customary exclusions of loss from zoning ordinances, earth movement, and water damage. Consequential loss due to power, heating or cooling failure brought on by damage to equipment away from the premises is also excluded. Additional exclusion of trailers, motorized campers, camper bodies and their equipment is contained in the forms.

DEDUCTIBLE

The deductible clause of each of the Farm owners - Ranch owners forms applies a $100 deductible to the amount of each loss to:

1) each building, including property within;
2) personal property in each building covered under the policy; and
3) personal property in the open.

The maximum is up to an aggregate limit per occurrence of $500.
MOBILE HOME POLICIES

The Mobile home policy is a basic policy jacket to which is attached any one of the Mobile home Forms and any endorsements that are mandatory or optional. The first part of the Mobile home policy contains the Declarations section and a description of the insured mobile home. Other information about the risks appears on the Declaration Page that is useful for rating purposes. Pages 2, 3 and 4 of the Mobile home policy contain general conditions and special conditions applicable to either Section I or Section II of the Mobile home form. The Mobile home Policy is roughly the equivalent to the Homeowner’s Broad Form 2.

PERILS

The perils insured against under a mobile home policy are: fire and lightning; windstorm or hail; explosion; riot or civil commotion; aircraft; vehicles; smoke damage; vandalism or malicious mischief; glass breakage; theft; falling objects; weight of ice, snow or sleet; collapse; water escape; rupture of steam boilers, hot water heaters, etc; freezing of plumbing; and artificial electrical currents.

COVERAGES

There are mandatory coverages and minimum limits under the mobile home policy.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Min Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage A - Mobile home</td>
<td>Actual cash value</td>
</tr>
<tr>
<td>Coverage B - Unscheduled Personal Property</td>
<td>$2,000</td>
</tr>
<tr>
<td>Coverage D - Additional Living Expense</td>
<td>$15/ day up to 45 days</td>
</tr>
<tr>
<td>Coverage E - Personal Liability</td>
<td>$25,000 ea occurrence</td>
</tr>
<tr>
<td>Coverage F - Med pmts to others</td>
<td>$500 each person / 25,000 each accident</td>
</tr>
</tbody>
</table>

Coverage C is completely optional for awnings, shelters, cabanas, porches, etc. The schedule for these additions appears on the Declaration Page and each item must be described, with limits and premiums listed.

INSURING AGREEMENT

The insuring agreements for each coverage are, in most respects, similar to those found in Homeowners forms. The major differences will appear under Coverage A where coverage is provided on parts or equipment and accessories originally built into the structure. Also furniture and appliances though not built-in, are covered with the mobilehome if they were furnished by the manufacturer or dealer at the time of purchase and described on the sales invoice.

Collision coverage is available, under Coverage A, to cover short periods while the mobilehome is being moved to a new location.

EXCLUSIONS

The mobilehome policy contains the basic property policy exclusions. Certain exceptions and exclusions pertaining to specific perils are contained within the agreements for these perils.

We will not review all these exclusions, but agents selling this type of contract should become familiar with all terms and conditions of the policy.

ELIGIBILITY

The mobile home must be a least 10 feet wide and 40 feet long, cost when new not less than $4,000, must be capable of being towed on its own chassis and designed for year round living. The home must
be owner-occupied, but may be occupied by one additional family or up to two roomers or boarders. The home may not be subject to farm rules and rates.

DEDUCTIBLE

The deductible clause is for a flat $100+ applied to each occurrence of a covered loss.

SPECIAL MULTI-PERIL POLICIES

The Multi-Peril policy is intended to cover all exposures common to ownership and operation of certain commercial risks, excluding automobile and surety coverages. Depending on the choice of the insured, coverages may be those of the general property form providing fire and extended coverage and may be supplemented with endorsements covering additional perils, or may be those of the special property form providing coverage on an "all risk" basis.

FORMS - PERILS INSURED AGAINST

MP General Building Form - a named peril form for buildings and structures, provides coverage for losses caused by fire; lightning; windstorm and hail; explosion; "sudden and accidental damage from smoke; vehicles or aircraft; riot, riot attending a strike or civil commotions; vandalism and malicious mischief. The insured may have the added protection of Optional Perils included by endorsement. This endorsement would extend the perils to include glass breakage; falling objects; weight of snow, ice or sleet; water damage; and collapse of the structure.

MP Special Building Form - insures against all risks of direct physical loss to buildings and structures to which it is made applicable subject to specific exclusion and limitations.

MP General Personal Property Form - is a named peril form providing coverage on personal property of the insured, with personal property of others as optional. The perils insured against are the same as those in the General Building Form.

MP Special Personal Property Form - insures against all risks of direct loss to personal property of the insured and, optionally, personal property of others in the care, custody or control of the insured.

The policies contain four sections. Section I provides property coverage for both real and personal property. Section II provides liability coverage for bodily injury and property damage, premises medical payments. Section III provides crime coverage. Section IV provides Boiler and Machinery coverage. Sections I and II are mandatory coverages, while Section III and IV are optional coverages.

The first page of the Special Multi-peril Policy is normally the Declaration page showing insured’s name and address, policy period, type of entity which is insured, location(s) of premise(s), limits of liability for each coverage applicable, identification of forms and endorsement attached to the policy, identification of any mortgagee, and premiums. The back side of the Declaration page may contain the Standard Fire Policy's 157 numbered lines.

The SMP conditions and definitions of the basic property and liability insurance provisions are contained in a six page publication in booklet form. Page one contains the general conditions applicable to both Section I and Section V of the policy. Pages two and three contain the conditions applicable to the Property insurance in Section I. Pages four and five contain the conditions pertaining to the Liability Insurance in Section II. Page six contains the definitions applicable to Section II Liability. In these pages are restatements of many of the general provisions of the Standard Fire Policy.

SPECIAL MULTI-PERIL POLICY CONDITIONS

General Conditions - ten clauses are the general conditions applicable to Section I and Section II coverages. The ten clauses relate to premium; time of inception; cancellation; concealment or fraud; assignment; subrogation; inspection and audit; liberalization; insurance under more than one
coverage, part or endorsement; and waiver or change of provisions.

**Conditions Applicable to Section I** - twenty-three clauses pertain to Section I coverages. These clauses are: policy period, territory; deductible; coinsurance; removal; debris removal; war risk and governmental action exclusion; nuclear clause and nuclear exclusion; other insurance; duties of the named insured after a loss; appraisal; company options; abandonment of property; payment of loss; privilege to adjust with owner; suits; permits and use; vacancy, unoccupancy and increase of hazards; protective safeguards; mortgage clause; recoveries; loss clause; no benefit to bailee; and no control.

**Conditions Applicable to Section II** - nine clauses pertain to Section II coverage. These clauses are: supplementary payments; premium; Financial Responsibility Laws; insured’s duties in the event of occurrence, claim or suit; medical reports, proof and payment of claim; action against company; other insurance; annual aggregate; and nuclear exclusion.

**Definitions Applicable to Section II** - the last page of the booklet contains definitions for various words and terms used in liability insurance.

### SPECIAL MULTI-PERIL BUILDING FORMS

As previously stated the General Building Form provides coverage against named perils and the Special Building Form provides coverage for all risks.

The Special Building Form has seven parts:

1) Property Covered
2) Property Not Covered.
3) Property Subject to Limitations.
4) Extensions of Coverage.
5) Perils Insured Against.
6) Exclusions.
7) Valuation.

The General Building Form has six parts:

1) Property Covered
2) Property Not Covered.
3) Extension of Coverage.
4) Perils Insured Against.
5) Exclusions.
6) Valuation.

Those parts titled Property Covered, Property Not Covered, Extension of Coverage, and Valuation are identical in both forms.

**Property Covered** - Building(s) or structure(s) including additions and extensions; fixtures, machinery and equipment constituting a permanent part of and pertaining to the service of the building(s); materials and supplies intended for use in construction, alteration or repair of the building(s) or structure(s); yard fixtures; personal property of the insured used for the maintenance or service of the building(s).

**Property Not Covered** - the building coverage does not apply to property in five specific categories:

1) Outdoor swimming pools, fences and detached retaining walls, waterfront property, paved surfaces.
2) The cost of earth moving, underground property and underwater property.
3) Outdoor signs.
4) Lawns, trees and plants.
5) Property which is more specifically insured (except for excess coverage).
**Extensions of Coverage** - it is possible for the insured to recover the full amount of the building coverage and recover the full limit stated under the extensions at the same time. The actual extensions are contained in four agreements: Newly Acquired Property; Off-Premises; Outdoor Trees, Shrubs and Plants; and Replacement Cost.

1) **Newly Acquired Property** - is new buildings or other structures being erected on the designated premises and newly acquired buildings at any other location within the territorial limits. The limit is 25% of the policy’s building limits, but not more than $100,000. The coverage is for 30 days from the date construction begins on the premises or from the date of acquisition of another building.

2) The **Off-Premises** extension is for building property which is temporarily removed from the premises for cleaning, repairing, construction or restoration. The limit is 2% of the building limits, but not more than $5,000.

3) **Outdoor Trees, Shrubs and Plants** are covered for as much as $250 on any one item or a maximum of $1000 in any one occurrence, including cost of debris removal.

4) **Replacement Cost** provides for the adjustment of “mall loss, less than $1000 without taking depreciation into account.

**Valuation** - establishes for valuation of property at actual cash value at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss, nor in any event for more than the interest of the named insured.

The Exclusion part of the General Form contains four exclusions, the Special Form contains the same exclusions that appear in the General Form, plus seven additional exclusions:

**General Form Exclusions.**

1) Statutes or ordinances affecting zoning or construction may require a particular building, once substantially damaged, to be torn down and reconstructed to meet new requirements. The cost of meeting new requirements are not covered.

2) No coverage for damage to electrical appliances, wiring, devices, fixtures caused by artificially generated electricity, except for ensuing fire damages.

3) No coverage for loss caused directly or indirectly by interruption of power or other utility service furnished to the premises if interruption takes place away from the designated premises.

4) No coverage for loss caused by earth movement, flood, tidal wave, sewer back-up, and underground seepage.

Other exclusions that appear in the Special Form are:

1) The usual clause in all risk property insurance that eliminates coverage for wear, tear and deterioration.

2) No coverage for loss caused by explosion of steam boilers, steam pipes, steam turbines or steam engines except for ensuing fire damage.

3) No coverage for vandalism, malicious mischief, theft or attempted theft, if building is vacant or unoccupied beyond 30 days.

4) No coverage for leakage or overflow from plumbing, heating, air conditioning or other equipment or appliances caused by freezing while the building is vacant or unoccupied, unless heat is maintained, or systems drained and shut off during such vacancy or unoccupancy.

5) No coverage for theft of any property not attached to the building.

6) No coverage for unexplained or mysterious disappearance of any property or shortage.

7) No coverage for continuous or repeated seepage or leakage of water or steam which occurs over a period of weeks, months or years.

In the Special Form is a part that does not appear in the General Form. It is **Property Subject to Limitations.** These limitations and exceptions to the all risk coverage are similar to the exclusions already reviewed and will not be reviewed again for testing purposes, but you must become familiar with these limitations in order to properly explain the contract to your clients.
SPECIAL MULTI-PERIL PERSONAL PROPERTY FORMS

Like the Building Forms, the General Personal Property Form provides against named perils and the Special Personal Property Form provides coverage for all risks.

The Special Personal Property Form has seven parts:
1) Property Covered.
2) Property Not Covered.
3) Property Subject to Limitations.
4) Extensions of Coverage.
5) Perils Insured Against.
6) Exclusions.
7) Valuation.

The General Personal Property Form has six parts:
1) Property Covered.
2) Property Not Covered.
3) Extension of Coverage.
4) Perils Insured Against.
5) Exclusions.
6) Valuation.

Those parts titled Property Covered, Property Not Covered and Valuation are identical in both forms.

Property Covered: Business Personal Property owned by the insured and usual to the occupancy of the insured, including the insured's interest in personal property owned by others to the extent of the value of labor, materials and charges furnished, performed or incurred by the insured, all while (1) in or on the building(s) or in the open (including within vehicles) on or within 100 feet of the designated premises. This insurance shall cover for the account of the owner (other than the named insured) personal property belonging to others in the care custody or control of the insured while in the building(s), or in the open (including within vehicles) on or within 100 feet of the designated premises.

Property Not Covered - the personal property coverage does not include:
1) Animals and pets; aircrafts; watercraft, including motors, equipment and accessories, except rowboats and canoes, while out of the water and on the designated premises; and automobiles, trailers, semi-trailers, or any self-propelled vehicles or machines, except such property not licensed for use on public thoroughfares and used principally on the premises of the insured.
2) Outdoor trees, shrubs and plants, except when held for sale, or sold but not delivered.
3) Household and personal effects contained in living quarters occupied by the insured.
4) Accounts, bills, currency, deeds, evidences of debts, money and securities.
5) Outdoor signs whether or not attached to the building.
6) Growing crops and lawns.
7) Property which is more specifically insured (except for excess coverage).

Valuation - The following bases are established for valuation of property:
1) The value of: all stock actually sold but not delivered shall be the price at which it was sold, less all discounts and unincurred expenses.
2) Tenant's Improvements and Betterment's if repaired or replaced at the expense of the named insured within reasonable time after loss, the actual cash value of the damaged improvements and betterments. This provision gives a method of prorating the loss to the end of the lease or rental agreement if the damage is not repaired or replaced.
3) Valuable Papers and Records - loss shall not exceed the cost of blank books, cards or other blank materials plus the cost of labor incurred for transcribing or copying such records.
4) All other property at actual cash value at the time of loss, but not exceeding the cost to repair or replace the property with like kind and quality, but in no event more than the interest of the named insured.

The other parts of both forms will not be reviewed at this time. Again, you are cautioned not to try and service your clients in the SMP program until you are familiar with all terms, conditions and provisions.

OTHER SPECIAL MULTI-PERIL COVERAGE

At this point the review has covered Section I, Division I, Coverage A and B. Division II of Section I, simply labeled Additional Coverages. This allows for the agent to endorse many other coverages to fulfill the needs of a particular risk. Some of these other coverages might be Business Interruption, Extra Expenses, Sprinkler Leakage, Earthquake Extension, Inland Marine Floaters.

Section II: Liability Coverage

The SMP Policy Liability Insurance Form has a single limit for all coverage agreements required for Premises and Operations, Product and Completed Operations, and Premises Medical Payments. This form is available to many classes of insureds. Most of these insureds must have their complete operation from the designated premises, since the insuring agreement specifically states coverage is for "business of the insured conducted at or from the insured premises." Other General Liability coverage which a company offers can be added to the SMP policy by endorsement, including the substitution of Comprehensive General Liability.

The SMP Liability form is similar to the Comprehensive General Liability Policy. The major distinction between the two is that the SMP form applies only to designated premises and necessary or incidental operations. The insured who anticipates branching out into other locations or taking on other unrelated operations should be best served by the Comprehensive General Liability form.

Section III: Crime Coverage

There are two forms that may be written with the SMP policies. One is the Comprehensive Crime form providing separate insuring agreements, each optional, with a limit of liability applicable to each separately. The other is a Blanket Crime form written to a single, uniform limit for all coverages.

The Comprehensive Crime form allows the insured to choose which coverages are needed for a particular operation. The form allows a choice of five coverages.

1) Employee Dishonesty - coverage applies to fraudulent or dishonest acts committed by employees.
2) Loss Inside the Premises - coverage against actual destruction, disappearance or wrongful abstraction of money and securities within the premises or from within banking premises or similar recognized places of safe deposit.
3) Loss Outside the Premises - covers money and securities against actual destruction, disappearance and wrongful abstraction while being conveyed by a messenger or an armored car company; or while in the living quarters of the home of a messenger, with no requirement that the money and securities be in the course of conveyance.
4) Money Orders and Counterfeit Paper Currency coverage is for loss due to acceptance in good faith of any money order if the instrument is issued or is purported to have been issued by a post office or express company.
5) Depositors Forgery - coverage applies to loss caused by forgery or alteration of a check, draft, promissory note or similar written promise.

The Crime coverage form has three general agreements and a number of exclusions, conditions and limitations. The first general agreement concerns consolidation, mergers or purchase of the assets of another concern and provides automatic protection for new employees taken on by these means, subject to a requirement of written notice within 30 days and pro rata additional premium. The second general agreement is a provision governing relationship between company and joint insureds. The
third general agreement provides coverage for any loss which is discovered during the life of the policy
or within one year after, even if the loss occurred during the life of a prior bond or policy.

The SMP Crime coverage is identical with the coverage of the corresponding Blanket Fidelity bond,
Commercial Blanket or Blanket Position and so are the pertinent conditions.

Section IV: Boiler and Machinery

To provide Boiler and Machinery insurance, two forms must be attached to the basic Special Multi-Peril
contract: first, the SMP Boiler and Machinery coverage form; second, the Boiler and Machinery
Declarations form. Additional endorsements may be attached to cover additional kinds of objects other
than the pressure vessels and piping covered by the SMP Boiler and Machinery coverage form.

The SMP Boiler and Machinery provides Broad coverage against sudden and accidental breakdown,
which includes not only explosion or rupture of the object but such accidents as bulging, burning or
cracking. Insurees with pressure vessels that do not qualify for Broad coverage are generally not
considered good risks for packaged Boiler and Machinery coverage.

There are four coverages in the Boiler and Machinery coverage form compared to five mandatory
coverages of the standard Boiler and Machinery policy.

- Coverage I  Loss to property of insured.
- Coverage II Expediting expenses.
- Coverage III Liability for property of others.
- Coverage Defense, settlement supplementary payments.

Bodily Injury Liability insurance is omitted from the SMP Boiler and Machinery form since liability is
mandatory under Section II of the SMP policy.

ELIGIBILITY

Virtually any kind of commercial or institutional operation is eligible for the SMP program, except farms,
granaries, businesses centering on motor vehicles, and boarding or rooming houses or one and two
apartment dwellings.

FAIR PLANS

PURPOSE

Certain states, like California, issue "FAIR Plan" which are designed to provide a means for the
purchase of basic property insurance to those who are entitled to such insurance, but who cannot
obtain it through ordinary channels. Basic property insurance means insurance against direct loss to
real or tangible personal property from perils insured under the standard fire policy and extended
coverage endorsement and vandalism and malicious mischief and other insurance coverages as may
be added with respect to such property by the association, or the commissioner.

ORGANIZATION

The "Association" typically a joint reinsurance association formed by insurers licensed to write basic
property insurance within the state to assist persons in securing basic property insurance. The
association formulates and administers a program for the equitable apportionment among any such
insurers writing basic property insurance.

The association designates an organization, with the approval of the commissioner, to act as the
"inspection bureau". The inspection bureau makes inspections to determine the condition of the properties for which basic property insurance is sought and to perform duties authorized by the association.

ELIGIBILITY

Any person having an insurable interest in real or tangible personal property, at a fixed location in those geographic or urban areas designated by the commissioner, who, after diligent effort, has been unable to obtain basic property insurance through several companies, but does not include automobile or farm risks, may apply.

GEOGRAPHICAL AREAS

Various geographic delineations will be made. Most are determined by a description of a particular hazard and further organized by the degree of risk. For instance, a certain territory between a highway and a body of water may be designated as "brush" for high fire incidence.

ISSUANCE OF INSURANCE COVERAGE

When application is made the inspection bureau will inspect the property. The inspection bureau may advise the applicant of needed repairs or changes in occupancy. The inspection report is made to the company or companies designated by the Association. A copy is sent to the association and to the applicant on request. If the risk is accepted, the Association will issue and deliver to the applicant the policy or binder upon payment of the premiums.

In issuing the coverage responsibilities the Association has the following:

1) Determine and collect the premium charges.
2) Disburse return premiums, commissions and return commissions.
3) Direct and control investigation, adjustment, defense, and payment of losses and claims on policies issued pursuant to the plan.
4) Determine the rate of commissions paid the producer.

PARTICIPATION BY LICENSED INSURANCE AGENTS & BROKERS

Fire and Casualty agents and brokers can handle applications for insurance under FAIR Plans and render all proper assistance to applicants for such insurance. Agents and Brokers must first make a bona fide effort to secure required insurance through ordinary channels before making application for coverage through the plan. In the application, the applicant certifies that he or she has tried, without success, to obtain insurance in the voluntary market.

The agent or broker designated by the applicant as the producer of record receives a commission for his/her services from the insurer issuing the policy through the plan. It is not an unlawful rebate if the agent receives commissions and is not an appointed agent for the insurer issuing the policy.

No insurance agent, broker or solicitor shall make any charge to the applicant, directly or indirectly, for furnishing any person necessary application forms, technical assistance and services necessary to perfect an application to the plan other than the commissions as paid by the insurer.

OTHER PROVISIONS

The applicant or insurer has the right of appeal from any act or decision of the Association to the governing committee. A decision of the governing committee may be appealed to the commissioner within 30 days after the decision. All decisions of the commissioner shall be subject to judicial review.

OCEAN MARINE INSURANCE
Ocean marine insurance covers hazards involved in shipping and transportation on navigable waters. While there are rarely standard state marine forms, the fact that marine insurance is written worldwide has given rise to a basic ocean marine policy which is varied to meet particular needs. An ocean marine policy is normally an "agreed value" policy, meaning that the value of the ship or cargo is agreed upon prior to attachment of the risk. Losses are adjusted on the same basis. Another type of policy is the "Open" marine cargo policy issued by marine insurance companies to persons or firms regularly engaged in exporting, importing or shipping goods by water. It constitutes agreement by the insured to report to the insurance company all shipments made at his/her risk, and to pay premiums at agreed rates. The insurance company agrees to automatically insure all such shipments on agreed conditions from the moment they become risk to the insured.

There are three principal types of ocean marine insurance:

1) Hull insurance - which insures the ship owner against direct loss to the vessel, its machinery and equipment. It usually includes legal liabilities arising out of collision with another ship or vessel. Hull policies are usually written for a period of one year.

2) Cargo insurance - which covers the owners of merchandise in transit by water, including land transportation and dock storage incidental to the shipment. Cargo insurance is usually written on a voyage basis. Normally the policy covers when the goods leave the shipper's warehouse and continues during the ordinary course of transit until delivered to the warehouse of the consignee. This would include land transportation and storage on docks or piers awaiting shipment or delivery (if in the course of transit). By employment of the Marine Extension clauses, the coverage is continued during delay or deviation provided any interruption in transit is beyond the control of the insured.

3) Protection and indemnity insurance - which covers liabilities of the ship owner arising out of operation of the vessel (insofar as it is not covered by the hull policy). These liabilities include:

   A) Loss of life and personal injury of the crew and others.
   B) Loss or damage to cargo.
   C) Third party liabilities and property damage to docks, etc.

Protection and indemnity insurance is generally written on an annual basis with specified limits of liability. On yachts and small crafts, this insurance is usually combined with hull insurance in a single policy.

PERILS CLAUSE

All policies on both hull and cargo include the basic "perils clause" which reads:

"Touching the adventures and perils which we, the said insurers, are contented to bear and take upon us, they are of the seas, fire, rovers, assailing thieves, jettisons, criminal barratry of the master and mariners and of all other like perils, losses and misfortunes that have or shall come to hurt, detriment or damage of the aforesaid subject matter of this insurance or any part thereof."

The term "perils of the seas" includes such losses as stranding, sinking, collision, heavy weather, striking submerged objects.

In cargo policies the "perils clause" is commonly modified by either of two restrictive clauses to eliminate minor claims.

1) One is the "free of particular average" clause (F.P.A.). This has the effect of excluding partial losses unless the vessel is involved in one of the major casualties of stranding, sinking, fire, or collision (English conditions) or unless the partial loss is caused by one of these major casualties (American conditions).

2) The other is the "with average" clause (W.A.). This clause is very similar in wording to the "F.P.A."
clause except that instead of excluding all partial losses, except those caused by major casualties, it excludes only small claims amounting to less than a prescribed percentage (often 3 percent) of the insured value.

For many commodities it is now common practice to broaden the "W.A." clause to include all claims caused by a "peril of the sea" irrespective of percentage. It is therefore a broader coverage than "F.P.A."

The term "average" is synonymous with "loss" in marine insurance language. A "partial loss" to ship or cargo due to damage caused accidentally is known as a "particular average" loss.

When a ship and its cargo are placed in imminent peril, as by fire or the stranding of the vessel, and if a part of the ship or her cargo is voluntarily sacrificed to save the remainder (such as the dumping overboard of part of the cargo or ship's fuel to lighten the vessel), or if extraordinary expense is incurred for the common benefit, as for salvage assistance, such voluntary losses and extraordinary expense are known as "general average" losses. By maritime law such losses must be made good by contributions from the owners of properties saved by these sacrifices or expenditures, the contributions being proportional to the values saved.

Liability for general average contributions is founded in maritime law, but marine insurance policies will indemnify the owners of the properties for their general average liabilities.

Another important feature of all marine policies, both hull and cargo, is the "sue and labor" clause providing additional benefits to the insured. The clause not only confirms the general insurance law requiring the insured to take all reasonable steps to avert or minimize a loss, but gives the insured the right to recover expenses resulting from such efforts, even when those efforts are unsuccessful. The insured could, under such circumstances, recover more than the face value of the policy.

**EXCLUSIONS**

Basic marine policies exclude loss or damage caused by hostilities or warlike operations (whether declared or not), and damages caused by strikes, riots, civil commotions or persons taking part in labor disturbances. These risks may be added to the policy by endorsement for an additional premium.

**INLAND MARINE INSURANCE**

Inland marine insurance is historically related to ocean marine insurance and usually applies to the insuring of property of a movable nature that is carried or transported. Certain types of fixed property, such as bridges, docks, piers, radio-towers; generally referred to as instrumentality's of communication and transportation--may also be insured. The term "Inland Marine" is therefore somewhat of a misnomer and is sometimes referred to as "all risks insurance," or "transportation insurance."

Such policies are written to insure against specified hazards which may include explosion, riot, earthquake, windstorm, flood, theft, etc., in addition to the usual perils of fire and transportation, or "all risks." Usually the property insured is covered wherever it may be.

As transportation is a basic characteristic of inland marine insurance, only certain property may be covered. To classify the risks eligible under this branch of insurance, a "nationwide definition and interpretation of the insuring powers of marine and transportation underwriters" was accepted by the National Association of Insurance Commissioners. This definition is somewhat general, but it does list classes that may be written as Marine, Inland Marine or Transportation. Classes are divided into six groups: (1) Imports (2) Exports (3) Domestic Shipments (4) Means of Communication (5) Personal Property Floaters Risk (6) Commercial Property Floaters Risk. For testing purposes we will review only some of the classes of Personal Property Floaters and Commercial Property Floaters.

**PERSONAL LINES**
Personal Articles Forms are attached to the "Inland Marine Floater Policy - Personal Lines" to form the policy to provide coverage for personal property. This combination is now the principal contract used to provide coverage on the classes of valuable personal possessions which are insured on a scheduled, all risk basis.

**Types of Personal Articles by Classes**

1) **Cameras and Photographic equipment** - equipment eligible for coverage includes cameras, projection machines, equipment used with these, portable sound and recording equipment and miscellaneous property such as films, and when used in conjunction with photographic equipment coverage also can apply to binoculars, telescopes, microscopes and other similar equipment.

Each piece of equipment must be individually described and valued. It may be necessary to furnish evidence of the value of property to be insured. The description of the property includes make, model, serial number and date of purchase.

2) **Fine Arts** - paintings, etchings, pictures, tapestries, art glass-windows and other bona fide works of art such as valuable rugs, statuary, marbles, bronzes, antique furniture, rare books, antique silver, manuscripts, porcelains, and rare glass may be insured under the Personal Articles Form. These fine arts losses apply to private collections only. Private collections include property owned by a firm, corporation, association, public schools as well as property owned by an individual.

There are important differences from other classes of property eligible for the Personal Articles form in the fine arts class. The differences relate to valuation, territorial scope and Pair and Set clause.

**Valuation** - is on a valued basis, not on actual cash value basis as other forms of eligible property.

**Territorial Scope** - is restricted to the continental United States, Hawaii and Canada. Coverage is not worldwide.

**Pair and Set Clause** - for articles of fine art which are a part of a set, the company agrees to pay for the full value of the set but then takes possession of any remaining part or parts.

Additionally, the Fine Arts form excludes coverage on fine arts for damages resulting from repairing, restoration or retouching.

3) **Golfers Equipment** - coverage to golf clubs, golf clothing and other golf equipment owned by an individual.

4) **Personal Furs** - personal furs, including imitation furs, garments trimmed with fur or consisting principally of fur, and fur rugs may be insured. Generally, a statement is required that shows when and where the insured furs were purchased and the price paid for them. Most companies will not permit furs to be covered for more than the original purchase price regardless of the garment or appraisal value. Depreciation is customarily applied to losses after the first year.

5) **Personal Jewelry** - is defined as articles of personal adornment composed in whole or in part of silver, gold, platinum or other precious metals or alloys. These articles may or may not contain pearls, jewels or precious or semi-precious stones.

These policies may be written for persons who are not related only when they reside together and are co-owners of the property to be insured. However, a policy may be written on engagement rings, wedding rings and guard rings in the names of two interested individuals regardless of where they live. The insurance applies "as interest may appear."

It is not possible to blanket items of jewelry, each article to be insured must be completely described and a specific amount of insurance shown for it. The companies require the original bills of sale or a complete signed appraisal from a reputable jeweler. The appraisal must show the physical
condition of the property at the time of the appraisal.

Because of the potential moral hazard involved insuring jewelry requires careful underwriting. Insurers may require the personal recommendation of the agent or broker who produces the business.

6) **Musical Instruments** - musical instruments, sheet music and equipment pertaining to musical instruments may be insured under the Personal Articles form. The policy may be written to cover individuals; orchestras, bands, chamber music ensembles and similar groups; and boards of education and municipalities. When the insured is an individual the contract excludes instruments played for pay, unless the appropriate professional rates are charged.

All insured instruments must be itemized with the amount of insurance shown for each.

**NOTE:** The same insurance may be provided under a Musical Instrument Floater - Broad Form written as a separate policy. Coverage is also available on a limited form "named perils" for orchestras and bands, and on a blanket basis for school boards or municipalities covering school owned instruments (See Inland Marine Floater Commercial)

7) **Silverware** - silverware, gold ware, pewter ware and plated ware may be covered as an insured class of property under the Personal Articles form. It is not always practical to schedule each item for this class, so it can be written on a blanket basis, if desired. Any newly acquired property in this class must be added to the policy for coverage to be effective.

8) **Stamp and Coin Collections** - individually owned stamp and coin collections may be insured under the Personal Articles form.

The stamp item insures all types of postage stamps including due, envelope, official, revenue, match and medicine stamps, cover, locals, reprints, essays, proofs and other types of philatelic property owned by or in the custody or control of the insured. Coverage on coins applies to rare and current coins, medals, paper money, bank notes, tokens of money and other numismatic property, including coin albums, containers, frames, card and display cabinets used in connection with such collections that are owned by or in the custody or control of the insured.

Blanket coverage is provided on both stamps and coins, but there is a limit of $250 to each stamp or coin. If the insured has items exceeding $250 it would be advisable to schedule those items. There is a 100% coinsurance clause applying to blanket coverage.

Exclusions that apply to stamp and coin coverages:

1) Fading, creasing, denting, scratching, tearing, thinning, transfer of colors, wear, tear, inherent defects, dampness, extremes of temperature, insects, vermin, gradual depreciation and deterioration and damage sustained from handling or while being worked on and resulting from such work.
2) Theft from unattended automobiles unless the property is being shipped by registered mail (may be removed for an additional premium).
3) Mysterious disappearance of unscheduled items unless they are mounted in a volume and the page to which they are attached is also lost.
4) Stamps or coins in the custody of transportation companies.
5) Property which is not an actual part of a stamp or coin collection.

All of these classes may be covered individually or together under the Personal Articles form, depending upon the classes of property for which the insured needs coverage.

**Personal Line Sections**

Inland Marine Floater Policy (Personal Lines) will generally consist of nine sections, insuring agreement, perils insured against, exclusions, territorial limits, additionally acquired property, loss
deductible clause, special conditions, additional exclusions and general conditions.

**Insuring agreement** - states that the company agrees to provide insurance to property owned by or in the custody or control of the insured for those classes of property listed with a specific premium charge in the schedule.

**Perils Insured Against** - the policy insures against all risks of loss or damage to the insured property except for exclusions provided in the policy.

**Exclusions** - the policy does not insure against:
- loss or damage caused by wear and tear, gradual deterioration, insects, vermin, or inherent vice.
- the usual war clauses in property insurance.
- the usual nuclear energy clauses.

**Territorial Limits** - unless otherwise stated coverage is wherever the property is located (world wide).

**Additionally Acquired Property** - automatic coverage on newly acquired property, this extension applies only to jewelry, watches, furs, cameras and musical instruments. Protection is provided for 30 days for any classes on which insurance is already written.

**Loss Deductible Clause** - states the amount deducted from each loss for each class of property.

**General Conditions** - besides the usual conditions found in property insurance policies.

The Inland Marine Floater Personal Lines Policy has the additional conditions reviewed below.

**Definition of Insured** - the named insured or a member of the insured's family living in the same household.

**Valuation** - (Loss Settlement Clause) - the limits of the insurer's liability on covered property will be the lowest of these four amounts:

1) actual cash value;
2) repair cost within reasonable expectations;
3) the cost, within reasonable expectations, of replacing a lost article with one "substantially identical" to it; or
4) the amount of insurance specified in the policy.

This valuation clause is worded to make the Personal Article form an "open policy". The value of the property insured is not agreed upon but shall be determined at the time of loss or damage.

**Pair, Set or Parts** - in the event of loss or damage the insurer has two options.

1) Repair or replace the damaged article to restore the pair or set to its value before the loss; or
2) Pay the insured the difference between the actual cash value of the intact pair or set and the actual cash value of the articles remaining after the loss.

The special exclusion and special conditions have been included in the review of each class of personal property and will not be repeated.

**The Inland Marine Floater** - Personal Articles form may be written in conjunction with or as a supplement to a Homeowners policy. If this is done it is important to remember that the Personal Articles coverage remains a separate contract despite its appearance as an endorsement. The Homeowners policy applies to its coverage of unscheduled personal property, an exclusion of property which is separately described and specifically insured in whole or in part by any other insurance. This exclusion rules out any contribution by the Homeowners policy as to loss involving property which is scheduled in the floater. If the Personal Article schedule is written in amounts less than full value, the Homeowners coverage will not make up the difference.

**Personal Property Floater** - provides all risks coverage to insured’s unscheduled personal property...
on a blanket basis. Specific items may be taken out of blanket coverage and scheduled using the appropriate form. Jewelry and furs are generally removed from blanket coverage and listed on a Personal Articles form as scheduled items.

Personal Effects Floater - this protection is all risks and applies anywhere in the world except at home. Personal Effects Floater does not cover "unscheduled personal property", but only property of a type which is usually carried by a tourist or traveler.

COMMERCIAL LINES

Scheduled Property Floater - is the basic commercial inland marine form. The provisions of the Scheduled Property Floater are required to be incorporated into the following lines.

Commercial Camera Floater - equipment eligible for coverage includes cameras, projection machines, equipment used with these, portable sound, recording equipment and miscellaneous property such as films, binoculars, telescopes, microscopes and similar equipment used with cameras. This floater provides the same coverages as the Personal Articles Camera and Photographic equipment. The primary reason for the separation is that this form is used for professional and not personal use.

Camera and Musical Instrument Dealers - provides all risks coverage on the insured’s stock in trade. This stock must be principally of cameras and accessories or musical instruments and accessories. Other stock that is incidental to the insured’s primary stock may be covered even if such incidental stock is not cameras or musical instruments. Examples: radio, recorder players.

Equipment Dealers Floater - provides all risk coverage to dealers in agricultural implements and contractor’s equipment on personal property held for sale, display, demonstration, storage, service, or repairs.

Fine Arts Floater - provides all risk coverage to dealers in fine arts including paintings, etchings, pictures, tapestries, art glass windows, other bona fide works of art such as valuable rugs, statuary, marble bronzes, antique furniture, rare books, antique silver, manuscripts, porcelains, rare glass and bric-a-brac.

Furrier’s Block Floater - is an all risks form for the insured’s stock in the fur trade. Stock in the trade consisting principally of furs, fur garments, garments trimmed with furs and accessories pertaining to furs. There are six limits of liability in the Furrier’s Block Floater.

Limit A Property at the insured’s premises which must be designated in the form.

Limit B Property in transit, whether by contract, common carrier, or registered mail.

Limit C Property in custody of a merchant’s parcel delivery services.

Limit D Property at the premises of sales agents, dealers, processors and similar custodians.

Limit E Property of insured while in storage at premises not specified in Limit D which must be designated in the form.

Limit F Property located elsewhere and not otherwise included, but not excluded by this form.

Since the furrier block floater excludes customer’s garments, the furrier may protect the customer’s garments while in the furrier’s care, custody or control by obtaining or endorsing Furrier’s Customer coverage. This coverage provides all risks on customer’s garments up to a limit agreed on by the furrier and his customer as witnessed by the customer’s storage receipt. It is normally written under reporting forms.

Mobile Agricultural Equipment - provides all risks coverage of farm machinery and equipment which
has come into the custody or control of parties who intend to use it for the purpose it was manufactured for. There are two forms that may be used for mobile agricultural equipment.

Form A is used to provide blanket coverage.

Form B is used for scheduled coverage with an optional feature to blanket unscheduled property for the lesser of $5,000 or 10% of the total amount of scheduled coverage, but not exceeding $250 on any one item.

**Livestock Floater** - provides named perils coverage to insure cows, calves, bulls, heifers or steers kept for feeding, dairy breeding or show purposes; sheep, swine, horses and mules. There are two forms that may be used for livestock coverages.

Form A is blanket coverage, subject to a limit of liability on any one of each class insured. Classes may be described by age, type, use or some other means, but individual animals may not be scheduled.

Form B is used to provide scheduled protection on individual animals, but may also be written by type of animals.

**Musical Instruments** - coverage of musical instruments can be written on a Broad Form providing all risks coverage, or on a Limited Form providing named perils for orchestras and bands, and on a blanket basis for school boards or municipalities covering school owned instruments. The Broad Form excludes instruments played for remuneration unless professional rates are charged.

**Neon Sign Floater** - provides all risks coverage on neon, fluorescent, automatic or mechanical electric signs or lamps. Insured property must be scheduled, the schedule containing a description of each sign, the lettering on it, its location and the amount of insurance on each sign.

**Physician’s and Surgeon’s Equipment Floater** - provides all risks to physicians, surgeons and dentists for professional equipment and optionally may be extended to furniture, fixtures, improvements and betterments. Under a separate insuring agreement they may select a more limited coverage that applies only to portable equipment (that type of property usually carried by the insured).

**GENERAL PROVISIONS**

All general provisions discussed below apply to each line listed above, except where superseded in the individual forms. Each form listed above had special conditions and exclusions which will not be reviewed, but every licensee should become familiar with these provisions before attempting to sell these lines.

**Misrepresentation and Fraud** - the policy will be void if the insured has concealed or misrepresented any material fact or circumstance concerning the insurance subject. This relates to violations whether before or after any loss.

**Notice of Loss** - requires the insured to report any loss to the company or its agent as soon as practicable. Proof of Loss must be filed within 90 days from the date of loss. Failure to report or to file the necessary proof of loss within the prescribed time invalidates the claim.

**Valuation** - the company shall not be liable for more than the actual cash value of the property, with deduction for depreciation, at the time the loss or damage occurs. In any event it shall not be liable for more than it cost to repair or replace the same. Since the value is determined at the time of the loss this is an open policy not a valued policy unless the schedule states “insured and valued at”. 

**Settlement of Loss** - all adjusted claims shall be paid to the insured within 60 days after proof of loss. No loss shall be paid or made good if the insured has collected the same from others.

**No Benefit to Bailee** - the insurance will not in any way cover directly or indirectly the benefit of any
carrier or other bailee.

**Loss Clause** - any loss shall not reduce the amount of coverage, except in the event of a total loss of an item specifically scheduled. If a claim is paid for total loss on one or more scheduled items, the unearned premium applicable to such items will be refunded or applied to premium due on items replacing those on which the claim was paid.

**Pair, Set or Parts** - in the event of loss or damage to:

1) any article or articles which are a part of a pair, or set, the measure of loss or damage shall be a reasonable and fair proportion of the total value of the pair or set, giving consideration to the importance of the loss article or articles, but in no event shall be construed to mean total loss of pair or set; or
2) any part of property covered consisting, when complete for use, of several parts, the company shall only be liable for the value of the part lost or damaged.

The Scheduled Property Floater has other conditions usual to most insurance contracts, Subrogation, Protection of Property, Suit, Appraisal, Cancellation, Changes and conformity to Statutes.

**NOTE:** You are again reminded that each line has conditions and exclusions that are special to that line of insurance and will not be reviewed for testing purposes. The licensee should become familiar with these special conditions and exclusions before trying to sell these contracts.

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**SURETY & FIDELITY BONDS**

**SURETY**

A contract of suretyship is a written instrument involving three parties (in contrast to insurance policies, which are two-party contracts). In suretyship one party binds himself/herself for the performance by another party of an obligation or undertaking. The parties in a contract of suretyship are the primary obligor or principal, the obligee and the surety.

The **principal** is the one whose obligation or undertaking is to be guaranteed.

The **obligee** is the one in whose favor the obligation or undertaking is made.
The surety is the one who guarantees that the obligation or undertaking will be performed.

The contract of suretyship must be in writing to be valid.

The need for suretyship arises when a right or privilege has been granted in consideration of an agreement to do something in the future. The surety provides a guarantee of performance. They may cover the whole range of human activities and the surety may guarantee the performance of any lawful obligation by a principal. The following are typical circumstances requiring suretyship:

1) A person appointed or elected to public office is required by law to provide a bond to guarantee faithful performance of duties in such office.

2) A person appointed to a position of trust, under the jurisdiction of a court (probate proceedings) is required by law to provide a bond to guarantee faithful performance of duties.

3) A person or firm against which a judgment has been rendered in a legal action that may be appealed to a higher court upon providing a bond to guarantee payment of the judgment if affirmed.

4) A person or firm awarded a construction contract may be required to provide a bond guaranteeing the performance of the obligations under the contract.

A surety bond is a joint obligation and may be enforced by suit against the principal and surety jointly or against the surety alone. This becomes particularly significant where default is due to insolvency of the principal.

The general rule is that the surety is obligated, upon default of the principal, to perform the contract, duty or obligation of the principal or to indemnify the obligee for the actual loss or damage which directly results from the default, not exceeding the amount for which the bond is written. When the surety must perform the undertaking, the surety is subrogated to the rights of the obligee against the principal, with every legal right to enforce such rights either in the name of the obligee or the surety itself. In other words, the defaulting principal becomes legally obligated to reimburse the surety for any loss paid.

The surety usually requires its principal to make application and to execute the indemnity agreement which is a part of or which may be appended to the application. Under the indemnity agreement the principal agrees to protect the surety from loss or expenses. In the absence of an executed indemnity agreement, the law implies such agreement and the courts enforce such implied agreement requiring the principal to reimburse the surety or hold it harmless from loss. The application also contains questions that bring out information which the surety requires for underwriting consideration of the risk.

If an applicant makes a material misrepresentation(s) to obtain an insurance policy, the insurer can usually deny liability in event of loss. Not so in surety. The rights of the obligee are not affected by any misrepresentations made by the principal to induce a surety to execute a bond, however material and even though fraudulent. Therefore, the surety may require a financial statement and will want to feel satisfied that the applicant has a good reputation and the ability to perform the terms of the contract.

The agreement of the applicant for a bond to pay the premium charged for the bond is not the consideration which makes the bond valid. The consideration is the grant by the obligee to the principal of the right or privilege for which the bond was given. When the bond is executed and delivered and the principal acquires the right or privilege of the bond, the bond is in force regardless of whether the premium has been paid. Once in force and valid, a bond may not be canceled by the surety unless the right to cancel is reserved by an express provision in the bond or exists as a legal right without such reservation. In some cases the law permits the surety to secure relief from future liability upon compliance with prescribed requirements or procedure, but in most cases the surety bond may not be terminated until the underlying contract or obligation has been satisfactorily performed or discharged.
Some typical surety bonds that an agent or broker may encounter are as follows:

**Fiduciary bonds** - bonds given by a person entrusted with the care or custody of the property of another. The bond guarantees that the principal will faithfully perform duties and account for the property in accordance with the terms of the trust and of the law. The most common fiduciary bonds are given in probate proceedings by administrators, executors and guardians.

An administrator's bond is given by a person appointed by the court to administer and settle the estate of a deceased person.

An executor's bond is one required to be given by a person named in the will of a deceased person to settle the decedent's estate.

A guardian's bond is one given by a person appointed by the court to care for and manage the estate of a minor or incompetent person.

**Judicial bonds** - also called litigation bonds - are given in civil action. The most common of these judicial bonds are attachment bonds, release of attachment bonds, and appeal bonds.

Attachment bonds - in certain civil suits the plaintiff may secure a writ of attachment before judgment. By virtue of such writ the sheriff or other proper officer is empowered to seize and hold the property of the defendant in order to assure satisfaction of plaintiff's claim. The bond is required and given to protect the defendant from loss arising from the attachment in event the defendant defeats the plaintiff's claim and prevails in the suit. Though not limited to breach of contract, this type of bond is used principally in such cases.

Release of attachment bonds - if the plaintiff has attached property of the defendant, a release of attachment bond guarantees that if the property is returned to the defendant, any judgment awarded to the plaintiff will be paid.

Appeal bonds - if the judgment or order denies the plaintiff the remedy sought, the plaintiff must post an appeal bond to have a higher court hear the argument. The appeal bond guarantees that the plaintiff will pay court costs on appeal. When losing, and the defendant desires to appeal the case to a higher court, the appeal bond posted guarantees payment of the entire judgment plus interest and court costs should a higher court rule against the defendant.

License bonds - are given by parties who are licensed by a public body for their performance of all or a certain part of the functions and obligations of a profession, occupation or trade. Example: An insurance broker must have a $5,000 bond on file with the Department of Insurance as a condition for keeping the license in force.

Retail sales tax bond - a person conducting a business provides a retail sales tax bond to guarantee payment to the State of the amount of sales tax due on retail sales.

Freight charge bond - is given to a railroad or similar carrier by a regular shipper or receiver of freight and guarantees that if the carrier will waive the collection of freight charges at the time shipments are delivered, the principal will pay charges within the time limit set by the carrier.

Bid bond - also called proposal bond - guarantees execution and delivery of the contract and any required bonds upon award of the contract to the principal.

Contract bond - guarantees that the principal will perform all terms of the contract.

Public official bond - is given by a public official, to guarantee the faithful discharge of the duties of the office. Example: The Insurance Commissioner is required to file a $20,000 bond upon appointment.
FIDELITY

Fidelity bonds provide protection or indemnity to employers against loss caused by dishonest acts of their employees. If the employees were required, as a condition of employment, to give bond with surety, and if each employee that made application for bond, agreed to pay the premium and filed such bond with the employer, then the document would be a surety bond. This is rarely the case in actual practice. Instead, the employer takes the initiative and arranges for the writing of a bond (usually on a blanket basis) and agrees to pay the premium. The employees are not direct parties to the contract and often do not know the bond exists. Thus, fidelity bonds are logically thought of as "honesty insurance."

The surety may reserve, and sometimes exercises, the right to require applications and indemnity agreements from employees. Often the applications-are waived and the employees are covered automatically when the bond becomes effective and thereafter when a new person enters the employer’s service. The surety reserves the right to approve employees and may designate, by notice, particular individuals it will no longer cover under the bond. The surety may secure reimbursement from the employee whose dishonesty caused a loss. Employers may purchase either a name schedule bond, position schedule bond, blanket position bond or a commercial blanket bond.

**Name schedule bond** - covers only those employees listed by name in the schedule attached to the bond. The amount of coverage is the specific amount provided for the named individual.

**Position schedule bond** - covers any employee occupying a position named in the bond or in a schedule attached to the bond. The amount of coverage is the specific amount provided for each named position.

**Blanket position bond** - covers the employer against loss of money or other personal property due to the dishonesty of any employees. Neither the employees nor their positions are named in the bond. The surety’s liability is limited per employee to the stated amount of coverage on each employee, and in the aggregate, to the stated amount of coverage per employee multiplied by the number of such employees. Example: Employee X has a $10,000 blanket position bond. Three employees each steal $10,000, the employer would recover $30,000.

**Commercial Blanket Bond** - covers the employer against loss of money or other personal property due to the dishonesty of any employees. Neither the employees nor the positions are named in the bond. The surety’s liability is limited both per employee and to the stated amount of coverage. Example: Employer X has a $10,000 commercial blanket bond. Three employees each steal $10,000. The employer would recover only $10,000 the limit of the bond.

Fidelity bond coverage or employee dishonesty insurance is provided as an insuring agreement in the comprehensive Dishonesty, Disappearance and Destruction Policy, the Blanket Crime Policy and the Broad form Storekeepers Policy. The coverage also appears as an insuring clause in the forms designed to protect financial institutions, such as: Bankers Blanket Bond, Brokers Blanket Bond, Savings and Loan Blanket Bond, Insurance Companies Blanket Bond and the like.

In the development of the multi-peril or "package" approach to commercial risks, provision is usually made for including the coverage provided by a fidelity bond.

Surety and Fidelity bonds are written by corporations licensed and permitted to engage in this type of business when they have complied with special requirements, and obtained a certificate of authority to operate under the laws of this State. Its operation in this State is supervised by the Insurance Commissioner. A personal surety is an individual who may sign a bond or guaranty as an individual. The individual may pledge real estate or other property to secure the bond or guaranty. Any person may become or act as a surety without first being admitted or licensed as a surety. It is only when they engage in acting as a surety professionally or charge a premium for their bonds that they become subject to the Insurance Code.

The authority of an agent to act on behalf of a company on surety matters is usually delegated in
writing with the extent of such authority clearly defined. Executing authority (permitting commitment of the company by signing a bond or undertaking) is usually extended by a power of attorney, and states a dollar limit on specified types of obligations. Separate and apart from this document the agent may receive verbal or written instructions, limitations and conditions to be followed. It is important that every agent holding such underwriting authority be absolutely certain that all requirements have been met and that the obligation is within that authority before signing any instrument. All cases not clearly within an agent’s authority should be submitted to the company’s underwriters, with the bond being issued only after receiving the proper approval. Violations of authority are viewed with great alarm by surety underwriters. Frequency of violation will invariably result in cancellation of authority.

**Undertaking of bail** is one of the types of bonds executed by corporate sureties for the release of a person arrested for an alleged violation of the law. Bail bonds are issued and delivered by an individual.

A fire and casualty insurance agent who holds a power of attorney to execute bonds for his company cannot sign undertaking of bail, except when given on behalf of an insured under a policy of automobile liability insurance. If an agent desires to execute bail bonds a bail agent’s license must be secured.

**GLASS INSURANCE**

Glass insurance (also known as plate glass insurance) indemnifies the insured for damage to the glass, lettering and ornamentations on the glass described in the policy. The insurance company either repairs or replaces damaged property with other property of the nearest obtainable kind and quality or reimburses the insured. Generally the glass policy will have four parts, the declarations, insuring agreements, exclusions and conditions.

**DECLARATIONS**

Declarations appear on the front page of the contract and will contain three items.

- **Item #1** - Name and address of the insured.
- **Item #2** - Policy period.
- **Item #3** - Schedule with areas to indicate the premium, specific limits, number of plates and sizes of the plates, description of the glass, lettering and ornamentation, location in building and type of glass.

**INSURING AGREEMENT**

The Insuring Agreement insurer agrees to pay for damage during the policy period to glass described in the declarations and to the lettering and ornamentation’s separately described in the declarations, by breakage of the glass or by chemicals accidentally or maliciously applied. In addition to paying the actual expenses to replace the glass, lettering or ornamentations, the insurer agree. to paying up to $75 for each of the following:

- **A)** Repairing or replacing frames immediately encasing and contiguous to such glass when necessary because of damage.
- **B)** Installing temporary plates in or boarding up openings containing such glass when necessary because of unavoidable delay in repairing or replacing such damaged glass.
- **C)** Removing or replacing an obstruction, other than window displays, when necessary in replacing such damaged glass, lettering or ornamentations.

**EXCLUSIONS**

The policy does not apply to the following:

- **A)** Loss by fire.
B) Loss due to war, whether or not declared, civil war, insurrection, rebellion or revolution, or any act or condition incident to any of the foregoing.
C) Loss due to nuclear reaction, nuclear radiation, or radioactive contamination, or to any act or condition incident to any of the foregoing.

CONDITIONS

The glass policy includes the miscellaneous provisions under the conditions. There are nine conditions in the glass policy.

1) Limit of liability and Settlement options - The insurer’s liability shall not be more than the actual cash value of the property at the time of loss, nor more than it would cost to repair or replace the damaged property with the nearest obtainable kind and quality. The limit of the insurer’s liability under each division (a) (b) or © of the insuring agreement is $75 for any one occurrence at any one location separately occupied. Any property paid for or replaced shall become the property of the insurer.

2) Insured’s duties when loss occurs - to give notice of loss as soon as practicable to the insurer, and upon the insurer’s request, file a proof of loss on forms provided by the insurer.

3) Other insurance - provides for pro rata liability with other insurance.

4) Action against insurer - no action shall be taken against the insurer unless conditions of the contract have been met, nor until 30 days after the required proof of loss has been filed with the insurer.

5) Subrogation - the usual subrogation clause.

6) Cancellation - The usual cancellation clause, except that ten days written notice must be given to the insured.

7) Assignment - the usual assignment clause.

8) Changes - all changes in the contract must be endorsed to the contract in writing.

9) Declaration the insured agrees all representations made to the insurer are truthful.

Glass insurance is of particular interest to small businesses. Larger businesses are generally self-insurers and will buy glass insurance when they are convinced that their average yearly loss will exceed the premium.

Most insurers issuing this type of coverage make risk selection based on occupancy, merchandise display and operating practices, physical condition of buildings, neighborhood type of setting, kind of glass, use of glass and the position in the building.

The glass policy may be endorsed to provide an "all risk" or "all loss" type of coverage on neon signs, stained glass set in leaded sections, half tone screens and lenses, and rotogravure screens.

Blanket coverage on fixed glass in a one, two, three or four family house or in an individual apartment of a residence apartment building may be written without listing or describing any piece of glass. Most insurers limit their liability to $50 for any one plate. Some insurers write this type of coverage with a limitation of liability on a per plate basis or an exclusion on certain types of expensive glass. Full insurance as to any glass may be provided by specifically describing it and paying an additional premium.

LIABILITY INSURANCE

Liability insurance protects against loss arising from a negligent or wrongful act of a person or those for whom that person is responsible or against liability assumed by contract. A liability policy is a third
party contract requiring the insurer to pay on behalf of the insured any damages the insured may be legally obligated to pay to a third party who suffered bodily injury or property damage. The term "legally obligated to pay" is important in liability insurance. If a third party has suffered bodily injury or property damage arising out of the insured's premises or operation it does not necessarily mean that the insured is legally obligated. Payment is made under the policy only if the insured is guilty of a legal wrong (in a liability contract other than workers' compensation).

There are three classes of legal wrongs, crime, tort and breach of contract.

**Crime** is a public wrong, a violation of a duty owed to society for which society, as a whole, seeks punishment of the violator in a criminal action.

**Tort** is a civil wrong, other than a breach of contract, for which the law provides money damages as one possible remedy.

**Breach of Contract** is a violation of a duty, owed to a specific entity, which arises out of a contractual agreement voluntarily entered into between the party breaching the contract and the party to whom the cause of action is given.

A legal wrong is an unjustified invasion of a legal right for which there must be at least one legal remedy. At this point, we will only review the class of torts for which liability insurance most frequently provides protection.

**Intentional Torts** - a liability policy excludes the exposure for harm which an insured may intentionally inflict on others, but insurance is available for the vicarious liability of an insured for intentional torts of its employees or other agents. **Vicarious liability** is when one person is held responsible for the acts of others. Examples:

1) A parent’s responsibility for a child.
2) An employer's responsibility for an employee's acts.
3) A vehicle owner's responsibility for a permissive user of the vehicle.

**Strict Liability** - in imposed on those activities that present an extreme likelihood of harm to others when mishaps occur, but have substantial benefits to society when performed without mishap. Examples:

1) Keeping of wild animals.
2) Dams.
3) Blasting operations.

**Negligence** - is the failure to do or not to do what a reasonably prudent person would do or not do under the circumstances. Negligence may involve acts committed or acts omitted.

Few states have standard forms for liability policies. However, a basic liability coverage form, meeting the requirements of most states is published by the Insurance Services Office and is provided to the insurance companies writing liability coverages. The companies will follow the coverages as shown on this basic form or will expand the coverages to broader areas.

All liability insurance policies have the same purpose, to assume the insured’s liability for financial loss resulting from being found legally liable for an action or inaction. The different liability policies are designed to provide insurance against liability arising from different circumstances and conditions, all according to the hazards inherent in the operation or conduct of a specific business, profession, home or farm. All liability policies provide for two things:

1) To pay on behalf of the insured all sums for which he/she is legally liable; and
2) To defend the insured against any claims, both real and alleged.
GENERAL LIABILITY

Exposures for commercial risks can be classified as:

**Premises - Operations** - coverage is written on an Owners, Landlords and Tenants (OLT) form for Mercantile Risks (such as stores, apartments and offices) where the exposure to loss arises from the existence of, or operations conducted at, any designated premises. Manufacturer’s and Contractor’s (M&C) coverage is written on a Manufacturers and Contractors form which provides coverage for the operations of the manufacturer or contractor anywhere in a designated state (or states) and the premises exposure of the manufacturer or contractor is automatically included in the operations coverage.

**Owners and Contractors Protective Liabilities** - provides protection against loss resulting from acts of independent contractors, including sub-contractors and others performing work on the insured's behalf, and for whose acts the insured may be held responsible.

**Products or Completed Operations** - provides coverage after the product has been sold and has left the custody and control of the insured, or a service has been finished and the insured has departed from the project. Exposure to loss does not cease with the sale of a product by a merchant or manufacturer or completion of a job by a contractor. This coverage is not a guarantee of the product, but protection against losses caused by the product or completed operation.

**Contractual Liability** - applies to liability assumed by the insured under a written agreement. For example, a manufacturer with a sidetrack on his premises may have signed an agreement with the railroad company assuming liability of the railroad for accidents occurring on the sidetrack.

**Professional Liability** - provides protections against liability arising from rendering of or failure to render professional services. This type of coverage is referred to as malpractice insurance needed by professionals such as lawyers, doctors, accountants, engineers, architects and insurance producers.

Whenever possible, all of the insured's liability exposures should be included in one policy since most exposures can be combined. Professional liability is generally written by insurers specializing in a professional field of malpractice and is generally not combined with the other exposures.

**Types of General Liability Policies**

First, the General (Schedule) Liability Policy is used to allow the insured to choose the various types of coverages and exposures the insured may wish to insure. Coverage forms that may be scheduled are premises and operations coverage, contractual liability, independent contractor’s coverage, and products and completed operations coverage.

Second, the Comprehensive General Liability Policy which includes all of the coverages that can be scheduled in the General Liability Policy which will be reviewed briefly at the end of this section.

**The General Liability Policy Jacket**

A General Liability policy is made up of the policy jacket, the declaration page and one or more coverage forms. The policy jacket contains certain provisions, definitions, and conditions which apply to all general liability policies. The declaration page contains information usual to any insurance policy such as the insured’s name and address, inception and expiration dates. The limits of liability may be shown on the declaration page or the coverage form depending on the format used by the insurer. The individual coverage parts set forth provisions and agreements relating to the forms of liability insurance being issued (OLT, M&C, Owner’s and Contractor’s Protective Liability, Products or Completed Operations).

The policy jacket contains four sections.
Supplementary Payments - provides that the insurer will pay, in addition to the applicable limit of liability:

1) All expenses in defending a suit arising from a covered event, whether claim is false or fraudulent.
2) Pay premiums on appeal bonds, premium on bonds to release attachment, cost of bail bond for accident or traffic law violation arising out of the use of any automobile to which the policy applies.
3) Expenses incurred for first aid to others at the time of accident for bodily injury.
4) Reasonable expenses incurred at the insurance company’s request, not to exceed $25 per day.

Definitions - some of the definitions found in the policy jacket are:

1) Bodily Injury - bodily injury, sickness or disease sustained by any person which occurs during the policy period, including death at any time resulting from that injury, sickness or disease.
2) Property Damage - physical injury to or destruction of tangible property which occurs during the policy period, including loss of use.
3) Named Insured - the person or organization named in the declarations of the policy.
4) Occurrence - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damages neither expected nor intended from the standpoint of the insured.

NOTE: The term "exposure to conditions" does not require that the injury or damage results from a sudden event.

Conditions - the conditions found in the policy jacket are:

1) Premiums - states that premiums are computed in accordance with company’s rules and rating plans. The deposit premium is an "advance premium" credited to the earned premium “final premium” determined by audit at the end of the policy period.
2) Inspection and Audit - gives the company permission to inspect the insured’s property and operations at any time. The company does not assume responsibility for inspections or failure to inspect. Additionally, it gives permission to the insurer to audit and examine the insured’s books and records at any time during the policy period and within three years after the termination of coverage.
3) Financial Responsibility Laws - states that if the policy is subject to Motor Vehicle Financial Responsibility Law, the policy limits are extended to comply with the law.
4) Insured’s Duties in Event of Occurrence, Claim or Suit - requires insured to give notice as soon as practicable of any occurrence which might be the basis for a claim and to assist and cooperate with the insurer.
5) Action Against the Company - states the insured may not sue or take legal action unless there shall have been full compliance with all the terms of the policy, nor until the amount of the insured’s obligation to pay shall have been finally determined either by judgment against the insured after actual trial or by written settlement between insured, claimant and the company.
6) Other Insurance - coverage of this policy is primary, unless stated otherwise. States the methods for determining the insurer’s proportion of the loss when other insurance also applies.
7) Subrogation - the usual subrogation clause.
8) Changes - the usual change clause.
9) Assignments - the usual assignment clause.
10) Three Year Policies - if the policy is issued for a period of three years the limit of the company’s liability stated in the "aggregate" shall apply separately to each consecutive annual period.
11) Cancellation - insured may cancel anytime at short rate table, insurer may cancel by giving 10 days written notice at pro rata percentage factor.
12) Declarations - insured agrees all statements made are the truth.

Nuclear Energy Liability Exclusions - this exclusion contains a number of definitions of the terms applying to it. It excludes coverage for bodily injury or property damage with respect to which an insured under the policy is also an insured under a nuclear energy liability policy.
Owner’s Landlord’s and Tenant’s Liability Insurance (OLT) This coverage form is used in a General Liability policy. It is used on risks where the exposure to loss is the existence of operations conducted at designated premises rather than risks of a nature where the exposure to loss is away from the premises. Eligible risks are stores, churches, schools, apartments, dwellings, hotels and motels, and others where the exposure arises out of the public entering upon the premises.

On the front page of the O L & T coverage there is a space for policy number, additional declarations stating location of insured premises and interest of named insured in the premises and a schedule for listing advance premiums, limits of liability, premises-operations, escalators and structural alterations.

The second page contains five sections.

1) Insuring Agreement - the company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which the insurance applies, caused by occurrence and arising out of the ownership, maintenance or use of the insured premises and all operations necessary or incidental. The company shall have the right and duty to defend any suit against the insured seeking damages on account of such bodily injury or property damage, even if suits are groundless, false or fraudulent. The company may make such investigation and settlement of any claim or suit it deems expedient, but shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of the company’s liability has been exhausted by payment of judgments or settlements.

Within this section is a list of eighteen exclusions. This number of exclusions might give the appearance of making the contract very restricted. This is not the case, since most exclusions deal with exposures that would be insured under other contracts.

2) Persons Insured - this section gives a lengthy definition of who is and who is not an insured.

3) Limits of Liability - states that the limits of liability shown for Coverage A - Bodily Injury and Coverage B - Property Damage shall be the maximum amount for each occurrence.

*NOTE: When more than one occurrence happens, within a policy period, the limits apply to each occurrence.*

4) Additional Definition - gives the definition of insured premises.

5) Policy Territory - the United States of America, its territories or possessions, or Canada.

Premiums for O L & T are usually determined by the area of the premises insured, and rate classification of the risk (store, apartment, motel, etc.) applied to each 100 square feet of area. Premiums for some classes are based on frontage, receipts, admissions, teams or units.

Manufacturer’s and Contractor’s Liability Insurance (M&C). This coverage form is used in a General Liability policy for risks of a nature where the exposure is from operations on and away from the insured’s premises, rather than from the existence of the premises.

The M&C coverage form is similar to the O L & T form, the insuring agreement is briefer and simply refers to "bodily injury or property damage caused by an occurrence". The exclusions, persons insured, limits of liability, policy period and territory are essentially the same.

Premiums for M&C are usually based on the amount of payroll for various work classifications. Experience ratings (claims) normally are taken into account in determining the premium on large risks.

Completed Operations and Products Liability. The Completed Operations coverage is for liability arising out of defects in work completed by or for the insured.

The Products Liability coverage is for liability arising out of defects in products manufactured, sold, handled or distributed by an insured.

*Insuring Agreement* - the company will pay on behalf of the insured all sums which the insured shall
become legally obligated to pay as damages because of Bodily Injury or Property Damage to which
this insurance applies, caused by an occurrence, if the bodily injury or property damage is included
within the completed operations hazard or the products hazard.

NOTE: Insurance is effective during the policy period. It does not matter when the operations
were completed or when the product was manufactured or sold, or who was the insurer at that time.
The insurer at the time of injury is liable even though it might be a different insurer and several
years after the product was manufactured or sold or after operations were completed.

The exclusions, under the Completed Operations and Products Liability coverage form, are similar to
those found in other liability forms. The general provisions, insuring agreement and exclusions all
combine to make certain that the insured operations must be completed, or in products liability the
injury or damage must occur away from the premises of the insured and physical possession of the
products must have been relinquished to others.

Contractual Liability. Contractual liability assumes liability under a written contract or agreement.
Contractual liability does not include warranties for fitness or quality of products, or that work
performed shall be done in a workman-like manner. Example: A contractor is to construct a building
and the owner includes in the construction contract an agreement that the contractor will hold the
owner harmless for all liability in connection with the construction. The contractor assumes the liability
of the owner.

Insuring Agreement - states that the company will pay on behalf of the insured all sums which the
insured, by reason of contractual liability assumed under a contract designated in the schedule
for the insurance, shall become legally obligated to pay as damages because of bodily injury or
property damage to which the insurance applies, caused by an occurrence.

All the coverages forms reviewed to this point require that the coverages be scheduled on the General
Liability Policy. The second type of General Liability Policy is the Comprehensive General Liability
Policy which allows a combination of all of the various forms of liability insurance such as Owners,
Landlords and Tenants, Manufacturers and Contractors, Owners and Contractors Protective,
Products, and Contractual. The Comprehensive General Liability coverage part is used with the basic
policy jacket and combines the various forms of liability insurance except contractual for which a
separate coverage part is still needed.

The Comprehensive General Liability form gives automatic coverage for extensions of the insured's
operations, such as new buildings, whether at premises already designated or at other locations, and
additional operations begun after the inception date of the policy. Exposures which are not known to
exist at the inception of the policy are covered. The usual exclusions that apply to liability policies are
contained in the Comprehensive General Liability form.

LIABILITY GAP COVERAGE

The CGL policy has many exclusions that can cause agents and insureds some big problems. Following are some of the prominent coverage gaps:

- CGL excludes coverage for damage to a product is the damage arises out of a faulty product.
- CGL excludes coverage for damage to completed operations is the damage arises out of faulty
  workmanship.
- CGL excludes coverage for property that cannot be used because of defective work if the property
can be restored to use by replacement of the work (impaired property).

Until recently, there was no way to insure these coverage gaps. Now, CGL gap policies are popping
up which provide the following coverages for manufacturers and contractors
• Property damage liability for damage to manufactured product,
• Property damage liability for damage to completed work.
• Property damage liability for damage to impaired property.
• Product recall expense and off-site product modification expense.
• Employment practices liability (occurrence basis).

These new gap policies are written by excess and surplus lines companies which means that coverage is provided by a Non-admitted company. As such, state guaranty protection would not cover any insolvency of the insurer. So, as good as gap coverage sounds, there are some drawbacks as well as exclusions such as contractual liability, Y2K failures, normal wear and tear, professional liability (such as engineer design, surveying, etc) and coverage for products that are already protected by normal contract warranty.

**WORKERS’ COMPENSATION INSURANCE**

Workers’ compensation insurance provide protection to the employer against the liability imposed by law to pay benefits (known as "compensation") to any worker injured in the course of, and arising out of employment, without regard to fault or negligence on the employer’s part or that of any other person.

Workers’ compensation policies also provide employers’ liability insurance for the protection of the employer against claims for damages brought by the employees, injured in the course of their employment in the event an accident occurs which is not covered under the compensation law. Such coverage rarely applies since most employees are covered by the workers’ compensation law and its benefits are the exclusive remedy of such employees.

Workers’ compensation law guarantees the employee (1) medical, surgical and hospital treatment, (2) weekly benefits for disability and (3) burial and death benefits. In the event of a dispute between the employee and either the employer or the insurer, as the case may be, original jurisdiction for the settlement of that dispute is usually given to a Workers’ Compensation Appeal Board. The board also has authority in proper cases to approve compromises and releases, and has jurisdiction over the establishment of lump sum payments in lieu of weekly disability benefits.

Chief functions of a Workers’ Compensation Appeals Board are:

1) To secure the recovery of workers’ compensation by the employee;
2) To enforce against the employer or the insurer claims for compensation imposed by the Labor Code;
3) To foster, review and approve the carrying out of voluntary rehabilitation plans for the rehabs of injured employees;
4) To determine questions compensation payments; as to the distribution of
5) To determine questions of dependency;
6) To make such other orders and determinations and do all other things necessary and convenient to the exercise of the powers and jurisdiction conferred upon it by the Labor Code.

A typical Workers’ Compensation Appeals Board consists of five to seven members appointed by the Governor with the advice and consent of the Senate.

A Workers’ Compensation Insurance Rating Bureau is an association of workers’ compensation insurers and is licensed under the Insurance Code, to perform the functions of a rating bureau with respect to workers’ compensation insurance and employer’s liability insurance. Its chief functions are:

1) To collect and tabulate information and statistics, and on the basis of such information and statistics to make classifications of risks and minimum adequate premium rates to be submitted to the Insurance Commissioner for issuance or approval;
2) To formulate rules and regulations in connection with the issued or approved rates, and the
administration of classification and rating systems, and to present these to the Insurance Commissioner for approval;

3) To develop equitable rating plans and systems so that each employer will receive the benefit of any accident prevention efforts, and to present such rating plans and systems to the Insurance Commissioner for issuance or approval;

4) To inspect employers’ operations for classification and rating purposes;

5) To review workers’ compensation insurance policies and endorsements providing insurance under the laws of this state to determine compliance with the Workers’ Compensation Insurance Manual and other applicable regulations of the Insurance Commissioner governing the underwriting of workers’ compensation insurance.

The manual is a compilation of rules, classifications and basic rates for workers’ compensation insurance approved and issued by the Insurance Commissioner.

The minimum premium rates for workers’ compensation insurance are approved by the Insurance Commissioner, and no carrier may charge the published minimum rates. Dividends, however, may be carrier, provided it has sufficient surplus from workers’ compensation business to support the dividend payment. When soliciting workers’ compensation risks, no promise of a dividend may be made to the prospect.

Most states Do not prescribe any standard workers’ compensation policy form. However, no form can be used unless approved by the Insurance Commissioner. Most carriers use substantially the same basic form, varying it where necessary by the addition of appropriate endorsements.

There are three ways in which an employer may secure the payment of compensation. He or she may either become a self-insurer by securing a certificate of consent to self-insure, or insure in a private carrier (stock, mutual or reciprocal), or in a State Compensation Insurance Fund. Under a workers’ compensation policy the insurer agrees to provide the protection outlined in the Labor Code, and by issuance of the policy assumes the employer’s liability for workers’ compensation.

SELF-INSURERS

If an employer wishes to become a self-insurer he/she must apply to the state or commissioner for a certificate of consent to self-insure. At the time application is made the employer must furnish proof of the ability to pay any compensation that may become due the employees, and deposit securities or a bond usually in the minimum amount of $200,000 or 125 percent of the private self-insurer’s liability for the payment of compensation, whichever is greater.

The state may revoke a certificate of consent to self-insure at any time for good cause after a hearing. Good cause includes, among other things, the impairment of the solvency of an employer, the inability of the employer to fulfill obligations, or the practice by an employer or agent in charge of the administration of obligations of any of the following:

1) Habitually and as a matter of practice and custom inducing claimants for compensation to accept less than the compensation due or making it necessary for them to resort to proceedings against the employer to secure the compensation due;

2) Discharging compensation obligations in a dishonest manner;

3) Discharging compensation obligations in such a manner as to cause injury to the public.

SELF-INSURERS’ SECURITY FUND

Some states have established a “Self-Insurers’ Security Fund” as a Nonprofit Mutual Benefit Corporation, with each private self-insured employer required to participate as a member in the fund as a condition of maintaining its certificate of consent to self-insure.
INSURE WITH A PRIVATE CARRIER

If the employer wants to secure the payment of compensation from a private admitted insurer he/she must make application to that insurer the same as in any other contract of insurance. The information generally required by the insurer in an application for workers’ compensation is: exact name of the insured, type of organization (individual, partnership, corporation or association), mailing address and location of principal operations, policy period, description of operations, payroll estimate by manual classifications, and a statement of previous loss experience and the name of previous insurer.

Generally the workers’ compensation contract will have four parts, the declarations, insuring agreements, exclusions and conditions.

DECLARATIONS

These appear on the front page of the contract and will normally contain five items.

- **Item 1** - Name and address of the insured; whether insured is an individual, partnership, corporation or association; location of all usual workplaces.
- **Item 2** - Policy period.
- **Item 3** - Identifies the state laws to which the policy must conform for Coverage A.
- **Item 4** - Premium basis, rates and classification of operations, deposit premium and minimum premium.
- **Item 5** - Limits of liability for Employer’s Liability.

INSURING AGREEMENTS

Agreements contain four sections:

**Section I - Coverages:**
- Coverage A -- The insurer agrees to assume liability imposed upon the insured by the workers’ compensation laws.
- Coverage B -- The insurer agrees to provide coverage for those amounts which the employer is found legally obligated to pay because of bodily injury, sickness or disease not otherwise paid under workers’ compensation.

**Section II** The insurer agrees to pay in addition to the amounts payable under Coverage A or the applicable limit of liability under Coverage B, the cost of defense, premiums or bonds to release attachments and appeal bonds, reimburse the insured for reasonable expenses incurred at the insurer’s request.

**Section III** is primarily definitions: Workers’ Compensation Law is the law of any state designated in Item #3 of the declarations and includes any occupational disease law of that state.

State means any State or Territory of the United States and the District of Columbia. (The policy uses the term "State" laws; there is no automatic coverage for employees who are subject to Federal compensation law such as the United States Longshoremen’s and Harbor Workers’ Compensation Act.)

**NOTE:** The following definitions may not appear in all workers’ compensation policies. but the Labor Code defines the terms and all policies.
Injury - signifies an injury or disease sustained, arising out of and in the course of employment, including injury to artificial members and medical braces of all types. In most states, "injury" is not limited to accidental injury, but is broad enough to include any disease or functional disturbance caused by employment.

Occupational disease - one which is produced by hazards peculiar to the occupation carried on by the employee. Occupational disease is compensable if it can be shown to be caused or aggravated by employment.

Section IV -- Application of Policy - states that the policy applies only to injury caused or aggravated by exposure during employment and during the policy period.

EXCLUSIONS

The first two exclusions apply to both Coverage A and B, and the last four exclusions apply to Coverage B only.

1) Concerns other insurance and is aimed at avoiding overlapping coverage.
2) Excludes domestic and farm or agricultural employment. NOTE: Some states do not require coverage of these classes in most cases, therefore this exclusion will not always apply.
3) Coverage B does not apply to any liability under any workers’ compensation law, unemployment compensation or similar laws.
4) Coverage B excludes damages to any employees employed in violation of law.
5) Coverage B will not apply, to any claims made after thirty-six months, after the end of the policy period.
6) Coverage B excludes liability assumed by the insured under any contract or agreement.

CONDITIONS

Conditions can be placed into two groups. The first group would be all those conditions usually found in contracts of insurance, such as other insurance, subrogation, action against the company, assignments, and cancellations. The second group would be those conditions that set out the mechanics of the policy, and generally set out the duties of the insured and set limits of liability for the contract.

1) Premiums - this condition sets the basis for the premiums and the rating classification for developing the premium charged.
2) Long Term Policy - allows the policy to be written for a longer period than one year, but allows for any rating changes in subsequent years.
3) Inspection and Audit - allows the insurer to inspect the workplaces and audit the payroll records and any other records necessary to determine the premium due.
4) Notice of Injury - insured shall notify the company as soon as practicable of any injury that occurs. States what information is necessary in the report.
5) Notice of Claim or Suit - if a claim or suit is filed, the insured shall immediately forward to the company- every demand, notice, summons or other process received.
6) Assistance and Cooperation of the Insured - the insured must cooperate with the insurer in any hearing or trials and shall not voluntarily assume any obligation, except for immediate medical attention.
7) Statutory Provisions - Coverage A - make the company directly and primarily liable in place of the insured to any person entitled to benefits of workers’ compensation laws.
8) Limits of Liability - Coverage B - the limit of liability is as stated in Item #5 of the declaration.
9) Terms of Policy Conformed to Statute - Coverage A - terms of the policy which are in conflict with the provisions of the workers’ compensation laws are amended to conform to such laws.

STATE COMPENSATION FUNDS

In the section of this manual titled, "insurers", legal form of organization included only "private enterprises". There is a legal form of organization termed as "public". The term "public" would be an insurer that has governmental sponsorship and control.

In many states there are public insurers that compete directly with private insurers in the class of workers’ compensation insurance: It is the State Compensation Insurance Fund and is commonly called the State Fund.

If an employer wishes to secure payment of compensation from the State Fund, an application would be made similar to making an application with a private insurer. The State Fund issues a contract similar to those used by private insurers and it must conform to the Workers’ Compensation laws the same as a private insurer’s contract.

The following definitions typically apply to Workers’ Compensation coverages.

**Weekly Benefits**: An employee will receive 66 2/3 percent of his/her average weekly earnings. In computing the average earnings for temporary disability and permanent total disability, the average weekly earnings shall not be less than $73.50 nor more than $262.50. In computing the average earnings for permanent partial disability, the average weekly earnings shall not be less than $45.00 nor more than $105.00.

There are other methods used for those persons working other than a normal 40 hour week with regularly scheduled pay scales, such as piecework, commission basis, and part-time employees that are employed less than 30 hours a week. (This is mentioned so that you are aware that the methods shown in the above paragraph are not always the case. For examination purposes, you need only study the above method.)

**Death Benefits**: In case of two or more total dependents $75,000, and any partial dependents receive no benefits.

In the case of one total dependent and one or more partial dependents, the one totally dependent will receive $50,000, and partial dependents shall receive $25,000 divided among them in proportion to the extent of dependency.

In cases of no total dependents and one or more partial dependents, four times the amount annually denoted to the support of the partial dependent, but in no case more than $50,000.

**Types of injuries conclusively considered to be total and permanent**:

1) Loss of both eyes or the sight thereof;
2) Loss of both hands or the use thereof;
3) Practically total paralysis;
4) Incurable imbecility or insanity resulting from brain damage.

**Limits of Medical Expenses** - The law provides that the injured employee shall be furnished all medical, hospital and surgical treatment required to cure and relieve the effects of the injury, therefore there is no limitation placed on medical treatments.

**Employee** - An employee is any person in the service of an employer under any appointment, or contract of hire or apprenticeship, expressed or implied, oral or written, whether lawfully or unlawfully employed.
BOILER & MACHINERY INSURANCE

Boiler and machinery insurance provides coverage for losses caused by accidental occurrences to various types of pressure vessels and machinery used for power, heating, processing, refrigerating and air conditioning. The term "Object" is used to identify each piece of insured apparatus and the term "Accident" to describe the type of occurrence to the object that is covered. The policy contains four sections and the insurance shall apply only to a loss from an accident to an object in the section or sections designated and described as the declaration schedule.

Section A - Boilers, Fired Vessels and Electric Steam Generators.

Section B - Unfired Vessels - this section would provide coverage to various types of moving machinery, such as turbines, wheels and shafting, and various kinds of electrical equipment.

Section C - Systems of Refrigerating and Air Conditioning Vessels and Piping.

Section D - Auxiliary Piping.

Boiler and Machinery insurance may be written two ways

1) Scheduled basis - each object must be specifically itemized and described in the appropriate schedule. Newly installed objects or objects at new locations are not covered automatically but must be added by endorsement in order for coverage to apply.

2) Blanket group plan - the coverage applies at all described locations to all objects in use or connected ready for use of the types shown in the schedules as subject to blanket coverage. In using the blanket group plan, care must be taken to be sure that the object classes are properly described so as to include all objects on which coverage is desired and omitting those objects which are not covered.

Most states have no statutory form for boiler and machinery insurance. The forms used by most insurers are similar. The basic policy is used for all coverages and contains the insuring agreement, exclusions, conditions, declarations and the endorsement containing definitions and special provisions.

THE INSURING AGREEMENT

The insuring agreement is simple and comprehensive, it covers the insured against loss from an "accident" during the policy period to an "object". There are six coverages provided by the basic boiler and machinery policy.

Coverage A- Loss on Property of Insured - covers the insured object and all other property damaged in an insured accident.

Coverage B - Expediting Expenses - covers reasonable cost of temporary repair and expediting permanent repair.

Coverage C - Property Damage Liability - covers liability for property of others directly damaged by an insured accident.

Coverage D - Bodily Injury - liability protection for bodily injury arising out of an accident.

Coverage E - Defense, Settlement, Supplementary Payment - provides legal defense, interest on judgments rendered and premiums for Appeal or Release of Attachment bonds.

Coverage F - Automatic Coverage - (blanket group plan only) covers any object similar to those described in the policy, which the insured may install at any location described in the schedule. Also, covers any object existing in newly acquired property.
NOTE: All coverages are mandatory except Coverage D.

EXCLUSIONS

The exclusions in the boiler and machinery policy are in four parts. The first two parts apply to the entire policy and consist of the War Damage Clause and the Nuclear Damage Clause, since these exclusions have been reviewed in other policies the wording will not be repeated.

The third part is exclusions that apply to Coverage A and B. The last part applies to Coverage D when the coverage is included.

The exclusions that apply to Coverages A and B are as follows:

1. from fire accompanying or following an accident or from the use of water or other means to extinguish fire,
2. from an accident caused directly or indirectly by fire or from the use of water or other means to extinguish fire,
3. from a combustion explosion outside the object accompanying or following an accident,
4. from an accident caused directly or indirectly by a combustion explosion outside the object,
5. from flood unless an accident ensues and the company shall then be liable only for loss from such ensuing accident,
6. from delay or interruption of business or manufacturing or process,
7. from lack of power, light, heat, steam or refrigeration, and
8. from any other indirect result of an accident.

The exclusion that applies to Coverage D, when that coverage is included in the policy, is liability under any worker’s compensation, unemployment compensation, or disability benefits, and for injury to employees arising out of and in the course of their employment by the insured.

CONDITIONS

The conditions contained in the boiler and machinery policy can be placed into two groups. The first group would be all those conditions usually found in property insurance, such as notice of accident, other insurance, subrogation, action against company, assignments and cancellation. The second group would be those conditions unique to boiler and machinery insurance and are as follows:

**Inspection and Suspension** - provides that the insured shall permit the insurer to make inspections at reasonable times during the policy period. If the insurer finds a dangerous condition affecting the insured object the insurer can suspend the coverage by giving written notice to the insured. The insurance may be reinstated by endorsement after the condition is corrected. The insured is entitled to a pro rata return of premium for that period of time the policy was suspended.

**Limits of Liability** - the boiler and machinery policy has a group of conditions dealing with the settlement of a loss. Basically these conditions state that the loss shall not exceed the actual cash value of the damaged property. Also, losses under a boiler and machinery policy are paid on a priority basis, in a definite order or sequence of payments. A loss under Coverage A, Loss to Property of Insured, is paid first. If the payment under Coverage A has not exhausted the policy limits, the remaining amount is applied next to Coverage B, Expediting Expenses. It should be noted that Coverage B is limited to $1,000. Loss under Coverage C is paid next after loss under Coverage A and B has been deducted from the limit per accident; the balance is then applied to eligible claims for property damage liability under Coverage C. The final apportionment of the limit per accident would be applied to Coverage D, any portion of the policy remaining after losses for Coverage A, B and C have been satisfied will be available to pay bodily injury liability claims. It should be noted that Coverage D is not mandatory and must have been included in the coverages for any loss to be paid.

**Premium Gradation** - if the premium for the policy was determined by applying a discount any additional or return premiums shall be subject to the same discount.
**Malicious Mischief** - subject to the provision of the War Damage exclusion, any accident arising out of strike, riot, civil commotion or acts of sabotage, vandalism or malicious mischief is considered "accidental".

**Blanket Group Plan** - allows for the adjustment of premiums for any object added or withdrawn from use during the policy year.

**DECLARATIONS**

The declarations in the boiler and machinery policy contain the usual information identifying the insurer, the insured’s name and address, premiums and space for identifying the forms attached to the policy. The schedule for listing the objects may also appear on the declaration page. The schedules used in boiler and machinery insurance perform the same functions as most insurance schedules, identifying the location and types of property to be insured. The schedule in a boiler and machinery policy will also define the coverage by indicating whether the policy is on a blanket group plan or a scheduled basis. The schedule will include a column to list whether or not the coverage is "broad" or "limited". Limited coverage has a less liberal definition of accident. The limited form covers strictly against the peril of "explosion". Broad form provides for explosion, accidental bulging, burning or cracking.

**DEFINITIONS**

The Definitions and Special Provision Endorsement - defines the objects and accidents for each type of vessel under Section A, B, C and D. In addition to the definitions there are exclusions and special provisions for each of these four sections.

**BURGLARY INSURANCE**

General usage of the term "burglary insurance" refers to that type of coverage providing indemnity for loss of property due to burglary, robbery or theft. The general term, however, also refers to certain "all risk" policies which include indemnity for loss due to other perils in addition to burglary, robbery and theft.

The meanings of the terms burglary, robbery and theft as used in this type of insurance differ in some respects from their legal and common meanings. A knowledge and understanding of the following broad definitions is therefore essential.

1) Burglary--Feloniaious abstraction of insured property from within the premises by a person making felonious entry or felonious exit by actual force and violence as evidenced by visible marks made by tools, explosives, electricity or chemicals upon, or physical damage to the exterior or interior of the premises at the place of entry or exit.

2) Robbery--Taking of property from a messenger or custodian: (1) by violence; (2) by putting him or her in fear of violence; (3) by any overt felonious act committed in his or her presence and of which he or she was actually cognizant; (4) who has been killed or rendered unconscious.

3) Theft--Technically a term that is broad enough to include any act of stealing or taking of another’s property. This term would include: (1) burglary (2) robbery (3) larceny.
The various policies also cover damage (except by fire) to the premises and contents if caused by the insured peril or attempt there at.

A review of the Mercantile open stock burglary policy will be made to allow the applicant to become familiar with the terms and conditions of a burglary policy. This will be followed by a listing of other common forms of burglary policies giving their purpose and coverages.

**MERCANTILE OPEN STOCK INSURANCE**

Mercantile Open Stock Burglary insurance is available for store and warehouse owners and manufacturers. It insures against loss by burglary of merchandise, furniture, fixtures and equipment. It pays for damage caused by burglary to such property and to the premises if the insured is the owner or is liable for such damages.

**INSURING AGREEMENT**

The Insuring Agreement states that the insurer will pay for loss by burglary or robbery of a watchman, while the premises are not open for business, of merchandise, furniture, fixtures and equipment within the premises or within a showcase or show window used by the insured and located outside the premises but inside the building line of the building containing the premises.

**DECLARATIONS**

The declarations contain the statements of the insured which form the basis for the issuance of the policy. In addition to the usual information about the insured, the insured's business, address, and exact location and description of the premises are most important. It is also important that all types of businesses engaged in by the insured be stated. The declaration contains space for indicating the various protective devices which the insured maintains, including private watchmen who are on duty while the premises are closed. The insured must declare whether he/she suffered any losses, received any indemnity for a burglary, robbery or theft loss in the past five years and whether any such insurance has been canceled by any company. The statements contained in the declaration must continue to be true during the entire policy period.

**EXCLUSIONS**

The mercantile open stock burglary policy contains the following exclusions:

1) To loss due to any fraudulent, dishonest or criminal act by any insured, partner, officer, employee, director, trustee or authorized representative of the insured, while working or otherwise and whether acting alone or in collusion with others.
2) To loss of manuscripts, books of accounts or records.
3) To loss of furs or articles containing fur which represents their principal value, by removal of such property from within a showcase or show window by a person who has broken the glass from outside the premises or by an accomplice of such person.
4) To loss occurring while there is any change in the condition of the risk or during a fire in the premises.
5) To damage by vandalism or malicious mischief.
6) To loss, other than safe or vault, by fire whether or not such fire is caused by, contributed to or arises out of occurrence of a hazard insured against.

Also included in the exclusions are the usual war clause and nuclear exclusion clauses.

**CONDITIONS**

The mercantile open stock burglary policy contains a number of conditions not similar to other contracts of insurance. A review of these conditions will be made and a list of those conditions not
reviewed will be given at the end of the section.

TERRITORY

This policy applies to loss which occurs in any of the States of the United States, the District of Columbia, Virgin Islands, Puerto Rico, Canal Zone and Canada.

DEFINITIONS

Definitions of Premises, Burglary, Robbery of a watchman, loss and jewelry are given in one condition.

OWNERSHIP OF PROPERTY

Provides that insured property need not be the property of the insured. Coverage includes articles held by the insured in any capacity and the insured legal liability for property of others.

JOINT INSURED

If more than one insured, knowledge possessed or discovered by any insured shall constitute knowledge possessed or discovered by every insured.

BOOKS & RECORDS

Books and Records shall be kept of all insured property in a manner that insurer can accurately determine the amount of loss.

COINSURANCE

Every mercantile open stock burglary policy contains a coinsurance clause, similar to the fire insurance coinsurance clause, except it contains a limit beyond which it does not apply. The amount of insurance is compared with amount required by the coinsurance percentage and coinsurance limit stated in the policy. If the amount of insurance is equal to the product of the coinsurance percentage and the value of the loss or the coinsurance limit, whichever is less, the coinsurance clause does not apply.

Example:

| Required coinsurance percentage is ............ 60% |  |
| Cash value of stock at the time of loss ... | $12,000 |
| Amount of insurance at time of loss .......... | $ 7,000 |
| Coinsurance limit .............. | $ 6,000 |
| 60% of cash value at times of loss . | $ 7,200 |
| Cash value of goods stolen.......... | $ 4,000 |

The amount of insurance ($7,000) exceeds the coinsurance limits ($6,000), the amount of insurance ($7,000), is actually less than 60% of the cash-value of the stock ($7,200) but will not reduce the amount paid to less than $4,000 because the amount of insurance exceeds the coinsurance limit.

The clause applies only to merchandise and not to furniture, fixtures or equipment, jewelry, or pledged goods.

LIMITS OF LIABILITY / SETTLEMENT OPTIONS

Limits of Liability / Settlement Options payment is based on the actual cash value of the property at the time of loss. The insurer may elect to replace or repair the property rather than make a money payment.

1) loss of the contents of any showcase or show window is limited to $100.
2) loss of jewelry is limited to $50 per article.
3) coverage on articles held by the insured as a pledge, or as collateral for an advance or loan is limited to the value shown by the insured's record when the transaction was arranged. In absence of such record a loss is limited to the unpaid portion of the advance or loan, plus occurred legal interest.

Those conditions not reviewed, but which are similar to those provisions found in most property policies, are insured's duties when loss occurs, other insurance, appraisal, action against company, subrogation, change, cancellations and assignments.

OTHER BURGLARY POLICIES

Other common types of burglary policies in use include:

**Mercantile Safe Burglary** insurance provides coverage for loss by safe burglary of money, securities and other valuables. This insurance may be written under a separate policy or included in other forms of comprehensive crime policies. It may also be included in the Special Multi-Peril policy. Mercantile Safe Burglary insurance pays for:

1) Loss of money, securities and other property from a described vault or safe by safe burglary or attempted safe burglary.
2) Damage to property, other than money and securities, by safe burglary or attempted safe burglary.
3) Damage to the premises if the insured is the owner or is liable for such damage.

**Mercantile Robbery** insurance provides coverage to insured business for loss by robbery of money, securities and other property at the business premises and also outside the premises when in the custody of an authorized employee. Coverage may be written on a schedule basis or blanket basis, coverage may also be included in the Special Multi-Perils policies. Mercantile Robbery insurance pays for:

1) Robbery inside the premises - loss of money, securities and other property by robbery or attempted robbery within the premises. Also pays for damages to the premises caused by robbery or attempted robbery if the insured is owner or is liable for such damage.
2) Robbery outside the premises - loss of money, securities and other property by robbery or attempted robbery outside the premises while being conveyed by an authorized employee.

**Storekeepers Burglary and Robbery** provides coverage to insured store owner for losses due to burglary or robbery under seven insuring agreements. Premiums are charged for a limit of insurance of $250 for each of the insuring agreements. The limit may be increased in multiples of $250 up to a maximum limit of $1,000 per insuring agreement. This coverage can be written in a separate policy, or included in the Special Multi-Perils policy. A Storekeepers Burglary and Robbery policy is a package policy providing a fixed amount of insurance under each of the following insuring agreements:

1) Robbery inside the premises pays for loss of money, securities, merchandise, furniture, equipment by robbery within the premises.
2) Robbery outside the premises pays for loss of money, securities and merchandise, including the wallet or bag containing the property, by robbery while being conveyed by a messenger outside the premises.
3) Kidnapping pays for loss of money, securities, merchandise, furniture, fixtures and equipment within the premises by kidnapping.
4) Safe burglary, premises burglary pays for loss of money, securities and merchandise by safe burglary within the premises and for loss, not exceeding $50, of money and securities by burglary within the premises.
5) Theft, night depository or residence pays for loss of money and securities by theft within any night depository in a bank or within the house or apartment occupied as a residence by a custodian or messenger.
6) Burglary, robbery of watchman pays for loss of merchandise, furniture, fixtures and equipment by burglary or by robbery of a watchman within the premises, while the premises are not open for business.
7) Damage to the premises and to money, securities, merchandise, furniture, fixtures and equipment within the premises, by such robbery, kidnapping, burglary, safe burglary, robbery of a watchman, or attempt at any of these, provided the insured is the owner or is liable for such damage.

**Broad Form Storekeepers** insurance provides comprehensive crime coverage for a storekeeper under nine insuring agreements. The policy is similar in style to the storekeeper burglary and robbery policy, and provides coverage in a basic amount of $250 per insuring agreement. The limit may be increased in multiples of $250 up to a maximum limit of $1000 per insuring agreements. It is designed to give small businesses a low cost broad form "package" policy. Most insurers limit its use to businesses occupying a single location and employing not more than four employees. The nine insuring agreements provide coverages for:

1) Employees dishonesty;
2) Loss inside premises;
3) Loss outside premises;
4) Burglary of merchandise, furniture or fixtures, and robbery of a watchman;
5) Acceptance in good faith of counterfeit money or money orders;
6) Theft of money or securities from residence of a messenger;
7) Depositor’s forgery;
8) Damage by vandalism or malicious mischief to interior of premises or insured property therein following burglaries entry;
9) Damage to premises or insured property by burglary, robbery or safe burglary.

**SPRINKLER LEAKAGE INSURANCE**

Sprinkler leakage insurance provides coverage for loss of or damage to the insured building or personal property, caused by water released through breakage or leakage of an automatic sprinkler system. The use of the separate policy has been largely discontinued, but may still be written by some companies. Generally, the insurance is written by endorsement to a Fire policy or under the special multi-peril policies.

When sprinkler leakage insurance is written on the building, all additions, extensions attached to it and all permanent fixtures, machinery and equipment which form a part of the building are covered. The cost of repairs and replacement to the sprinkler system is covered if caused directly by either breakage or freezing.

Various types of coverage of personal property are available:

1) **Contents** - covers all contents in the building, additions or extensions except those items excluded in the standard fire policy -- accounts, bills, currency, deeds, evidences of debt, money, notes or securities and unless specifically insured, bullion and manuscripts.
2) **Stock only** - covers merchandise, material and supplies usual and incidental to the occupancy of the insured while in the building.
3) **Furniture and fixtures; machinery; property of employees or members** -- all may be insured separately, but only while in the building.

**INSURING AGREEMENT**

The insuring agreement states simply that coverage is to provide for direct loss by sprinkler leakage. The policy or endorsement contains definitions for the following:

1) **Sprinkler leakage** - is leakage or discharge of water or other substance from within any automatic sprinkler or direct loss caused by collapse or fall of a tank if a part of such system.
2) **Automatic sprinkler system** - means any automatic fire protective system including sprinklers, discharge nozzles and ducts, pipes, valves, fittings, tanks (including component parts and
supports), pumps and private fire protection mains, all connected with and constituting a part of an automatic fire protective system; and non-automatic fire protective systems, hydrants, standpipes or hose outlets supplied from an automatic fire protective system.

**EXCLUSIONS**

The sprinkler leakage policy or endorsement does not cover loss by sprinkler leakage or fall of tanks caused by:

1) Water from any source but from within an automatic sprinkler system.
2) Fire, lightning, windstorm, earthquake, blasting, explosion, rupture of steam boilers or fly wheels, riot or civil commotion.
3) Order of civil authority.

There is the standard war and nuclear exclusion clause.

**CONDITIONS**

The sprinkler leakage endorsement or policy has basically the same conditions found in the fire policy except that the coinsurance clause may require from 10% to 100%. The discount on the rates for sprinkler leakage runs on a scale of 60% reduction for the 10% coinsurance through 91% reduction for the 100% coinsurance. The minimum coinsurance is 10%.

**FINANCIAL RESPONSIBILITY LAWS**

The purpose of any Compulsory Financial Responsibility Law is to ensure that drivers and owners of vehicles using the streets and highways shall be financially responsible for any damage or injury caused by automobile collision, regardless of fault, and to remove financially irresponsible drivers from the highways.

The provisions of the Compulsory Financial Responsibility Law apply to you if: You were the driver or owner of a motor vehicle involved in an accident on a street or highway which resulted in property damage in excess of $500, bodily injury or death.

Even if you are not at fault, you must report the accident to the Department of Motor Vehicles and establish financial responsibility. The report must be filed on a specific form. This is in addition to any other report made to the police, highway patrol, or insurance company. To meet a state’s financial responsibility requirements, your automobile liability insurance must provide at least the minimum coverage: usually $15,000 for a single injury or death; $30,000 for injury to, or death of, more than one person; $5,000 for property damage caused by one accident.

If you do not report the accident to the department or establish financial responsibility (liability insurance) as required by this law, your driving privilege will be suspended.

An admitted insurer is typically prohibited from issuing an automobile liability policy for less than the amount required for an individual to demonstrate the ability to respond under the Financial Responsibility Law.

In accordance with the law, one must provide proof of financial responsibility after you are cited by a peace officer for a traffic violation. The Financial Responsibility Act requires that you provide the officer with the name of your insurer and the policy identification number. Your insurer will provide written evidence of this number. The back of your vehicle registration form contains a space for writing this information. Failure to prove your financial responsibility can result in fines of about $250 and loss of your driver license. Falsification of proof can result in fines of up to $500 and/or 30 days in jail.
Under some jurisdictions, driving privilege will be suspended if you are involved in an accident that results in damages over $500 or any injury or fatality and you do not have financial responsibility.

**AUTOMOBILE ASSIGNED RISK PLANS**

**PURPOSE**

An Automobile Assigned Risk Plan is designed to provide a reasonable plan for the equitable apportionment among liability insurers, of those applicants for automobile liability and property damage insurance who are unable to procure such insurance through ordinary methods.

**ORGANIZATION**

Admitted liability insurers are typically required by law to subscribe to and participate in the Assigned Risk Plan. However, only those insurers transacting automobile liability and property damage insurance must accept assignments of risk under the Assigned Risk Plan. The subscribing insurers administer and operate the Assigned Risk Plan through a manager and staff and governing committee. This administration is subject to review by the Insurance Commissioner.

Applications for assignment under the Assigned Risk Plan are filed with the manager on a form prescribed by the governing committee. Risks are assigned in such a sequence that each insurer receives a number of assignments that develop the same percentage of premiums in the Assigned Risk Plan as its percentage of the total automobile liability premiums written in the state.

The Assigned Risk Plan shall be available to all residents of the state and to nonresidents with respect to automobiles registered in the state, except nonresidents who are members of the U. S. military forces stationed in this State with automobiles registered in other States and are otherwise eligible for insurance under the Assigned Risk Plan.

**ELIGIBILITY**

The Assigned Risk Plan must contain standards for developing eligibility of the applicant for insurance. In establishing these standards, the following may be taken into consideration in respect to the applicant or any other person who may reasonably be expected to operate the applicant’s automobile with the applicant’s permission.

1) Criminal conviction records;
2) Record of suspension or revocation of a license to operate an automobile;
3) Automobile accident records;
4) Age and mental, physical and moral characteristics which pertain to the ability to safely and lawfully operate an automobile;
5) The condition or use of the automobile.

The usual grounds for ineligibility for assignment are:

1) If any person who usually drives the motor vehicle does not hold or is not eligible to obtain an operator’s license, except if such person’s driving privilege can be restored upon the filing of proof of financial responsibility; or
2) If the applicant or anyone who usually drives the motor vehicle fails to meet all obligations to pay to any insurer any automobile insurance premiums due during the immediately preceding 12 months.
CLASSIFICATION OF RISKS

The Assigned Risk Plan divides its rating plans into these classifications:

1) "Private passenger automobile risk" and "risks to whom named non-owner policies" are issued to cover the operations of a private passenger automobile (other than fleets and public automobiles).
2) "Public automobile risk" refers to motor vehicles used in carrying passengers for hire or compensation providing the seating capacity does not exceed 16 persons including the driver.
3) "Long haul truck risks" refers to insurance covering trucks or truckers operating beyond a radius of 50 miles from the city or location of their principal garaging and subject to Federal or State regulations pertaining to trucks or truckers.
4) "All other risks" including fleets and risks to whom named non-owned policies are issued to cover operations of commercial automobiles (commercial risks) are subject to the rules, rates, minimum premiums, rating plans and classifications which the insurer receiving the assignment normally applies to its voluntary business, but are subject to a surcharge.

AMOUNTS OF COVERAGE

The coverage provided must meet the minimum amounts necessary to provide exemption under the Financial Responsibility Laws. Typically, the plan requires issuance of a policy affording coverage of $15,000 for bodily injury or death of each person as a result of any one accident, $30,000 for bodily injury or death of all persons as a result of any one accident, and $5,000 for damage to property of others as a result of any one accident. The plan cannot require issuance of a policy in excess of these amounts of coverage, except for truckers subject to PUC or ICC regulations.

PARTICIPATION BY INSURANCE AGENTS

Any fire and casualty agent or broker can handle applications for insurance and render assistance to the applicants for insurance under the Assigned Risk Plan. The application for assignment must be signed in every case by the applicant. Agents and brokers must first make a bona fide effort to secure insurance through ordinary channels before making application for coverage through the Assigned Risk Plan. In the application, the producer certifies that he/she has read the plan provisions and has explained them to the applicant. The applicant certifies that he/she has tried without success to obtain automobile liability insurance in the voluntary market within the preceding 60 days.

The agent or broker receives a commission for services from the designated insurer issuing a policy through the Assigned Risk Plan. The rate of commission is fixed by regulations and is a percentage of the premium. It is not an unlawful rebate if the agent who receives the commission is not an appointed agent for the insurer. The agent may also receive commissions on any automobile or liability coverage written by the same insurer for the same insured in addition to the assigned risk policy.

No agent, broker or solicitor shall make any charge to the applicant, directly or indirectly, for furnishing any person any necessary application forms, technical assistance and services necessary to securing insurance under the Assigned Risk Plan. The only compensation allowable is the commission paid by the insurer issuing the policy.

OTHER PROVISIONS

The Assigned Risk Plan regulations set out the mechanics for making application, apportionment and appeal procedures by persons who believe themselves aggrieved by the Assigned Risk Plan. The Assigned Risk Plan also contains numerous rules and regulations governing its administration and operations.
AUTOMOBILE INSURANCE

The Insurance Code in many states does not prescribe any particular policy form for writing automobile insurance, but it does require that every such policy must contain two specified conditions:

1) Bankruptcy or insolvency of the insured shall not relieve the insurer of any of its obligations, and

2) Whenever judgment is secured against the insured or the executor or administrator of a deceased insured in an action based upon bodily injury, death, or property damage, the person who has secured the judgment is entitled to bring an action against the insurer to recover on the judgment, subject to the terms and limitations of the policy.

Most policies issued by insurers allow the insured to choose from several types of coverages.

BODILY INJURY LIABILITY COVERAGE

Bodily injury liability coverage is an agreement by the insurer to pay on behalf of the insured, up to the limits in the policy, all sums for which the insured becomes legally liable because of bodily injury, sickness or disease, including death at any time resulting from such injury, sustained by any person, arising out of the ownership, maintenance or use of the automobile.

PROPERTY DAMAGE LIABILITY COVERAGE

Property damage liability coverage is an agreement by the insurer to pay on behalf of the insured all sums, up to the limits in the policy, for which the insured becomes legally liable because of damage to property of others, including the loss of use, arising out of the ownership maintenance or use of the automobile.

MEDICAL PAYMENTS COVERAGE

Medical payments coverage is an agreement by the insurer to pay, up to the medical payment limit in the policy, all reasonable expenses incurred (within a specified time) from the date of accident, for necessary medical, surgical, and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services to and for each person who sustains bodily injury, sickness or disease, caused by accident while in or upon, entering or alighting from the automobile if the automobile is being used by the named insured or with his/her permission. It is not necessary to prove that the insured was legally liable for payment under this coverage. Coverage also applies to the named insured and each relative who resides within his/her household, if struck as a pedestrian by an automobile or injured while riding as a fare paying passenger in autos used as public transportation.

UNINSURED MOTORIST COVERAGE

Uninsured motorist coverage is an agreement by the insurer to provide benefits on account of bodily injury or death caused by accident and arising out of the ownership, maintenance or use of uninsured automobiles, including hit-and-run automobiles, to the named insured, and while residents of the same household, to the spouse of the named insured and relative of either. This coverage also applies to any other person while occupying an automobile insured under the policy. More recent legislation requires uninsured motorist property damage coverage to be offered as part of motor vehicle liability policies which do not contain collision coverage, on policies issued or renewed on or after a certain date. Minimum limits of liability for bodily injury is that amount required under the financial responsibility laws of the state. California law, for example, requires an agent to offer high limits for uninsured motorist (up to $30,000/$60,000) when higher limits apply to Bodily Injury and Property Damage coverages.

Protection against uninsured motorists must typically be included in all automobile liability policies issued. The law provides, however, that the insurer and the insured may by supplemental agreement
waive application of the provision covering damage caused by an uninsured motor vehicle.

AUTOMOBILE DEATH & DISABILITY

Automobile death and specific disability benefits this coverage is normally added by endorsement and contains three insuring agreements.

Coverage A
Death Benefit

Coverage B
1) Dismemberment and Loss of Sight Benefit
2) Fractures and Dislocation Benefits

Coverage C
3) Total Disability Benefits

This coverage may be written with all automobile liability policies which include Bodily Injury liability, but it applies only to named persons for automobiles classified as private passenger automobiles.

PHYSICAL DAMAGE COVERAGE

Physical damage coverage is where the company agrees to pay the insured for direct loss of or damage to the automobile(s) described in the policy. The coverages available are comprehensive, collision, named perils or combined additional coverage. It is important to remember that Physical Damage deals with the damage to the insured's automobile(s).

AUTOMOBILE LIABILITY COVERAGE

Automobile liability coverage is designed to protect the insured against financial loss if a claim is made against him/her by a third party because of bodily injuries, death, or damage to property arising out of the ownership, maintenance, or use of an insured automobile. If the insured is liable, the insurer will pay damages on his/her behalf up to limits in the policy. If suit is brought the insurer will defend him/her in court and pay certain expenses on his/her behalf. In transacting automobile liability insurance, it is important to bear in mind that this is a liability policy and is not a compensation policy. Merely because the insured injures someone or damages someone's property, it does not necessarily follow that he/she is liable. The insurer is required to pay only if the insured is legally liable for injuries or damage. The term "legally liable" refers to any legally enforceable obligation for which a person may be held financially responsible. In short, the policy is written to protect the insured, not the third party claimant.

As is true with all insurance, the licensee should be thoroughly familiar with the policy forms issued by the insurer(s) with which he/she places insurance.

BASIC AUTOMOBILE POLICY

The Basic Automobile policy becomes the Combination Automobile policy when both Liability and Physical Damage coverages are written under one policy. The Combination Automobile policy will be reviewed, but the licensee should be aware that Liability and Physical Damage may be written under separate policies. The provisions remain the same regardless of how it is written.

The Combination Automobile policy is used to insure commercial automobiles regardless of ownership, and non-commercial automobiles owned by other than individuals (partnerships, corporations, associations).

Coverages Provided:

1) Bodily Injury Liability
2) Property Damage Liability
3) Medical Payments
4) Comprehensive
5) Collision
6) Fire, Lightning and Transportation
7) Theft
8) Windstorm, Hail, Earthquake or Explosion
9) Combined Additional Coverage
10) Towing and Labor costs
11) Uninsured Motorist

**Bodily Injury Coverage**

Insuring Agreement to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury, sickness or disease, including death at any time resulting therefrom, sustained by any person caused by accident and arising out of the ownership, maintenance or use of the automobile.

**Property Damage**

Insuring Agreement - to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of injury to or the destruction of property, including the loss of use, caused by accident arising out of the ownership, maintenance or use of the automobile.

**Supplementary Benefits - Bodily Injury and Property Damage** In addition to the insurance for bodily injury and property damage, the insurer shall:

1) Defend any suit which alleges injury or damage even if the suit is groundless, false or fraudulent.

2) Pay premiums for bonds to release the insured's property which may have been attached, costs of appeal bonds, and cost of bail bond in the event the insured is arrested for an accident or traffic violation. The premium for bail bond shall not exceed $100 and the insurer does not have to furnish a bail bond.

3) Pay all expenses of defense including any interest and court costs.

4) Reimburse the insured for immediate and necessary medical expense paid for anyone injured in the accident.

5) Reimburse the insured for expenses incurred at the insurer’s request, except loss of earnings.

**Persons Insured - Bodily Injury and Property Damage Liability**

1) The named insured in the declarations.
2) If the named insured is an individual, the insured's spouse if a resident of the same household.
3) Any person using the car with the permission of the named insured or spouse.
4) Any person or organization legally responsible for the use of the automobile, provided permission is given by insured or spouse.

**Automobile Medical Payments**

Insuring Agreement - to pay all reasonable expenses incurred within one year from the date of the accident for necessary medical, surgical, and dental services, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services.

**Division I** - applies to any injured person, including the insured, who meets the following:

1) The injury must be sustained by accident.
2) The accident must have occurred while the person was in or on or was entering or leaving an insured automobile.
3) The car must have been in use by the named insured or spouse or with the permission of either.
Division II - applies only to an insured, and covers while the insured is in or on or entering or leaving or through being struck by an automobile. Insured means the named insured, if an individual, or spouse and the relatives of either if all are residents of the same household.

Definitions

Automobile - All coverages except Division II of Medical Payments.

1) The motor vehicle or trailer listed in declarations.
2) Any trailer not listed, if designed for use with a private passenger automobile, unless it is being used for business purposes with some other type of automobile.
3) A temporary substitute automobile while used as a substitute for the automobile listed when withdrawn from normal use because of breakdown, repair, servicing, loss or destruction.
4) A newly acquired automobile, if the insurer insures all automobiles owned by the insured and spouse on the date of its delivery. A newly acquired automobile means an additional automobile if the insurer is notified within 30 days of the delivery date.

NOTE: Under Division II of Coverage C, the word "automobile" means a land motor vehicle or land trailer not operated on rails or crawler-treads.

Private passenger automobile means:

A private passenger automobile.

1. A station wagon.
2. A jeep-type automobile.

Any automobile whose use is pleasure and business.

Semi-trailer - the word trailer includes semi-trailers.

For the purpose of bodily injury and property damage motor vehicles with a trailer or trailers attached are considered as one automobile.

Comprehensive

Insuring Agreement pays for direct and accidental loss of or damage to the automobile except loss caused by collision of the automobile with another object, or by upset of the automobile, or by collision of the automobile with a vehicle to which it is attached.

When comprehensive is carried, certain types of losses are specified as coming under comprehensive coverage, no matter how caused. Breakage of glass, and loss caused by missiles, falling objects, fire, theft, explosion, earthquake, windstorm, hail, water, flood, malicious mischief or vandalism, riot and civil commotion will not be considered collision or upset.

Collision or Upset

Insuring Agreement - to pay for direct and accidental loss of or damage to the automobile caused by collision with another object, or by upset of the automobile. Collision is almost always written with a deductible and the insurer is responsible only for the amount in excess of the deductible stated in the declarations.

Other Physical Damage Coverages - an alternative to having comprehensive coverage is selecting from four named perils coverages.
1) Fire, lightning and transportation.
2) Theft.
3) Windstorm, hail, earthquake or explosion.
4) Combined Additional Coverage, which covers loss due to windstorm, hail, earthquake, explosion, riot or civil commotion, aircraft, flood or rising waters, malicious mischief or vandalism, external discharge or leakage of water except rain, snow or sleet.

Commercial vehicles are often insured under one or more of these miscellaneous named perils. Private passenger automobiles are normally insured under comprehensive coverage.

Uninsured Motorist - this coverage must be added by endorsement to the Basic or Combination Policy, but its provisions are substantially the same as those described in the Personal Automobile Policy.

Exclusions

This policy does not apply:

1) Under all coverages: While the automobile is used as a public or livery conveyance, unless such use is declared in the policy.
2) Under Bodily Injury and Property Damage: To liability assumed by the insured under any contract or agreement.
3) Under Bodily Injury and Property Damage: While the automobile is used for towing any trailer owned or hired by the insured and not covered by like insurance in the same company.
4) Under Bodily Injury and Medical Payments: To any obligation for which the insured may be liable under any Workers' Compensation or similar laws.
5) Under Property Damage: To property owned or controlled by the insured.
6) Under Medical Payments: To any employee of an auto sales agency, repair shop, service station, storage garage or public parking place if injury arises out of such businesses.
7) Under Medical Payments and Physical Damage: To loss resulting from war, civil war or insurrection.
8) Under Physical Damage: To any damage due to wear and tear, freezing, and mechanical or electrical breakdown or failure.
9) Under Physical Damage: To robes, wearing apparel or personal effects.
10) Under Physical Damage: To tires, unless loss was caused by fire, theft or collision damage.
11) Under Physical Damage: To loss due to confiscation by duly constituted government or civil authority.
12) Under Physical Damage: To loss due to radioactive contamination.

COMPREHENSIVE AUTO LIABILITY

The Comprehensive Auto Liability Policy is used for insuring the automobile exposure of a commercial business where a number of units are to be covered and there are frequent additions and substitutions during the policy term. Coverage includes non-owned and hired autos and for Employer's Non-ownership Liability as well as owned autos. Coverage is automatic for newly acquired autos during the policy period. The premium payable at the time the policy period begins is based on autos known and declared at that time. After the expiration of the policy an audit is made of all exposures which existed during the policy term and the premium is adjusted. When physical damage is included, a vehicle which replaces another vehicle is insured for the same coverage which was provided on the auto being replaced. In case of additional autos, coverage is automatic for 30 days. Coverage can be fully automatic by attaching the Fleet Automatic Endorsement. The policy audit will pick up the charge for additional vehicles at the end of the policy term.

The Comprehensive Auto Liability Policy may be combined with a Comprehensive General Liability Policy to cover all liabilities exposure of an insured in one contract. This combined policy is a Comprehensive General Automobile Liability Policy.

FAMILY AUTOMOBILE POLICY
This broad coverage policy is available for automobiles owned by an individual, or by a husband and wife resident in the same household. The automobile must have four wheels and be a private passenger, station wagon or jeep type, or a utility or farm automobile.

Coverage under this policy is provided by five parts.

Part I Liability
Part II Expenses for Medical Services
Part III Physical Damage
Part IV Protection Against Uninsured Motorist
Part V Policy Conditions

Declaration - This page shows the policy number, name and address of the insured, policy period, occupation of named insured, coverages, limits of liability, premiums, description of owned automobiles and trailers, where vehicles are garaged, loss payee (if any), and auto insurance history (if any).

Part I - Liability

Insuring Agreement - Coverage A Bodily Injury; Coverage B Property Damage - To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of:

Coverage A - bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury" sustained by any person;

Coverage B - injury to or destruction of property, including loss of use thereof, hereinafter called "property damage";

arising out of the ownership, maintenance or use of the owned automobile or any non-owned automobile, and the company shall defend any suit alleging such bodily injury or property damage and seeking damages which are payable under the terms of this policy, even if any of the allegations of the suits are groundless, false or fraudulent, but the company may make such investigation and settlement of any claim or suit as it deems expedient.

Supplementary Payments Under Part I - these supplementary payment provisions are basically the same as in the Basic or Combination policy, and, with the exception of defense of suits, are included in the insuring agreement in this contract.

Persons Insured Under Part I

For owned automobiles:

1) The named insured and any resident of the same household.
2) Any other person using such automobile with the permission of the named insured, but within the scope of such permission.
3) Any other person or organization, but only with respect to liability because of acts of omission of any insured defined in (1) or (2) above.

For non-owned automobiles:

1) The named insured.
2) Any relative, but only with respect to a private passenger automobile or trailer, provided the actual operation, or, if the user is not operating, the actual use is with the permission, or reasonably believed to be with the permission, of the owner and is within the scope of such permission.
3) Any other person or organization not owning or hiring the automobile, but only with respect to
liability because of acts or omissions of an insured defined in 1l) or (2) above.

**Definition**

**Part I - Liability**

**Owned Automobile**

1) A private passenger, farm or utility automobile described in the policy for which a premium is charged.
2) A trailer owned by the named insured.
3) A private passenger, farm or utility automobile which has been acquired by the named insured during the policy period, provided it replaces an owned automobile or the insurer insures all such automobiles owned by the named insured on the date of acquisition, and the named insured notifies the insurer during the policy period or within 30 days after the date of acquisition of his or her election to make this policy apply to such automobile.

**Temporary Substitute Automobile** - any automobile or trailer not owned by the named insured, while temporarily used with the permission of the owner as a substitute for the owned automobile or trailer when not in normal use because of its breakdown, repair, servicing, loss or destruction.

**Non-Owned Automobile** - an automobile or trailer not owned by or furnished for the regular use of either the named insured or any relative, other than a temporary substitute automobile.

**Private Passenger Automobile** - means a four wheel private passenger, station wagon or jeep type automobile.

**Farm Automobile** - means an automobile of the truck type with a load capacity of 1500 lbs or less not used for business or commercial purposes other than farming.

**Utility Automobile** - means an automobile, other than a farm automobile, with a load capacity of 1500 lbs or less of the pick-up body, sedan delivery, or panel truck type, not used for business or commercial purposes.

**Trailer** - means a trailer designed for use with a private passenger automobile, if not being used for business or commercial purposes with other than a private passenger, farm or utility automobile, or a farm wagon or farm implement while used with a farm automobile.

**Automobile Business** - the business or occupation of selling, repairing, servicing, storing or parking automobiles.

**Use** - includes the loading and unloading of the automobile.

**Exclusions under Part I** - the Family Auto policy does not apply:

1) To any automobile while used as a public or livery conveyance.
2) To bodily injury or property damage caused intentionally by or at the direction of the insured.
3) To losses insured under a nuclear energy liability policy.
4) To bodily injury or property damage arising out of the operation of farm machinery.
5) To bodily injury to any employee of the insured arising out of and in the course of employment by the insured.
6) To bodily injury to any fellow employee of the insured in the course of his or her employment if injury arises out of the use of an automobile in the business of the employer.
7) To an owned automobile while used by any person employed or engaged in the automobile business.
8) To a non-owned automobile while maintained or used by any person employed or engaged in the automobile business, or any other business or occupation of the insured.
9) To injury to or destruction of property owned or transported by the insured, or to property rented to or in charge of the insured.
10) To automobiles acquired by the named insured during the policy or any substitute
automobile, if the named insured has purchased other automobile liability insurance applicable to such automobile.

Part II - Expenses For Medical Services - Coverage C

**Insuring Agreement** - pays all reasonable expense incurred within one year from the date of accident for necessary medical, surgical, X-rays and dental service, including prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services.

Division I - To or for the named insured and each relative who sustains bodily injury, sickness or disease, including death resulting therefrom, hereinafter called "bodily injury" caused by accident:

1) While occupying the owned automobile.
2) While occupying a non-owned automobile, but only if such person has, or reasonably believes they have permission of the owner to use the automobile and the use is within the scope of such permission, or through being struck by an automobile or by a trailer of any type.

Division II - To or for any other person who sustains bodily injury, caused by accident while occupying the owned automobile, while being used by the named insured, by any resident of the same household or by any other person with permission of the named insured; or

1) A non-owned automobile, if the bodily injury results from its operation or occupancy by the named insured or its operation on the insured's behalf by his/her private chauffeur or domestic servant.
2) A non-owned automobile, if the bodily injury results from its operation or occupancy by a relative, provided it is a private passenger automobile or trailer, but only if such operator or occupant has, or reasonably believes he/she has, the permission of the owner to use the automobile and the use is within the scope of such permission.

**Exclusions under Part II - Expenses For Medical Service** - Coverage does not apply to Bodily Injury:

1) Sustained while occupying an owned automobile while used as a public livery conveyance, or any vehicle while located for use as a residence or premises.
2) Sustained by the named insured or relative while occupying or through being struck by a farm type tractor or other equipment designed for use principally off public roads while not upon public roads, or a vehicle operated on rails or crawler treads.
3) Sustained by any person other than the named insured or a relative while occupying a non-owned automobile used as a public or livery conveyance.
4) Sustained by any person other than the named insured or a relative resulting from the maintenance or use of a non-owned automobile by a person other than the named insured or a relative while employed or otherwise engaged in the automobile business, or in any other business or occupation.
5) Sustained by any person covered by Workers' Compensation Law or similar laws.
6) Due to war.

Part III - Physical Damage - Coverage D

The Family Auto policy provides the same physical damage coverage as the Combination Auto Policy. The most often requested coverages are comprehensive, collision and towing and labor costs. The Family Auto Comprehensive coverage is broader in the following:

1) Coverage is provided up to $100 for loss caused by fire and lightning to robes, wearing apparel or other personal effects which are the property of a named insured or relative while such effects are in or upon the owned automobile.
2) Comprehensive coverage is extended to non-owned automobiles being used by the named insured and relatives with the permission of the owner of the car. This applies as excess...
insurance if the owner carries comprehensive coverage.

3) Colliding with a bird or animal shall be considered as covered under comprehensive, instead of collision.

Collision is broader under the Family policy, collision coverage applies to non-owned automobiles under the same condition as (2) above.

Exclusion under Part III - Physical Damage - The Family Auto policy does not apply:

1) To any automobile while used as a public livery conveyance.
2) To loss due to war.
3) To loss to a non-owned automobile arising out of its use by the insured while he is employed or engaged in the automobile business.
4) To losses to any vehicles not described in the policy or any temporary substitute if the insured has other collectible insurance for the loss.
5) To damage caused by wear and tear, freezing, mechanical or electrical breakdown or failure, unless damage is caused from a covered theft.
6) To tires, unless damaged by fire, malicious mischief or vandalism or stolen, or unless the loss is from the same cause as others covered by this policy.
7) To loss due to radioactive contamination.
8) Under collision coverage, to breakage of glass if insurance is otherwise offered under this policy.

Part IV - Protection Against Uninsured Motorists.

This coverage provides for payment under this policy of sums which an insured would be legally entitled to recover as bodily injury damages from another, following an accident with an uninsured automobile. These provisions are basically the same as those that appear in the Personal Auto Policy.

Part V - Policy Conditions - these are the same conditions found in most insurance contracts. Of which the major conditions are:

1) Notice of Loss.
2) Two or more Automobiles.
3) Assistance and Cooperation of the Insured.
4) Action Against the Company.
5) Insured’s Duties in Event of Loss.
6) Proof of Claims.
7) Payment of Loss.
8) Subrogation.
9) No Benefit to Bailee.

SPECIAL AUTOMOBILE POLICY

The Liability coverages are written as a package with the following coverages:

**Liability** - is on a single limit basis with a single limit applying to bodily injury and property damage. The minimum single limit is equal to the amount required by any Financial Responsibility Law. In California that amount is equal to $35,000.

Medical Expense - ranging from $1000 to $5000.

**Accidental Death Benefits** - of $1000 paid to beneficiaries of the named insured or spouse, in the event of death resulting from an automobile accident.

**Uninsured Motorist** - coverage is written on a single limit basis.

**Physical Damage** - is optional and may be collision and comprehensive, or comprehensive alone. When comprehensive coverage is included the policy provides for towing and labor, and personal effects up to $200.
While there are some differences between the provisions of the Family Policy and the Special Policy, we will not review the Special Policy for testing purposes anymore than that which is presented here.

PERSONAL AUTO POLICY

The personal auto policy is a simplified auto policy form. This policy was designed to replace the family automobile and the special package auto policies. This change made the auto policy simpler and easier to read for the insurance buying public. The personal auto policy has six parts, to which the insurers add their own jacket and declarations page.

Part A - Liability
Part B - Medical Payments
Part C - Uninsured Motorists
Part D - Damage to Your Auto
Part E - Duties After an Accident or Loss
Part F - General Provisions

Endorsement forms can be used to cover tapes and recording equipment, customizing equipment and other situations, including towing and labor costs.

Declarations - as with most policies this page shows the policy number, names and addresses of persons identified as the named insured, identification of the vehicles insured, area of normal use, policy period, deductibles, coverages and limits, and premium charges for each coverage. The declaration page may be part of the jacket and somewhere in the jacket appears a general insuring agreement, followed by a series of definitions. While each coverage part has its own insuring agreement, the general insuring agreement has two important functions: (1) it identifies the premium as the consideration given by the insured; and (2) it incorporates, by specific reference, all subsequent terms of the policy.

Definitions contained in the jacket are:

You and Yours - refers to named insured and the spouse if a resident of the same household.

We, Us and Ours - refers to the company providing the insurance.

Family Member - means a person related to you by blood, marriage, or adoption who is a resident of your household. This includes a ward or foster child.

Occupying - means in, upon, getting in, on, out or off.

Trailer - means a vehicle designed to be pulled by a private passenger auto, pickup, panel truck or van. It also means a farm wagon or farm implement while towed by a vehicle included in this definition.

Private Passenger Type Auto - normally must be a four wheel vehicle which is not a truck, (except a pickup, panel, or van) which is owned or leased (leasing period must be at least six months) by an individual or a husband and wife and which is not rented to others, and not used in public or private livery.

Your Covered Auto - means any vehicle shown in the declarations. Any private passenger auto, pickup, panel truck, or van not used in any business or occupation other than farming or ranching on the date you become the owner. Any trailer you own. Any auto or trailer you do not own while used as a temporary substitute for any other vehicle described in this definition which is out of normal use because of its breakdown, repair, servicing, loss or destruction.

Additional vehicles or trailers will be covered on the date you become the owner if you acquired the vehicle during the policy period; and ask us to insure it within 30 days after you become the owner.
If the vehicle you acquire replaces one shown in the Declarations, it will have the same coverage as the vehicle it replaced. You must ask us to insure a replacement vehicle within 30 days only if you wish to add or continue coverage for damage to your auto. If the vehicle you acquire is in addition to any shown in the Declarations, it will have the broadest coverage we now provide for any vehicle shown in the Declarations.

**Part A - Liability Coverage:**

**Insuring Agreement** - We will pay damages for bodily injury or property damage for which any covered person becomes legally responsible because of an auto accident. We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability, we will pay all defense costs we incur. Our duty to settle or defend ends when our limit of liability for this coverage has been exhausted. The limits of liability is shown as a single limit for both bodily injury and property damage.)

Coverage for liability is for 1) the named insured, spouse, or any family member for the ownership, maintenance or use of any auto or trailer; 2) any person using the covered auto; 3) for the covered auto, any person or organization but only with respect to legal responsibility for acts or omissions of a person for whom coverage is afforded under this Part; and 4) for any auto or trailer, other than your covered auto, any person or organization but only with respect to legal responsibility for acts or omissions of you or any family member for whom coverage is afforded under this Part. This provision applies only if the person or organization does not own or hire the auto or trailer.

**Supplementary Payments under Part A** - these payments are in addition to policy limits (pare-phrased).

1) Up to $250 for cost of bail bonds required because of an accident, including related traffic law violations.
2) Premiums on appeal bonds and bonds to release attachments in any suit the insurer defends.
3) Interest accruing after a judgment is entered in any suit the insurer defends.
4) Up to $50 a day for loss of earnings, because of attendance at hearings or trials at insurers request.
5) Other reasonable expenses incurred at insurers request.

**Exclusions under Part A**

Insurer will not provide Liability Coverage for any person (pare-phrased):

1) Who intentionally causes bodily injury or property damage.
2) For damage to property owned or being transported by that person.
3) For damage to property rented to, used by, or in the care of that person.
4) For bodily injury to an employee of that person during the course of employment.
5) For that person’s liability arising out of the ownership or operation of a vehicle while being used to carry persons or property for a fee.
6) While employed or otherwise engaged in the business or occupation of selling, repairing, servicing, storing or parking vehicles designed for use mainly on public highways.
7) Maintaining or using any vehicle while that person is employed or otherwise engaged in any business or businesses or occupation not described in number 6 above (eliminates coverage for non-owned panel trucks, vans or pickups used for business).
8) Using a vehicle without a reasonable belief that the person is entitled to do so.
9) Eliminates liability coverage for any accident where an insured was or would have been covered by a nuclear energy liability policy.
10) Any motorized vehicle having less than four wheels.
11) Any vehicles the insured owns, but does not list on the policy.

**Other Insurance under Part A** - If there is other applicable liability insurance, insurers will pay only their share of the loss. Their share is the proportion that their limit of liability bears to the total of all applicable limits. However, any insurance the insurer provides for a vehicle you do not own shall be
excess over any other collectible insurance (pare-phrase).

**Part B - Medical Payments:**

*Insuring Agreement* - We will pay reasonable expenses incurred for necessary medical and funeral services because of bodily injury caused by accident and sustained by a covered person. We will pay only those expenses incurred within 3 years from the date of the accident.

Covered person as used in this Part means: You or any family member while occupying or as a pedestrian when struck by a motor vehicle designed for use mainly on public roads or a trailer of any type, and any other person while occupying your covered auto.

**Exclusions under Part B** - Insurer will not provide Medical Payments for any person for bodily injury (pare-phrased):

1) Sustained while occupying any motorized vehicle having less than four wheels.
2) Sustained while occupying your covered auto when it is being used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool.
3) Sustained while occupying any vehicle located for use as a residence or premises.
4) If Workers’ Compensation is required or available for the bodily injury.
5) Sustained while occupying or struck by any vehicle owned or furnished or available for your regular use, but not listed in the policy.
6) Sustained while occupying a vehicle without reasonable belief that the person is entitled to do so.
7) Sustained while occupying a vehicle when it is being used for business purposes. An exception provides coverage for a private passenger auto or a pickup, panel truck, or van so used. A private passenger auto may be "your covered auto" or a non-owned auto, but an eligible truck must be owned and it must be a "covered auto" under the named insured’s policy. A trailer, as defined in the policy is covered for business use if used with one of the vehicles described here.
8) Sustained involving nuclear radiation or radioactive substances, or losses related to war, insurrection or rebellion.

**Other Insurance under Part B** - reads basically the same as Part A, except one is liability and the other is medical payments.

**Part C - Uninsured Motorist Coverage:**

*Insuring Agreement* - We will pay damages which a covered person is legally entitled to recover from the owner or operator of an uninsured motor vehicle because of bodily injury:

1) Sustained by a covered person; and
2) Caused by an accident.

The owner’s or operator’s liability for these damages must arise out of the ownership, maintenance or use of the uninsured motor vehicle. Any judgment for damages arising out of a suit brought without our written consent is not binding on us.

**Uninsured Motor Vehicle** - means a land motor vehicle or trailer of any type:

1) To which no bodily injury liability bond or policy applies at the time of the accident.
2) To which a bodily injury liability bond or policy applies at the time of the accident. In this case its limits for bodily injury liability must be less than the minimum limit for bodily injury liability specified by the financial responsibility laws.
3) Which is a hit and run vehicle whose operator or owner cannot be identified and which hits you or any family member, a vehicle which you or any family member are occupying, or your covered auto.
4) To which a bodily injury liability bond or policy applies at the time of the accident but the bonding or insuring company denies coverage, or is or becomes insolvent.

Covered Persons - means you or any family member, any other person occupying your covered auto, or any person for damages that person is entitled to recover because of bodily injury to which this coverage applies sustained by a person in this definition.

Exclusions under Part C - We do not provide Uninsured Motorists coverage for bodily injury sustained by any person:

1) While occupying, or when struck by, any vehicle owned by you or any family member which is not insured for coverage under this policy. This includes a trailer of any type used with that vehicle.
2) If that person or the legal representative settles the bodily injury claim without our consent.
3) While occupying your covered auto when it is being used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool.
4) Using a vehicle without a reasonable belief that the person is entitled to do so.
5) This coverage shall not apply directly or indirectly to benefit any insurer or self-insurer under any of the following or similar laws:

   A) Workers’ Compensation Law
   B) Disability Benefits Law

Part D - Coverage for Damage to Your Auto:

Insuring Agreement - We will pay for direct and accidental loss to your covered auto, including its equipment, minus any applicable deductible shown in the Declarations. However, we will pay for loss caused by collision only if the Declarations indicate that Collision Coverage is provided. "Collision" means the upset, or collision with another object, of your covered auto.

NOTE: This part of the policy provides Comprehensive insurance with or without Collision insurance on covered autos.
Supplementary Payment - In addition, we will pay up to $10 per day to a maximum of $300, for transportation expenses incurred by you. This applies only in the event of total theft of your covered auto.

Exclusions - We will not pay for:

1) Loss to your covered auto which occurs while it is used to carry persons or property for a fee. This exclusion does not apply to a share-the-expense car pool.
2) Damage due and confined to wear and tear, freezing, mechanical or electrical breakdown or failure, or road damage to tires. This exclusion does not apply if the damage results from the total theft of your covered auto.
3) Loss due to or as a consequence of radioactive contamination, discharge of any nuclear weapon (even if accidental), war (declared or undeclared), civil war, insurrection, or rebellion or revolution.
4) Loss to equipment designed for the reproduction of sound. This exclusion does not apply if the equipment is permanently installed in your covered auto.
5) Loss to tapes, records or other devices for use with equipment designed for the reproduction of sound.
6) Loss to a camper body or trailer not shown in the Declarations.
7) Loss to any vehicle while used as a temporary substitute for a vehicle you own which is out of normal use.
8) Loss to TV antennas, awnings or cabanas, or equipment designed to create additional living facilities.
9) Loss to any citizen band radio, two-way mobile radio, telephone, or scanning monitor receiver and their accessories, unless permanently installed in the opening of the dash or console of the auto.
10) Loss to any custom furnishings or equipment in or upon any pickup, panel truck or van. Custom furnishings or equipment include, but are not limited to, special carpeting and insulation, furniture, bars or television receivers, facilities for cooking and sleeping, height extending roofs, or custom murals, paintings, or other decals or graphics.

Part E - Duties After an Accident or Loss:

We must be notified promptly of how, when and where the accident or loss happened. Notices should also include the names and address of any injured persons and of any witnesses. A person seeking coverage must:

1) Cooperate with us in the investigation, settlement or defense of any claim or suit.
2) Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
3) Submit, as often as we reasonably require, to physical exams by physicians we "elect. We will pay for these exams.
4) Authorize us to obtain medical reports, and other pertinent records.
5) Submit a proof of loss when required by us.

Additional Duties for Uninsured Motorists Coverage. A person seeking Uninsured Motorists Coverage must also:

1) Promptly notify the police if a hit and run driver is involved.
2) Promptly send us copies of the legal papers if a suit is brought.

Additional Duties for Coverage for Damage to Your Auto:

1) Take reasonable steps after loss to protect your covered auto and its equipment from further loss. We will pay reasonable expenses incurred to do this.
2) Promptly notify the police if your covered auto is stolen.
3) Permit us to inspect and appraise the damaged property before its repair or disposal.
Part F - General Provisions:

General provisions apply to all coverages of the policy and include:

1) Bankruptcy of a covered person.
2) Changes in the policy.
3) Legal Action against insurer.
4) Subrogation.
5) Policy period and territory.
6) Cancellation.
7) Policy transfer.
8) Other insurance.

BUSINESS AUTO POLICY

The Business Auto Policy is a readable policy that has simple language and avoids legalistic terms. The policy is used to cover commercial auto exposures. For some insurers this contract replaces the Basic, Combination and Comprehensive Auto policies. The Business Auto Policy consists of the declaration, printed provisions and the necessary endorsements needed to complete the proper coverage.

The declarations are contained in four pages listing seven items to identify the insured, state the policy period, and includes various schedules to identify auto classification, exposures covered and premiums for each coverage.

Item 1 Identity of Named Insured.
States the named insured, address, form of business, name of business, policy number and policy period.

Item 2 Schedule of Coverages and Covered Autos.
Provides four columns, the first column lists the different coverages. The second column lists the covered autos by entry of one or more symbols from Item 3 which shows covered autos. The third column states the limits of liability and the last column shows premiums for each coverage chosen.

Item 3 Description of Covered Auto Designation Symbols.
This item gives a description of ten symbols used to identify the class of covered autos.

Symbol 1 Any Auto.

Symbol 2 Owned Autos Only - only those autos you own (and for liability coverage any trailer you do not own while attached to power units you own). This includes those autos you acquire ownership of after the policy begins.

Symbol 3 Owned Private Passenger Autos only - only the private passenger autos you own. This includes those private passenger autos you acquire ownership of after the policy begins.

Symbol 4 Owned Autos Other Than Private Passenger Autos Only - only those autos you own which are not of the private passenger type (and for liability coverage any trailer you do not own while attached to power units you own). This includes autos not of the private passenger types you acquire ownership of after the policy begins.

Symbol 5 Owned Autos Subject to No Fault - may not apply in all states.

Symbol 6 Owned Autos Subject To A Compulsory Uninsured Motorist Law

Symbol 7 Specifically Described Autos - only those autos described in Item 4 for which a
premium charge is shown (and for liability coverage any trailers you do not own while attached to any power unit described in Item 4).

Symbol 8 Hired Autos Only - only those autos you lease, hire, rent or borrow. This does not include any auto you lease, hire, rent or borrow from any of your employees or members of their household.

Symbol 9 Non-owned Autos Only - only those autos you do not own, lease, hire or borrow which are used in connection with your business. This includes autos owned by your employees or members of their households but only while used in your business or your personal affairs.

Symbol 10 Blank item to allow any description not listed above that the insured may need.

Item 5 Schedule of Hired or Borrowed Covered Auto Coverage and Premiums - has two sections, the first is for liability and the second for physical damage.

Item 6 Schedule For Non-Ownership Liability - Basically this identifies the number of employees that use their auto in the insured's business and the premium for such coverage.

Item 7 Schedule For Gross Receipts or Mileage Basis For Liability Insurance on Public Auto or Leasing Firms

Policy Provisions

The printed policy provisions contains six parts.

Part 1 - Words and Phrases with Special Meaning
The following words and phrases have special meaning throughout this policy and appear in boldface type when used:

"You" and "your" means the person or organization shown as the named insured.

"We", "us" and "our" means the company providing the insurance.

"Accident" includes continuous or repeated exposure to the same conditions resulting in bodily injury or property damage the insured neither expected nor intended.

"Auto" means a land motor vehicle, trailer or semitrailer designed for travel on public roads but does not include mobile equipment.

"Bodily injury" means bodily injury, sickness or disease including death resulting from any of these.

"Insured" means any person or organization qualifying as an insured in the WHO IS INSURED section of the applicable insurance. Except with respect to our limit of liability, the insurance afforded applies separately to each insured who is seeking coverage or against whom a claim is made or suit is brought.

"Loss" means direct and accidental damage or loss.

"Mobile equipment" means any of the following types of land vehicles:

1) Specialized equipment such as: Bulldozers; Power shovels; Rollers, Graders or Scrapers; Farm machinery; Cranes; Street Sweepers or other cleaners; Diggers; Forklifts; Pumps; Generators; Air Compressors; Drills; Other similar equipment.
2) Vehicles designed for use principally off public roads.
3) Vehicles maintained solely to provide mobility for such specialized equipment when permanently attached.
4) Vehicles not required to be licensed.
5) Autos maintained for use solely on your premises or that part of roads or other accesses that
adjoin your premises.

“Property damage” means damage to or loss of use of tangible property.

"Trailer" includes semi-trailer.

Part II - Which Autos are covered Autos

Item Two of the declarations shows the autos that are covered autos for each of your coverages. The
numerical symbols explained in Item Three of the declarations describe which autos are covered autos.
The symbols entered next to a coverage designate the only autos that are covered autos.

Owned Autos You Acquire After the Policy Begins.

1) If symbols "1", "2", "3", "4", "5" or "6" are entered next to a coverage in Item Two, then you
already have coverage for autos of the type described until the policy ends.
2) But, if symbol "7" is entered next to a coverage in Item Two, an auto you acquire will be a
covered auto for that coverage only if:

   A) We already insure all autos that you own for that coverage or it replaces an auto you
previously owned that had that coverage; and
   B) You tell us within 30 days after you acquire it that you want us to insure it for that coverage.

Certain Trailers and Mobile Equipment

If the policy provides liability insurance, the following types of vehicles are covered autos for liability
insurance:

1) Trailers with a load capacity of 2,000 pounds or less designed primarily for travel on public
roads.
2) Mobile equipment while being carried or towed by a covered auto.

Part III - Where And When This Policy Covers

We cover accidents or losses-which occur during the policy period: In the United States of America,
its territories or possessions, Puerto Rico or Canada.

Part IV - Liability Insurance

We will pay:

1) We will pay all sums the insured legally must pay as damages because of bodily injury or
property damage to which this insurance applies, caused by an accident and resulting from the
ownership, maintenance or use of a covered auto.
2) We have the right and duty to defend any suit asking for these damages. However, we have
no duty to defend suits for bodily injury or property damage not covered by this policy. We may
investigate and settle any claim or suit as we consider appropriate. Our payment of the Liability
Insurance limit ends our duty to defend or settle.

We will also pay:

In addition to our limit of liability we will pay for the insured:

1) Up to $250 for cost of bail bonds (including bonds for related traffic law violations) required
because of an accident we cover. We do not have to furnish these bonds.
2) Premiums on appeal bonds in any suit we defend.
3) Premiums on bonds to release attachments in a suit we defend but only for bonds up to our limit of liability.

4) All costs taxed to the insured in a suit we defend.

5) All interest accruing after the entry of the judgment in a suit we defend. Our duty to pay interest ends when we pay or tender our limit of liability.

6) Up to $50 a day for loss of earnings (but not other income) because of attendance at hearings or trials at our request.

7) Other reasonable expenses incurred at our request.

We will not cover -- Exclusions.

This insurance does not apply to:

1) Liability assumed under any contract or agreement.

2) Any obligation for which the insured or his or her insurer may be held liable under any workers' compensation or Disability benefits law or under any similar law.

3) Any obligation of the insured to indemnify another for damages resulting from bodily injury to the insured's employee.

4) Bodily injury to any fellow employee of the insured arising out of and in the course of his or her employment.

5) Bodily injury to any employee of the insured arising out of and in the course of his or her employment by the insured. However, this exclusion does not apply to bodily injury to domestic employees not entitled to workers' compensation benefits.

6) Property damage to property owned or transported by the insured or in the insured's care, custody or control.

7) Bodily injury or property damage resulting from the handling of property: Before it is moved from the place where it is accepted by the insured for movement into or onto the covered auto, or after it is moved from the covered auto to the place where it is finally delivered by the insured.

8) Bodily injury or property damage resulting from the movement of property by a mechanical device (other than a hand truck) not attached to the covered auto.

9) Bodily injury or property damage caused by the dumping, discharge or escape of irritants, pollutants or contaminants. This exclusion does not apply if the discharge is sudden and accidental.

Who is insured.

1) You are an insured for any covered auto.

2) Anyone else is an insured while using with your permission a covered auto you own, hire or borrow except:

   a) The owner of a covered auto you hire or borrow from one of your employees or a member of his or her household.

   b) Someone using a covered auto while he or she is working in a business of selling, servicing, repairing or parking autos unless that business is yours.

   c) Anyone other than your employees, a lessee or borrower or any of their employees, while moving property to or from a covered auto.

3) Anyone liable for the conduct of an insured described above is an insured but only to the extent of that liability. However, the owner or anyone else from whom you hire or borrow a covered auto is an insured only if that auto is a trailer connected to a covered auto you own.

Part V - Physical Damage Insurance

1) **We will pay** for loss to a covered auto or its equipment under:

   A) Comprehensive Coverage. From any cause except the covered auto's collision with another object or its overturn.

   B) Specified Perils Coverage. Caused by

   1) Theft;
2) Fire or explosion
3) Windstorm, hail or earthquake;
4) Flood;
5) Mischief or vandalism;
6) The sinking, burning, collision or derailment of any conveyance transporting the covered auto.

C) Collision Coverage. Caused by the covered auto's collision with another object or its overturn.

2) Towing. We will pay up to $25 for towing and labor costs incurred each time a covered auto of the private passenger type is disabled. However, the labor must be performed at the place of disablement.

We will also pay up to $10 per day to a maximum of $300 for transportation expense incurred by you because of the total theft of a covered auto of the private passenger type. We will pay only for those covered autos for which you carry either Comprehensive or Specified Perils Coverage. We will pay for transportation expenses incurred during the period beginning 48 hours after the theft and ending, regardless of the policy's expiration, when the covered auto is returned to use or we pay for its loss.

We will not cover - Exclusions.

This insurance does not apply to:

1) Wear and tear, freezing, mechanical or electrical breakdown unless caused by other loss covered by this policy.
2) Blowouts, punctures or other road damage to tires unless caused by other loss covered by this policy.
3) Loss caused by declared or undeclared war or insurrection or any of their consequences.
4) Loss caused by the explosion of a nuclear weapon or its consequences.
5) Loss caused by radioactive contamination.
6) Loss to tape decks or other sound reproducing equipment not permanently installed in a covered auto.
7) Loss to tapes, records or other sound reproducing devices designed for use with sound reproducing equipment.
8) Loss to any sound receiving equipment designed for use as a citizens' band radio, two-way mobile radio or telephone or scanning monitor receiver, including its antennas and other accessories, unless permanently installed in the dash or console opening normally used by the auto manufacturer for the installation of a radio.

How we will pay for losses - The Most We will Pay.

1) At our option we may:
   a) Pay for, repair or replace damaged or stolen property; or
   b) Return the stolen property, at our expense. We will pay for any damage that results to the auto from the theft.

2) The most we will pay for loss is the smaller of the following amounts:
   a) The actual cash value of the damaged or stolen property at the time of loss.
   b) The cost of repairing or replacing the damaged or stolen property with other of like kind or quality.

3) For each covered auto, our obligation to pay for, repair, return or replace damaged or stolen property will be reduced by the applicable deductible shown in the declarations. Any Comprehensive Coverage deductible shown in the declarations does not apply to loss caused by fire or lightning.

Glass Breakage. - Hitting A Bird Or Animal - Falling Objects Or Missiles.
We will pay for glass breakage, loss caused by hitting a bird or animal or by falling objects or missiles under Comprehensive Coverage if you carry Comprehensive Coverage for the damaged covered auto. However, you have the option of having glass breakage caused by a covered auto’s collision or overturn considered a loss under Collision Coverage.

Part VI - Conditions

The insurance provided by this policy is subject to those usual conditions found in insurance.

1) Your duties after accident or loss.
2) Other insurance (pro rata liability).
3) Our right to recover from others (subrogation).
4) Canceling this policy during the policy period.
5) Legal Action Against Us.
6) Inspection.
7) Changes.
8) Transfer of your interest in this policy.
9) No benefit to bailee - Physical damage only.
10) Bankruptcy.
11) Appraisal for Physical damage losses.
12) Two or more policies issued by us.

Auto Medical Payments

The Business Auto Policy provisions do not include those necessary for auto medical payments. Medical payments coverage is not generally used in commercial auto insurance, since most business exposures are covered by workers’ compensation. When the exposure of nonemployee guest passengers exists, the need for auto medical payments should be covered by adding the endorsement to provide the coverage. The provisions of this endorsement are similar to those reviewed in the Personal Auto Policy, and will not be reviewed again.

Uninsured Motorist

The Business Auto Policy provisions do not include those necessary for uninsured motorists. Whenever these provisions are to be included, they must be endorsed into the contract. The provisions of this endorsement are similar to the uninsured motorist provisions of the Personal Auto Policy and will not be reviewed again.
BUSINESS AND INSURANCE LAW

The insurance business is part product knowledge and part law. Agents receive a good dose of law in everyday dealings with clients and the need to understand it better is crucial to serving insureds and knowing when to refer out.

THE COURT SYSTEM

In each of the states of this country there are two separate systems of law in force, namely, state law and federal law. Federal law operates uniformly throughout the United States, with few exceptions. State law, however, may vary considerably from state to state since each state has its own constitution, statutes and court decisions.

Both the national and state governments are controlled in what they can do by provisions in their respective constitutions. The fundamental difference between the two constitutions is that the Constitution of the United States is a grant of power to Congress, i.e., Congress has the power that has been expressly conferred upon it, whereas the state constitution is a limitation of power, i.e. the state legislature has the powers that have not been denied it. Thus, unless restricted by the federal or state constitution, the state legislature has any power it chooses to exercise.

As pointed out, there are two separate systems of law in force, namely federal law and state law. In certain types of proceedings the federal courts have exclusive jurisdiction; however, in most frequent situations where parties become involved in court action, the state courts have jurisdiction. An understanding of the court structure and the nature of judicial proceedings are essential for the agent to understand.

In most States, there are three systems that make up the State Courts System: Trial
Courts (Small claims, municipal and superior), Appellate Courts and Supreme Court.
Disputes are first heard at trial level and progress to Appellate and supreme based on the type of
case and appeals that are made on decisions in the lower courts.

The following dollar amounts are typical guidelines in deciding which state court a claim may be
entered.

- $5,000 or less -- Small claims court (excluding evictions)
- $25,000 or less -- Municipal court, including evictions, misdemeanor and criminal
cases.
- Over $25,000 -- Superior court including divorces, adoptions,

Federal courts also have three tiers: Federal District Courts, Courts of Appeal and Supreme
Court. In several types of cases, the federal courts have exclusive jurisdiction. These include
actions involving bankruptcy and overall civil actions. Federal cases are commenced in the local
United States District Court. The United States is divided into about 100 districts, each with its own
district court.

The highest and "last resort" court is the Supreme Court of the United States. This court is made
up of nine judges, appointed for life by the President. Most cases that reach the Supreme Court
are on appeal from a lower federal court, or from state supreme court where a question of federal
law is involved.

RISK & LIABILITY

A discussion of law must contend with the concepts of risk and liability since they represent the
conditions leading to almost every legal event.

Risk

Risk is the uncertainty or chance of loss which can result in social as well as individual costs.
Therefore, society and individuals are interested in how it is assumed and handled. **Insurance
is considered the "first line of defense" in shifting the burden of risk.**

Risk may be assumed by written agreement, e.g., leases signed by apartment renters where the
lease waives the tenants right of action against the landlord and require the tenant to assume
liability for others that might ordinarily be the landlord's responsibility.

Risk may also be presumed, e.g., a spectator at a hockey match is hit with a puck. Does he have
cause of action? No, the presumption is that spectators assume this risk. It can be said, that a
majority of effort is spent by business and individuals finding legal methods to shift risks.

**Hedging is a risk shifting technique** that is accomplished by making commitments on BOTH
sides of a transaction so the risks offset each other. An example might be a grain elevator
operator. He buys grain from farmers for shipment to a central market. The farmer receives the
prevailing price for grain the day it is purchased although it will not be shipped for sometime. No
one knows what the price of grain will be until it arrives at the central market. The grain operator
stands a chance it may be up or down. To "hedge" this, the operator shifts his risk to a grain
speculator who buys and sells futures.

Subcontracting is another method of shifting risk. A building contractor shifts his risk by hiring
subcontractors. Although the general contractor still has residual liability for losses, portions of
the risk have been shifted to the subcontractors.
Hold harmless agreements allow liability risks to be shifted. One party agrees to assume the legal obligations of the other in a lawsuit for damages to a third party.

Incorporation is another method of shifting risk. Stockholders, if their shares of stock are fully paid, have no liability. Their losses are limited to their investment in the stock.

**Liability**

The legal basis for liability exposures are torts and contracts.

A **tort is a wrongful act** committed by one person against another that may result in civil action. The **wrongful act must cause bodily injury, property damage or personal injury**. Personal injuries may include a number of wrongs: defamation, false arrest, mental distress.

Tort claims result from three main actions: intentional interference, liability without fault and negligence. By far, most tort claims are based on negligence.

**Intentional Interference Torts**

These torts involve actions against the person and actions against the property of others. A person may not be liable for intentional interference if the conduct was privileged. Mistakes and prior consent are events that may excuse liability and establish privilege.

Interference with the person includes events like:

**Battery**-- The intentional, unpermitted contact with the person of others. NO harm need be done nor any hostility intended. Only the absence of expressed or implied consent of the violated person is necessary to constitute battery.

**Assault** -- To attempt or threat physical violence against another. Assault involves threatened contact; battery requires contact. Intent is not a factor in assault, simply the belief that the threat may materialize is enough.

**Defamation** -- Actions that injure another's reputation. Acts may be either libel (written) or slander (oral). To be actionable, the defamatory statements must be intentionally or negligently communicated to someone other than the defamed party and understood by the third party.

**False Imprisonment** -- The intentional restraint of another's freedom of movement. The restraint must be intended but does not have to malicious. Further, it need not be physical restraint but may consist of threats of force designed to intimidate someone into compliance.

**Malicious Prosecution** -- To knowingly institute groundless civil or criminal action against another party. Damages are usually based on the fact that there is no probable cause for the action.

Interference with the property of others includes trespass to real or personal property and "conversion".

**Trespass** -- The wrongful entry on the land of another or failure to remove property from another's land. Trespass includes the invasion of the area above and below the land as well as the surface. Trespass to personal property is the intentional interference with its possession or physical condition without legal justification. An innocent mistake is no defense against liability. However, proof of damage is usually required to establish liability for any trespass to personal property. Willful trespass to real property requires no proof of damages to establish liability.

**Conversion** -- The wrongful disposition and detention of the personal property of others. Conversion differs from trespass in that prior to conversion the converter was legally justified in possessing the property. An example might be a parking lot attendant taking a "joy ride" in a
customer’s car.

**Liability Without Fault**

This occurs when a person is held liable for injury to others even though the injury may be neither intentionally or negligently inflicted. Exposure for this liability typically arises from sources like dangerous instruments (explosives, wild animals, etc), hazardous operations (blasting and mining) and defective or unsafe products

**Negligence**

Virtually everyone is exposed to loss from negligence. The law imposes an obligation on all persons to use prudence in their actions so others will not suffer bodily injury or property damage. Failure to do so gives the injured party a right of action against the wrongdoer for damages.

Negligence is the act of an unreasonable and imprudent person. Often it results from carelessness, but it may be due to forgetfulness, bad temper, ignorance, bad judgment or stupidity. *Negligence never involves intent.*

The standard for what is reasonable is never clear. Often, where a judge believes the standard of care is clear, he or she will decide if negligence has occurs. Where there is room for disagreement, negligence issues are typically decided by jury.

There are many forms of negligence:

**Presumed Negligence** -- Three conditions establish presumed negligence:

1) The injury was caused by a defective object, 2) The injury could NOT have occurred without the defendant's negligence and 3) The object causing the injury was controlled by the defendant.

Presumed negligence causes typically arise in cases involving injuries where there are no witnesses, railroad and aviation injuries, medical malpractice claims and damages from defective products.

**Imputed Negligence** -- A person is responsible for the negligent acts of others. Examples include and employer liable for the actions of his employees or the imputed liability a landlord has when his tenants cause injury from a negligent act.

**Contributory Negligence** -- A case where the plaintiff is also negligent and that negligent act contributed to the loss establishes this form of negligence. Once established that both defendant and plaintiff are responsible, recovery is denied the plaintiff.

**Comparative Negligence** --Where reasonable negligence can be determined among several parties, the court will levy damages according to comparative degrees of negligence.

**Last Chance Negligence** -- In some cases, a defendant can prove that the plaintiff had the last clear chance to avoid an accident. In this situation, the last clear change doctrine will assign contributory negligence to the plaintiff and thus deny him recovery.

**Contract Liability**

Liability may also be assumed under contract or arise from a breach of an expressed or implied warranty.

**Assumed Liability** -- A person may sign a contract and assume the whole or part liability of another, e.g., a tenant agrees to assume a landlord's liability for negligence. Risk-shifting clauses are standard practice in leases.
**Breach of Warranty** -- Compared to assumed liability, proof of negligence is not required for damages under a breach of implied warranty. The plaintiff need only prove that an implied promise was not fulfilled.

**Tort and Contract Dual Liability**

In some instances, damages may be sought for liability in the areas of BOTH tort and contract law. Typical events include:

**Product Liability** -- A person injured by a defective product may bring suit on an implied warranty basis, i.e., that the goods 1) were not fit for the purpose intended, 2) were not adequately packaged and labeled and 3) did not conform to the promises and statements made on the package or label.

In addition, a defective product claimant has two causes of tort action: negligence and liability without fault.

**Professional Liability** -- Professional persons and others may be held liable for breach of an implied warranty to render the agreed-upon service. Most cases here involve the failure of the professional to exercise reasonable care.

**BUSINESS LAW**

**Contracts**

In everyday law, a contract is an agreement or exchange of promises between two or more people that is enforceable by law. The important thing to remember is that **BOTH parties to a contract must promise something of value.** A promise to give someone a car for free does not create a contract because nothing of value was received by one of the parties -- there was NO consideration. Consideration can be an act or promise to do something, refrain from doing something or a legal benefit (money).

There must be an offer and acceptance in every contract with terms that are definite and certain. **It must also be proved that the offer was communicated** since someone cannot agree to something of which he has no knowledge.

A contract can be in writing or it can be oral. Some contracts, MUST or SHOULD be in writing to be binding. Following are examples:

- Real estate sale contracts
- The sale of personal property or goods for $500+
- A lawyer's fee agreement
- An employment contract with agents
- Agreements that take longer than one year to complete

Without a written document, however, the burden to prove that a contract was made is very difficult.

Because contracts are consensual (mutually agreed) there needs to be a **"meeting of the minds"** to be enforceable. This requires contracts to be made under conditions with no duress (no pressure), no undue influence (full disclosures) and without fraud.

**Recision**

Even if someone signs a contract, in certain instances the law allows some time to reconsider and "back out" of the deal. Federal law, for example allows a 3-day Recision right on contracts involving door-to-door sales for more than $25 as well as sales made at locations other than the seller's
store/office (a sale made at a convention hotel, outdoor exhibit, etc). Three business day rescission is also allowed where home improvement loans and second mortgages are concerned.

Otherwise, the discharge of a contract can occur when something causes a binding promise to cease to be binding. This can happen by the acts of the parties involved or by operation of law. Also, parties to a contract can rescind or terminate their respective duties by mutual rescission.

**Breach**

When someone doesn’t keep a promise, a contract is broken or breached. There are many remedies for the damaged party including arbitration, mediation, a negotiated settlement or court. The person who is damaged must do two basic things:

1) Attempt to minimize his/her losses. An example might be a plumber who made a repair that later leaked. The damaged party should at least shut the water off so further damage won’t occur. And,

2) Spell out exactly what he expected to get and how much was not done.

The damaged party has the right to claim action for damages which could include compensatory damages (putting him in the same position as though the defendant performed), nominal damages (damages even though a loss has not occurred), punitive damages (“punishment monies” in addition to normal compensation and/or liquidated damages (a fixed sum specified in the contract or by law). This is discussed more under claims.

If a contract was made that involved something illegal or extremely unfair to one of the parties the courts may not enforce the terms of the contract.

**Claims**

Consumer claims result when a dispute between two parties cannot be settled. Claims can be made by way of lawsuit or small claims. Anyone who is at least 18 years old and mentally competent can file a claim. Minors must have a parent or guardian sue for them. Also, businesses that require licenses or state registration must legally hold these licenses and be registered with the State to bring action.

**Venue**

Under State law, the rules of venue and the amount of a claim determine where claims are first made. A suit can be filed in the district where someone lives, does business or where real estate is located. Damage or personal injury occurring in a district is also a determinant. The location where a contract was signed, performed or performed can further determine where a claim is filed.

Federal claims are limited to issues of federal law (civil rights, free speech), diversity (people who live in different states) or by special statute (bankruptcy, patents, copyrights).

**Statute of Limitations**

Time is still another factor in the ability to file a claim. A statute of limitation is a deadline for filing a claim or lawsuit. Following are some common time limits:

- Breach of oral contract -- two years from date broken
- Breach of written contract -- four years from date contract is broken.
- Property damage -- three years from date damaged
- Judgement debts -- ten years from judgement date
- Injury -- One year from first discovered

The court may refuse to hear a case if the statute of limitation has passed. Certain situations,
however, may suspended for a period of time if a defendant is out of state, in prison, a minor or insane. Things would proceed when the condition no longer exists.

Another situation might be the death of a party to a claim. When this happens, the statute of limitation is extended while the proxies or heirs "carry the torch". The main condition is that these same people file papers within six months of the death.

**Settlements**

A claim may follow several courses on the way to being finally resolved. Settlements, agreements between two or more people to end a dispute, may occur at anytime. In fact, most lawsuits are settled without ever going to trial. If this occurs, the parties typically ask the court to enter a judgement for the amount of the settlement or dismiss the case. A request for **dismissal** should include the words "with prejudice" -- meaning the plaintiff agrees to not sue again.

A plaintiff has the right to have a case decided by the judge or a trial by jury. Decisions by either are decrees and a judgement of the court.

Even a case that has already been decided, an appeal may be filed. **An appeal is actually a request for a higher court to hear a case again** in hopes that the decision will be changed.

**Debts**

Laws pertaining to debt are important to this course because the creation and maintenance of debt is one of the most significant issues in society.

Debt is created everyday by actions as simple as signing loan documents and credit card charges. No one can be jailed for not paying debt but there are legal recourses.

**Bankruptcy**

Some people and businesses find they can escape or relieve debt through Bankruptcy (discussed later in our report). Certain types of debt, however, still survive bankruptcy proceedings such as:

- Monies paid within 20 days of filing bankruptcy for
- $1,000 or more
- Damages caused while driving drunk
- Damages through embezzlement
- Fraud damages
- Willful personal injury damages
- Many federal, state and local taxes
- Child Support / Alimony
- Debts not listed in a bankruptcy
- Judgement fines levied for violations like traffic tickets

**Collecting Debts**

Actions to collect debts are given much attention under the law witness the passing of major state an federal laws such as the Federal Fair Debt Collection Practices Act (specifically for collection agencies).

Someone who is owed money must not use abusive methods to collect a debt like:

- Phone harassment
- Pretending to be an attorney
- Printing the debtors name in the paper
• Mail letters that have embarrassing "debt collection" language printed outside
• Threaten to take outrageous legal action
• Phoning a third party who may know where the debtor is but not disclosing the purpose of the call
• Threaten bodily harm
• Charging illegal interest or penalties not in the original contract or not allowed by law

Claims for Debt

When reasonable methods do not result in collection of the debt, the injured party may initiate a claim or lawsuit (discussed elsewhere in our report). The result of this action may be a judgement. The prevailing party is called the judgement creditor while the losing party is the judgement debtor.

Methods that a judgement creditor can use to collect a debt owed include Garnishment of Wages, Property Seizure and/or Liens. **A Garnishment of Wages can require an employer to withhold up to 25% of paychecks; 50% if the judgement involved child support.** Property Seizure can involve the legal takeover of just about anything a debtor owns (cash, real estate and personal property). Property that is specifically excluded from seizure however includes tools of trade, Government benefits like social security, household items necessary to live (appliances, chairs, cars worth less than $1,200) and specific benefits like life, disability and health insurance.

A lien is a legal claim placed against property or real estate owned by a debtor. They allow the judgement creditor to collect when a certain property of the debtor is sold or refinanced. The difference between liens and garnishment/seizure procedures is that **many liens do not require a court judgement in order to be levied.** Examples include mechanics liens, escrow liens, tax liens and child support liens.

Institutional Debt

Banks and other regulated lenders live by different debt disclosures and collection procedures. Federal Truth in Lending, for example, requires specific disclosures on interest rates, late fees, balloon payments and prepayment penalties of loans. Loan documents that include these same disclosures may also include certain debt collection powers that go beyond normal creditor rights. Where it is written in a signed loan agreement, for instance, lenders may be able to take money from a savings or checking account to pay a late loan payment. This is called a setoff. By the same loan document, a lender may automatically possess the right to assign wages or be awarded a judgement against a debtor without having to sue. Of course, lenders also have security interest which allows the right to repossess for nonpayment of a loan or debt.

PERSONAL INJURY LAW

Liability for personal injury is based on the following principles:

• Someone was negligent or unreasonably careless
• An employer is generally responsible for his employees actions while working.
• An owner is responsible for dangerous conditions, even though he did not create them.
• A manufacturer and seller are liable for defective products no matter who created the condition.

Occurrences where liability is doubtful include:

• Where the injured party was not supposed to be (a burglar is injured by a surprised owner)
• Where the injured party knew a risk was possible (a spectator at a ball game gets hit by a ball).
• Where a person is injured someone by the actions of a 3rd party (the person committing the injury may be partially liable).

AGENCY LAW

If the law required that every party to a contract or business transaction deal or participate directly, business enterprise would be extremely limited. Doing business as a corporation would be impossible, because a corporation is an artificial legal entity that can only act through its agents, officers and employees. All partners in a partnership would have to be present at every deal and individuals, who through agents now enter 100 to 500 business transactions each year, might have to negotiate every contract personally.

For these reasons, the creation and law of "agency" is an important area of business.

Agency is the relationship between two persons whereby one of them is authorized to act for and on behalf of the other. The person who is authorized and consents to act is the agent. The one for whom he acts is the principal.

The law of agency states that the authorized acts of the agent bind the principal and create legal rights and duties when dealing with third parties.

Creation & Scope of Agency

An agency can created by contract or agreement between the principal and agent. This is the most common method and typically involves the mutual consent of both agent and principal.

Agency may also result, however, from one person giving direction to another to act for or on his account. The relationship or principal and agent may exist even though the element of consideration is lacking. This is creation by estoppel.

As general rule, whatever a person may do personally he may do through an agent. It also stands, that whatever he CANNOT legally do himself he cannot authorize another to do for him. Also, a person having an adverse interest to that of the principal is not allowed at act as his agent.

Capacity of Agents

For agency to exist, there must be capacity of the principal. Thus, contracts entered into by a principal who is a minor or an insane person are voidable.

Capacity of an agent is not so clear cut. The incapacity of an agent because he or she is insane or a minor may void the contract between the agent and principal, but it does not mean that the contract between a third party and the principal is void.

Types of Agents

Agents may be actual or ostensible. An actual agent is one whom the principal has given express or implied authority. An ostensible agent is one to whom the principal has given no authority but by conduct has induced others to reasonably believe that he or she has the authority to act.

Agents may also be classified as general or special. A general agent is one employed to transact all of the business of his principal. A special agent is one employed to act for his principal only in a specific transaction or only for a particular purpose.

A subagent is a person employed by an agent with the knowledge and consent of the principal to assist the agent in transacting the affairs of the principal. The subagent possesses authority to bind the principal.
Agent Duties & responsibilities

The Law of Agency requires agents to fulfill certain duties for their principal.

- Duty of Care and Skill -- Use standard care and skill
- Duty of Good Conduct -- Act so as to not bring disrepute to principal.
- Duty to Give Info -- To communicate with principal and third parties
- Duty To Keep Accounts -- To keep an account of money
- Duty to Act As Authorized -- To act in accordance to principals consent
- Duty to be Practical -- To not attempt the impossible which will subject principal to exposure
- Duty to Obey -- To comply with principal's directions

Beyond these duties insurance agent/broker generally assumes duties normally found in any agency relationship. The primary obligation here is to select a company and coverage and bind the coverage (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically request coverage, the basic duty may expand to include the agent deciding whether the requested coverage is available and whether the insured qualifies for it (Harnett, Responsibilities of Insurance Agents - 1990).

The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to advise the insured on specific insurance matters (Jones vs Grewe - 1987). Duty also DOES NOT require the broker/agent to secure complete insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are widely available at a reasonable cost (Southwest Auto Painting vs Binsfield - 1995). An agent’s duty to provide correct coverage is not triggered by a client’s request for “full coverage” because that request is NOT a specific inquiry about a specific type of coverage (Small vs King - 1996). In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a specific type of coverage, the agent is responsible to see if it is available and determine if the client qualifies.

An insured is entitled to rely on an agent/broker’s advice on the meaning of policy provisions. In Stivers vs National American Insurance - 1957, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent “is in patent conflict with the terms of the policy”.

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

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

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however,
it is the client’s burden to show that greater duty is the result of an express or implied agreement between agent and client (Jones vs Grewe - 1987) where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed.

Agents as Fiduciaries

In addition to the duties above, the agent has fiduciary duty. The fiduciary duty of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commission. New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable "deep pocket". A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent’s contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent’s liability as a fiduciary simply comes with the territory . . . it’s part of selling insurance.

In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies (Glenn vs Leaman - 1983). Other fiduciary related liabilities relate to an agent’s duty of care. These cases even rear-up in a one-time business transaction, i.e., you don’t have to be a longstanding advisor to be liable as a fiduciary. More often than not, the issue of fiduciary exposure surfaces where an agent proposes a “full coverage” policy but failed to describe a certain provision or exclusion that existed in the written policy (Eddy vs Sharp - 1988). In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have special “expertise” where the client is unsophisticated (Sobotor vs Prudential Insurance -1984) / Kurtz vs Insurance Communicators -1993), or when an agent promises to provide "complete coverage" (Magnavox Co of Tennessee vs Boles & Hite - 1979) The exposure also seems to exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer. (Glenn vs Leaman & Reynolds - 1983).

Duties of the Principal (Insurer)

The Law of Agency requires principals to fulfill certain duties for their agents.

- Duty to Perform -- Abide by agent's contract
- Duty to Furnish Work -- Not to interfere with agent's opportunity to work
- Duty to Not Interfere -- Refrain from interfering with work
- Duty To Give Info -- Inform agent about risks and more
- Duty to Keep Accounts -- Keep track of commissions owed
- Duty of Good Conduct -- Keep agent's reputation from harm
- Duty of Indemnity -- Reimburse expenses & damages
- Duty To Pay -- To pay commissions as promised

Binding of Agents & Principals

If someone represents himself to be an agent, but is not, the third party is not liable unless the principal ratifies the contract. Ratification occurs when the principal agrees to a contract performed on his behalf by another without his authority. The express or implied acceptance by a principal binds him as though it was originally authorized. Casualty agents have the power to bind since they are contract writing agents. Life and health agents do not since they are soliciting agents.

An agent who acts as an agent for a fictitious or non-existent principal is personally liable on a contract entered into with a third person.

An agent who enters into a contract with a third person on behalf of a principal who died prior to
making the contract is personally liable unless the third party knew of the principal's death.

If an agent with authority to collect money owing his principal receives payment from a third party but fails to remit it to the principal, the third party has no right of action against the agent. His debt or payment owed to the principal, however is discharged when payment was made to the authorized agent.

An agent is liable to a third party for fraudulent representations which he makes to such person as well as other false statements upon which the third person relied.

**Termination of Agency**

Termination of an agent's authority may take place by: 1) mutual agreement of the parties; 2) fulfillment of the purpose of the agency; 3) revocation by the principal; 4) renunciation by the agent; 5) bankruptcy of the principal or agent; 6) death of the principal or agent; 7) insanity of the principal or agent; 8) change in business conditions; 8) loss or destruction of the subject matter; 9) loss of qualification of principal or agent; 10) disloyalty of the agent; 11) change of law whereby the exercise of the authority is illegal; 12) outbreak of war which impacts the agreement.

The principal may revoke the authority of the agent and terminate the agency by notice to the agent. However, the power of the agent to bind the principal by contract to third persons will continue until the third person has knowledge of the termination.

**EMPLOYMENT LAW**

There are volumes of rules and laws that supervise the actions of employers. The reader is encouraged to consult state and federal agencies and codes such as:

- Various State Department of Fair Employment & Housing
- Health & Safety Codes
- Federal & State Fair Labor Standards Acts
- The Civil Rights Act of 1964 Title VII
- The Federal Equal Pay Act
- Employee Polygraph Detection Act
- State Labor Codes -- 230.7 & 230.8
- The Federal Pregnancy Discrimination Act
- Health Insurance Portability & Accountability Act of 1996

**Violations of Employment Law**

We have summarized some of the most popular employee violations of employer/employee law below to aid agents in their practices. Always consult an attorney before imposing or enforcing any kind of employee rule.

1. If an employer is found to train, pay by the hour, set hours of work, work at your office, pay travel expenses, furnish work tools and materials he has hired employees not independent contractors.

2. It is illegal to discriminate by refusing to hire by race, religion, political affiliation, previous arrest record (no conviction), age, sex, disability or because an applicant is pregnant. Also, unless the task involves a clear and compelling need, it is illegal to discriminate against non-English speaking candidates.

3. Children under 14 years of age may not be employed. Fourteen and fifteen year olds may work restricted hours ONLY.
4. A company with 15 or more employees cannot refuse to hire an Aid's or HIV infected applicant. Firing of same is also prohibited. Testing for AIDs / HIV also prohibited.

5. **Testing employees for drugs is prohibited** unless behavior or performance on the job is critical. Testing job applicants is illegal unless they are aware it is part of the job review.

6. The firing of any employee requires an employer to hand them a paycheck and all vacation pay immediately.

7. It is against the law to fire an employee unless they have violated defamation rules (false statements about someone else) or public policy (health/OSHA rules) or an employment contract.

8. An employer cannot threaten or fire an employee for not taking a lie detector test unless the position requires security and drug handling.

9. An employer **must not prohibit a parent from taking reasonable time off** to deal with a child's school or illness.

10. It is illegal to refuse to hire or promote and otherwise fire on the basis of pregnancy. As long as the employee is able to perform duties she can work. Up to four months unpaid pregnancy leave can be requested by your employee. Her position must be held open four months.

11. The invasion of an employees privacy by requiring medical exams, divulging confidential information from an application, monitor comings and goings when off work, monitor phone calls without notice, search employees possessions or use criminal record of employee in employment decisions is illegal.

12. Attorney's advise employer's should not keep personal remarks in an employees files. They can be viewed by them any time if the employee requests it.

13. The use of psychological testing to ask applicants about sexual orientation is prohibited.

14. The offer **sick leave or vacation time** to one employee and not another is illegal. There should be a set policy.

15. A 40 hour work week is all that can be required of employees unless the employer offers an equivalent value in time off or pay at the rate of 1.5 times the normal rate for overtime.

16. Employer group health plans cannot deny coverage or apply pre-existing condition exclusions to individuals who had prior health coverage for at least 12 months.

**Employer Duties**

In addition to many of these duties, an employer owes certain tort duties to his employees. Among these is the duty to provide reasonably safe conditions of employment, and to warn the employee of any unreasonable risk involved. A employer is also liable to his employees for damage caused by conduct of other employees doing work for him to the same extent as he is to a third persons. The duty of an employer as to working conditions for his employees extends to the maintenance, inspection and repair of the premises under his control and of the tools which his employees use. Where an employee understands the risks of employment and voluntarily enters or continues, an employer may not be liable for harm or injury. Employers are also under a duty to supply competent supervisors and enforce suitable rules for safety.

**OWNERSHIP LAW**

**Property**
In the United States, the concept of "property" is highly valued. While a large part of our rules on property stem from English law, property in America occupies a unique status because of its protection granted by the Federal and State Constitutions.

By itself, property is difficult to define because it encompasses a bundle of rights. For example, there is the right to use a piece of land or sell it, and to say to whom it pass when you die.

Under the law, it can better be expressed that property is not so much defined as a thing capable of physical possession as it is an interest or group of interests, that will, at any given time be honored by society.

**Types of Property**

Courts frequently get involved in classifying property. Four primary types to discuss include tangible, intangible, real and personal.

**Tangible property** refers to physical objects: a 40 acre farm, a chair, a household pet are all tangible property.

**Intangible property** is property that has a legal reality but may not be capable of physical possession. A stock certificate, a promissory note or a right-of-way grant deed are examples of intangible property.

Far more legal issues center around real and personal property. Briefly, **Real property** might simply be defined as land and all interest therein. Every other thing or interest can be identified as **Personal property**. Personal property brought onto land may still remain as personal but may also become real property. For example, materials used to build a building come onto the land as personal property. But, worked into the building as its construction progresses from the foundation up, they become real property because buildings are part of the land.

Conflicting claims of ownership often center around fixtures. Many fixtures are brought onto real property such as heating, lighting and air conditioning systems, cooking appliances, cabinets, window coverings, awnings, etc. These items may be so firmly attached that they have lost their character as personal property and become real property.

As between landlords and tenants, a presumption exists that the tenant is entitled to all of the fixtures installed by him, provided that they may be removed without material injury to the landlord's property. It is probably more common, however, that leases require that all personal property affixed to the real estate accrues to the landlord.

**Degrees of Ownership**

When a person speaks of "owning property", many things come to mind: a piece of land, a stock certificate or a personal possession. In any of these cases, full and complete ownership is anticipated.

There are likewise situations, where "owning property" may mean less than full ownership: A mortgage holder has a property interest in the mortgaged property but the legal ownership is with the person who secured the debt.

**Real Estate Ownership**

Real property may be owned by a sole owner, or it may be owned jointly by two or more persons. A person who is the sole owner of real property is said to be the owner thereof in severalty. Where there are more owners than one, their ownership is referred to as co-ownership. There are several ways to co-own real estate:
Joint ownership usually occurs in four ways — joint tenancy, tenancy in common, tenancy in partnership and community property. Each type of co-ownership has distinct characteristics, and a knowledge of the legal effects of the different forms of ownership is essential to anyone acquiring real property.

**Joint tenancy** is regarded as a single estate held by two or more persons jointly, such joint tenants holding as though they collectively constituted but one person, a fictitious unity. The main characteristic of joint tenancy is the **right of survivorship**. When a joint tenant dies, his interest in the land is terminated, and the estate continues in the name of the survivor or survivors. When there is only one survivor, the estate becomes an estate in severalty, and upon the death of this last survivor, title vests in his or her heirs. The usual method of creating joint tenancy is a deed describing the grantee as follows: "To A and B as joint tenants". The words "with right of survivorship" are often added but not necessary since the right is an incident of any joint tenancy.

If one of the grantees in a joint tenancy deed is a minor or incompetent person, and funds of the minor or incompetent person are used in the purchase of the property, the joint tenancy is questionable. An agreement by the minor or incompetent to take title in joint tenancy would be void or voidable under the usual rules governing contracts of persons under disability.

Problems frequently arise regarding the true character of ownership by a husband and wife who record a deed as joint tenants. Joint tenancy and community property are separate and distinct forms of ownership. However, it has been held that where a husband and wife elect to take title as joint tenants, this establishes an agreement between them that the property in question shall NOT be held as community property but instead as a joint tenancy with all the characteristics that apply.

A joint tenancy may be terminated by express agreement. For example, an agreement that "if the joint tenant dies, the interest of that one shall go to a third party" destroys the element of survivorship and terminates the joint tenancy. In this case, title would vest in the parties as tenant in common.

Joint tenancies have advantages and disadvantages. The main advantage is, of course, the incident of survivorship, eliminating the time and expense of probate proceedings. Disadvantages as compared with other methods of holding title include the following: 1) the possibility that the joint tenancy may be severed at any time by a transfer, voluntarily or by operation of law, 2) the fact that the joint tenant who dies first has no power of disposition over his or her property, 3) as between married joint tenants, the fact that a divorce court cannot award the true joint tenancy property to the innocent spouse, 4) the tax consequences, both as estate and income taxes, may be unfavorable, and 5) no provision exists for administering the estate of a joint tenant who has been missing for seven years and who is presumed dead.

**A tenancy in common** is characterized by only one unity, that of possession. The co-tenants in a tenancy in common own undivided interests, but unlike a joint tenancy, these interests need not be equal in quantity or duration. Also, there is NO right of survivorship, each tenant owns an interest which on his death vests in his heirs. A tenancy in common is created whenever property, real or personal, is transferred, whether by conveyance, descent, or by operation of law, to several persons in their own right, UNLESS acquired by them in partnership, declared to be joint tenancy or by community property. Where it is desired to specifically be established as a tenancy in common, the deed should recite: "To A and B, as tenants in common, each as to an undivided one-half interest". If the amount of the interest is not specified, such as one-half or one-third, there is a presumption that their interests are equal. As in the case of joint tenancy, the interest of a tenant in common may be transferred, either voluntarily or by operation of law. So, if A owns one-third undivided interest in a piece of property and B owns two thirds, when A transfers or sells his interest to C, the new grantee "C" owns one-third interest as tenants in common with B.

Community Property states assign BOTH husband and wife a present, equal and existing interest in any property they acquire with community property funds. In determining whether property is separate or community property, the recorded title is not necessarily the controlling issue. For
example, property may be community property even though the record title stands in the names of the husband and wife as tenants in common or as joint tenants. Evidence may be submitted by either party that the intention was to take or own the property as community property even though it was assumed as joint or tenants in common. The basic presumption is that all property acquired during marriage by either husband or wife, or both, other than by gift, bequest or descent is community property. Whether property of a husband and wife is separate property or community property is extremely important, as different rules apply in various actions or proceedings affecting the property of a married person. In the case of a divorce, for example, the laws of succession distinguish between separate and community property. The power to award property is dependent upon the character of the property being community property or homestead property, and does NOT extend to separate property.

Partnerships may own property in the name of the partnership, since a partnership is considered an entity capable of acquiring title to real property. Title may also be acquired in the names of one or more of the individual partners, with or without reference to the partnership. A judgment against an individual partner is not a lien upon the partnership property or the partner’s interest. Upon the death of a partner, his right in specific partnership property vests in the surviving partner or partners. The interest of the deceased partner is his or her right to an accounting and a share in the profits and surplus of the property. The surviving partner has the title to the partnership property and the exclusive right of management of the partnership business, but only for the purpose of winding up the partnership and accounting to the state of the deceased partner.

**Joint ventures** result from an agreement of two or more persons to jointly conduct a business enterprise for profit. The principal difference between a joint venture and a partnership is that a joint venture is ordinarily formed to conduct a single enterprise. The persons who may associate to form a joint venture are considered to be the same as those who may become partners. There are no statutory or legal requirements or authorization for filing or recording any certificate or statement to establish the existence of a joint venture. For title insurance purposes, the preferred method of titling a joint venture is: "A and B, doing business as X Company, a joint venture".

A corporation qualified to do business in a particular state may acquire, dispose of, or otherwise contract with respect to property in that state, subject to limitations on its powers contained in its charter or articles of incorporation. The authority of an officer to execute a conveyance or contract affecting real property of a corporation must ordinarily be evidenced by a resolution of the board of directors.

**PARTNERSHIP AND CORPORATION LAW**

**Partnerships**

As distinguished from the conduct of a business by a single individual, a partnership is generally defined as the association of two or more persons for the purpose of carrying on a business as co-owners for a profit. A partnership is a relationship or association of persons which has the quality of oneness but it cannot be legally described as a legal entity but as an aggregation of individuals. Unlike a corporation, a partnership is not an artificial person having a distinct legal existence separate from its members. This was the prevailing theory at common law and is the view adopted by the Uniform Partnership Act.

As a result of the legal characterization of a partnership as an association of individuals, it necessarily follows that a **partnership can neither sue or be sued in the firm name**. And since a partnership is not a legal entity, the **debts of the partnership are the debts of the individual partners**, and any one partner may be held liable for the partnership’s entire indebtedness.

Even though a **partnership is not a legal entity**, it is nevertheless an entity and clearly recognized in the following respects:
1. For bookkeeping purposes, assets liabilities and business transactions of the firm are treated as those of a business unit and are considered separate and distinct from the individual assets, liabilities of the member partners.

2. In the marshalling of assets, creditors of the partnership have prior right to partnership assets, while creditors of the individual members have prior right to assets of the individual.

3. Title to real estate may be acquired in the partnership name and conveyed in the partnership name.

4. A bankruptcy may involve the partnership without involving the individual members.

5. Income tax of a partnership is paid by the individual partners although the partnership must file an information return each year.

A partnership is a highly personal relationship. Because of this, partnerships must be based on mutual trust and confidence. Occasionally a person may be chosen as a partner because of his ability to make a needed capital contribution, the mutual choice of partners is based largely on desirable personality, good business ability, sound judgment, good reputation and integrity. Whatever the criteria, the important issue is that a person has the right to choose his partners. This principle is called delectus personae.

Each partner has a right to take part in the management of the business, to handle partnership assets and act as agent of the partnership.

Co-ownership of alone does not establish a partnership. For example, a group of farmers who purchase a threshing machine for their mutual use and agree to rent the machine to others and divide the profits is not a partnership. In order for a partnership to exist there must be an agreement to share in or contribute to the losses of the business and the exercise of the power of management and control.

**Formation of Partnerships**

Persons become partners by associating themselves in business together as co-owners. The association may result from an oral or written agreement between the parties, or it may be such an informal arrangement that the agreement is not definitely articulated but left to subsequent expression.

Naturally, in the interest of a better understanding of the terms and scope of a partnership, it is preferable to have a contract between the parties reduce to writing. The written agreement creating a partnership is referred to as articles of partnership. Important items contained in these articles include:

- The firm name and the identity of the partners
- The nature and scope of the Partnership
- Duration of the partnership
- The capital contributions of the partners
- The division of profits and sharing of losses
- The time each partner will devote to the business
- Provision for salaries, if desired
- Restrictions of authority
- The right for a partner to withdraw
- Provisions to continue partnership of one partner dies

While articles of Partnership are not necessary to the formation or existence of a partnership, the advantage of having a written contract tailored to meet the requirements of a particular situation and encompassing the full understanding and agreement of the partners is obvious.
Partner Ownership Rights
A partner's ownership interest in any specific item of partnership property is not that of an individual owner. Following are the principle characteristics of a tenancy of partnership:

1) Each partner has an equal right with his co-partners to possess partnership property for partnership purposes.

2) A partner may not make an individual assignment of his right in specific partnership property.

3) A partner's interest in partnership property is not subject to attachment his individual creditors.

3) Upon the death of a partner, his right in specific partnership property vests in the surviving partner or partners.

Partnership Rights & Duties
Partners are fiduciaries and therefore owe each other a duty of good faith and utmost loyalty. Partners have a right to share in the profits and losses of the business and to be repaid any capital contributions when the partnership terminates.

Partners have a right to participate in management and are entitled to full information on all partnership matters including an inspection of partnership books at any time.

Also, because partners are considered agents for the partnership a partner may bind the partnership on transactions that within the scope of the partnership. If the act is not apparently within the scope of the partnership business then the partnership is bound only where the partner had actual authority and the third person dealing with the partner assumes the risk of existence of such actual authority.

Dissolution of a Partnership
Upon an application by a partner, a court will order a dissolution of a partnership if it finds 1) a partner is insane or suffers some other incapacity 2) a partner has willfully breached the partnership agreement 3) the business can only be carried on at a loss 4) other circumstances render it infeasible for the partnership to continue.

Corporations
A corporation is a body established law and existing separate and distinct from the individuals whose contributions of initiative, property and continuing control make it possible for it to function.

A corporation is a legal entity separate and apart from its members or shareholders with rights and liabilities entirely distinct from theirs. It may sue or be sued, or contract with, any one of its members.

The corporate entity may be disregarded whenever it is used to justify wrong, protect fraud, promote crime or circumvent the law. This is frequently referred to as piercing the corporate veil or going behind the corporate entity and holding accountable the individuals who are attempting to utilize the corporation to insulate themselves from the consequences of their wrongdoing.

Formation of a Corporation
Several steps are required in the formation of a corporation:

1) State issuance of a corporate charter
2) Assembling subscribers to but stock
3) Execution of Articles of Incorporation
4) Organization meetings
5) Recording of the Certificate of Incorporation
The incorporators of a corporation are the persons who execute the articles of incorporation. They are required to be twenty-one years old and subscribers to the stock of the corporation to be organized.

**Corporate Powers**
Every corporation organized under general statute has all the general powers granted by the statute, which may include:

- To sue and be sued in the corporate name
- To have a corporate seal
- To buy, lease, own, hold and use real and personal property
- To sell, convey, mortgage and dispose of its assets
- To lend money to its employees other than officers and directors
- To buy, sell or dispose of shares of other partnerships and corporations.
- To make contracts and incur liabilities
- To invest surplus funds
- To elect or appoint officers and agents
- To make and alter by-laws
- To cease activities and surrender its corporate franchise.

**Corporate Liability**
A corporation is liable for the torts and crimes committed by its agents and employees in the course of their employment. A corporation may also be found guilty of fraud, malicious prosecution, libel and other torts.

Officers and directors of a corporation are not liable for causing the corporation to do any act or engage in any activity in excess of its powers where they acted in good faith. However, where directors and officers acted in utter disregard for charter limitations and apply corporate funds for unauthorized purposes, they become individually liable for any loss sustained by the corporation.

**Dissolution of a Corporation**
The life of a corporation is terminated by dissolution which may be brought about in many ways:

- Act of legislature by the State
- Expiration of the period of time for which the corporation was formed
- Voluntary action by all shareholders
- Voluntary action by the corporation by board of director resolution and a two-third vote of all shareholders.
- Decree of the court for franchise tax violations or fraud

**REAL ESTATE LAW**
Real property, unlike personal property is subject to the laws of the state within which it is located. A major part of the law relating to real property is contained in statutes enacted by the state legislature. Most of these statutes are contained in numerous codes, including the Civil Code, the Probate Code, the Corporations Code, the Public Resources Code and the Government Code to name a few. In addition, there are many local codes affecting real property through zoning ordinances and building codes.

**Elements of Real Property**
The term real property applies not just to the land itself, but to the rights or interest an owner has in the land. Further, the nature of property may change from one class to another. For example, land in place is immovable and is definitely real property, but when it is removed it becomes movable and therefore personal property. Similarly, personal property becomes real property
when it is attached with the intention of making it a permanent part of the land.

The Civil Code defines real property as the ground or soil and the things attached to it, whether by course of nature, such as trees and other vegetation, or by artificial means, such as the construction of a house or other structure. Real property also includes things that are incidental to the use of the land, such as an easement or right of way. It includes not only the surface of the land, but everything under it and above it (mineral rights and airspace).

**Acquisition & Transfer of Real Property**

The word title has been defined as the "evidence of ownership", i.e., the method by which an owner's right to property is established or evidenced. There are many different ways of acquisition and transfer of title to real property.

The most familiar method of transfer of title to real property is by deed. This includes voluntary transfers by the act of the parties and involuntary transfers by act of the law. A **deed** is described briefly as a written instrument, executed and delivered, by which the title to real property is transferred from one person, called the grantor, to another person, called the grantee.

There are two types of deeds in general use. They are the grant deed and the quitclaim deed. The main distinction between a grant deed and a quitclaim deed is that grant deeds contain implied covenants and warranties. Grant deeds also convey the rights after acquired title. A quitclaim deed, on the other hand, transfers only such interest as a grantor may have at the time the conveyance is executed.

Trust deeds are also commonly used in many states, but not primarily for the purpose of conveying title from one person to another; rather, they are used to create a lien on real property. Another form of deed, called the reconveyance deed, may used to convey the title from the trustee in a transaction to a trustor when the debt secured by the trust deed has been paid.

The requisites of a valid deed are as follows: 1) a competent grantor, 2) a grantee capable of holding title, 3) a sufficient description of the property, 4) operative words of conveyance, 5) due execution by the grantor, 6) delivery and 7) acceptance. Nonessential matters include consideration, a date, acknowledgment and recording -- although it is common practice to record deeds for title insurance purposes.

Any form of written instrument that contains sufficient words of conveyance, such as "grant", "transfer" or "convey" is usually sufficient to pass title to land. There is no fixed and absolute form.

A deed must designate a grantor, whose name must appear in the body of the deed. A person may assume any name he chooses when he obtains title to property. With assumed names, however, the difficulty most often occurs in connection with the statement of identity required by a title company where the person taking title under an assumed name has insufficient proof that he or she is in fact the same person.

A deed must designate a grantee to whom the title passes. The grantee must be named or designated in such a way as to be ascertainable, and must be a person or entity capable of taking title. A deed to a dead person or a fictional person is void. Grantees, on the other hand can be infants, insane or incompetent persons.

A deed must be executed by the grantor or his attorney-in-fact. Usually a grantor writes his name in ink in longhand. However, signatures by mark (a person making an "x") is valid as long as two witnesses are present. Also, the grantor's name may be written for him or her by another person at the grantor's request and in his presence.

A deed must also be delivered to be effective. In some cases delivery is presumed if a deed is found in the possession of the grantee or if it has been recorded. Otherwise, manual delivery is the best evidence of delivery. This can be accomplished by "handing" the deed to the grantee or where it is understood, by agreement, that the deed will be delivered to the grantee or a third party
for benefit of the grantee.

So far, the discussion of real property transfers has been limited to voluntary acquisitions. A surprising number of transfers, however, occur by involuntary means. Examples of this method include:

**Adverse possession** is a means of acquiring title to real property based on continued use for a certain period of time. Specifically, a person who openly and in a manner hostile to the owner takes possession of a property, pays its taxes for a period of five continuous years may claim title to this property under adverse possession.

**Condemnation** is the method by which cities, counties, states and other government agencies can acquire real property. The right to do so is called the power of eminent domain. To be legal, there must be a reason to take the land e.g., streets, drainage, necessary easements and other public uses.

**Accession** is still another method of acquisition of title through annexation, accretion or relliction. **Annexation** occurs when a person affixes his property to the land of another without an agreement permitting him to remove it. The manner in which an item is affixed determines if it belongs to the owner of land. **Acretion** is defined as the process of additional land is formed along rivers and streams where the action of water has washed up sand, earth or other materials. **Relliction** is the opposite effect where land has been worn away from the action of the water.

Still other methods of involuntary transfers of property include escheat (where a person dies without leaving a will and without heirs -- the land reverts to the state), alienation (where the operation of law such as a judgement or tax lien forces a transfer), estoppel (where a true owner permits another person to appear to be the owner an innocent third party may actually acquire title) and forfeiture (where a transfer takes place as a consequence of a default -- a lender foreclosure).

**Ownership of Real Property**

Once the transfer of real property has been enacted, an owner enjoys certain rights and is subject to various duties and responsibilities -- a breach thereof, may create liability to third parties.

As a general rule, an owner of real property may make lawful use of his property as he sees fit as long as he does not injure others. An owner has the right to remove trees and brush growing on his land and cannot be restrained from cutting trees. However, the felling of trees into a stream such that the flow of water is restricted to a downstream owner is illegal. In a similar vein, an owner cannot divert surface or storm waters onto the land of another that were not there before.

Owners must be careful to avoid trespassing on adjoining landowners. An encroachment occurs when a projection of a building or other structure rests in part on an adjoining land. As long as a claim is brought within three years, the person who has trespassed can be required to remove the structure or pay damages. Additional nuisances included, unlawful obstructions to a neighbors free use of his property. This might include polluting adjoining streams, fencing his access road, negligent excavation such that rains cause mud slides or undermine a neighbor's foundation.

Liability is another incident of ownership. An owner owes to persons who come on his land a duty of care. Normally, these duties do not extend to persons outside the land, e.g., someone on adjacent land or on the highway. Interestingly, streets and sidewalks that are in dangerous condition should not represent a liability to an owner. If a city notifies an owner to make repairs, however, and an owner refuses to do so, he may be liable to pay for repairs or reimburse the city, but not to pay damages for an individual for injuries incurred. Where the owner builds something that extends into the street or constructs a well in the sidewalk, he is under duty to keep them in repair and is typically liable to third parties who are injured as a result of his failure to make necessary repairs.

The degree of liability an owner may possess depends on the how the injured party came to cross
the property. For example, the least duty owed by a landowner to a person entering his property is the duty owed a trespasser. A trespasser is one who enters or remains on the land of another without privilege or consent. As a general rule, the owner is not under a duty to maintain his property in safe condition for the reception of trespassers. Exceptions to this rule include intentional traps and certain attractive nuisances like an unguarded or unfenced swimming pool that attracts a child who drowns. A licensee is a person who enters the property of another by consent or permission, but usually for his own purposes. An owner has a responsibility to notify a licensee that a condition of the land or property represents a hazard or potential risk of injury. An invitee enters at the express or implied invitation of an owner or occupant for mutual benefit, or in connection with the business of an owner. In addition to warning an invitee of potential risks, an owner must exercise ordinary care to keep the premises in a reasonably safe condition. The fact that an owner has no actual knowledge of the dangerous condition is not a defense; he has an affirmative duty to inspect the premises or take care unsafe conditions.

**LANDLORD & TENANT LAW**

### Tenancy

The relationship of landlord (lessor) and tenant (lessee) is the result of a contract known as a lease. A lease imports the giving, for a consideration by the owner of the property, of the possession and use of his property with a reversion to the owner at the end of the term. The lease has a dual character, being BOTH a contract and a conveyance.

### Creation of Tenancy & Lease Terms

A lease may be either verbal (oral) or written, but a lease for longer than one year must be in writing and signed by the lessor, under most state Statute of Frauds. An oral agreement for a one-year lease to be annually renewed for one year terms at the desire of the tenant violates the statute of frauds.

A lease need only be signed by the lessor and not by the lessee, because the lessee's acceptance is sufficient and acceptance may be indicated by taking possession or paying rent. Ideally, however, all leases should be written and signed by both parties, whether the term is fixed or month to month. Both husband and wife, as well as any other adults or employed minors, should sign the contract. Either spouse may request the other to sign for both, e.g. John Doe by Jane Doe or simply Jane Doe, Tenants.

Where an agent or manager of the owner signs the contract for the owner, the following form should be used: John Roe, Owner, By Ruth Gray, Manager. If, however, a lease is for longer than one year and is signed by the manager of the lessor, the lease is invalid unless the authority of the agent or manager is in writing.

**A written lease must be delivered** to be legally executed. The usual method of delivery is manual -- handing the lease to the tenant. Although this is the best method, delivery may also be constructive. Constructive delivery is implied from the acts of the parties and their intentions. Thus, there would be a valid delivery where the manager left the lease in the prospective tenant's room with the intent that the tenant should take it when moving in.

While there is no particular form for a lease, the written instrument must be intended as a lease, and give the names of the parties, description of the premises and the term. It is essential that the document also establish a relationship of landlord and tenant.

The term of the lease should be stipulated. If not, it is presumed to be month to month tenancy. If a lease provides a specified term for which the tenancy is to run, as for six months, one year, three years, etc, this is called a fixed term tenancy. If a lessee of real property remains in possession of the premises after the expiration of the lease and the lessor accepts rent from him, the parties are presumed to have renewed on the same terms. The term, however, reverts to
month to month and the tenancy changes from a fixed term tenancy to periodic tenancy.

In common law days, there is no limitation on the term for which a lease can be created. The complications that can develop when a lease runs 500 years, however, has prompted most states to adopt lease limitations. California, for example, now has statutes providing that a lease for a term longer than 99 years is invalid. For the most part, this applies to town or city lots and mineral leases. In the case of agricultural properties, the legal limit for some state leases is 51 years. Government buildings are usually limited to 55 year leases, while recreational lands are allowed 99 year limits.

Any alteration of a lease must be in writing and the lease cannot be changed by mutual oral agreement unless these agreements have been fully performed. An example might be a landlord who temporarily accepts a lower lease payment than what is written in the contract. This constitutes an oral agreement that has already been performed.

A landlord who sells his property or land in the middle of a lease term conveys his rights, as original lessor, to the person he sold to -- the vendee. Exceptions to this occur often in the case where the lease contains a provision that a sale of the land or property prior to the expiration of the leasehold term shall terminate the lease.

A tenant may assign or sublease all or part of his leased premises subject to any restrictions in the lease against assignment or subletting. Whether a transfer is an assignment or a sublease is important since the respective rights and liabilities of the parties vary. In the case of an assignment, for example, the assignee must take precisely the same estate that the assignor has in the property. If the assignee defaults the lease and abandons the premises, the lessee may sue to recover the rent to the same extent as though the assignee had been the original lessee. In the case of a sublease, a sublessee is ordinarily ONLY liable to the sublessor and not the original lessor, since he does not acquire the whole estate but only a portion of the unexpired term.

In a lease to a husband and wife, community property laws determine who is liable for ultimate payment of the contract. Where the property is leased by the husband and wife by a written instrument in which they are described as husband and wife, the presumption is that the community property is liable for the lease. The law has even determined that the community property is responsible for lease contracts of either spouse made after & prior to marriage if said contracts were made after January 1, 1975.

**Termination of the Lease**

A lease will expire upon its termination. Additionally, a lease may be lawfully terminated prior to the expiration of the term on several grounds. A lease may be terminated by the tenant for violation of the landlord's duty to place him in possession, or for violation of the landlord's duty to repair, or upon eviction by the landlord. The lease may be terminated by the landlord if the premises are used by the tenant for an unauthorized or illegal purpose. Either party may terminate the lease upon breach of a condition of the lease by the other party, or upon the destruction of the premises if there is no covenant to repair.

A lease may also be terminated by the surrender of the lease premises by the lessee where the lessor accepts such surrender. In such case, the lessee is released from all further liabilities under the lease.

**Condition of Premises**

As a general rule, a lessor owning land is not liable for injuries resulting from a defective condition of the land. Liability for injuries is placed upon the one who is in control of the land, which is the lessee. Where injuries result from a defective condition of a building where the lessor or landlord is in control -- stairs, common hallways, etc -- the lessor is liable and not the lessee. However, a liability may not arise where the defect is so obvious that anyone could have predicted their own
injury or damages. As such, the duty of the landlord is to use reasonable care in the maintenance of property under his or her control.

Where premises are leases as a dwelling, there are statutory duties placed upon the landlord to keep it fit for human occupancy. To be habitable, a residential rental should be weatherproof and free of rodents. Each unit should include a toilet, bath or shower, kitchen with sink, hot water, adequate heat, natural light, a smoke detector, adequate garbage removal and electricity if it is available.

If a unit is not habitable because a landlord has failed to make repairs necessary to the health and safety of the tenant, a tenant corrective actions may move out, withhold rent, call the building department, sue the landlord or make the necessary repair and deduct it from next months rent. Before any of this can be done, however, the landlord must have reasonable notice of the repairs, repairs cannot cost more than one month's rent and the problem must not have been caused by the tenant or his guest.

Landlord notifications to tenants should include such items as asbestos and any shared utility arrangements.

**Deposits**

A security deposit should be exactly what it sounds like: Security . . . for the landlord. It is one of the most powerful means of control a landlord has over tenants and the way they take care of the property. Federal fair housing laws prohibit apartment owners from discriminatory practices related to security deposits. For example, an owner who requires a larger security deposit from tenants because they have children would be violating the law. Security preferences must allow the same treatment for all potential tenants. Legal restrictions may also effect security deposits applied to damages, refund procedures, payment of interest and keeping security deposits in interest-bearing accounts.

No matter what the security deposit is called -- last month's rent, security deposit, cleaning deposit -- the law limits the amount a landlord may charge to no more than two month's rent for an unfurnished unit or three month's rent for a furnished unit. It is unlawful for the security deposit to be "non-refundable", but the law does allow landlords to retain part or all of the deposit under certain circumstances. Deposits collected on rentals are refundable so long as the tenant moves out leaving the premises clean and undamaged. Deposits may not increase during the term of the lease unless the agreement specifies or it is a month-to-month agreement and the landlord has given 30 days notice. Interest does not need to be paid on deposits, but they must be refunded within three weeks of the tenant vacating the premises. Deposit funds can only be used for overdue rent, repairs on damages caused by tenant, cleaning and replacement of personal property (landlord furniture).

The most common disagreement between landlords and tenants is about the refund of security deposits after the tenant leaves the rental. For this the law in most states specifies a procedure that a landlord must follow if he or she wants to keep all or any part of the security deposit. Within 21 days after the tenant moves, the landlord must either send a full refund of the security deposit, or an itemized statement that lists the reasons for and amounts of any deductions from the deposit, wit a refund of any amount not deducted.

When a building is sold, the selling landlord must do one of two things: either return the security deposit to the tenants following the sale or transfer the deposits to the new landlord. The selling landlord may deduct amounts from the security deposit just as if the tenants had moved from the rental unit (for example, to cover unpaid rent or damage to the rental). If the selling landlord makes deductions from the security deposit, he or she must return the balance of the deposits to the tenants or transfer the balance to the new landlord. In any case, the selling landlord must account to the tenants for any deductions. If the selling landlord transfers the security deposits to the new landlord, the selling landlord must notify the tenants of this in writing. The written notice must also tell the tenant the name, address and telephone number of the new landlord. If a selling
landlord fails to follow this procedure, BOTH he and the new landlord are legally responsible to the tenants for the security deposits.

A new landlord cannot charge a new security deposit to current tenants simply to make up for security deposits he or she failed to obtain from the selling landlord. But if the security deposits have been returned to tenants, the new landlord may collect new security deposits. Also, if the tenants cause damage to the rental unit that costs more to repair than the amount of the security deposit, the new landlord can recover this excess from them.

If a tenant feels that a security deposit refund is deserved but has not been received, and pursues the collection in court, and wins a judgment that the refusal to refund was unreasonable (in “bad faith”), the court has the option of ordering the landlord to pay the amount of the improperly withheld deposit plus up to $200 in punitive damages, as well as interest at the rate of 2% per month from the date the refund was due until it was paid. These additional amounts can be recovered if a landlord who has purchased the building makes a “bad faith” demand for replacement of security deposits. Whether a tenant can collect attorney's fees in such a suit will depend on what is stated in the original rental agreement. If attorney's fees are provided for in the agreement, the tenant can claim such fees as part of the judgment, even if the original agreement stated that only the landlord can claim such fees.

In recent years, certain cities and municipalities have initiated their own security deposit rules, particularly with reference to interest paid on these accounts. In Los Angeles, for example, a landlord must pay a current rate of interest on security deposits held over one year. Payments need only be made every five years or when the tenant moves out. In Santa Monica, there is no specific requirement that a tenant need pay interest. However, failure to do so is a “factor” in the city denying a landlord's request for a rent increase or granting a tenant a rent decrease.

**Tenant Eviction**

Tenant Eviction can only be started by a written notice from the landlord. With a month-to-month agreement, 30 days notice is required and the landlord does not have to provide a reason for ending the tenancy. Where notice is given because of non payment of rent, only three days notice to vacate is necessary. If the tenant corrects the problem within the three days, the tenancy still exists. It is illegal for landlords to evict a tenant by force, lock the tenant out, change the locks, remove doors or windows, remove tenant's furniture or property or shut off any utilities or cause them to be shut off. The penalty for doing this is $100 per day.

**Tenant Privacy**

Tenant privacy is upheld under the law. A landlord, manager or employee may enter a tenant's unit only in case of emergency, to make necessary agreed-upon repairs, to show the property to prospective tenant's or purchasers or when the tenant gives permission. Except for emergency situations, tenants must receive 24-hour notice of intent to enter the suite.

**MISC LAW**

**Emergency Issues**

Things do not always go as planned. For example, even when a person has executed a valid health care power, the person authorized to make decision may not be around and no one may know the power exists.

That is why hospitals have the authority to provide emergency care, even if a person is unconscious and unable to consent to treatment. Certainly a hospital would prefer to have the consent of a family member or “fact attorney”, but emergency care can be provided anyway. In fact, hospitals have a general duty, by law, to provide emergency care where a person is able to consent or has no insurance.
Organ and body donation is an important contribution to society. However, unless a dying person has clearly indicated intentions to allow transplant, hospitals will not proceed.

**Good Samaritans**

People who in good faith administer emergency aid are not liable for any act of error or omission.

Good Samaritans who, in good faith, offer to help someone and in the process is injured or killed is entitled to make a claim to the state to cover losses.

**Parent Liability for Children**

Ordinarily, parents are not liable for the negligent or clumsy acts of their children unless:

1. The act is willful -- A $10,000 limit exists for medical, dental or hospital expenses / $7,500 for school and teacher damages / $500 for stolen or damaged library books
2. A gun was used -- Up to $30,000 per person in a willful death claim, $60,000 maximum.

**Deceptive Advertising**

False or misleading statements can be punishable by up to $2,500 or six months in jail. Here are some guidelines:

- Packaged goods must list the packaged price. Large print showing the price of only one item is misleading.
- Rebate ads must not show the rebate price without indicating that the product must first be purchased.
- "Former Pricing" must fairly represent the former market price.
- An owner who runs an without a "limit" must allow the purchaser to buy as many as he/she wants.
- An owner must have "reasonable" supplies on hand before advertising "limited quantities".
- It is illegal to "bait and switch"
- Items advertised as "new" or "high quality" must indeed be so.
- Claims of "Made in USA" must be accurate.

**Mandatory Insurance**

In some states, every driver in must carry auto insurance with a minimum coverage, e.g.:

1. Bodily injury $15,000 per person / $30,000 per accident
2. Property damage -- $5,000 per accident
3. Liability coverage to insure against someone else operating the vehicle and damage a driver causes to property

Drivers may be required to show proof of insurance if involved in an accident or cited for a moving violation.

**Co-Signors**

Co-signors are liable for loans and other debts. However, the Federal Trade Commission now requires a disclosure statement be given prior to signing to disclose the full extent of obligations and risks.
**Bad Checks**

Recipients of bad checks may collect up to three times the original amount by demanding full repayment of the bad check by certified mail within 30 days. If no payment follows, a suit for up to three times the original amount can be started.

Many people endorse the back of checks with the words "payment in full". However, the recipient of this check can merely strike out the words "full payment", cash the check and sue for the balance. To protect against this, a letter must first be sent and indicate that a "full payment" check will be mailed. After 15 days, but no longer than 90 days, a second letter (with the check attached) states "This check is mailed to you in accordance with my letter of _____ (date). If cashed, you agree that my debt is payment in full".

**Tree Limbs & Roots**

The location of the trunk of a tree determines who owns it. However, adjacent property owners have the right to cut off branches and roots that stray onto their property. Damage beyond these rights may result in fines of three times the actual monetary loss.

Trees that are unsound and cause damage to surrounding owners can represent liability on the basis that the owner was negligent. The courts believe that owners must know or should have known that damage was likely.

Similarly, tree roots that spread to an adjacent neighbor and cause damage are considered a private nuisance creating liability for the owner of the tree.

**Blighted Property**

Blighted property is property that has been allowed to fall into a state of disrepair. Certain city ordinances will require the maintenance of such properties when it creates a danger to people around or is considered an eyesore that is reducing neighborhood property values.

**Fences**

Most municipalities place height restrictions on fences. These restrictions can also apply to “natural fences” such as rows of bushes or trees. Restrictions may also set forth setbacks that fences must maintain from sidewalks or streets. Fences may also be classified as a hazard to the general public where they interfere with someone else’s use of their property or they diminish or block the view from a driveway or intersection.

**Weeds & Rubbish**

Unsightly weeds and rubbish may be classified as health problems because they encourage the breeding of insects and rodents or because they are fire hazards. Violations and fines to clean-up weeds and garbage may be enforced by fines added to the property tax bill.

**Noise**

Noise regulations are enforced by local police, landlords, associations and courts. Excessive, unnecessary and unreasonable noise are considered a public nuisance which can result in money damages. State laws also define excessive and deliberate noise violations as disturbing the peace or disorderly conduct . . . a crime punishable by fine or jail or both.

**Attractive Nuisance**

An attractive nuisance is a potentially harmful property that is interesting enough to lure a child to investigate. Swimming pools or fountains are good examples as are ordinary objects like
running autos, lawnmowers, open wells, etc. Natural conditions such as lakes or steep bank may not be considered attractive nuisances if they were not created or maintained by an owner. Lawsuits surrounding attractive nuisances focus on whether the owner should have known that children were likely to come on the property and/or were there reasonable precautions the owner could have taken to prevent injury.

**Obstruction of View**

General common law holds that a property owner has no right to a view. Yet some cities have adopted view ordinances which may protect an owner obstruction of view -- usually from growing trees. Rarely do these ordinances restrict structures or buildings that limit an owner’s view.

**Boundary Lines**

Surveys are the only way to legally determine boundaries. However, when all parties agree, these boundaries can be changed by using a quitclaim deed. **NOTE: THE TRANSFER OF EVEN A SMALL SLIVER OF PROPERTY TO SOLVE A BOUNDARY LIEN DISPUTE CAN CAUSE A LENDER TO CALL HIS LOAN DUE. CHECK WITH THE LENDER BEFORE TRANSFERRING ANY PROPERTY.**

**Dog Bites**

Regardless of the condition of the pet or the situation causing a dog to bite someone, the owner is at least liable for the injury.

To sue for more, the injured party needs to prove that the owner knew the dog was vicious or had vicious tendencies and/or the owner was negligent, e.g., violating the leash law by allowing a dog to roam free. Owners may be excused from the higher liability if the injured person was found to provoke the animal.

An owner must pay damages caused by a dog harassing livestock. The livestock owner who finds a dog in the act of harassment may kill the dog without liability.

**INSURANCE LAW**

**Risk**

Insurance is the single most effective device for reducing or transferring risk. The sole purpose of insurance is to provide indemnity for a loss.

The basis of insurance risk is the law of large numbers. This assumes that NOT everyone in a group of insureds will have a loss all the time. Further, insurers predict their experience of loss based on actual losses that have recently occurred.

**Liability**

The purpose of insurance is to shift the risk of a financial liability loss from the insured to the insurance company. However, this does come without restrictions or policy limits.

Policy limits may be expressed per person (how much will be paid for injury to any one person for an occurrence), per occurrence (losses occurring at a specific time or place), per accident (losses for a specific time and place). There may also be aggregate limits which place a limit for all losses occurring during a policy period.

Insurance will also include exclusions and conditions. Typical exclusions may deny coverage in instances where the insured damaged his own property or where other coverage is already in existence. Conditions to coverage may include cancellation for non-payment, misrepresentation,
fraud or the lack of duty to keep the premises safe after a loss.

**Contracts**

Contracts create the need for many types of insurance. Surety bonds, for example, guarantee that someone will faithfully perform what he or she agreed to do or pay as agreed. Business and professional liability coverage protects many parties for the unexpected losses that happen in the process of fulfilling contracts. Commercial property insurances pay for replacement or repair or premises or property to keep contracts legal. And life and credit life payouts help businesses and individuals complete contractual obligations.

The basic principles of contract law are applicable to insurance contracts. When someone buys an insurance contract, for example, a promise to pay the insurance company a specific amount of money or consideration within a specific period of time is exchanged for a promise to provide compensation from the insurance company upon the loss of a certain event.

Why is it important to know what constitutes an insurance policy? Because a contract defined to be insurance is subject to insurance regulation. Consider a nonrenewable service contract from an appliance manufacturer who agreed to maintain his product and replace parts for a specified period. This is NOT an insurance contract because it excludes loss by external causes (fire, theft, etc). On the other hand, a newspaper once offered to pay a sum of money to the heirs of anyone who was killed while holding a copy of the paper. Courts ruled this IS insurance. The newspaper withdrew the offer in lieu of securing its insurance charter.

**Principles of Insurance Contracts**

To be enforceable, an insurable interest must exist (John cannot take out insurance on Bill's car if he has no financial interest -- no insurable interest) and BOTH parties must extend absolute good faith. In addition, there must be an offer and acceptance, there must be competent parties, a legal purpose and consideration. Further, insurance contracts are unilateral (an act of payment is exchanged for a promise to pay) and conditional (the insured must meet certain conditions to collect).

Property, liability and health insurance policies are contracts of indemnity (compensating the insured for only the amount of the loss). Life policies, however, pay a specific amount and are NOT contracts of indemnity.
Life insurance is always in writing, but casualty is often verbally accepted over the phone. Eventually, a written document is produced. An agent wishing to review complete terms and conditions prior to committing the client can request a specimen policy from the insuring company.

Because insurance companies do a large volume of business over wide areas, their policy contracts are standardized. This method of business operation usually means that the insured must accept a given policy or do without insurance. That is why insurance is a contract of adhesion meaning that terms of the contract have been written by one side. The remaining party is agreeing, knowing that the insurer as prepared all terms of the contract.

Insurance policies are also executory contracts which are obligations to be consummated some time in the future based on a certain act or occurrence. Further, they are aleatory contracts where equal value is NOT given by both parties. This is because the insured may stand to receive far more in benefits (proceeds of a policy) than he/she pays out in premiums.

Typical insurance contracts include sections devoted to declarations, conditions, exclusions and insuring agreements.

Briefly, declarations include the names, addresses and premium amounts. Conditions refer to the procedures to follow when an event occurs. Exclusions establish the acts that do not apply to the policy and insuring agreements outline the promises to pay upon certain events.

**The Meaning of Insurance Contracts**

Typically, words employed in contracts of insurance will be interpreted not by what the insurance company intended the words to mean, but what a reasonable person in the position of an insured would have understood them to mean.

As simple as this sounds it can get complicated, especially when misunderstandings arise due to the “language barrier”. In *Parsaie vs United Olympic Insurance* a client prevailed against an insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, no intent by the insured was found.

**Commencement of Coverage**

Exactly when an insurance policy takes effect can be a gray area of the law. Only a written binder can provide clear evidence of an understanding between the parties. However, when a prospect says "I want it" and an authorized agent says "you have it" a legal oral binder has been executed so long as the remaining conditions of consideration and legal purpose are met.

Property & casualty agents typically have the power to bind. Life and Health do not since they are considered to be soliciting agents and not contract writing agents. However, life agents can accept a premium payment and issue a conditional receipt which generally provides limited coverage when certain procedures have been followed (medical exams, blood tests, etc) Until that time insurance is NOT in effect.

Compared to binders, policy declarations are very precise as to when they take effect. A policy stating a start time of 12:01 A.M. on the date the policy commences and ending at 12:00 noon or 12:00 midnight the date it ends is specific. There is NO such thing as a grace period. Losses suffered outside of these times are simply not covered.

**Policy Changes**
After an insurance policy is issued, it can only be changed by rider, endorsement or amendment. Policyowners must be aware of and accept the changes as well as receive a copy of the contract change.

Further, most policies include a change clause which state "only the president, vice president or secretary of the company have the authority to alter the contract or waive any of its provisions.

**Premium Rate Changes**

Life insurance contracts usually offer new policy guarantees on how long rates will be fixed and another schedule showing the maximum annual premium. After that period, the insurer may charge any amount less than or equal to the maximum premium. Rate changes must be equally applied across classes of policyholders and are rarely adjusted more than once a year.

Casualty contracts may institute rate increases within 60 days of an insured event (loss by fire, an accident, etc). After that time the insurer may not change the premium during the policy period.

**Breach of Insurance Contracts**

Terms of an insurance contract may be breached allowing the insurance company to deny benefits under the following conditions:

- **Breach of warranty** -- the insured did not do something he promised to do like keep his premises in safe condition.

- **Misrepresentation** -- the insured lied about being a smoker

- **Concealment** -- the insured committed bad faith by falsely claiming a fence was built around a pool when none existed.

In some instances, insuring companies grant insureds or limit themselves to stipulated period of time to uncover facts. An incontestable clause, for example, gives the insurer a period of time (about two years from issue) to find fraudulent facts in an insured's application. The suicide clause, invokes cancellation of the policy if the insured commits suicide within the first two years of the policy.

In casualty policies, the issues of misrepresentation and fraud are handled by warranties and waivers. A warranty is a condition of the policy that certain standards be adhered -- water pipes be drained each freeze. If a claim was filed and an inspection revealed this was not done, the insurer can void the policy contract. Waivers allow the insurer or his representative to knowingly overlook a condition that may have led to a cancellation or a denial of coverage from the outset.

Other parts of insurance policies set further conditions that must be met before payment or coverage of the contract can be released. A partial list might include surrendering the policy, a death certificate, timely notification of a claim, protecting the property, making the property available for inspection or meeting deductible and coinsurance payments.

**Cancellation**

Life, annuity and health insurance policies come with a 10-30 day examination period. During this "free-look" period, an unsatisfied policyowner may cancel the contract for a complete refund.

Additionally, most insurance contracts may be cancelled by the policyowner anytime before it expires. This is typically transacted by a letter from the owner answered by a request from the insurance company to surrender the policy. The insurance company will return to the policyowner any unearned premium (payments that have not been used up) and/or the cash value in the case of whole life type
insurance and annuities.

Insurance companies do not have the same freedom to cancel out policyowners. Non payment of premiums, concealment of false information or a major change in risk (a driver's license is revoked) are reasons for cancellation. However, a casualty insurer has the right to reject an application for coverage during the first 60 days after giving at least 10 days notice. Also, many disability and health insurers provide for cancellation rights for a specific class of policyholders (obviously to account for excess claims in one class over another).

Otherwise, and if the policy does not provide for guaranteed renewability, the insurance company must wait until the policy expires or renews to cancel.

Claims

Claim disputes in consumer law have many applications to insurance products and the agent. People buy insurance in anticipation of losses in hopes of avoiding claims and courts. And, the industry has responded with an almost limitless supply of coverages: from life, health and disability to property and casualty of all types and sizes.

Most often, it is the presence of an insurance carrier that settles a claim before it reaches major proportions. Thus, the insurance industry plays a very important "third party" role in everyday law.

Claims may also be "direct" between insurer and the insured. Generally, there are two types: Friendly claims and disputed claims

**Friendly Claims.** Those in compliance with the terms of the insurance contract -- such as submitting a claim for the payment of death benefits by submitting proof of death. The insurance company agrees to pay this claim within two months and all is settled.

**Disputed Claims.** One of the parties has disagreed with the payment or extent of coverage. In the case of the latter, the procedure is very different from consumer claims. The first hope in a situation where a dispute between an insured and an insurance carrier cannot be resolved is for settlement by internal remedies such as informal complaint from the insured to the insurance company (a letter to the company president or department supervisor) or binding or nonbinding arbitration (some policies stipulate this to be a means of settlement).

Most policies provide an additional "built-in" settlement device which can require the insured to assign all rights of recovery to the insurance company. This is called subrogation. It occurs when an insured has been damaged by another party who is clearly at fault but refuses to pay. The insurer may step in and pay his insured and then proceed against the party that did the damage by the right of subrogation -- transferring the right of recovery from the insured to the insurer.

Where a dispute cannot be settled by either of these means, legal claim by lawsuit may result. Again, there are typically two avenues:

**Breach of contract** -- a request to the court to compel the breaching party to comply under "specific performance".

**Bad-faith litigation** -- this is also called "suing in tort" and can result in damages far beyond breach of contract since a violation of the covenant of good faith and fair dealing has occurred. There are two types of bad-faith cases:

1) **First-party cases** -- where an insured and insurance company are dealing direct and one party has withheld benefits or compensation.

2) **Third-party cases** -- where an insurance company has settled a suit in a less than favorable way
leaving the insured exposed for more damages.

Issues that arise in claims against an insurance company include the following:

Waivers allow the insurer or his representative to knowingly overlook a condition that may have led to a cancellation or a denial of coverage from the outset. Consider an insured who operates an informal carpool from time to time. The agent explains that the practice is permissible, or perhaps the agents says nothing, issues the policy and collects the premium. When a claim occurs, it is likely the insurance company may deny the liability based on the exclusion of using a personal auto for public conveyance. The principle of estoppel would prevent the insurer from withholding payment in that the agent's actions constituted a "waiver" of the exclusion.

**Parol evidence** refers to any evidence, whether oral or in writing, which is extrinsic to the written contract. Under this rule, insureds may introduce information that convinces the court that an agent or representative of the insurance company changed the written contract. Since the courts recognize that some agents have the authority to "bind" contracts, their actions may create new contracts beyond the scope of the written document.

**Reformation** of a contract allows the courts to modify a fully executed contract to reflect the parties intentions. Consider an insured who acquires a second house. The agent incorrectly wrote the new house but dropped the first. A fire leaves the first house exposed and the insurer unwilling to pay. The court "reformed" the contract to meet the original intentions of the parties.

Claim settlement disputes represent the most frequent complaints filed with the Department of Insurance. New regulations, implemented January 10, 1997, affect agents and insurers alike.

**Debt & Insurance**

The association of insurance and debt is a long one. Lenders offer credit life or credit disability plans which pay off or takeover payments when debtors die or become unable to make payments. Families have purchased life insurance in order to have the choice to pay off major debts in the event of the breadwinners demise. And business pays for surety bonds to be sure that debts between parties are paid faithfully.

**Creditors**

Creditors have no rights to takeover the benefits provided by disability and health insurance. Further, most cash value insurance and annuities should include a spendthrift clause which prevents creditor access to the principal and payments of these policies. A typical spendthrift clause might read as follows:

"To the extent permitted by law, no payments under this policy shall be subject to the debts, contracts or engagements of the Owner, Insured or of any Beneficiary of this policy. Payments may not be levied upon or attached for the payment thereof"

**Policy Loans & Payment Plans**

Loans from cash value insurance or an annuity establish another debt relationship. Most policy loans set up the policy as sole security for the loan by automatic loan collateral assignment. Loan payments and interest that are not paid by the due date are usually added to any existing loans. A loan balance exceeding cash value may result in the policy maturing. Loans not paid back at time of death are deducted from the death benefit.

Many property insurance policies contain a **salvage clause** which allows the insurer to take title to damaged property after payment of loss. This may help the insuring company reduce or "salvage" a portion of the claim costs.
Periodic premium payments are yet another way that debt works inside insurance. Typically, premium due dates are "drop dead", final due dates which trigger cancellation if not paid. Life, health and disability policies, however, are unique in that a grace period of usually 31 days is permitted. Even though the due date has passed, the insurance remains in effect and the premium can still be paid. If death occurs during the grace period, the benefit will be paid minus the unpaid premium.

**Personal Injury & Insurance**

Claims arising from bodily injury and property damage to others may result from the condition of the insured's premises or the personal activities of the insured. This exposure is typically covered under a general liability policy.

Personal injury liability coverage, however, protects against liability claims for other than physical harm and property damage allegations. It covers claims alleging such intentional torts as false arrest, detention, malicious prosecution, libel, slander, wrongful entry, eviction and invasion of privacy. This coverage is generally available as endorsement to general liability policies.

**Agency & Insurance**

**Insurance Agency Concepts**

The usual rules of agency law are applicable to insurance agents in their dealings with applicants and insureds. An agent binds his principal when he acts within the scope of his authority.

Agency in the insurance industry is granted to an agent by three authorities. **Express authority**, either orally or in writing, which permits agents to countersign, issue, deliver policies, bind or conditional bind. **Implied authority**, not formally communicated, which allows the agent to perform all of the normal duties necessary to sell and service insurance contracts. And, **ostensible authority**, also not written or orally expressed, which is authority that agents are perceived to have by any reasonable person. This includes what a consumer would believe about the agent's ability to bind the policy, either in full or conditionally.

An agent is not personally liable on a contract made in the name of the principal (insurer) where the agent had authority to make the contract; but if the agent had no authority and represented that he did, the agent is liable to the third parties who relied upon his representations.

When an agent and an applicant together work to defraud an insurance company, the agent has voided his duty to imply knowledge to the principal. This contract would not bind the company and open the agent to exposure.

**Agency Structure**

There are many different agency arrangements now practiced.

Some insurance companies choose to be their own agents. These are called no load or direct mail companies. Their business is solicited primarily through advertising or direct mail.

Next, there are "captive" or direct agent companies who hire agents to handle their product exclusively. Since these agents are employed they may be paid by salary or a combination of salary and commission.

An exclusive agency arrangement occurs when an insurance company contracts with various agencies to represent them exclusively in contrast to independent agency arrangements where independent contractor type agents or groups of agents contract with several different insurance companies to sell their policies.
Finally, there are independent agents consisting primarily of individual agents who may represent several insurers and sell as independent contractors.

**Agents vs Brokers**

Agents and brokers are both licensed to sell insurance, however, there is a very important legal difference. Agents represent companies versus brokers who represent clients. The purpose of determining whether an insurance producer was acting as a broker or as the insurer’s agent is to establish potential liability when something goes wrong. An attorney suing an agent will generally proceed against him as a representative of the insurer **AND** as a broker or fiduciary of the client at the same time, thus seeking the deepest pockets available. An agent should be prepared to prove or disprove legal status at any given time.

**Dual Agency**

Wrongdoings outside the agency contract can subject the agent to additional exposure and liability under the banner of “dual agency”. All agents assume some form of dual agency since they first represent the client as agent, then switch to an agent of the company when business is placed. Problems occur, however, when an agent assumes non-agency duties by professing to have special expertise, e.g., financial planner, an auto insurance specialist, a health care professional, etc. This is a more serious and potentially damaging form of dual agency that exceeds the scope of the agency contract and establishes the agent as a “professional” in the eyes of the law. Failure to perform as promised can result in conflicts and litigation.

**Employment & Insurance**

There are many insurance issues that are tied to employer laws. Some are mandatory coverages like workers compensation insurance or legal design requirements of pension plans. More are voluntary like health, disability and life insurance benefits designed to attract a higher quality employee. Even so, these coverages have many legal rules which employers must know. Finally, there are employee issues that require employers to seek out insurance.

Worker’s Compensation is a mandatory requirement of employers to insure against work-related injuries that arise in the course of employment. A proper policy (private or publicly purchased) will help protect BOTH employer and employee. This is an extremely specialized area of insurance, but suffice to say, policies must cover injuries connected with work, occupational illnesses (those that are the gradual result of work conditions -- stress, toxic exposure, etc). In addition to medical benefits, employees are entitled to wages while off work. This can amount to about 2/3 of gross weekly pay for temporary conditions and about $150 weekly for permanent disability.

**Benefits Discrimination**

There are many employee benefit programs that involve insurance products. The Equal Employment Opportunity Commission is the federal enforcement agency that reviews employee discrimination including benefit programs involving insurance products. Most benefits legislation applies to companies with 20 or more employees. However, all employers should avoid discrimination practices such as unequal benefits by age -- the Older Workers Benefit Protection Act outlaws discrimination of employee benefits for anyone over age 40. The Equal Pay Act is federal legislation that requires employers to make equal pay for equal work, including fringe benefits like pension retirement plans which use insurance vehicles.

As of this writing, employers are not required to offer health insurance coverage to employees. However, health insurance provided for one employee **MUST** be available to all other employees in the same company. The most sweeping rules apply to employees that are terminated, their spouses and dependents under the **Health Insurance Portability and Accountability Act of 1996 (HIPPA)**.

HIPAA generally covers health care plans with at least two participants who are active employees of
single-employers, multi-employers, and collectively bargained units. Generally, the statute allows individuals who leave their employers to keep health care coverage or obtain new coverage, regardless of any pre-existing medical conditions.

Under HIPAA, the maximum pre-existing condition exclusion period that any group health plan or insurer may require for new enrollees is 12 months from the enrollment date or exclusion. This period is increased to 18 months for late enrollees. Group health plans and their insurers must reduce this pre-existing condition limitation period by the individual's aggregate period of previous health insurance coverage. The pre-existing condition exclusion period is reduced by one day for each day of an individual's creditable coverage under a former health plan. As a result, neither group health plans nor their insurers will be able to deny coverage or apply pre-existing condition exclusions to individuals who had prior health coverage for at least 12 months. The credit for prior coverage is lost, however, if an individual went 63 or more days without coverage.

Each employer or health care issuer is responsible for providing to terminating employees, their spouses, and dependents certificates evidencing their period of health coverage under that employer's health plan. Certificates of creditable coverage will have to be provided automatically upon certain triggering events. These events include when an individual loses coverage under the employer's health plan, when an individual becomes covered under COBRA, and when an individual is no longer covered under COBRA. In addition, certificates will also have to be provided to any former participant upon request within 24 months after coverage ceases.

HIPAA also expanded rights under COBRA for certain individuals. Under the new law, the definition of a qualified beneficiary has been amended to include a child born or adopted during the COBRA continuation period. This law also requires that qualified beneficiaries be permitted to change coverage status from individual to family upon the birth or adoption of a child under the same terms as are applicable to active employees. In addition, the new law expands the scope of the extension applicable to disabled employees and their dependents. Under the former law, an employee and his or her dependent could extend their COBRA coverage for an additional period of 11 months if they became disabled at the time of the qualifying event. The new law permits use of this extension for any employees and their dependents who become disabled during the first 60 days of the 18-month COBRA coverage period.

These changes have been effective since January 1, 1997 and notice of these changes was to have been given to all COBRA beneficiaries no later than November 1, 1996. Employers who have not taken steps to comply with these changes should take immediate steps to do so. Group health plans and insurers that fail to meet the requirements of the new law may be assessed a penalty of $100 for each day for each individual affected by the failure. Moreover, there is a minimum penalty tax where the failure is discovered after a notice of examination. This tax is equal to the lesser of $2,500 or the amount that would be determined under the $100 per day rule. Significantly, the $2,500 is increased to $15,000 if the violations for any year are more than de minimis. Under any circumstances, the maximum penalty is $500,000. Because of the potential liability involved, plan sponsors should take appropriate measures to amend group health plan summary plan descriptions and to assure the proper establishment and implementation of procedures for tracking and certifying periods of creditable coverage.

Pension Plans

While there is no law that requires an employer to provide a pension plan there are specific benefit rules that apply once one is established. Since many insurance products have long been associated with pension planning, they also fall under specific benefit rules.

An employer may offer qualified and non-qualified pension plans to employees.

Qualified plans must meet specific IRS requirements to qualify for tax benefits. For example, if a
company decides to offer a qualified pension plan to its employees, the Employment Retirement Income Security Act (ERISA) requires a plan document and an annual statement showing each employees pension benefits earned if requested by the employee. Plan documents must also spell out details of the plan and when an employee will be eligible for benefits as well as how to claim them.

**Discrimination** is probably the single most important factor when establishing qualified plans. Plans do not have to include all workers but must be laid out fairly to include a cross section of employees. Qualification to participate in plans may be set, including limitations on age and length of employment. Benefits that favor of officers and highly compensated managers are prohibited.

The hope of many companies is to use insurance to incorporate pension benefits and accomplish certain business agendas like the business buyout of a dead partner. Life insurance inside a qualified plan has been offered as a widespread solution. Unfortunately, IRS certain limits apply which limit the amount of life insurance purchase under the assumption that life insurance coverage should be "incidental" to other benefits provided by the plan. To accomplish this, the amount of death benefit is limited to 100 X the monthly pension benefit within defined benefit pensions. Defined contribution and universal life insurance have limits of 50% and 25% respectively. Nonqualified pension plans do not possess as many tax benefits as qualified plans. Examples of nonqualified plans would be IRA’s, annuities and deferred compensation plans. There are also fewer discriminatory rules.

In recent years, "personal pension plans" have become more prominent in business circles. *(Although these plans function identical to a pension plan, agents should know that there have been significant consumer protection pressure and in some cases penalties for not disclosing that "insurance" is the basis of this concept.)* These plans utilize a universal life product that is funded by the employee monthly. There are NO discrimination rules and NO IRS filings so long as all employees have equal access to belong to the plan. Highly paid executives of corporations can use Section 162 bonus deductions to fund monthly investments of just about any size in contrast to line employees who may wish to make no contributions.

Personal pensions can be added to any existing plan and accumulate tax deferred to values beyond traditional retirement vehicles. Tax favored withdrawals at retirement and "automatic completion" of the plan if the employee dies early are two of its benefits. To maintain its life insurance status, the primary limitation is that the maximum excess premiums that can be deposited into the fund can be no more than 5 X the original monthly premium. However, 1035 tax free exchanges of existing cash values can be transferred into the fund at inception.

**Ownership & Insurance**

An almost endless variety of property can be insured from tangible, intangible, real and personal. Coverage can be specific, designating a particular item, or blanket. Blanket insurance may insure property at one location or ALL of the insured’s property at multiple locations. Property insurance contracts are also designed for fixed coverage at a specific property or floater coverage which moves to protect insureds at various locations.

Additional issues focus on scheduled coverage which set a limit of reimbursement for each piece of property versus unscheduled coverage where one limit applies to all property. For the first half of this course, we explored property and casualty practices, industry trends and specific business law issues that effect your everyday dealings with clients and insurers. Now we would like to turn our focus to issues of marketing. Specifically, your legal responsibilities as an agent, ways you can reduce conflicts in your business and why you may need to counsel your clients to look “beyond insurance”.
LEGAL ISSUES OF MARKETING INSURANCE

We are discussing the legal side of marketing insurance because more often than not the line between legal responsibility and agent misconduct is often thin. Few agents can say they have never “crossed the line”. . . went out on a limb for a client . . . looked the other way or fudged just a little when selling or serving a client. These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong an agent’s biggest fear comes true. . . a malpractice lawsuit. Anyone involved in one can tell you its a living nightmare. Beyond the financial liability, victims are dragged, kicked and punched through the legal maze known as our “justice system”. It is the domain of judges, attorneys and plaintiffs, a place no one cares to revisit.

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

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

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

Even if you are lucky enough to avoid a claim for now, every time another agent is sued, it gets closer to you because our court system makes legal decisions based on precedents. Litigation experts believe this system is destined to expand liability to higher and higher levels because each decision in the chain sets the stage for the next step of expansion. For example, the recent Southwest vs Binsfield (1995) case decision automatically creates added exposure for MOST agents, i.e. a legal precedent is established. Agents who fail to comply, are potentially closer to a lawsuit than others. This, coupled with the willingness of judges and juries who sanction the expansion of legal theories in our courts, means that liability gets closer and closer to you for smaller and smaller violations. As a matter of fact, you will learn from these pages that you can be held responsible for matters related to the fact that you are a licensed insurance agent and your client is not! You will also learn that the root of most agent conflicts lies in the inability to understand statutory and fiduciary duties. When you know what is expected of you, proper legal and sales conduct can be followed and conflicts minimized.

Later, you will hear about the “blunders” agents have made and how insurance conflicts boil to the surface. Don’t panic if you suddenly discover that you have made some of these same mistakes . . . most agents are guilty of something. However, don’t believe that because you haven’t been sued you are in the clear. Thanks to our legal precedent system, seemingly innocent events of the past are potential big problems today. To survive it all you need to justify your actions, manage your errors and plan ways to avoid making them in the future, i.e., you must change the way you do business. There are many suggestions and guidelines provided under these covers to help you develop office and sales procedures that may be critical if a lawsuit develops.

Finally, don’t depend on this book to be a universal solution for avoiding litigation or handling your own defense, rather it is a big, bright WARNING BEACON. Study it, learn from it, but get legal advice before taking any action to reduce or defend a possible insurance conflict.

LEGAL CONDUCT FOR AGENTS

The agent of the late 1990’s deals with stiff competition, fast-paced decisions and some very unpredictable insurance markets. To aggravate this condition, we live in an era where courts are very sympathetic to consumers. People feel entitled to seek complete and generous compensation for the smallest problems, even when they are contributors or the discovered source. Furthermore, the consumer of our time has lost all respect for the status of the professional, any professional. This includes doctors, lawyers, teachers, clergy, real estate brokers, stockbrokers and insurance agents. Few would think twice about suing any one of these professionals to receive satisfaction for an honest mistake, let alone one leading to a financial loss or injury. Understanding this, it is easy to see that the selling of insurance can lead to conflicts and legal disputes.

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

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

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

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

Agents who have never been sued are sometimes lulled into believing that the way they do business must be working. Unfortunately, this ignores the real possibility that the same events of the past, that weren’t a problem, can now become a problem. It is a world of legal rights and little trust. The long-term client who you trusted, can change. Also, regulations change, industries change, economies change and no one can really keep up or control every aspect of their present business, let alone the future. Can you imagine, for example, the changes that will occur over the life span of a whole life policy between today and when it endows in fifty or sixty years? Will a state or federal regulation change the way automobile or health policy benefits are triggered? Will the IRS retroactively disallow tax benefits for a an annuity contract or single premium policy you sold three years ago?

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

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

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

LIABILITY BASED ON AGENT DUTIES AND STATUS

The most critical questions in determining agent liability is the extent to which accepted legal standards, state licensing and agency status obligates the agent. This process involves the investigation of many areas, including: Basic Agent Duties, The Law of Agency, Producer’s Status (relationship to the client/insurer) and the classification of the producer as Agent/Broker or Agent/Professional.
Basic Agent Duties

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

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

Agents are not required to obtain “complete” insurance protection for clients but may need to explain widely available options, gaps in coverage and in some cases monitor policies after the sale.

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

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

An insured is entitled to rely on an agent/broker’s advice on the content and meaning of policy provisions. In Perelman vs Fisher – 1998, the insured sued an agent for not informing him about the lack of cost of living benefits even though the agent advised the insured to review the policy which clearly did not provide it. In Stivers vs National American Insurance - 1957, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent “is in patent conflict with the terms of the policy”.

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

Knowing the specifics between different policies in an agent’s own product line is a legal responsibility that can’t be ignored.

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

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

Another area of legal conduct involves the Law of Agency.

The Law of Agency

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

An agency relationship begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be created by contract or agreement or it can take the form of casual mutual consent. What is interesting about the business of insurance is that most agents start out as an agent for the client, when coverage is requested, and then become an agent for the company, when business is placed. As you will see later, the exact status you occupy when a problem occurs affects your liability exposure.

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

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

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

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

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

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

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

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

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

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

**Insurance Producer Status**

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

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**When disputes occur and agency is not clear, the courts generally lean to the assumption that an “agency relationship” exists to establish links to the “deep pockets” of the insurer.**

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

In cases where the producer’s status is unknown at the time a problem occurs, the courts have the difficult task of trying to determine who initiated the relationship. Here again, when in doubt the law leans to the assumption that the majority of insurance transactions are agency relationships even though the client may have called the insurance agent first. Otherwise, the mere fact that clients request coverage . . . which they do in virtually every instance . . . would establish a principal-agent status every time. The courts feel this is NOT an appropriate conclusion.

A huge problem for agents occurs when they act as principals, when, in fact they are not, or when they have neglected to identify the principal, i.e., an undisclosed principal. An agent who advises a client that he is covered, with knowledge that the intended insurance company has not yet agreed to accept such coverage acts as the insurance company until coverage is accepted, i.e., the client has FULL REcourse against the agent for any uncovered loss. If it can be proven that it was reasonable for the client to assume that the agent actually had real authority to act for the principal, the client can hold the insurer to the contract, even when one did not exist *(Stock vs Reliance Insurance Company - 1968)*. The client who incurs coverage shortfalls is in a much better position to recover from the agent where a principal (insurance company) is NOT disclosed.
Of course, a **written disclosure agreement** indicating that the agent was a representative of the insurance company, acting as principal or not disclosing the principal for a specific reason would go a long way to clarify that the status between the agent and client, or agent and company. In commercial insurance transactions, agents go to great lengths to “clear the air” concerning agent status by using a **broker of record** letter. These letters authorize or terminate agency and stand as proof of evidence that an agent is representing the client/principal or “out of the loop”.

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**In a dispute, agents should be prepared to prove their agency status. A disclosure agreement between agent and client could help establish an “agency relationship” vs the higher liability of a “principal-agency” or broker relationship.**

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Company and as principal to the client in the form of an “expert or consultant”. As you will see, outside activities such as these create additional liability. Further, it is doubtful that the court will care whether an agency status or agent-principal relationship actually existed because wrongdoing will be actionable against any agent acting as a principal. Additionally, claims of this nature are difficult for agents to defend and NOT typically covered through errors and omission insurance.

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

**Agent vs. Broker**

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

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

An insurance **broker** is "a person who, for compensation on behalf of another person, transacts insurance, other than life with, but not on behalf of, an insurer”. Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer’s agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file.

In **Kiotas vs Life Insurance Co of Virginia – 1998**, the agent was deemed to be a “broker” representing the insured to obtain the most suitable and affordable life insurance from among various insurers. Specific rules that determined this status included: 1) who set the agent in motion (who called the agent); 2) who controlled the agent’s actions; 3) who paid the agent; and 4) whose interest did the agent represent.

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

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

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

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

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

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

Agent vs. Professional

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

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

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

If you are somewhat confused about this agent / professional controversy you are not alone. There are
many agents of professional status, such as CLUs, CPCUs, CICs, AAIs, ARMs
and more, who practice **due care** for all the right reasons. Most stay clear of conflict by managing it.

There may also be an entire army of extremely qualified agents who stay clear of professional
designations for fear that the added exposure can’t be managed. Perhaps there is room toward the
middle. A position we call **responsible agent**. These individuals also practice due care, yet operate
strictly within the bounds of agency. They accurately describe policy options that are widely available,
but “pass” on outside inquiries, not because they don’t know, rather the request goes beyond the
scope of their authority. They do not profess to be experts but know their product better than anyone.
Their goal is simply to be the most responsible agent possible.

**CONFLICTS THROUGH CONTRACT DISPUTES**

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

**Failure to Act/Procure Coverage**

This is one of the most important areas of agent/broker liability because an estimated 60 percent of
all claims result from agent malpractice in failing to procure coverage. In a typical
transaction, a broker or agent
agrees to procure a certain
**type of coverage for an
insured.** It is well established
that the broker has a duty to
**exercise reasonable care** in procuring that coverage. Consider the following cases: (**Jones vs
Grewe - 1987**) -- a failure to actually procure coverage; (**Keller Lorenzo Company vs Insurance
Associates Corp - 1977**); -- a failure to perform some function related to the insurance coverage or
a failure to see that policy was actually provided (**Port Clyde Foods vs Holiday Syrups - 1982**); or,
failure to forward premiums to prevent lapse (**Spiegal vs Metropolitan Insurance**). In general, when

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*An agent who professes special expertise establishes “dual agency” and assumes additional liability exposure to both his client and insurer.*
an agent negligently fails to obtain coverage for a client, he steps in the shoes of the insurance company and becomes liable for loss or damage the limits of the policy until insurance is found (Robinson vs J. Smith Lanier Co - 1996) and (Blumberg vs Paul Revere Life – 1998). Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate (Hamacher vs Tumy - 1960).

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

**Failure To Notify Lack Of Coverage**

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

**Failure To Place Coverage At Best AvailableTerms**

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

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Brokers have a higher standard of duty to place coverage at the best available terms.

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**Failure To Renew / Notify**

If an agent has a history with a client of automatically and voluntarily renewing or reminding them to renew a policy, he can assume exposure for the “one and only” time he forgot (Siemorama vs Davis Manufacturing Co - 1988). With the trend toward “direct billing” of clients by insurers, agents are not as close in contact as before. However, agents may still have renewal responsibility if the client depended on this service in the past.

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

**Policy Promises & Provisions**

Agents should ALWAYS review client policies and retain "specimen policies" on file to answer prospect/client questions and compare with policies received. In most states, agents are legally bound to accurately describe the provisions of policies they procure for their clients (Westrick vs State Farm Insurance - 1982) and point out the difference between different products he is selling Benton
Agents are legally bound and responsible to accurately describe the provisions of policies they sell. Many lawsuits have been pursued on misunderstood policy time limits which restricted the clients ability to perform or file a claim. Agents can easily become a focus of these dispute. Another misinterpretation might be: What is an "accident" defined to be? An insurer may deny a claim for lack of requirements establishing an "accident". Or, what is "reasonable medical treatment"? Some agents might be taught NOT to volunteer information on an issue such as this. But, insurers and agents have a fiduciary duty to their insureds to disclose full and complete information. Failure to do so may result in a claim of fraud (Ramirez vs USAA Casualty Insurance Co - 1991). Overall, an agent can reduce his exposure by knowing that his policy contains clear and unambiguous descriptions (Dahlke vs John Zimmer Agency – 1997).

Agent Promises

From time to time, agents make promises that EXCEED what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverages and exclusions. Agent liability also existed in a case where a producer promised to arrange "complete insurance protection" for a business or where an agent promised, but never did, to evaluate an appraisal of an individual's property or to determine its "insurable value" in order to insure a certain percentage of that value. In Blumber vs Paul revere Life – 1998, the agent went so far as to market guaranteed disability insurance to a company regardless of previous medical history. He was found liable for covering new employees. Additionally, an agent might promise to implement or increase a client's coverage "immediately" yet actual coverage might not be in force for 24 hours or until expiration of the existing policy. Less obvious, but equally as serious, are failed promises. A recent example is the marketing of "personal pension plans". Clients, who were promised a "pension plan", received a universal life insurance policy. Agents involved in this scheme are now subject to huge fines, client actions and possible license revocation.

Advertising Promises

Advertising violations are among the most costly mistakes. Regulators have been known to levy stiff fines of $1,000 or more per violation. In other words, 1,000 non-compliant flyers distributed in the mail or otherwise could amount to a fine of $1 million or more ($1,000 X 1,000 flyers). We have devoted an entire section advertising in the chapter titled CONSUMER PROTECTION ISSUES YOU CAN'T IGNORE. By contract, agents are required to secure company approval of all advertising. Few agents, however, would think twice about scrutinizing company provided ads. However, it is suggested that agents carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy. For example in Cunningham vs PFL Life – 1999, information from the insurance company and agent touted life insurance policies as investment vehicles. The insurance company was ultimately held liable for claims for failure to train and supervise its agents. Most violations of this type would probably not be actionable against the agent, but may name the agent nonetheless or may establish some form of "alleged" agreement that binds the agent / insurer.
What Policies Say vs What They Mean

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

Client Understanding and Reading of Policies

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

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

Minimum Standards

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

CONFLICTS CREATED BY AGENT TORTS

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

Negligence & Misrepresentation

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

**Bad Faith**

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

Agent negligence, bad faith and misrepresentation are proved in court using “expert witnesses” who testify that the accused agent acted outside the standards of other agents working in the same field.

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

In the property/casualty arena, many bad faith issues surface under the title of "claim avoidance". Some agents play judge and jury with client claims by advising them to NOT submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a breach of his fiduciary duty to the insured as well as a breach of the implied-in-law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages (Independent Life & Accident Ins Co vs Peavy - 1988).
CONFLICTS CREATED BY CLIENT/AGENT RELATIONSHIPS

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

Contributory Liability

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

In fact, plaintiff attorneys have and continue to develop legal strategies that establish contributory liability of agents by multiple approaches, including:

Lack of Client Knowledge

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

Improper Advertising

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

A higher standard of care is automatically assumed by agents who profess to have special knowledge, particularly when their clients blindly and substantially depend on them for their insurance needs.

Dual Agency

In many insurance transactions, the agent can generally be shown to have acted as a "dual agent" -- representing BOTH the insurer and client. As such, he owes a duty to exercise due care and reasonable diligence in the pursuit of the client's insurance business regardless of the insurer chosen or represented by the agent.
Errors & Omissions Insurance
The availability and wide subscription of errors and omissions insurance for agents creates an argument that agents can be liability targets in any insurance disputes. In some cases, the absence of errors and omissions coverage has practically absolved the agent of liability where attorneys assume there is nothing to go after. But, who wants to risk going bare in this market?

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

Agents as Fiduciaries
New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable “deep pocket”. A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent’s contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent’s liability as a fiduciary simply comes with the territory... it’s part of selling insurance. In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies (Glenn vs Leaman - 1983). Other fiduciary related liabilities relate to an agent’s duty of care. These cases even rear-up in a one-time business transaction, i.e., you don’t have to be a longstanding advisor to be liable. More often than not, the issue of fiduciary exposure surfaces where an agent proposes a “full coverage” policy but failed to describe a certain provision or exclusion that existed in the written policy (Eddy vs Sharp - 1988). In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have special “expertise” where the client is unsophisticated (Sobotor vs Prudential Insurance -1984) / Kurtz vs Insurance Communicators-1993) / Cunningham vs PFL Life – 1999, or when an agent promises to provide “complete coverage” (Magnavox Co of Tennessee vs Boles & Hite - 1979) The exposure also seems to exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer. (Glenn vs Leaman & Reynolds - 1983).

Another area of fiduciary responsibility concerns disputes dealing with Employment Retirement Income Security Act (ERISA) qualified funds. Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An ERISA fiduciary has been interpreted to be any person exercising managerial control over the plan or its assets, regardless of their formal titles. In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers be labeled ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries. The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that a commissioned agent who helps establish a retirement plan and recommends products to fund the plan violates these rules? The answer lies in whether the agent is actually deemed a fiduciary. If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary. If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent’s proposals without advice from other consultants, he can be classed as a fiduciary of the plan. On the other hand, where...
the agent is only acting in the capacity of an agent, offering a choice of products from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan "relied" heavily on the agent's advice in the purchase of insurance contracts. In *Brink vs Dalesio - 1981*, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In *Reich vs Lancaster - 1993*, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In *Kerns vs Benefit Trust Life*, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible. In yet another case, a Louisiana district court held that an insurance agent was a fiduciary a profit sharing plan, even though he only *sold* a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is to provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (*Schoegal vs Boswell*), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was "...*clearly more than a mere salesman"*. In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that the insurance transaction does NOT produce the anticipated or desired results for plan participants.

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

**INSURER CLAIMS AGAINST AGENTS**

When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal, (the insurer), *fiduciary duty* of the agent

| An agent is a fiduciary of the insurer and has a duty to exercise reasonable care, skill and diligence. |
prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself (Southland Lloyd’s Insurance vs Tomberlain - 1996). Beyond fiduciary matters, agents are bound to his insurer by other statutory duties. They include Duty of Care and Skill, using standard care and skill; Duty of Good Conduct or acting so as not to bring disrepute the principal, Duty To Give Information by communicating with the principle and clients; Duty To Keep Accounts by keeping track of money; Duty To Act as Authorized; Duty To Be Practical not attempt the impossible; and Duty To Obey or comply with the principal's directions. A violation of these duties can be considered grounds for termination and represent legal exposure for the agent.

Following are some examples:

**Basic Agency Violations**

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

**Misappropriating Premiums**

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

**Failure To Disclose Risk Factors**

An agent has a duty of good faith and loyalty to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss (Clausen vs Industrial Indemnity - 1966). In this case, it was successfully argued that an insurer may obtain indemnity from a broker, if the broker knows or should know that insurer is relying on the broker to supply information about the client; the information furnished is incomplete or incorrect; the incomplete or incorrect information is material to the decision accept or decline the risk; and the insurer is forced to pay a loss under a policy that the insurer would NOT have issued if complete and accurate information had been provided by the broker. In a similar case (New Hampshire Insurance Co vs Sauer - 1978), the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to the agent's negligence. In similar cases the insured sued the agent for failure to ask if the insured had been cancelled (Smith vs Dodgeville – 1997); or failed to indicate a known pre-existing heart condition (Life Investors vs Young – 1999); or failed to accurately disclose a client's prior loss history (Soho Generation vs Tri City Brokers – 1998).

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

Authorities To Bind

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

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

Premium Financing Activities

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

Unfair Practices

Insurers may also lash out against agents under the National Association of Insurance Commissioners "Unfair Trade Practices Law" which many states have enacted. The thrust of this code is contained below.
"Persons (defined to include insurance companies and insurance agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

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

**LIABILITY CREATED BY INSURER FAILURES**

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

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

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

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

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For now, agents are not usually responsible for client losses from an insurer insolvency UNLESS the agent knew or should have known that the insurer was insolvent at the time insurance was placed.

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried and a trend is developing that places greater legal responsibility on agents concerning insurer insolvency. In Wilson vs All Service Insurance, for example, the client commenced a lawsuit in 1975 and even though the agent prevailed, the decision was not rendered until 1979 -- that's four years of attorney and court fees! So aggressive was the client that two different appeals the State Supreme Court were attempted involving more defense fees. One must also ask . . . If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies REFUSE to defend and REFUSE indemnify agents where an insurer insolvency arises?

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the results of a 1971 lawsuit -- Williams-Berryman Insurance vs Morphis, (Ark. 1971) 461 S.W.2d 577, 580. It proclaims the following:
"The agent or broker is required to exercise reasonable care, skill and judgment in procuring insurance, and a failure in this regard may render him or her liable for losses covered by the policy but not paid due to the insolvency of the insurer." What is "reasonable care"? In Wilson v. All Service (above), the fact that the carrier was an admitted company proved to be adequate care. In Higginbotham & Associates vs Green - 1987, however, the courts further clarified:

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

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

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

**Misrepresentation & Insurer Failures**

Insurer insolvency cases against agents may be based on misrepresentations by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds. An even worse situation occurs where an agent knowingly distorts actual capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a detailed investigation of the insurer when, in fact, he did not. Examples where agent liability is not so clear, however, include cases where an agent convinces a client to surrender or cancel a policy from one company for a policy of another company and it is determined that the second insurer is weaker and maybe even be liquidated at some later date. In this instance, the law might interpret the agent actions to be more than just a "usual transaction", where a policy product is simply "sold". Here,
the agent acted more as an advisor. His actions might appear to be assurances that the new company is better than the old company when, in fact it was not, for purposes of generating a commission.

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

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

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

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

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

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

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

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

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

Virtually every state has enacted what are commonly known as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policy owners, wherever located, of insurers domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there. The law in some states, however, limits protection on several fronts: There are coverage limits or caps ranging from $50,000 to $1 million per claim; some completely eliminate claims or place severe restrictions on certain policies including life, variable life blends, disability, mortgage guaranty, ocean marine, surplus lines, HMOs, PPOs and other non-traditional markets. Learn more about guaranty funds in Chapter 3.

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

**Agent Relationships & Insurer Failures**

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

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

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


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

In the not-too-distant future, it is likely that agents will be held responsible for monitoring the financial status of insurance companies and for client losses due to failure.
insured cannot mitigate or control his damages since insurance cannot be purchased after a loss, i.e., the insured could have already paid for a benefit he cannot receive if an insolvency occurs.

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

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

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

Congress has also chimed in by suggesting that:

"Brokers should be required to check the integrity of the people and records which determine ultimate premiums and losses charged on policies".  

SALES CONDUCT FOR AGENTS

In the last section you learned that legal conduct is a broad area of agent responsibility you are duty-bound to know. Sales conduct, on the other hand, is responsibility you choose to uphold in order to do a better job for your clients. If you need more reasons why you should practice proper sales conduct here’s a short list:

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process, i.e., you have more control over the sales process and less compliance.
- Sales conduct violations drive up the cost of doing business which could effect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation, i.e., violations can mean less money.
- Sales conduct problems erode the public trust and that can cut into your sales.
- Sales conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.
There are many industry groups and agent associations who feel that the movement toward sales ethics is way behind schedule. Too much emphasis and money has been spent on grooming sophisticated “salesmen”, they say, when there is a greater need for agent diligence and fair dealing.

The cornerstone of this agent diligence movement is now called agent due care or sales conduct. Roughly translated, the meaning of sales conduct is an agent's professional and ethical handling and choice of company, product and sales presentation to best serve a client’s financial planning. Others have embellished on this definition where the practice of sales diligence might read like this: “Conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would demand for itself. Provide competent and customer-focused sales and service. Engage in active and fair competition. Provide advertising and sales materials that are clear as to purpose and honest and fair as to content. Provide fair and expeditious handling of customer complaints and disputes”.

If you went a step further and combined legal conduct and sales conduct you might run your business by the following credo:

- I will know everything possible about my client’s financial and insurance needs.
- I will have a complete understanding of all products I sell and present them fairly.
- I will find the most suitable product for my client and make sure I place him with financially capable companies without “bashing” the competition.
- I will document any lack of knowledge with a full disclosure agreement.
- I will request each client to sign a binding arbitration agreement for any potential misunderstanding or dispute.

While it would be wonderful if every agent lived by these rules “real world” situations often get in the way. Taking the time to follow each and every rule would probably add to your work load. On the other hand, a little less free time today might save you considerable time and money by avoiding a major legal confrontation later. Likewise, the loss of a policy sale or two today might make it a whole lot easier to sell one . . . or be referred one . . . next year.

Fundamental to sales conduct is the understanding that all insurance is constructed of the same elements -- expenses; experience (claims risk or mortality); and return or profit. Therefore, a policy that appears to be significantly better than others in the marketplace should be suspect. Once a suitable product can be found, the decision to buy should be based on the assumptions in the policy and the financial stability of the company. Policy illustrations and quotes are one method to make this assessment. Unfortunately, agents and clients rely too much on these presentations to the extent that policies are rarely read. As a result, agents should be sure that any projection or estimate disclose the assumptions that went into the projection and the fact that variations in these assumptions can significantly change insurance results. Recent laws have even made it mandatory to bold or highlight any “guaranteed” portions, as compared to simple projections. It is further suggested that illustrations be run again, without forecasting better times or improved rates into the future, to see if they still meet client expectations.

**Sales conduct is an optional agent duty that involves proper handling and choice of company, product and sales presentation to best serve a client’s financial planning**

Proper sales conduct requires an agent be suspicious about policies that sound “too good to be true”
With reference to agents choosing safe companies to insure their clients, it will be demonstrated that sales conduct involves many disciplines including: disclosure, diversification among multiple carriers, product variation diversification, regulatory knowledge, multiple rating verification, key ratio comparisons, periodic monitoring and more. A recent business magazine survey is a painful reminder to the industry that the road to agent diligence may still be cluttered with potholes and a fair share of detours. Money Magazine tested 20 insurance agents on their accuracy and clarity in explaining their insurance products and the role they played in a client's financial planning. Most of the agents failed simple standards of due care, including the ability to demonstrate simple financial assumptions concerning the solvency of a chosen insurer -- either at time of purchase or later. Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status.

No doubt, it will be the same attorneys who expect an agent to quote code and verse about the company, a policy or illustration when something goes wrong. There is no question that young lawyers, and some very rich lawyers alike, are increasingly aware of the numerous legal theories available to hold the insurance producer liable for failing to meet some kind of professional standard. Could a jury be convinced, for example, that an insurance professional, especially one who has earned a designation such as CLU or CFP, neglected his professional duties in not explaining the full impact of estate taxation to a now deceased, but underinsured client? Is a casualty agent, possibly a CIC or CPCU, liable for placing a client with a B-rated carrier that liquidates at the very time a client files a claim or failing to recommend a specific policy option that later involves losses?

The answers to these questions are continually being litigated as we saw in Chapter 1. The significance, however, is that the courts in just about every state, have made it absolutely clear that insurance agents are selling a lot more than a mere contract of insurance. They are selling security, peace of mind and freedom from financial worry in the event of a catastrophic claim.

**SALES CONDUCT IN CHOOSING A COMPANY**

Agent legal conduct in choosing a company centers on the ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations. Sales conduct considers diversification, to spread risks among carriers and to meet state guaranty fund protection, and on going monitoring by private rating services.

Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency. Agents help businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss. Sometimes, however, policy owners find that the "safety net" they purchased is not always as safe as it started out to be. The recent increase in frequency of insurance

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**Sales conduct involves disciplines of disclosure, diversification, periodic monitoring and knowledge of product, ratings and regulation.**

**Agents are selling more than an insurance policy . . . they sell security, peace of mind and freedom from financial worry in the event of a catastrophic claim.**
company failures and inability to pay claims is proof. It is further substantiated by the substantial increase in claims submitted to state guaranty funds which are forced to step forward and make good on failed promises of defunct or faltering companies.

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

There are NO set rules on solvency due care techniques since the actual process must consider the risk capacity of a client, the current economy and the specific financial result or exposure needing coverage. However, there are some steps that agents might take to help mitigate bad choices. It is hoped that at least a few of the following sources and considerations will have application and will involve the agent in an area of due care that has been largely ignored. If this is considered too time consuming, an agent would be advised to concentrate only on those companies where this information can be acquired. In some cases, due care is not simply a matter of collecting a financial ratio. The story behind the numbers is often as important.

**Using the Rating Services**

An agent choosing a company for his or her client would be advised to consult the major rating services. The activities of insurance company rating agencies have become increasingly prominent with the industry's recent financial difficulties and the well publicized failures of several large life insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policyholders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems. There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s. Questions have been raised about the motivations and methods of the raters in light of the recent sensitivity regarding insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to recent declines in the junk bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

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

**On Going Monitoring & Policy Replacement**

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

**Company Deals**

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

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

**Company Diversification, Business Lines & Parent Affiliation**

In the quest to exercise proper sales conduct, a strategy of multiple company coverage may be the answer. For a client's life insurance needs, some combination of term, whole life, variable life or universal life may be employed to spread the risks among many different insurers and product lines. The variable life component could be diversified even more by using multiple asset purchases. On the casualty side, similar diversification might be employed between business and home owners policies, workers' compensation, professional liability, etc.

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

An agent may not have many choices concerning the company he writes, e.g., worker's comp coverage can only be secured with a carrier willing to write worker's comp. It has been suggested, however, that agents may consider the nature of multi-line companies to determine if one of the lines is weak enough to "down-drag" a profitable line. An example could be a life company that also writes health insurance as a direct line of business or by affiliation. If health carriers

*A strategy of using multiple insurers may satisfy the need for client diversification.*
become threatened under a new national health care proposal, it could spell trouble for an insurer's health line which can affect ALL lines of business written. Of course, this is not to say that a multi-line carrier cannot be profitable and solvent.

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

Name recognition can go a long way in giving a client a high level of comfort. In the early 1980's, for example, Cal Farm Insurance, a B rated company, was proud to point out that it was owned by the California Farm Bureau, a 100-year-old company. By the mid 1980's, however, Cal Farm Insurance was liquidated by the California Department of Insurance for overextending itself on financial guarantee bonds that it could not pay. Because the claimants were considered to be sophisticated investors, they received only 25 cents on the dollar and forced to foreclose on the properties behind the financial guarantee bonds themselves. The California Farm Bureau was not "forced" as a source to pay any deficiencies.

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

Conflicts of Interest

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission from the same company represents a definite conflict of interest. An ethical agent should disclose this fact in reference to the choice of the company selected. Where the commission is higher than normal, one might question the specific policy elements that will be affected, higher surrender or cancellation charges, etc or considerations about the financial qualifications of the insurer and include these facts in any disclosure. An insurer recently placed in liquidation, for instance, had a known history of paying higher than prevailing commissions.

Reinsurance

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

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

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners for implementation starting in 1994. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: "... If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged".

**Size of Company & Loan Portfolio**

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

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

**State Admission**

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

**Risked Based Capital**

Risked Based Capital guidelines could prove to be one of the most useful tools for quantitative analysis. In a nutshell, it is a **capital sufficiency test** which compares actual capital, surplus, to a
required level of capital determined by the insurer’s unique mix of investment and underwriting risks. Guidelines for this new regulation took effect in 1994 for life and health companies and 1995 for property/casualty insurers. **Risk Based Capital** is the brainchild of the National Association of Insurance Commissioners. Since its inception, the National Association of Insurance Commissioners has strived to create a national regulatory system by the passage of *model acts* or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners.

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**Risked based capital ratios define acceptable levels of risk an insurer may incur.**

The **Risk Based Capital Model Act** defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners. Formulas, under risk based capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and non-insurance assets; and allow single-state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed 5 percent of total business written.

The risked based capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

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

It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an *asset-default test* under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the **C-1 surplus requirements** alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risked Based Capital reports are based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1 rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective Risked Based Capital levels. Even though, a majority of companies exceeded the 150 percent threshold--thus, not requiring regulatory correction--the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when Risked Based Capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.
On the surface, Risk Based Capital seems to solve many regulatory concerns. Solvency rulings are standardized from state to state and specific action is mandated across the board. This would appear to be acceptable by insurance companies who could now predict regulatory response in any state. However, as we have seen, Risked Based Capital could also adversely affect financially sound companies simply because they own more real estate -- performing or not.

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

SALES CONDUCT IN CHOOSING PRODUCT

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

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

An agent seeks coverage as a means of transferring pure risk. A client views policies in terms of obtaining reduced uncertainty, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in any insurance purchase. The greater agent due care exercised, the more valuable the service. It is also why, when viewed from an agent's liability, ALL options should be disclosed.

Policy Choices & Risk Management

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

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

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

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

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

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

Options to deal with risk can be evaluated after specific risks have been identified. The risk manager's goal is to reduce the "post loss" resources needed by the client using the most efficient method. In essence, this is the age old battle of balancing costs and benefits. That is why risk management is maximized when using more than one insurance company to carry the burden. In this decision, however, there is temptation to resist paying for excess coverage of any type which can rob the client of cash flow that could otherwise be used to build assets more quickly and less expensively -- specifically, assets that are needed to provide for the present or to create a "living" for the future.

As part of this consideration, it may just be that the client pays premiums for many years, is never disabled or does not die earlier that his life expectancy. Or, he may never sustain a loss of property. The responsible agent should advise the client that this too, is a possible outcome.

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

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

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

While the process of risk management is conceptually similar across most product lines . . . life, health, disability, property, casualty . . . the analysis of exposure is quite different. Following is a discussion of possible due care precautions an agent might explore when working in each product line. In cases where the agent does NOT handle multiple lines of insurance, a simple disclosure and referral may be advised to meet minimum due care.

SALES CONDUCT -- LIFE/HEALTH

Questionable market conduct in the 1980's and early 1990's created new demands for today's agent. For life and health agents, past abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been further tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together -- less support in marketing and support materials. The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive. Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as we saw in Chapter 1. Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

Life Insurance Risk Analysis

Before determining the amount of life insurance needed by a client, due care would involve the agent and client in a discussion concerning the various types of life insurance available . . . annual renewable term, deposit term, decreasing term, level term, whole live, modified whole life, single premium whole life, universal life, variable life, etc. The attributes of these different policies are best left to a course on basic life insurance. However, it is critical, under due care, that agents recognize the "pure risk" need of clients and counsel them on the proper choice. For example, persuading a client to accept a high monthly premium whole life policy with a settlement payoff that leaves a significant financial gap at the death of a breadwinner, is NOT exercising due care. This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations here a client's age and situation call for the agent to consider future estate settlement costs and liquidity as prime directives in making policy choices. There may even be conditions where due care by the agent might involve a recommendation for a client to carry little or no life insurance at all. Issues regarding life insurance needs for singles, non working spouses and children are often debated among financial planners and agents alike.

One process for determining an estimate of the amount of life insurance needed is called capital needs analysis. Financial planning courses cover this process in considerable detail and typically include a sample capital needs worksheet. For purposes of proper sales conduct by agents, factors to consider by agents include:

Capital needs for family income
Most families will be able to maintain their standard of living with about 75% of the former breadwinner's income. Depending on the skills and resources of the surviving spouse, this fund may be large enough to provide lifetime income or for a specified period of transition.

Capital needs for debt repayment
Typical debts to consider include home mortgages, charge cards, bank notes, business debt, etc. A
decision can be made to totally liquidate the debt or to use life insurance proceeds to set up a "sinking fund" to make payments for the life of the loan or a specified period.

**Other Capital Needs**  
This might include emergency reserve funds, estimated to be between 50 percent and 100 percent of a client's annual after-tax income, and possible college education funds for surviving children.

**Estate Settlement Costs**  
Final expenses can be expensive. Uninsured medical costs and funeral expenses are one aspect. In addition, there are federal and state death taxes. Although the Economic Recovery Tax Act of 1981 eliminates the federal estate tax on property passed to a surviving spouse, the estate of the survivor may face a large death tax liability. Further, there have been recent attempts by Congress to lower the exemption levels. State death taxes vary considerably.

**Current Assets Available for Income Production**  
What current assets, such as savings accounts, investments, real estate, pension plans, etc, are currently available for income production or liquidity needs to offset the capital needs above?

**Net Capital Needs**  
By combining the above factors, the agent can arrive at the net capital needed to be replaced by life insurance.

Where capital needs analysis indicate that a $500,000 gap will occur at the death of the breadwinner(s), the agent's *due care life insurance recommendation* should be for $500,000 of life insurance. Anything less could leave the client *underinsured*. Lesser amounts may be purchased where the client cannot afford the premiums or makes the choice to carry less. If there are additional concerns, such as a client’s long-term health, the agent might be advised to disclose his recommendation even though a more expensive policy with less coverage is purchased.

On going monitoring of capital needs is necessary to plan for new client objectives, repositioning of debt, inflation, estate settlement changes and potential health problems that may prohibit coverage in the future.

Another due care consideration concerning life insurance is *ownership or title of the policy*. Agents should recognize conditions where it would be beneficial to keep life insurance proceeds out of a client's estate by using a life insurance trust or alternative ownership. Due care may be sufficient where agent disclosure of estate tax consequences of life insurance owned by a client and a proper referral to a competent estate planning attorney is pursued.

**Essential Life Insurance Due Care Questions**

- What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- Who is insured? Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?
- Are there existing life policies that can be cash surrendered or tax exchanged to more efficient plans?
- Is waiver of premium available? Is this a desirable benefit for this client?
- Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
• Is coverage decreasing term? Is the balance sufficient?
• Is there a substandard rating that can be removed?
• Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
• What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc)
• Is there a plan for the "common disaster" involving BOTH husband and wife?

**Disability Insurance**

Statistics have surfaced which indicate that the average person is three times more likely to suffer a lengthy disability than die. Providing a source of financial income in the event of a major disability is probably the most overlooked portion of client financial planning.

By definition, a **disability** can be a temporary or permanent loss of earned income due to illness or accident.

**Essential Disability Due Care Questions**

• How much monthly protection is needed? Is an individual policy needed to supplement work plans?
• When does protection need to start? (30, 60, 90 days etc -- the elimination period), i.e., can the client "self-insure" for a period of time?
• Does the client have discretionary income to buy needed protection?
• Is the coverage noncancellable or guaranteed renewable? Can a block of insureds, including your client, be canceled?
• If multiple policies are owned (employer, association, individual), will the benefits of one be reduced by the other? Is there a case for eliminating a policy?
• Is there an employer supported uninsured sick-pay plan available?
• What is the definition of a disability in the client’s policy? How severe? How long?
• Does the policy include occupational and non-occupational coverage?
• Is there a substandard rating or waiver of condition? Will the company remove it? Will another company write without a waiver?
• Is there a waiver of premium benefit? Would this be necessary for the client?

Similar to life insurance, due care analysis by the agent involves "need analysis". Through inquiries and available financial papers the agent should determine the current after-tax income needs of the client. This amount could be reduced by expenses that might be eliminated due to the disability. For example, if the client is homebound, he will not need to cover transportation costs of commuting to work or other work related expenses. Next, an adjustment for possible government benefits can be made using Maximum Benefit Amounts that might be available from Social Security. Minimum employment history and limitations on the term of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases.

For just about every client, the above process will establish that some form of disability protection is generally needed beyond the limits granted social security, and in some cases private, employer provided protection.

Once a disability need is established, it can be compared to the participation limits allowed by insurers and the ability of clients to afford it. **Disability sales conduct** would involve an agent/client discussion explaining how disability insurers may ONLY offer certain maximum allowable coverage tied to income, e.g. a client who earned an after tax monthly income of $7,500 might be eligible for a maximum of $3,000 of monthly disability coverage. There may also be limits of how long this protection is covered, e.g., 24 months, five years, or to age 65. Further, there may be minimum waiting periods before
coverage begins, e.g., 90 days, 180 days, etc. Also, there may be reductions in the amount of
disability protection paid based on the degree of the disability, e.g., a partial disability that allows a
client to continue working may reduce benefits substantially. Finally, watch for renewability features.
Some policies are truly noncancellable and guaranteed renewable. Others may appear to be
renewable unless cancelled by "class". Thus, if an insurer has a particularly bad block of business with
a higher than normal claims experience, it can cancel that class of insureds. Clients need to be
counseled that the "gaps" in coverage outlined by these events require them to seek alternative forms
of protection, develop contingency plans or rely on available pension plans, family members and
accumulated savings to make ends meet during times of disability.

**Health Insurance**

Health insurance is one of the most valuable segments of risk management and the most difficult to
predict. This is further complicated by recent efforts to create a national health care system. Hours
of agent due care to develop a long term plan for clients may be broadsided by an entirely different
style of health care brought on by federal directives.

The most efficient form of health protection is by group coverage. Group insurance is the predominant
way of providing health insurance today with a definite trend toward HMOs (health maintenance
organizations). **Due care in health counseling** would involve fact finding to determine sources of
social insurance available to the client such as Medicare and occupational worker's compensation.
Any gaps in coverage need to be filled through blanket health coverage or medical benefits under a
liability policy if the health condition developed as a result of an accident.

In addition, an agent-to-client discussion should cover points concerning:

**Basic Eligibility**
Exactly who is covered? Does "family" include the subscriber, spouse, one, two or more children? How
old can the children be and still be covered? Does this change if the children are married? Will family
members lose their eligibility when they turn 65 and Medicare takes over? How will a divorce affect a
members coverage? Will a foreign or out of state residency longer than six months affect coverage?
How long will a retarded or physically handicapped child or member be covered?

**Total Maximum Coverage**
A limit to coverage could be present in form of duration and/or a dollar cap. Is this a "lifetime cap"?
Is this cap per family member or for the entire family? A lifetime cap of between $2 and $5 million, per
family member would not be uncommon and might be considered a minimum considering the high cost
of medical care.

**Deductibles**
How much is the deductible, if any exists? Is it per family member? Per year? Is there a maximum
deductible per family? Are there specific deductibles for medicines vs. health care? Are there
deductible surcharges if the client does NOT pre register with the insurer, say for non emergency
care?

**Stop Loss & Co-Payments**
After deductibles, is the client expected to share or co pay any medical expenses? Is there an
established time, usually after a specific amount of expenses have been incurred, that the co pay will
stop and benefits will be 100% covered by the insurer?

**Pre-Existing Conditions & Waivers**
Are certain known pre-existing health conditions prohibited or waivered? If waivered, for how long?
Is there a waiting period for unknown pre-existing conditions? Some policies specify a 6 to 12 month
waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins,
nasal surgeries, foot and toe surgeries, breast reductions, otis media (ear problems), etc.

**Exclusions**
Possible policy exclusions or highly limited protection might include conditions and services as follows: medical costs exceeding limits, unlisted services, service covered by occupational insurance (worker's compensation, etc), health problems due to acts of war, government provided services, Medicare benefits, services from relatives, private nursing fees, custodial care, long-term care, inpatient diagnostics (x-rays not related to specific surgery), dental and hearing aids, vision care, speech therapy, cosmetic sex changes, infertility, weight reduction, orthopedic devices, maternity care, outpatient drugs, acupuncture, nutritional counselling, physical or occupational therapy outside the hospital.

Some "bare bones" plans may cover costs ONLY at prescribed hospitals, although emergencies are typically covered no matter where. Some only pay for procedures incurred in the hospital by hospital employed physicians, i.e., regular doctor visits or follow-up sessions are not covered unless specified by the hospital doctor. Further, many plans may cover certain hospital procedures but NOT the supplies, e.g., a blood transfusion procedure may be covered, but NOT the cost of blood.

One of the latest trends is the requirement that certain procedures, such as organ and tissue transplants, be pre-authorized. Additionally, some procedures, like bone marrow transplants, are considered experimental and not covered under any conditions.

Mental health and home health care are usually very limited areas of care. Dollar limits per day with annual maximums are not uncommon, as are maximum visits per year.

**Guaranteed Renewability & Rate Changes**
Can the insurer modify or change premium costs? Under what conditions? Can a class or "block" of subscribers be changed without changing rates for all subscribers? Can the subscriber be canceled? If so, how long will benefits last if client is in the middle of a health crisis?

**Important Dates & Notification**
While many of the above exclusions and limitations are typically spelled out in policy brochures or in bold print, issues of important dates and notifications can "fall through the cracks". Proper due care would involve a discussion or memo to the client concerning policy time lines. Examples include: "All claims must be filed within 15 days on approved claim forms"; "the insurer must be notified within 60 days of any newborn or adopted children"; "annual notice is required to sustain coverage for a retarded or handicapped child who is older than the specified age limits"; "a family member must apply for his or her own plan within 31 days of the main subscriber's ineligibility".

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**Agents who handle multiple lines of insurance for clients should consider health insurance a clear priority.**

Agents who handle multiple lines of insurance . . life, health, disability, property/casualty . . . must consider the impact of health insurance on the client's financial planning. A medical catastrophe can permanently devastate a family. Despite the important of life insurance, disability protection and certain property/casualty coverage, health insurance is a clear priority. It would NOT be considered due care for an agent who handles different product lines to market a $250 per month whole life insurance plan to a financially limited client when there was NO health insurance in place. A more prudent approach would combine a "basic hospital plan" for major medical emergencies at $150 per month and a term life plan for $100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.
Essential Health Coverage Due Care Questions

- What available sources of health care are available to your client -- group plans (employer provided), HMO's, Medicare, other?
- Does your client have enough medical expense benefits to meet basic hospital needs or major medical expenses?
- What family members of the client require coverage and are they eligible? Does the client or family member need supplemental coverage?
- Should the client terminate any existing or duplicate medical expense premiums?
- Does the client have dependents who have or will soon terminate coverage under the family plan? If so, can they purchase their own? What conversion rights do they have?
- Is your client's policy guaranteed renewable?
- Does the client's health care continue to protect dependents in the event of his or her death?
- Does the client have a substandard rating or waiver of coverage? Will the insurer remove it? When? Will another company write without the waiver or rating?

Annuity Analysis

Sales conduct concerning annuity investing first involves fact finding to determine what portion, if any, annuities should play in a client's overall financial plan. Next, a needs analysis should be conducted to uncover growth vs. income requirements, risk tolerance, liquidity specifications, now and in the future, and whether tax deferral benefits are worthwhile to pursue.

Who should invest in annuities? One rule of thumb follows that a client looking for a long-term investment with a tax bracket greater than 15 percent might consider annuities. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time, i.e., retirement monies.

Fixed rate annuities might be an alternative for CDS, GNMA's (Ginnie Maes), T-Bills or other similar obligations. Variable annuities are better geared to individuals who seek tax deferral, yet willing to ride with the ups and downs that accompany stock and mutual fund investments.

Once an annuity can be established as an appropriate investment opportunity, agents must carefully weigh the following choices and discuss same with each client:

Immediate Annuity vs. Deferred Annuity
Clients may have current income needs or the desire to defer income for greater growth. Perhaps a combination is appropriate. Tax planning and liquidity are key considerations for the agent.

Single Premium vs. Flexible Premium
Client's generally have a lump sum to invest or need to accumulate by paying into a savings plan. Short and long-term liquidity is an important consideration.

Fixed Rate vs. Variable Rate
Client's may have needs to lock-in their yields or go for growth. One group is typically a CD type investor as opposed to those who are willing and able to incur greater risk. Agents needs to carefully explain the potential loss of principal possible in variable plans. Agents should review potential interruptions in return of principal and yield that can develop with either fixed or variable contracts.

Yield vs. Guarantees
It is logical that the stronger the guarantee the lower the yield. Agents must explain that a higher first year yield may include bonuses or special incentives to invest that later disappear. This type of contract should be compared to other contracts that may offer a slightly lower yield that is locked in for a specific period, i.e., determining overall predictable yield over time is important due diligence. In the same vein, a disclosure would be appropriate as to the method used by the insurer to adjust yield. A contract with a guaranteed yield spread may be more appropriate for some clients than a yield that is adjusted by the insurer's board of directors. Equally important is whether yield is banded, i.e., are yields adjusted separately for certain blocks of investors or are investors who entered five years ago
given the same yield as new investors.

**Yield vs. Liquidity**
Clients demanding easy access to their money should be prepared to settle for lower overall yields. Agents need to go farther to determine special needs such as the potential for large sums of money to pay for a potential illness or nursing home. Certain contracts allow penalty free withdrawals for special circumstances. Due care dictates that agents carefully and clearly explain all surrender charges associated with the contract and when they occur.

**Maturity options**
Annuity contracts may mature at specific ages. This can affect BOTH a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85. Further, agents MUST disclose the potential tax affect of a maturing annuity. Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal. Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

**Withdrawals & IRS Penalties**
Where the client is withdrawing all or part of an annuity contract PRIOR to age 59.5, he should be apprised of the ten percent IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies or becomes substantially disabled or, where annuitization is chosen within one year of investing in the annuity contract.

**Guaranteed Death Benefits**
Where agents assist in estate planning, due care would involve a disclosure concerning death benefits. Most fixed rate contracts guarantee the return of principal and any appreciation (interest left to grow). However, agents should uncover and review factors concerning potential surrender penalties or how they may be avoided, as well as the basis of the guarantee. Is the death benefit guarantee, for example, the greater of ALL contributions of principal OR simply the value of the contract on the date of the annuitant's death?

**Settlement Options & Taxes**
Clients should be made to understand that, at best, annuities represent tax deferral, not tax free income. Unless the beneficiary of the annuity is a surviving spouse, taxes on the accumulated growth will be due -- there is NO step-up in basis. The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket. Options to mitigate this include five year or lifetime annuitization of the contract.

Other settlement options that should be discussed with the client include possible options such as life annuity, joint and last survivor, lifetime with period certain, etc.

**State Guaranty Fund Coverage**
Rules governing state guaranty coverage should be disclosed to the client. If the State does NOT permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases. The primary concern? Is the full amount of the annuity covered against insurer failure. Perhaps due care is served by diversifying among several insurers and/or between fixed AND variable contracts to take full advantage of guaranty protection.

**Titling Options**
If the agent is advertising tax and estate planning advice he should disclose the consequences of titling contracts. Where no tax or estate counseling is provided, the agent should still exercise due care by disclosing the fact that titling consequences may result and offer to refer a competent attorney or tax expert before any purchasing decisions. As a general rule, the death of an owner or annuitant triggers a death benefit which carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary
must take a lump sum and pay the tax or annuitize over a minimum five-year period. An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

**Essential Annuity Due Care Questions**

- Is the client interested in growth or income?
- Is the client interested in current income or retirement income? How soon does he need to start receiving income?
- How much risk is the client ready to accept today and in the future? Could he stand the loss of his entire investment? How would an interruption in income affect him?
- What are the client's liquidity needs in the short-, intermediate- and long-term?
- What is the client's federal/state tax bracket? Does tax deferral through annuities make sense?
- Is the client under age 60, and is it likely that he will need to withdraw major portions of the annuity in the future? Will the ten percent penalty offset the benefits of tax deferral?
- Does the client demand full and complete protection of principal? Or, can the client afford to take risk in hopes of greater appreciation using variable contracts?
- Is the preservation of principal more important to the client than the effects inflation may have against a fixed yield?
- What are the survivor spouse/family needs in the event the client dies? How can these needs be accomplished?

**Business Insurance**

The risk managing agent recognizes that due care extends to businesses as well as individuals, since businesses are composed of the same people. The illness, disability or death of these people represent an exposure to businesses in terms of their survivability and commitments to principals, employees and their families. **Sales conduct in business analysis** involves a determination of the reduced revenues and increased expenses that may result from the death or disability of a key person in the business, including the possible costs to replace or sell the business, if necessary. The degree of risk protection in business insurance varies by the person who is affected and the legal structure of the company. Following are some due care considerations for three major forms of ownership -- sole proprietors, partners and corporations:

**Sole Proprietorships**

There is no legal distinction between personal and business assets . . . debts of the business are debts of the sole proprietor's estate. Agents should determine needs or **preloss arrangements** of the surviving family to continue the business, sell it or liquidate it in the event of the owners death and disability. Capital deficiencies can be filled through the appropriate insurance line.

**Partnerships**

The legal relationship between partners is personal . . . each is fully responsible for acts of the business and business debts of all others. If a partner withdraws or dies, the partnership must be terminated or reorganized. The disability of one partner can also create a significant financial strain on the entire business. Due care planning here involves learning the wishes of the surviving family and surviving partners. Where a deceased or disabled partner's family wishes to exit the business a **buy-sell agreement** can satisfy the purchase of his share with the business passing to the surviving partner. Alternatively, the heirs of the deceased may become partners or sell the lost partner's interest, assuming this is permitted in the partnership agreement. Again, preloss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

**Corporations**

Most agents will deal with the "close corporation" where the stock is closely held by a few individuals
and not offered for public sale. Typically, the stockholders are also employees of the company. In this case, situations similar to the partnership can develop. A key employee or stockholder can become disabled or die creating additional financial burdens on the company. Most corporation charters provide that remaining stockholders can purchase the share of the withdrawing or deceased shareholder. The risk manager needs to uncover the “formula” for purchase and plan available funds via buy-sell policies, disability protection, health care, etc.

Other significant due care factors concerning business insurance include planning for taxes and liability. For planning purposes, most transfers or sales of business interest become part of your client's gross taxable estate for purposes of death taxes. Income taxes become a factor in corporations where the challenge is to transfer assets out of the corporation without claims of dividend. This is a very complicated area of planning best left to other courses. The issue of liability will be discussed in sections below.

**Essential Business Insurance Due Care Questions**

- Who will control the business when your client dies or becomes ill for an extended period?
- Will there be a market for the business if it has to be sold?
- Will the business provide adequate income for the heirs of your client?
- How will the value of the business affect the taxes and liquidity needs of your client's estate?
- Will the client be able to continue in business if one of his associates dies?
- How will working capital be kept intact where a partner or owner dies or is seriously disabled?
- How can a business be transferred to a new owner without shrinkage in value?
- What will become of your client's interest in the business if he or she retires?

### SALES CONDUCT -- PROPERTY & CASUALTY

Risk management in the property/casualty arena is extremely complicated, yet the primary goal is the same as other forms of insurance -- the transfer of risk. However, a higher standard of due care and agent liability exist in property/casualty because of binders, indemnity disputes and redlining.

A **binder** can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible. Abuses occur where agents do NOT have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

Property and casualty insurance contracts are **contracts of indemnity** in that they provide for compensating the insured for the amount of loss or damage. Due care is accomplished when an adequate amount of compensation is provided that will avoid profit or loss from a peril or hazard.

Elementary insurance defines a **peril** as the cause of a loss. Fire, lightening and collision are all examples of perils. A **hazard** is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard. Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard.

While there are, as yet, no formal rules on **insurance redlining**, there is pending legislation that would force insurers to comply with rules similar to Community Reinvestment requirements now imposed on banks. If passed, a majority of the burden would fall on underwriters. However, agents should be aware that clients living in inferior, low income or minority communities should NOT be denied application for coverage. The logic behind this is obvious -- without access to insurance, clients would not be able to buy housing.

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**Clients depend more on agents in casualty matters because there is less public understanding of casualty policies than other forms of insurance.**
Compared to life and health contracts, it can be said, that fewer property/casualty policies are read by clients. There is generally less understanding of liability or casualty matters, and therefore, a greater reliance is placed on agent advice and counsel. That is why proper sales conduct would encourage clients to read their policies and help them review the fine print to fully understand exact limits of coverage, define perils, clarify what constitutes a hazard and recognize policy owner duties. Having specimen policies available for this purpose should be standard procedure.

Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital. This should not occur, however, without also recognizing the value of other forms of insurance, i.e., A deluxe homeowner's policy should be scaled back where high premiums might not allow clients to purchase basic health insurance. There may also be validity to the argument that insurance premiums should not be so excessive as to preclude clients from starting necessary retirement savings plans.

In addition to these points, there are many contributions that can be made by agents to promote greater client understanding of risk, loss control and proper valuation. (See below). By educating clients in these disciplines, a higher level of insurance efficiency will be realized. The result can be stabilized or lower premiums through a lower claims experience. It is true, that this may NOT initially improve agent commissions, but in the long run client retention and income stability will be greater.

**Essential Liability Due Care Questions**

- What is the insured's "insurable interest"?
- Is the peril covered?
- Is the property covered?
- Is the type of loss covered?
- Is the person covered?
- Is the location covered?
- Is the time period covered?
- When does the policy take effect?
- Are there hazards that exclude or suspend coverage?
- What are policy owners duties after a loss?
- What are the insurer's options in settling a loss?
- What are the time limits for the policy owner to recover from the insurer?
- What are the time limits for insurers to pay

Next, a due care discussion might include:

**Risk**

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

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

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

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

Homeowners Insurance
Agents should exercise due care in several important capacities:

Selection of Policy
The selection of policy type . . . HO-1, HO-2, HO-3, HO-4, HO-6 and HO-8 . . . should be a function of client need. Obvious factors to consider include dwelling type, dwelling size, dwelling construction, dwelling replace ability, additional structures, type and extent of personal property, loss of use and basic liability. Refinement of the process occurs where agent due diligence uncovers clients the true "limits of need" and special circumstances. This can only be accomplished by interview or systematized fact finding concerning key issues:

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

Concerning personal property, does an inventory exceed policy limits? Is replacement value available? Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets, etc? Are "sublimits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns, etc?

After primary values are established, the client's "insurable interest" must be determined since a policy owner will NOT recover for an amount greater than their insurable interest.

**Eligibility**

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

**Deductibles**

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

**Policy Exclusions**

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions. Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walls, walls, floors, roofs or ceilings, rodent or pest infestations.

**Liability & Liability Exclusions**

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

**Auto Insurance**

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

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

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

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

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

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

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

**Named Insured**
Who is the insured? Is the insured the policy owner, his spouse, a resident of the household, other family members?
Auto User
Is everyone who uses the auto a named insured?

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

Commercial & Professional Lines
Commercial and professional insurance takes many forms: investment and commercial property coverage, business owners insurance, farm coverage, commercial auto plans, commercial liability policies, for directors, officers and professionals, workers compensation and more. A full discussion of each goes beyond the scope of this course. However, there are some important due care factors for agents to disclose and discuss with clients.

Policy Limits
As with most other forms of insurance, a client needs analysis should determine the extent of assets to protect, including any personal exposures. Policy endorsements and/or commercial umbrella protection may be considered as options. Special occurrences may have individual limits which must be evaluated for each client. For example, a "products-completed" limit may be small for a bakery but should be expanded for a lawnmower repair service.

Eligibility
Rules of eligibility in the commercial arena are very complex. Suffice to day, clients should be aware of ALL limitations that might exclude coverage, including: building size or height restrictions, e.g., buildings not exceeding 15,000 square feet and no more than four stories; business class restrictions, e.g., office uses permitted / manufacturing prohibited or retail permitted / restaurants prohibited, etc. Where liability is concerned, is the policy based on a "claims made" basis or a "claims occurred" basis? Clients should be well informed that coverage may exist ONLY while they are in business and paying premiums. A claim made ten years after a client retires can be financially devastating.

Policy Endorsements
Due care should involve the listing of available options to extend coverage, reimburse for loss of use, loss of rents, loss of income, business expense coverage, builders risk protection, for buildings under construction, add or exclude specific accidents, products, work or locations, employment occurrences (termination, defamation, discipline, discrimination, etc), liquor liability, products completed protection, pollution liability, malpractice, errors and omissions, personal and advertising violations, contractual liability, employee use of vehicles coverage, product defects or deficiencies, product recall protections, inflation upgrade protection, replacement cost coverage, personal effects protection, debris removal, etc.

Scheduled Losses
The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises. In the case of liability policies, premises and operations exposure is the heart of coverage. Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage, etc.

Policy Exclusions
As important as what is covered, clients should understand exactly what is excluded: Building ordinances, government actions, power failure, water damage, bursting pipes, explosion of steam boilers, mechanical breakdown, money, animals, autos for sale, illegal property, underground pipes, fences, antennas, signs, etc.
Named Insured
Since multiple parties may share insurable interest, it is important that ALL parties understand that the "first insured" is typically the "notified insurance partner". In the event of cancellation and policy changes, the conditions of the policy normally name the first insured to be responsible to notify other named insureds. In essence, the first insured is the "point man" for most policy transactions.

SALES CONDUCT -- QUOTES & ILLUSTRATIONS

In the past few years, media "sound bites" and state regulator attention concerning the financial stability of insurers and sales misrepresentations have been the primary focus of sales conduct. Not far behind are the issues and supporters demanding agent due care in choosing the right policy -- after all, an industry cannot rise to responsible status, perhaps even survive, if its members take a "sale at all cost" attitude. Both these issues have and will be the target of new company compliance procedures and new regulatory standards. These efforts, however, have been pursued more in a "broad brush" fashion with an emphasis on concerns such as fraud, misrepresentation and twisting.

Many professional agent groups feel that sales conduct should include a new dimension: fair and understandable illustrations and quotes. The reason? Most insurance purchasing decisions are made by clients and agents using illustrations and quotes. Minor variations in the assumptions that go into these projections can produce dramatically different results -- especially if they are spread over long periods of time.

With the advent of computers, multiple page illustrations, some with graphics, literally predict results a client can expect from almost any given product, at any given time in the future using an almost unlimited choice of assumptions. Agents also use mass mailing technology that can tap public records, such as property values, ages, names to personalize and customize a quote without even visiting the property or client. Stiff competition has made the use of computerized quotes and illustrations widespread. Given the sophistication and high quality of these proposals, agents and clients are depending more and more on the face value of the illustration, rather than the actual policy itself. In many instances, clients and agents alike completely pass on reading the policy. This, in turn, has resulted in some surprises for clients and the call for greater scrutiny of sales presentations from professional associations and some regulators.

The problems that surface with most illustration sales relate to the disclosure of assumptions made in illustrations, e.g., interest rates that went down instead of up, insurer insolvencies that could not meet minimum policy rates and/or return of principal, surrender values well below projected results, premiums that were expected to "vanish" simply continued, premium quotes well below replacement value of the property, quotes that do not reflect necessary endorsements, etc. For the most part, the responsibility of misleading illustrations lie with insurer actuaries and marketing departments that produce them. Some agents have also manipulated quotes to specifically avoid true comparisons, i.e., presenting only projected cash values NOT guaranteed values OR quoting skeleton plans void of necessary endorsements.

In recent cases, the misuse of illustrations has led to significant charges of questionable sales tactics by state regulators. The MetLife case involved fines totaling $20 million among 40 state agencies and $75 million in restitution to as many as 60,000 customers. Shortly after these fines were levied, the Florida department of insurance filed charges against the company's top agent, and at least 100 more, accusing them of fraudulent sales practices.

While there is no one single solution to the problem, some remedies are underway in the areas of education, disclosure and better illustration design. In the MetLife case, the company has created a corporate ethics and compliance department which will audit agent offices in the area of sales techniques, including the use of illustrations. Regulators have threatened to prohibit certain proposal techniques altogether, require specific "full disclosure" requirements. Others are launching new
compliance orders like requiring insurers to conduct internal investigations designed to uncover illegal illustration marketing practices. Further, the National Association of Insurance Commissioners has outlined the misuse of policy illustrations as a violation of their Unfair Trade and Practices Act and Congress has proposed the Insurance Marketing and Sales Reform Act to strengthen consumer protection laws concerning advertising and illustration mishandling by agents, brokers and insurers.

Currently, illustration disclosure is different from company to company. Certain professional organizations and government agencies, such as the National Association of Insurance Commissioners, are proposing "model" illustration disclosures. In the mean time, some states have already passed laws requiring agent due care to disclose all assumptions of the quote and/or highlight or bold the guaranteed portions of these proposals to contrast the "anticipated" results. Further, life insurance companies are required to answer certain questions in their annual statement filings pertaining to the "basis" of dividend and interest rate projections. These questions include:

- What is the company's opinion of its ability to continue supporting current dividends and nonguaranteed elements (interest rates).
- Are company assumptions of these factors exceeding the company's current experience level.

To a great extent, the answers to these questions fall on the shoulders of company actuaries. These individuals maintain personal standards of practice that require full and complete disclosure. The Society of Actuaries has also promoted education of this problem to its members and the Academy of Actuaries has made recommendations to the National Association of Insurance Commissioners (NAIC) on possible regulatory actions that could be useful now and in the long term.

Some industry groups, feel that much of the pressure to greatly restrict or eliminate the use of illustrations is unwarranted. They believe that illustrations can be a valuable tool to educate clients with visual interpretations of their options. Rather than scrap the entire illustration system, for example, it is suggested that, as a minimum, agent illustration sales conduct can focus on treating the client fairly by implementing the following considerations:

- Specimen policies should be on file to compare with specific illustration issues and/or client questions.
- Before doing business with a specific company, request a copy of illustrations for policies the agent intends to handle. Clear up any questions as soon as possible. If the company's management say they don't know the answer, or they avoid requests altogether, it may be a clue that they will handle client policies in a similar way.
- Agents should be certain that all illustration pages are printed and that all projected interest rates are disclosed and discussed with the client. In casualty quotes, if an “All Risk” policy is presented list ANY & ALL exclusions.
- Particular attention should focus on matters of age, gender, classification, avocations, past experience and other "default" conditions of the life illustration. For casualty, does the quote match the requested coverage, is the principal disclosed, do words imply that client is bound?
- Be sure that the client receives all pages and disclosures.
- On the life side, look for sudden jumps in cash values or premiums -- especially in later years.

MANAGING AGENT CONFLICTS

It is estimated that one in seven agents face an errors and omissions claim each year. Charges like these will challenge your reputation, waste enormous time and could threaten your financial well-being. Basic measures to limit liability always begin by avoiding claims at the outset. Of course, this is easier said than done, since there is NO foolproof method to sidetrack a lawsuit from a client or an
insurer. There are, however, some suggestions that agents can use to help reduce the possibility of a claim developing and present a reasonable defense if one does. Of course, this can NOT be considered a complete list since special circumstances may require additional precautions.

Step 1
Know your basic legal responsibilities as an agent and only exceed them when you are absolutely sure what you’re doing (Legal Conduct Section). Pull out your agency agreement right now and read it!! When you decide that you want to be more than an agent, i.e., a counselor to your clients, understand that it comes with a high price tag -- added liability. Also, make sure you are complying with basic license responsibilities to keep from becoming a commissioner’s target for suspension or revocation.

Step 2
Learn from other agent mistakes (Agent Blunder Section). The best school in town is the one taught by agents who have already had a problem. Study their errors, learn from them and make sure you don’t repeat them.

Step 3
Be aware of and avoid current industry conflicts that could develop into problems for your agency (see Future Conflicts). There are hundreds of professional industry publications that will help you keep abreast. Once you are aware of a potential problem, take action to make sure it doesn’t end up at your doorstep.

Step 4
Maintain a strong code of ethics (this section). As you will see from our discussion of ethics, you don’t need a list of degrees or designations to be ethical. Simply be as honest and responsible as possible.

Step 5
Be consistent in your level of “due care” (see Sales Conduct Section). Write a procedures manual that forces you to treat client situations the same way every time. Courts and attorneys alike are quick to point out any inconsistency or lack of standard operating procedures where the client with a problem was handled different than another client.

Step 6
Know every trade practice and consumer protection rule you can (See Consumer Protection Section). The violation of “unfair practice rules” is a really big deal to lawyers. They will portray you as something short of a “master criminal” for the smallest of violations.

Step 7
Use client disclosures whenever possible (this section). There is nothing more convincing than a client’s own signature witnessing his knowledge of the situation.

Step 8
Get connected to the latest office protocol systems (this section). The ability to access a note concerning a client conversation or the way you “package” correspondence can make a big difference in the outcome of a claim or avoiding one at the outset. You want a system that will produce solid evidence not “hearsay”.

Step 9
Maintain and understand your errors and omission insurance (this section). This policy is your “first line of defense”, but know its limitations and gaps.

The discussions that follow will expand on most of the steps we just mentioned.
KNOW YOUR AGENT & LICENSE RESPONSIBILITIES

Agent/Client Duties

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

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

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

Agent/Company Duties

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

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

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

Agent Integrity

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

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

Lack of Business Skills or Reputation
Licenses have been revoked where the agent is NOT of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss. In Goldberg vs Barger (1974), an application for an

Many states set minimum standards for agent integrity.
insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

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

**Agent Dishonesty**
Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In *McConnell vs. Ehrlich (1963)*, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers who licenses had been suspended or revoked. The Commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their "volume plan". Moreover, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents for the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

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

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

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

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

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

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

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

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

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

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

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

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

**Agent Business & Marketing Practices**

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

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

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

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

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

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

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

**Unfair Business Practices**
It is a violation in most states for agent/brokers to fail to act promptly and in good faith regarding an insurance claim, fail to confirm or deny coverage applied for within a reasonable time, dissuade a claimant from filing a claim, persuading a client to take less of a claim than he or she is entitled to, fail to inform and forward claim payment to a client or a beneficiary, fail to promptly relay reasons why a claim was denied, specifically advise a client NOT to seek an attorney when seeking claim relief, mislead clients concerning time limits or applicable statutes of limitation concerning their policy, advertising insurance that the agent does NOT have or intend to sell, use any method of marketing designed to induce a client to purchase through the use of force, threat or undue pressure, use any marketing method that fails to disclose (in a conspicuous manner) that the agent is soliciting insurance and/or that an agent will make contact.

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

Privacy
Information gathered in connection with an insurance transaction should be confidential and have specific purpose. Clients are entitled to know why information is needed and have access to verifying its accuracy where a claim or application is denied.

AGENT ETHICS

It is difficult to discuss matters of agent responsibility and reducing liability without exploring ethics. As it relates to insurance agents, ethics go beyond the maintenance of "moral standards". Insurance ethics involves the maintaining of honest standards and judgments that place the client first. To keep it simple, just remember the old adage "the customer is king".

Someday, it may be real important for a court and jury to hear that you have a history of serving the client without consideration for how much commission you made or how busy you were, i.e., you are a person with good ethic

Take the case of Grace vs Interstate Life (1996). An agent sold his client a health insurance policy while in her 50's. After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court did not look favorably on the agent's lack of duty to notify his client.

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

For some, the very effort to be as ethical as possible brings its own rewards. Consider, for example, the satisfaction that agents realize when the interest of a client has been served by the proper placement of insurance:

- The capital needs of a family are met by a $1 million life insurance policy when the breadwinner dies prematurely.
- The estate of an entire family is left intact because an umbrella liability policy sheltered against a major accident claim.
- A business is able to survive after the death of a partner because a life policy payment provided necessary capital to replace the devastating loss.
- The retirement plans of a once young married couple are made possible through investments in pensions and annuities.
- The owner of income property financially survives a major fire because his liability policy included "loss of income" provisions.
- A family survives a mother's long term bout with cancer because their health insurance carried a sufficient "lifetime" benefit.

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

Casualty Underwriters and the International Association of Financial Planning. Following are some examples:

• In all my professional relationships, I pledge myself to the following rule of ethical conduct -- I shall, in the light of conditions surrounding those I serve, which I will make every conscious effort to ascertain and understand, render that service which, in the same circumstances, I would apply to myself.
• In a conflict of interest situation, the interest of the client shall be paramount.
• Take responsibility for knowledge of the various laws and regulations affecting my services.
• Avoid sensational, exaggerated and unwarranted statements.
• Improve my professional knowledge, skills and competence.
• Maintain a high degree of integrity.
• Maintain a professional level of conduct in association with peers and others involved in the same activities

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

AGENT DISCLOSURE

Client Disclosure

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

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

Agents have successfully used disclosures to qualify a promise of coverage as in T.G.I. East Coast Construction vs Fireman’s Fund Insurance (1985). Here, an agent’s letter to a client regarding future coverage commitments included a very important disclosure: “You will be covered subject to our normal underwriting requirements.” Of course, when the time came, the client automatically assumed he was covered. However, on the strength of the disclosure, the courts disagreed.
Agents may also want to use disclosures to *narrow the scope* of their duties. For example, agents have been held liable for NOT securing “complete” coverage. If an agent is unwilling to assume responsibility and take the time necessary to provide “complete” coverage, it might be wise to disclose that coverage is for a specific property, condition or a specific insurance carrier. Further, it might be appropriate to say that the agent has NOT reviewed client coverage needs concerning leases, contracts, directors, product liability, estate taxes, etc.

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

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

**InsurerDisclosure**

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

As accountability grows, some agent contracts are including aggressive hold-harmless agreements that impose liability on agents for any claims, regardless of fault, while others contain personal indemnification clauses that place an agent’s home and personal assets at risk. With ALL these disclosures present, it is a wonder how disputes develop between agents and their insurance companies. The answer lies in the interpretation of these agreements and circumstances that can be quite different for each transaction.

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

**Agency Relationship**

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

**Proximate Cause & Reliance**

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

**Estoppel**

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

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**Sample Agent / Client Disclosure**

*(Speak to an attorney before using ANY disclosure form)*

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Dear Client:

As you know, we are an insurance agency and not an insurance company. Our service to you includes the pricing and presentation of various insurance programs which may fit your needs, and the transmittal of your application to the insurance company. There are, however, limitations to our service, including the following:

1) **Premium quotation and coverage** are controlled by the insurance company and may be subject to change. We do not warrant or guarantee that a premium or coverage quoted by an insurance company will be identical to the ultimate premiums or coverage of the policy as issued by the company. There is no coverage promised or implied beyond the policy as written and endorsed. Your acceptance of the policy replaces all other agreements, either oral or written.

2) **While we are pleased to provide to you and explain the industry ratings of a particular company or alternate insurers, we do not make any independent investigation of a specific company's solvency or financial stability. We do not warrant or guarantee that any insurance company will remain solvent, and we will not be liable to any insurance applicant or insured for the failure or inability of an insurance company to pay claims.**

3) **Insurance companies rely on the truthfulness and accuracy of information provided in the application.** It is your sole responsibility to complete the application accurately, and if the insurance company should deny a claim based on its contention that the application has not been truthfully or accurately completed, we take no responsibility for such inaccuracy.

We ask that our client applicants signify their understanding of the foregoing points and their agreement to defend, indemnify, and hold us harmless against any loss or liability which may arise from the applicant's failure to truthfully and accurately complete the application, by signing and dating this letter in the place provided below and returning the copy to us. Kindly do so at your earliest convenience.

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

**ERRORS & OMISSIONS INSURANCE**

Like other professionals, insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients. While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives. After all, we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some policies do not cover punitive damages). Faced with these kinds of actions, insurers, who many times foot the bill for agent mistakes, are less timid about suing their agents and brokers for any malfeasance. Of course, to some extent, the very existence of errors and omissions insurance may be a factor in an agent being named in litigation that he may otherwise have avoided. In a case involving several security salesmen, for example, a pre-trial judge asked for a show of agents who did NOT have errors and omissions insurance. They were excused from the case! This could happen again, or not at all. Who wants to take the chance?

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

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

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

**Exclusions**

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

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

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

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

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

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of even one protected client claim and any subsequent judgement requiring an agent to pay any deficiencies and possible attorney/court fees. The cost of the average errors and omissions policy is cheap when compared to these costs.

If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy options that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits ($1 million minimum), the availability of prior-acts coverage and carrier solvency.

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

**Working With E&O Claims**

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

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

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can’t afford to “prejudice” your case in any way. Violating
this errors and omissions contractual promise is the sure way for coverage to be canceled.

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

**OFFICE PROTOCOL**

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

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

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

Following are some areas of office protocol that may make or break a claim against an agent:

**Automated Equipment**

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

**Application For Insurance**

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

**The Agent's File**

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

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

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

**Correspondence**

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

**E-Mail**

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

E-Mail communications are just as binding, admissible and prohibitive in court as other communications. Attorneys are finding damaging information in E-Mail files that they can’t find elsewhere. A recent high profile class action lawsuit against State Farm Insurance is a case in point. The plaintiff attorney’s used various e-mail communications to determine that State Farm violated terms of its policies by using non-factory authorized or manufactured parts to repair insureds' vehicles. This one more reason why it is imperative to have **use guidelines** for E-Mail.

For liability purposes, all parties who have access to E-Mail in your company should apply good judgment. They should communicate with E-Mail as they would in a public meeting. Sensitive information should be encrypted to protect it from being transmitted via the Internet. For the best protection, use software that requires passwords.

**Operations Manual**

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

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

- Client needs and requests should always be noted in the file. Many agents routinely take 5 minutes
after a client interview or phone call to document the needs and requests of the client in the file. Even if you have to shut the door and set the answering machine, this is important. Our sales conduct section discusses many routine questions concerning agent due care and client needs.

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

Rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed agents that fall under the category of consumer protection. Conflicts that surface here are usually the result of violations in advertising and deceptive or unfair trade practices. Agents in the real world find it near impossible to know each and every consumer statute, yet a single mistake could jeopardize a career and personal assets. Sometimes, it is the tiny indiscretions in business that create the problem. For example, placing a small and seemingly harmless “sub-title” on your letterhead that says “Professional Services Guaranteed” could hold you accountable for more than you bargained. Or, how about sending a withdrawal or surrender of cash value form to an insured to sign and mail back. This seems both efficient and convenient for the client, and a practice familiar with many agents. However, the client signature is not truly witnessed. Will a spouse or surviving family member who did not participate in any cash distribution deny the signature is real? Such is the way that matters of simple mistakes grow to legal conflicts. Knowing what is expected of agents in the consumer protection arena is the best place to reduce and avoid these problems.

INSURANCE ADVERTISING

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

What is Advertising?

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

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

What Isn’t Advertising?

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

Advertising Compliance

The consequences of using nonapproved advertising are both severe and damaging. Insurance regulators concerned about an advertisement’s content may require that ALL future advertising for the
Identity of Insurer or Product
If advertising focuses on a specific company it is advised that the FULL NAME of the company be used along with the home office address (City and State). Initials or abbreviations are not acceptable to most companies or insurance regulators.

Advertising should identify the insurer, the policy type and be understood by a person of average intelligence.

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

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

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

Words like “safety” should be supported while terms like “legal reserve” should be avoided, as should other words that might lead a purchaser to believe he was getting something other than insurance.

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

Comparisons, Ratings and Competition References
Comparisons made between policies and investment products, e.g., comparing an annuity to a savings account or a split limit quote to a single limit estimate, must be complete, accurate and not misleading. Agents have lost their license by using solicitations and letters that inferred that insurance is available at lower rates than others because of a special “volume plan”. All statistical information should be recent, relevant and the source and date identified. Any reference to a commercial rating should be clear in describing the scope and extent of the rating. If an A.M. Best, S&P, Moody’s or other rating is advertised, the appropriate disclosures should be given. References to the competition should be
factual and not disparaging. Comparisons to competitor’s products ought to be fair and complete and there should never be a reference to State Guaranty Associations as a means to induce the purchase of an insurance product.

**Disclosures**

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

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

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

**Illustrations or proposals must not be misleading.**

**Ratings should be supported and reference to competition should be fair.**

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

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

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

**Testimonials and Endorsements**

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

**OTHER UNFAIR INSURANCE PRACTICES**

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

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

**Identification**

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

**Defamation**

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

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

False Financial Statements

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

Stock Operations

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

Discrimination

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

Rebates

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

Deceptive Name or Symbol

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

DECEPTIVE OR UNFAIR BUSINESS PRACTICES

In addition to specified insurance codes, insurance agents must answer to generalized consumer protection laws carrying titles such as "Deceptive Trade Practices" or "Unfair Trade Practices". For the most part, these consumer laws apply to insurance and agents because an insurance policy is deemed a "service" and the purchaser of a policy is deemed a "consumer". Therefore, insurance
services fall within the meaning of widely adopted consumer protection acts. Agents are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by agents where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insureds or policy owners were not considered to be "consumers". By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked. The Uniform Consumer Sales Practices Act was enacted by the federal government and adopted by many states to protect consumers from deceptive marketing practices and establish a uniform policy. The essence of this legislation, as well as local and state laws, is that "buyer beware" is an old attitude now replaced by real laws and enforceable legal limits. The courts frown on oppressive and unconscionable acts and consider it the duty of any sales person and agent to disclose information available to him which gives him an unfair advantage in a sale. False statements constitute fraud, and the fine print in contracts may be construed, under certain conditions, as an intent to conceal.

Unlawful Trade Practices

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

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

**Burden of Proof**

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

**Legal Remedies**

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

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

**UNFAIR COMPETITION AND UNFAIR PRACTICES BY INSURERS**

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

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

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

**Unauthorized Insurer False Advertising**

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

**Unfair Settlement Practices**

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

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

**Discrimination by Handicap**

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

**Discrimination by HIV Testing**

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

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

**Discrimination in Rates or Renewal**

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

**Benefits Protection**

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

**Health Policy Benefits**

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

**Contract Entirely**

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

**Insurer Mergers**

The conditions and regulations necessary for two insurance companies to merge or consolidate are well documented in state insurance codes. Concerning consumer protection, however, it is important to know that all policies of insurance outstanding against an insurer must be assumed by the new or surviving corporation on the same terms and under the same conditions as if the policies had continued in force with the original insurer.

**Reinsurance Assumptions**

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

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

**INSURANCE THAT FAILS TO INSURE**

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

**WHAT GOES WRONG WITH INSURANCE**
Coverage Shortfalls

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

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

Coverage Disputes

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

One form of coverage dispute results when the agent fails to secure the promised coverage (Bell vs. O’Leary - 1984). The courts have found that when an insurance broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client’s agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

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

LEGAL MANEUVERS
Attorneys at Work

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

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

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

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

**Agent Records**

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in the **ordinary course of business**. In other words, if you use as operations manual or stick “post-it” notes in your client files as standard operating procedure they are generally admissible. The test will be: Do you use these methods for every client? An example might be a standard checklist of coverages that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available.

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

**Agent Cooperation**

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

**Insurer Records**

One of the latest approaches to pursue insurers and agents alike is the “class actin lawsuit”. Lawyers say the industry should expect new cases to attract massive numbers of complaintants and have a wider scope, reaching beyond manufacturers and sellers, to building owners, landlords, contractors, public housing authorities as well as agents and their brokers.

Technology is also playing a role here. A case in point: Two Illinois residents recently filed a class action lawsuit against State Farm concerning the use of non-factory authorized parts to repair their vehicles. Their lawyers established a website to recruit additional litigants Other lawyers say they use the Internet to look for opportunities in class action insurance claims.

In essence, people today are not waiting for something to happen to sue, they’re out looking for vulnerabilities. Some of the emerging legal battles include Y2K computer problems, Fen-Phen and Redux diet drugs, latex, construction product defects (plastic pipes), intellectual property rights (copyrights, inventions, trademarks, etc), tobacco, asbestos, lead and carbon monoxide.

Like citizens, entities involved in the business of insurance possess certain rights to defend against these claims. By the same token, like individuals, insurance companies facing a class action lawsuit must comply with discovery requests. This could mean turning over various insurer records such as correspondence between agents and the company, e-mail, financial transactions, etc. Most of these records are completely exposed to plaintiff attorneys since many are also documents routinely provided to regulatory officials conducting routine examinations.

To combat this exposure, many insurers are attempting to invoke attorney-client privilege by passing all regulator requests through their legal departments. These actions have prompted tension between regulators and insurers since many states believe their role as regulator provides them clear and complete access to insurer information under state insurance codes. Other states are honoring the attorney-client privilege protection.

In hopes of forestalling more regulator intervention, An increasing number of insurers have begun to utilize formal self-evaluation programs to systematically monitor the effectiveness of their policies and procedures relating to ethical market conduct and compliance with federal and state laws. For example, the voluntary Insurance Marketplace Standards Association (IMSA) was established in 1997 to promote ethical market conduct in the sale of life insurance and annuities to individuals. IMSA requires the life insurer to have a formal self-evaluation program in place in order to become a certified member. Other reasons driving insurers to use formal self-evaluation programs include obligations imposed on an insurer’s Board of Directors to inform itself of the corporation’s compliance with laws and regulations, In re Caremark International Inc. Derivative Litigation, 698 A.2d 959, 970 (Del. 1996); incentives under the federal sentencing guidelines for organizations to have an effective compliance program; and requirements under the Committee of Sponsor Organizations (COSO) of the Treadway Commission that auditors have an effective system of internal controls. All these programs may generate confidential internal communications or reports containing subjective self-evaluations.

Proponents of the self-critical analysis privilege argue that the protection of internal self-evaluative documents from discovery by adverse parties in private litigation encourages free and open discussion and promotes self-criticism in the process. Similarly, they argue that if these self-evaluative documents are protected from access by regulators and the public, companies would be more likely to engage in formal self-evaluation programs. “The public policy behind this privilege is that unless corporations are permitted to engage in vigorous self-examination without fear of public disclosure, corporations will not do so, and society will suffer.” SDO6 ALI-ABA 991 at 995 (1998); Troupin v. Metropolitan Life Insurance Co., 169 F.R.D. 546 (S.D.N.Y. 1996); Flynn v. Goldman, Sachs &Co., No. 91 Civ. 0035 (S.D.N.Y. 1993). Proponents also argue that the regulator can still gain access to the underlying facts and objective documents or data. It also argue that the subjective self-evaluation that is subject to the privilege, when it is recognized.
There is substantial debate about the applicability of the privilege for self-critical analysis to insurer documents. Many states have recognized it for very specific areas, such as medical peer review or environmental audits. It is argued that businesses have an obligation to comply with the law and sound business practices would require self-evaluation regardless of whether the information is accessible to the public. *Hardy v. New York News, Inc.*, 114 F.R.D.633 (S.D.N.Y. 1987). In addition, critics have argued the privilege conflicts with modern discovery rules that encourage disclosure of all evidence. Privileges "are not lightly created nor expansively construed, for they are in derogation of the search for truth." *United States v. Nixon*, 418 U.S. 683, (1974).

**Insurance Litigation**

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

**Triggers of Coverage**

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

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

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

The "trigger" is plain under these three policy provisions when property damage or bodily injury "occurs" during the policy period. But, the trigger question becomes somewhat complicated when a long period of time has elapsed between the act giving rise to liability. Examples include a leak or spill involving hazardous waste or exposure to asbestos or lead which may result in problems years later.
Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage "occurs" and thus "triggers" coverage. 1) The date of exposure to the toxic substance (the "exposure" theory); 2) the years in which the claimant incurred tangible injury ("injury in fact" theory); 3) the date of manifestation of injury (the "manifestation" theory) and 4) the year in which damage "occurs" or "could have occurred (the "continuous trigger" theory). The "continuous trigger" theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination. In essence, the courts have generally ruled that casualty insurance policies can be "triggered continuously" from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holder attorneys adopt a "continuous trigger" approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and NOT A "REOCCURRENCE".

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

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

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

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

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

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

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

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

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

**Assignments**
Conditions of most standard policies prohibit assignments without written consent of the insurer. Such provisions are enforceable because they ensure that the risk the insurance company agreed to insure remains the same. In fact, the majority of courts have refused to hold an insurer liable for an occurrence derived from a risk not contemplated by the insurer at the time the policy was issued. It is important to note, however, that prohibiting assignments does not bar the assignment of insurance
Rules of Construction
The rules governing the construction of insurance contracts are usually the same as those for other contracts -- the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured. Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

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

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer. A PRP letter (Potentially Responsible Party), received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple demand letter which only exposes one to a potential threat of future litigation.

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

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

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

Bad Faith
There is increasing judicial recognition that the relationship between an insurer and its policy holder is fiduciary in nature. Courts have compared the relationship of an insurance company to its policy holder to that of a "trustee for the benefit of its insured". Where an insurance company allegedly has violated its fiduciary duties owed its policy holders a bad faith claim could be appropriate in addition to any breach of contract action.
Choice of Law / Venue
Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are state law questions even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as 1) the place where policies were contracted; 2) the location of the damage and/or 3) the principal place of business/residence of the policy holder.

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

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

Environmental Litigation
There are numerous actions pending in state and federal court concerning the interpretation of commercial liability policies and environmental claims. Much of the confusion was started by the insurance companies themselves when they first marketed the 1966 standard form Comprehensive General Liability (C.G.L.) policy which represented coverage for environmental hazards. Some companies went so far as to refer to environmental problems, in their sales literature and presentations, as a "hidden exposure" that policy holders should consider. Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure.

Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost $4 billion in settlements from waste generators, disposers and transporters of hazardous materials. Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.

In response to a flood of litigation, the insurance industry began making adjustments. In 1973, certain terms in the C.G.L. policy were revised. For example, the 1973 C.G.L. policy defines "occurrence" as "an accident, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured." Obviously, an occurrence under the 1973 definition required exposure to conditions over a period of time. "Property damage" was also changed to read "physical injury to or destruction of tangible property which occurs during the policy period . . . or, the loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period."

Thus, compared to the pre-1973 contracts, "property damage" now requires physical injury to tangible property. This distinction may be critical in certain hazardous waste cases and in asbestos property damage cases. In fact, courts have held that some insurers are not required to provide a defense in suits where the there was no covered "occurrence" or "property damage" as defined in the C.G.L.

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the omission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents. A growing number of courts are siding with insurers where the
absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates.

**Excess Insurance Claims**

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

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

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

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

**Business Insurance Disputes**

In recent years, the number and variety of claims brought against business has increased significantly. In spite of this fact, many businesses have not given adequate consideration to the potential insurance coverage for these claims. As an example, businesses which face claims only against their directors and officers, might tend to ignore the possibility of comprehensive general liability (C.G.L.) insurance coverage. Likewise, when companies face claims of unfair business practices or statutory violations, they consider the bodily injury and property damage portions of their C.G.L. policies only, failing to consider the advertising injury and personal injury provisions, which may provide broader coverage.

In one advertising coverage dispute, the court held that the insured was NOT covered by its C.G.L. policy because the insured failed to establish that its advertising activity caused the alleged injuries. The insured was selling a product that "infringed" on a competitor suggesting that the relationship of selling and advertising were the same thing. Another court's rejection of coverage involved copyright infringement. Here, an insured distributed brochures that merely advertised copyrighted material for sale.

**Directors and officers liability** coverage typically insures the directors and officers directly and provides that the insurer will pay on behalf of or reimburse the directors and officers for "loss" arising from claims alleging "wrongful acts". Coverage is NOT afforded under this insuring agreement if the corporation is required or permitted to indemnify the directors and officers. Coverage has also been denied for claims involving dishonest conduct, claims in connection with the Employee Retirement Income Security Act (ERISA), claims involving bodily injury, personal injury and property damage as well as claims involving seepage, pollution and hazardous waste.

In a "wrongful entry" claim, the courts first rejected the insured's coverage under his C.G.L. because the insured trespassed AND committed battery against a tenant. The courts ruled that actual damages resulted from the battery only. Later, on appeal, the court reversed its decision since it was determined that the battery could not have taken place if the insured had not trespassed. The trespass made the battery possible.
Other, **business insurance coverage exclusions** occur under the following conditions:

Liability under contract, willful violation of a penal statute, offenses relating to employment, libel and slander made prior to effective date of insurance or with knowledge that it is false.

**Defenses of the Insurer**

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

**Concealment**

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

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

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**The duty of a client to disclose information on an application applies only to facts and not his fears or concerns**

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Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to facts, and not to mere fears or concerns of the insured about his health or the subject matter of the policy. There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

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

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

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

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

**Warranties & Conditions**

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

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

**Limitations on Coverage**

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

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

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

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

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

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

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

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

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

**Settlement Disputes**

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

**Reproduction Cost Less Depreciation**

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

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

Insurer Insolvency

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

If an insurer is liquidated, all policy owners and other potential claimants MUST be informed and permitted to file a proof of claim with the insolvent estate. These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

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

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

If a reinsurer indemnifies a liquidating company, it is only required to pay to the liquidator the actual loss it indemnifies. In other words, the reinsurer can only be called upon to pay deficiencies up to the limit it has agreed, once the ceding company, the liquidating insurer, has made all possible payments.

This provision, which appears in most reinsurance contracts, is called an insolvency clause. The disadvantage of an insolvency clause is that policy owners, guaranty funds and other third-party claimants have no additional claim against reinsurance proceeds. An exception to this rule is where a cut through clause exists. A cut through endorsement would require a reinsurer to pay a loss or specified portion of a loss directly to the policy owner or insureds when an insolvency or another specific event occurs. General creditors and other third party claimants could be excluded under a cut through endorsement.

State Guaranty Funds

The liquidation process can be extremely involved and lengthy. This is the reason that guaranty funds were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state. Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes subrogated to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company.
The guaranty associations are non-profit legal entities whose members comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

**Exclusions**

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

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

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

**Limits of Protection**

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

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

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

**Dollar Limits**

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

**Life and Health Guaranty Funds**

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

**Property/Casualty Guaranty Funds**

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

**Triggers**

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

**Coverage Options**

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

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

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

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**AGENT BLUNDERS & CONFLICTS**

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

Agent responsibility, in the past generation, has evolved from contractual compliance to ethical duty. Recent cases, for example, lean toward the precedent that agents, as insurance professionals, should have known something was wrong compared to years ago where agents were generally held liable for outright negligence in a matter. There is a world of difference between the two that is best explained by the *legal precedent theory* discussed in the preface. In a nutshell, this theory claims that because our legal system makes legal decisions based on precedents it is destined to constantly expand. Each decision in the chain sets the stage for the next step of expansion. This chain reaction is demonstrated in some recent court cases. In *Southwest vs Binsfield (1995)* the agent should have known that a specific coverage option was important to the business he insured. In *Brill vs Guardian Life (1995)* the agent breached his fiduciary duty by not using an optional conditional receipt. Clearly, the expansion of agent liability from decades-old “negligence” issues to these types of fiduciary duties is a trend. In the next chapter, we discuss these controversies and other potential conflicts which may be the next expansion phase, i.e., *sales and legal conduct issues of the future.*
In reviewing the following court cases, keep in mind that issues in the past that did NOT result in agent liability might indeed represent exposure today, mostly because of the legal precedent theory and the fact that courts and juries in more recent years show a willingness to sanction this expansion. Further, an agent who escaped liability in a conflict may not have escaped the huge cost of a trial or legal fees. A lot of agents fail to insure for this contingency and errors and omissions carriers can also refuse to cover the claim. Also, don’t assume that a casualty court case has no application to you if you sell life insurance and vica versa. Many legal matters concerning duties are fully portable and transferrable between classes of agent. Finally, be aware that some court decisions appear to “clear” the agent of wrongdoing. These decisions can result from issues extraneous to the case or a technicality.


**TYPE:** Health  
**ISSUE:** Inaccurate quote  
**RESULT:** Agent liable to obtain coverage promised

Plaintiff Drea claims that the agent’s quote for a company medical plan was a policy that contained an “active-at-work” provision, but the policy issued excluded coverage for claims be employees who were not actively at work on the first day of the policy period. The suit forced the agent to obtain a policy with active-at-work provisions at this own expense.

Aetna of the Midwest vs Rodriguez (1988)

**TYPE:** Casualty / Homeowners  
**ISSUE:** Failure to assess client’s real need  
**RESULT:** Agent responsible

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

Alaniz vs Simpson (1998)

**TYPE:** Automobile  
**ISSUE:** Adequate notice of no insurance  
**RESULT:** Agent not liable due to proper procedures

An agent owes duty not to mislead an applicant for insurance into believing he is insured when he is not. This duty also inures to the benefit of innocent third parties. In this case, the agent was not liable because he used proper procedure when he faxed a letter to the applicant that he was uninsured several hours before the applicant’s employee drove a company vehicle and caused an accident. The victim of the accident (a third party) unsuccessfully tried to sue the agent on the basis that he was liable to third parties for misleading the applicant to believe he was insured. The courts disagreed and the agent was cleared of any responsibility.

American Pioneer Life vs Sandlin (1985)

**TYPE:** Life / Annuities  
**ISSUE:** Misrepresentation of future 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 agent was liable.

**Ahern vs Dillenback (1991)**

*TYPE: Casualty / Auto  
ISSUE: Failure to procure adequate coverage  
RESULT: Agent not liable but paid big legal fees*

In 1982, clients were visiting California and purchased an automobile policy which agent said would cover them on an up and coming trip to Europe. Client requested “the best policy available” and agent assured client that she and her husband would receive full insurance coverage with policy limits that would safely protect them. In 1984, the client was driving in France and was seriously injured in a hit-and-run accident with an unidentified and uninsured motorist. Claims by the client were denied since the following coverages were not in the policy: collision, medical payments and uninsured motorist. Client's lawsuit against the agent was not successful in this case because the courts felt that the general duty of reasonable care that an agent owes a client does not include the obligation to procure “complete liability protection”. Further, there was NO special relationship with client that held agent to a higher standard of care.

**Bayley Et All vs Pete's Satire (1987)**

*TYPE: Casualty / Commercial  
ISSUE: Failure to obtain proper coverage  
RESULT: Agent liable for current and future losses*

In an unusual case a client owned a bar/lounge and was assured by the agent that his business was “fully covered” for alcohol-related lawsuits. In fact, the policy obtained for client contained an exclusion for such lawsuits. The bar was eventually sued for negligence by permitting a minor to leave the lounge while intoxicated and causing an accident. The insurance company cited the exclusion and refused to pay. The client sued both the insurance company and agent for full reimbursement of his costs to settle the accident case. The courts concluded that the insurance company was NOT liable but the agent WAS. Further, because the error was rooted in complete negligence, the agent was held liable for all future alcohol related lawsuits the client might incur.

**Bedford vs Connecticut Mutual Insurance (1996)**

*TYPE: Life  
ISSUE: Misrepresentation of policy terms  
RESULT: Agent liable*

Client purchased a whole life policy from agent under the assumption that coverage would be fully “paid-up” in six years. When it became apparent that the policy would not be paid-up in six years client sued and the courts determined that the special relationship between agent and client was a factor in determining agent’s fraud.

**Bell vs O'Leary (1984)**

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

**Benton vs Paul Revere Life (1994)**

**TYPE: Disability**

**ISSUE: False statements by agent**

**RESULT: Agent liable**

Agent sold a disability policy to his client on 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 are 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.

**Bitz vs Knox (1998)**

**TYPE: Disability**

**ISSUE: Submitting false application**

**RESULT: Agent liable for coverage not received**

Agent Ed Knox was sued by Plaintiff Bitz saying he (Knox) inadvertently submitted erroneous financial information on Dr. Bitz’s disability insurance application. A subsequent disability occurred but the insurance company refused the claim based on false information in the application. Bitz had to sue the insurance company to get the full coverage he was entitled to receive, but after attorney fees he was left with 1/3 less than he needed. This led to a suit against agent Knox who won the first round in the lower courts on the basis that the insurance company didn’t rely on the wrong financial data. A higher court reversed this decision making Knox liable for the coverage Bitz did not receive.

**Blumberg vs Paul Revere Life (1998)**

**TYPE: Disability**

**ISSUE: Agent promises that exceed authority**

**RESULT: Agent liable for new claims**

An agent was found to be liable when he marketed “guaranteed disability insurance” to a group / association regardless of previous medical history. The courts felt that the agent exceeded his authority in making new members of the association, as opposed to existing members, eligible for the guaranteed plan. The courts rules that an agent who fails to obtain insurance coverage promised is personally liable as an insurer. In this case, new member claims may fall in the agent’s lap to pay.

**Born vs Medico Life (1988)**

**TYPE: Health**

**ISSUE: Gaps in coverage**

**RESULT: Agent not liable but paid huge legal bills**

A client purchased a new health insurance policy from agent with a typical six-month pre-condition waiting period. Client then canceled his old policy but soon developed health problems that were waived by the precondition waiting period of the new policy. Client sued agent for “gaps in coverage” but court decided that agent did not have a duty to advise client about maintaining his old policy until
the six-month waiting period of the new policy had expired. Also, it was discovered that agent advised client specifically about the six-month waiting period.

Brill vs Guardian Life (1995)

**TYPE:** Life  
**ISSUE:** Failure to advise conditional coverage  
**RESULT:** Agent liable

A client expressed a desire to obtain life insurance coverage as soon as possible. Agent took client’s application but failed to advise client his option to pay a small fee for a conditional receipt which would have provided immediate, although temporary life insurance. Upon client’s sudden death, his widow sued the agent and company for negligence in failing to recommend use of the conditional receipt. The court sided with the widow by determining agent’s negligence was a breach of duty.

BSF Inc vs Cason (1985)

**TYPE:** Casualty / Homeowners  
**ISSUE:** Inaccurate application by agent  
**RESULT:** Agent liable

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

Boothe vs American Assurance (1976)

**TYPE:** Casualty / Homeowners  
**ISSUE:** Failure to notify application not accepted  
**RESULT:** Agent liable

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

Campbell vs Valley State Agency (1987)

**TYPE:** Casualty / Auto  
**ISSUE:** Agent negligence due to special knowledge  
**RESULT:** Agent potentially liable

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

Cartwright vs Equitable Life (1996)
Multiple clients purchased life insurance policies from an agent on the strength that policies were “self-supporting” after only three premium payments. When clients learned that automatic premium loans were reducing face values agent again reassured clients he would “take care of the problem”. The courts sought $6.1 million in punitive damages from insurance company for failure to curb agent after his conduct was first reported. Agent was fined $30,000 for fraud even though he was retired at the time of the trial.

**Commissioner vs Grossman (1986)**

Plaintiff Charlin says she never signed a waiver on uninsured motorist coverage. After her policy was issued she was involved in an accident with an uninsured motorist. She says agent Donovan failed to advise about the uninsured motorist coverage and did not obtain a waiver. Courts concluded that Donovan was not agent of the insured and was acting within scope of his duties. Agent and insurance company found not liable.

**Crobons vs Wisconsin National Life (1984)**

Agent sold client a life insurance policy. Client later became very ill and lapsed into a coma. Agent, who was fully aware that client was in a coma, “witnessed” a change in beneficiary signature that led to a dispute in determining the proper beneficiary of the proceeds. Agent was responsible for his damages by his fraud.

**Cuismano vs St Paul Fire (1981)**

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

**Cunningham vs PFL Life (1999)**

Agent’s, who held themselves to be professionals with superior knowledge, were found to have misrepresented life insurance policies as investment vehicles. The insured’s sued on breach of fiduciary duty leading to claims against the insurance company which was found liable for reckless and wanton failure to train and supervise its agents.

**Daniel vs Florida (1998)**
The plaintiff set out to help his son obtain a loan for a home in which he would own but his son and new wife would reside. The mortgage agent faxed a request to agent defendant asking him to cover the property. A note to the agent said that the “son is going to live there’. After the policy was issued a fire and theft of the property caused substantial damage. The father filed a claim for property damage and the loss of the son’s personal property. The son’s personal property claim was denied by the insurance company as they were not insured. The plaintiff filed a claim against the agent for negligently failing to obtain adequate coverage. The courts are still deciding this one but are leaning to the plaintiff since the original request for mortgage included a note about the son’s intention to reside at the property.

**Dahlke vs John Zimmer Agency (1997)**

**TYPE:** Casualty  
**ISSUE:** Policy language  
**RESULT:** Agent not liable where policy language is clear

The importance of obtaining and reading a specimen policy is underscored by this case. Here, an agent was insulated from liability where the policy contained clear and unambiguous descriptions concerning the insured’s deductible. The agent prevailed because of this clear language and the fact that the insured did not read his own policy, choosing instead to rely on the agent to make sure he was covered.

**Durham vs McFarland Et Al (1988)**

**TYPE:** Casualty / Homeowners  
**ISSUE:** Failure to obtain adequate coverage  
**RESULT:** Agent liable

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

**Eddy vs Sharp (1988)**

**TYPE:** Casualty / Commercial  
**ISSUE:** Failure to obtain adequate coverage  
**RESULT:** Agent liable under fiduciary duty

Client owned multiple rental buildings requested coverage from new agent similar to old coverage. The agent prepared a proposal describing his coverage as “All Risk” subject to a list of eight exclusions. Additionally the proposal contained the following disclaimer: “This proposal is prepared for your convenience only and is not intended to be a complete explanation of policy coverage or terms. Actual policy language will govern the scope and limits of protection afforded”. Client relied on the proposal letter and decided it met his needs. When the policy arrived he did not read it. Client losses resulted from the back up of water through drains and sewers (due to a clogged city drain). This was not covered by the policy but was not listed as an exclusion in agent’s proposal. The court held that the agent owed his clients a fiduciary duty, a duty of care under agency principals, and a statutory duty to accurately describe the provisions of their policy. Further, when agent described proposed coverage as “all risk” and clients accepted same, there was a binding contract obligating agent to obtain the promised coverage.
Employers Fire Insurance vs Speed (1961)

**TYPE: Casualty / Builder’s Risk**
**ISSUE: Coverage not obtained**
**RESULT: Agent sued but not liable**

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

European Bakers vs Holman (1985)

**TYPE: Casualty / Business Interruption**
**ISSUE: Negligence in obtaining adequate coverage**
**RESULT: Agent liable**

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

Evanston Insurance vs Fred A. Tucker (1989)

**TYPE: Casualty / Marine**
**ISSUE: Agent’s broker took premiums without coverage**
**RESULT: Agent responsible for client losses**

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

Eyerly vs Gregary (1999)

**TYPE: Casualty**
**ISSUE: Agent failure to notify insurer**
**RESULT: Agent liable for judgement in excess of policy limits**

The plaintiff became seriously ill eating contaminated food at a hotel-lodge. The hotel was owned by a Florida Corporation which immediately filed for bankruptcy to avoid huge damages. Plaintiff attorneys, however, found a DBA for the hotel under the name Anthony Connor. Both Conner and the Florida Corporation were insured by Bill Eyerly.
The insurance company denied any liability claiming that it never received notice of the plaintiff’s claim as Eyerly failed to forward the original complaint and summons. The courts didn’t agree and awarded a large judgement against Connor and the defunct Florida Corporation for $317,000. The insurance company paid the policy limits of $300,000 but the agent was found liable for the excess based on negligence.

**Fitzpatrick vs Hayes (1997)**

**TYPE:** Casualty  
**ISSUE:** Agent duty to procure additional coverage  
**RESULT:** Agent not liable because his advertising did not make him an “expert”

An agent’s brochure promoted a “family insurance checkup”. These words did not, according to the courts, establish assumed duty by the agent to advise the plaintiff insured about the availability and need for personal umbrella protection. This duty would only be imposed if 1) the agent misrepresented the scope of coverage, 2) the insured made a specific request for a particular coverage, 3) if the agent assumed additional duty by holding himself out to be an expert.

**Flattery vs Gregory (1986)**

**TYPE:** Casualty / Auto  
**ISSUE:** Agent failed to obtain options he bought before  
**RESULT:** Agent responsible for optional coverage

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

**Foster vs American Deposit Insurance (1983)**

**TYPE:** Casualty / Auto  
**ISSUE:** Agent miscalculated coverage period  
**RESULT:** Agent liable

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

**Free vs Republic Insurance (1992)**

**TYPE:** Casualty / Homeowners  
**ISSUE:** Insufficient policy limits  
**RESULT:** Open for future trial

Since 1979 agent provided client homeowner’s coverage and assured same that the policy limits were sufficient to rebuild his home. In 1989 client’s home was destroyed by fire and insurance proceeds were found to be less than needed to rebuild. The client brought an action against agent and insurance company in that they failed to inform him of the inadequate limits of coverage despite years of assurance. The courts held that the agent was under NO general duty of care to advise client about the sufficiency of coverage to replace his home, but once he elected to respond to his inquiries he acquired special duty to use reasonable care. Due to some extraneous issues a new trial was to set to establish liability.
Gabrielson vs Warnemunde (1988)

**TYPE:** Casualty

**ISSUE:** Duty at purchase greater than on-going

**RESULT:** Agent sued but not liable

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

Gauntt vs United Insurance Co of America (1994)

**Type:** Life

**ISSUE:** Agent refused to tender policy

**RESULT:** Agent potentially liable

A client requested the insurance company pay the accumulated cash value in her life policy. The company refused because the policy had already been converted to another policy without a current surrender. As a result of the dispute, the agent refused to turnover the client’s policy. The courts found that even though the policy was rightfully converted, the agent’s wrongful detention of the policy effectively denied the client the ability to know her policy rights and thus constituted a conversion for which the agent could be liable.

Glenn vs Leaman & Reynolds (1983)

**TYPE:** Casualty

**ISSUE:** Failed coverage due to insolvency of carrier

**RESULT:** Agent liable

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

Goebel vs Suburban (1997)

**TYPE:** Life

**ISSUE:** Agency agreement

**RESULT:** Agent could not be reimbursed by insurance company

An insured brought a “frivolous” claim against an agent regarding negligence in procuring coverage. The claim was quickly dismissed by the courts but the agent wanted reimbursement based on a clause in his agency agreement whereby the insurance company would indemnify agent against certain liability caused by the insurance company’s acts of omission.

The lower court agreed that the agent could be reimbursed, however, on appeal, the higher court
reversed this decision based on an additional clause in the agency agreement where agent and insurance company agreed to abide by common law. Unfortunately for the agent, common law in this state does NOT require insurance companies to indemnify agents against meritless claims.

**Grace vs Interstate Life (1996)**

*TYPE: Health*  
*ISSUE: Policy not necessary any longer*  
*RESULT: Agent potentially liable*

Agent obtain a health insurance policy for client who kept it going for almost ten years. Benefits of this policy were substantially replaced by Medicare after age 65 but agent continued to collect premiums. The courts determined that the special relationship that existed between agent and client created a duty for agent to disclose this fact and his silence made him personally culpable in a second potential lawsuit.

**Great American Insurance vs York (1978)**

*TYPE: Casualty*  
*ISSUE: Failure to follow instructions*  
*RESULT: Agent liable*

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

**Greenfield vs Insurance Incorporated (1971)**

*TYPE: Casualty / Business Interruption*  
*ISSUE: Failure to cover specific machinery*  
*RESULT: Agent liable*

Client requested business interruption coverage including mechanical breakdown of an automobile shredder. Agent assured client this coverage was in place but a claim for lost production went unpaid as uncovered. The courts ruled that even though the client failed to read the policy, he had a right to rely on agent’s representations as well as years of agent/client relationship. The agent was liable.

**Gulf Insurance vs The Kolob Corporation (1968)**

*TYPE: Casualty*  
*ISSUE: Reasonable time to cancel*  
*RESULT: Agent sued and liable in a costly trial*

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

**Hardt vs Brink (1961)**

*TYPE: Casualty*
Client owned a metal products company and leased space for which agent obtained a comprehensive liability policy. Although the agent never saw client’s lease, it included language that excluded the tenant client from any benefits of the building owner’s coverage. Thus, when a major fire damaged the building, the client was uncovered. In fact, agent’s coverage specifically exempted the insurance company from liability for damage to the leased property. The agent was sued and the court ruled that even though agent was unaware of the lease provisions, he had breached his duty to advise the client to obtain sufficient coverage under the lease. This duty was solidified through previous dealings with client where client followed all agent recommendations. Agent was liable for damages.

**Heritage Mutual vs Stevens (1996)**

**TYPE:** Casualty  
**ISSUE:** Agent failure to act / procure coverage  
**RESULT:** Agent partially liable

Insurance company sued its own agent saying he negligently requested reduced uninsured motorist coverage even though insured did not sign the UIM waiver. A subsequent accident with an uninsured motorist resulted in damages beyond the insured’s $50,000 UIM limit but the insured said he was entitled to up to his full $300,000 limit since no UIM waiver was signed.

The insurance company paid the claim but sued the agent for indemnity. An appeals court determined that the agent was responsible to pay the difference between the premiums paid and the premiums that would have been paid if the issued policy had included the UIM coverage agreed.

**Honeycutt vs Kendall (1982)**

**TYPE:** Casualty  
**ISSUE:** Client not notified about lack of coverage  
**RESULT:** Agent liable

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

**Hutchins vs Hill Petroleum (1993)**

**TYPE:** Casualty  
**ISSUE:** Failure to add additional insured  
**RESULT:** Agent found negligent

Client owned a maintenance company specializing in oil refineries. Client requested that agent name a refinery as additional insured under his existing policy. An employee of client was witness to the phone conversation where agent was orally instructed to accomplish this. When the agent failed to add the refinery, the client’s maintenance contract was terminated resulting in business losses. The agent was sued and the court agreed that the contract termination was, for the most part, the agent’s failure to add the refinery.

**INCO Express vs Marketing Insurance (1984)**

**TYPE:** Casualty  
**ISSUE:** Non admitted company / insolvent insurer  
**RESULT:** Agent sued at costly trial but not liable
This case involved a non-admitted insurance company that eventually became insolvent. When the client incurred losses, the agent and the surplus line broker he used were initially found liable because the agent failed to investigate a low-rated carrier and disclose to client that they were a non-admitted company. On appeal, the surplus lines broker was determined to have ultimate responsibility.

**Independent Life vs Peavy (1988)**

**TYPE:** Life  
**ISSUE:** Agent fraud  
**RESULT:** Agent liable for big punitive damages

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

**Jarvis vs Modern Woodmen of America (1991)**

**TYPE:** Life  
**ISSUE:** Preexisting condition and incontestable period  
**RESULT:** Agent potentially liable

Agent encouraged client to drop an incontestable policy and purchase a new policy even after being advised about client’s certain mental and financial problems. Policy was later canceled when these facts were found missing from application. The courts awarded $500,000 punitive damages against the insurance company based on acts of its agent and agent’s gross, reckless and wanton negligence. Further action by the insurance company against the agent was contemplated.

**Johnson vs Illini Mutual Insurance (1958)**

**TYPE:** Casualty / Homeowners  
**ISSUES:** Agent described wrong house  
**RESULT:** Agent liable

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

**Julien vs Spring Lake Agency (1969)**

**TYPE:** Casualty  
**ISSUE:** Failed coverage but principal disclosed  
**RESULT:** Agent sued but insurance company liable

The client was a builder who dealt with agent regularly among a variety of properties. Client requested agent cancel a specific policy and add two others. Although agent noted the request to add two policies, only one was issued. As luck would have it, the uncovered property incurred damages. Since the claim went unpaid the client sued both agent and insurance company. The courts found for the client but denied the insurance company claim for reimbursement from agent on the basis that agent had binding authority and all previous business policies were written with the same insurer. In essence, the courts felt that the principal was adequately known to the client even though coverage was never obtained. (Compare this case to Employers Fire vs Speed).

**Karam vs St Paul Fire (1973)**

**TYPE:** Casualty  
**ISSUE:** Failure to obtain adequate coverage
RESULT: Agent liable

Client owned a Laundromat and requested agent obtain “as much property damage liability insurance as possible”. Agent said that $100,000 was the most he could get. Client approved but through agent error only $10,000 was written. A water heater exploded causing $20,000 of damage. Agent was sued and found liable for the difference between damages and policy limits. The courts felt that the client had no responsibility to read the policy or the bill sent by agent which stated “$10,000 of coverage”.

**Kioutas vs Life Insurance Company of Virginia (1998)**

| TYPE: Life | ISSUE: Agent vs broker status | RESULT: Agent deemed “broker” with additional liability |

This court case establishes some specific rules on the broker vs agent controversy. Following are parameters which may determine status: 1) who set the agent in motion (who called the agent), 2) who controlled the actions of the agent, 3) who paid the agent and 4) whose interest does the agent represent.

In this case, an independent insurance agent, with no fixed relationship with any insurance company, represented the insured to obtain the most suitable and affordable life insurance from among various insurers. The courts determined that he was an “insurance broker” and he had prior knowledge of the insured’s cancerous condition which was not imputable to the life insurer.

**Kurtz, Et Al vs Insurance Communicators (1993)**

| TYPE: Group Medical | ISSUES: Dual Agency & Agent Misrepresentation | RESULT: Agent liable |

In 1985, client obtained group medical, life and accident coverage for its employees. Client was not knowledgeable in this area of insurance and relied on agent, who held himself out as an “expert” in the field. Agent advised client to sign a Certificate of Non-Applicability which essentially exempted client from certain Medicare provisions of TEFRA. In fact, this exemption does not apply to companies with more than 20 employees. Agent informed insurance company that client had only 12 employees when, in fact, he knew they had 30. A serious illness with client’s employee was the source of major claims in 1987. The insurance company paid for some of the claims, then informed client that is was not required to pay for the employee’s treatment because client had violated the above TEFRA provisions. Late in 1987 the insurance company canceled the policy and then demanded that client reimburse it for amounts already paid. A lawsuit was commenced in 1989 by insurance company which believed its coverage to be secondary to Medicare coverage. Client filed a cross complaint against insurance company and agent alleging breach of contract, breach of implied covenant of good faith, fraud, negligent misrepresentation and unfair business practices. The complaints between the client and insurance company were a “wash”, but on appeal, the agent was found to be liable for negligence and negligent misrepresentation.

**Lazzara vs Howard Esser (1986)**

| TYPE: Casualty | ISSUE: Agent missed split limit gap in coverage | RESULT: Agent liable |

Client requested $1,000,000 automobile coverage. Agent purchased two policies: A primary with $300,000 maximum and an extended policy covering claims in excess of $250,000 up to $1 million. A few years later, the primary coverage was issued for split limits of $100,000 per person and $300,000 per occurrence, i.e., a $150,000 gap occurred but client was not notified. Upon a loss client sued agent for the gap in coverage. Client prevailed because agent “had a duty to act in good faith with reasonable care, skill and diligence”.

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Levine vs Allmerica (1999)

**TYPE:** Life  
**ISSUE:** Dual agency  
**RESULT:** Agent possibly liable

Levine purchased universal life from an agent who assured him that his initial lump sum premium would be the full extent of his out-of-pocket premiums. This was not the case since the insurer eventually called for additional premiums. Levine sued for misrepresentation saying agent Seymour Prell was a “dual agent”. The case was referred back to the California courts to determine this status.

Lewis vs Equity National Life (1994)

**TYPE:** Health  
**ISSUE:** Agent failure to disclose known information  
**RESULT:** Agent liable

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

Life Investors vs Young (1999)

**TYPE:** Life  
**ISSUE:** Agent misrepresented application  
**RESULT:** Agent liable to reimburse own insurer

Life company sued its own agent to recover $26,000 indemnity for negligent failure to indicate an insured’s pre-existing condition on a credit life application. The agent allegedly wrote life coverage on a vehicle purchased by the insured knowing that he had pre-existing heart condition. The insured died and the claim was paid but the courts agreed that the agent must reimburse his insurance company for his misrepresentation of known facts.

Lott vs Metropolitan Life (1993)

**TYPE:** Life  
**ISSUE:** Deceptive sales practices  
**RESULT:** Agent and company subject to fines

Client’s employees were sold life policies through a “cafeteria plan”. Agent mistakenly represented to employees that they must buy life insurance in order the plan to be granted tax savings. Agent and company found liable for undisclosed damages and fines.

MacGillivary vs W. Dana Bartlett (1982)

**TYPE:** Casualty  
**ISSUE:** Agent failed to disclose insolvent, non-admitted insurer  
**RESULT:** Agent liable

Agent obtained insurance on client’s boat which was later stolen. Insurance company failed to pay claim since it was declared insolvent. Client also found out that this company was not licensed to do business in state. The courts determined that the agent’s failure to apprise himself of the non-admitted status of insurance company was gross negligence.
Magnavox Co of Tennessee vs Boles & Hite (1979)

**TYPE:** Casualty / Builder’s Risk  
**ISSUE:** Failure to obtain adequate coverage  
**RESULT:** Agent liable

The agent set out to provide a construction company “complete” liability coverage. Agent had done business with client for over seven years and had in his possession the construction contracts used by the client which required client to “indemnify” his customers damages occurring in connection with his performance. An employee of client’s subcontractor died in an accident and all parties were sued for damages, including agent. The courts held that the agent had a duty to advise the client of the need to be covered for the peril and was negligent in failing to investigate this need based on the client contracts he had in his files.

Mate vs Wolverine (1998)

**TYPE:** Casualty  
**ISSUE:** Special relationship / agent’s file  
**RESULT:** Agent liable

The courts determined that in this case the agent had a special relationship with the insured. As additional support, the plaintiff’s attorney produced notes from the agent’s file showing personal knowledge of the insured and her family. As a result of this special relationship and knowledge, the courts believed that the agent had a duty of care to know that the insured’s son was an uninsured motorist driving a car that was owned and covered by the insured.

Metropolitan Life vs Haney (1999)

**TYPE:** Life  
**ISSUE:** Bad illustration software  
**RESULT:** Agent could not recover from insurer

An agent used software provided by an insurance company to develop policy illustrations. When policies were issued, however, differences between the original illustration and the policy caused several insureds to rescind. The agent sued the insurance company for loss earnings due to the stress this caused. The courts did not agree saying that policy illustration software was a benefit to the agent which was only incidental to the goal of increasing sales. The agent got to keep his commissions but paid legal fees for his lost case.

Moss vs Appell (1998)

**TYPE:** Life  
**ISSUE:** Insurer insolvency should have been known by agent  
**RESULT:** Agent potentially liable for breach of fiduciary duty

Agent represented himself as a pension consultant and sold annuities to client. The insurance company ultimately became insolvent and the courts determined that a fiduciary relationship existed between the agent and client since they had been doing business for several years. Plaintiff contended that agent knew of pending problems with the insurance company when he received a letter from them indicating they needed to find capital to bolster reserves. In the end, the courts narrowed the case to liability for a breach of fiduciary duty pending the outcome of the insolvency.

Naijmias Realty vs Cohen (1985)
Client builder asked agent to obtain “replacement cost” coverage for his rental property. Agent instead procured “actual cash value” coverage. A fire to the building and requirements to meet updated building codes resulted in damages exceeding policy limits. Agent was sued for deficit and the courts awarded same to client due to agent’s breach of duty to obtain the correct coverage as instructed.

Nationwide Insurance vs Patterson (1985)

A trial court concluded that an agent was liable for misrepresentation for not advising client about the “stop loss” payment feature of his policy when he accepted a revised group health policy proposal. Agent was responsible for the stop loss damages.

Osendorf vs American Family Insurance (1982)

Agent handled ALL client’s farm insurance business for 10 years. Agent had visited the operation many times during this period but failed to advise client that he needed liability coverage for his employees. An on-the-job injury caused uninsured damages which the agent was liable to cover.

Pacific Insurance vs Quarlls Drilling (1988)

Agent and client agreed that “crew and employee injuries” would NOT be covered under a hull and indemnity policy because it was already covered by another liability policy. Somehow the crew and employee coverage was “bound and written” with the hull and indemnity policy. Meanwhile, the insurer for the “other” policy became insolvent and an employee-related client loss occurred. The client filed his claim with the hull and indemnity company which denied it upon learning that agent and client agreed NOT to include it. Because the agent produced documentation that proved this arrangement, the courts sided with the hull and indemnity company and agent. The client’s higher level of sophistication was also a factor in this decision.

Padeh vs Zagoria (1995)

An investment advisor/agent recommended client invest the proceeds of an investment into a pension plan and purchase additional life insurance for the same purpose. Client launched a lawsuit for reasons that the pension plan was ill-suited for their financial goals and life insurance was inappropriate inside this plan. The courts established that the agent misrepresented claims of the
potential benefits and offered negligent advice. Where results of the plan are negative, the agent has a potential liability.

**Parlette vs Parlette (1991)**

**TYPE:** Life  
**ISSUE:** Agent failed to name beneficiary  
**RESULT:** Agent liable

Agent sold a life insurance policy to a client, the primary purpose being to benefit the mother of the client if he died prematurely. Despite this knowledge, agent failed to see that the mother was properly designated as beneficiary. Upon the client’s death, the mother proved she was the intended beneficiary and sued agent for his negligence in failing to see that it was accomplished.

**Perelman vs Fisher (1998)**

**TYPE:** Disability  
**ISSUE:** Failure to provide coverage  
**RESULT:** Agent potentially liable

A broker procured a disability policy that did not provide a cost-of-living adjustment. The plaintiff sued the agent for breach of duties. Agent prevailed in the lower courts based on the evidence that the plaintiff was advised in writing to review the policy. The appellate court, however, held that the insured’s failure to read and understand the terms of the policy was not an absolute bar to recovery.


**TYPE:** Casualty  
**ISSUE:** Incorrect description of policy coverage  
**RESULT:** Agent liable

Client advised agent that a new telephone system would be part of his building. Agent indicated that the phone system would automatically be covered under the building’s blanket policy. Damages that occurred to the phone system were denied by the insurance company since it was NOT covered under terms of the policy. The courts found the agent liable for negligently conveying false advice.

**R.H. Grover vs Flynn Insurance (1989)**

**TYPE:** Casualty  
**ISSUE:** Agent error and negligence  
**RESULT:** Agent liable

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

**Reserve National Insurance vs Crowell (1993)**

**TYPE:** health  
**ISSUE:** Agent misrepresented preexisting condition  
**RESULT:** Agent liable

Client requested Medicare supplement information from agent and disclosed certain preexisting health problems. The agent told client he could receive better coverage under a new policy. After policy was issued, a claim developed which was denied by the insurer upon learning of client’s preexisting condition. The courts awarded client contract damages and punitive damages totaling 600 times the out-of-pocket expenses based on the agent’s intentional misrepresentations about the preexisting condition.
Rieger vs Jacque (1998)

**TYPE:** Life  
**ISSUE:** Professional referral  
**RESULT:** Agent escaped liability

Agents should be concerned about referring their clients to other professionals who do not do their job. In this case, the agent was not liable for referring a client to a trust attorney. The client suffered injuries from a defective trust but the agent escaped liability because the attorney created the trust and personally asked the client about his goals. In essence, the attorney did not rely on any statements made by the agent.

Saunders vs Cariss (1990)

**TYPE:** Casualty / Automobile  
**ISSUE:** Alleged signature fraud  
**RESULT:** Agent liable

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

Seascape vs Associated Insurance (1984)

**TYPE:** Casualty  
**ISSUE:** Agent claim that coverage was available was in error  
**RESULT:** Agent liable

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

Small vs King (1996)

**TYPE:** Casualty  
**ISSUE:** Duty to procure correct coverage  
**RESULT:** Agent liable to insurer for client losses

The specifics of this case are not as important as the result. Client requested “full coverage”. In response, agent obtained additional coverage, but the wrong kind. Client losses were attributable to the insurance company who sued agent for reimbursement. The court in this case ruled that the agent’s duty to provide correct coverage cannot be triggered by a client’s request for “full coverage” because that request is not a specific inquiry about a specific type of coverage.
Smith vs Dodgeville (1997)

**TYPE:** Casualty  
**ISSUE:** Application errors  
**RESULT:** Agent not liable but incurred huge legal bills

The insured sued agent for failure to procure coverage alleging agent's failure to ask if the insured had been cancelled (which he had). This is a standard question on the application that was not answered. A fire caused $370,000 to the insured's property and the insurance company refused to pay based on misrepresentations in the application. The courts forced the insurance company to make good on the claim on the basis that their own agent failed to ask the cancellation question. The case against the agent was dismissed, but only after legal bills were incurred.

Smith vs National Flood Insurance Program (1986)

**TYPE:** Casualty  
**ISSUE:** Improper notification by agent  
**RESULT:** Agent liable

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

Sobotor vs Prudential Property & Casualty (1984)

**TYPE:** Casualty  
**ISSUE:** Agent as expert / Failure to procure coverage  
**RESULT:** Agent liable

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

Soho Generation vs Tri City Brokers (1998)

**TYPE:** Casualty  
**ISSUE:** Failure to disclose previous loss history  
**RESULT:** Agent liable

The broker failed to accurately disclose on the application the client’s prior loss history, including a $205,000 loss within the last two years. The courts deemed this a material misrepresentation which relieved the insurance company of its obligation to pay a claim but subjected the broker to full liability.
Southland Lloyd’s Insurance vs Tomborlain (1996)

**TYPE:** Casualty  
**ISSUE:** Fiduciary duty is highest on agent’s own contracts  
**RESULT:** Agent denied coverage

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

Southwest Auto Painting vs Binsfield (1995)

**TYPE:** Casualty  
**ISSUE:** Lack of reasonable coverage  
**RESULT:** Agent liable

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

Speir Insurance Agency vs Lee (1981)

**TYPE:** Casualty  
**ISSUE:** Replacement coverage not obtained  
**RESULT:** Agent liable

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

State Farm vs Gros (1991)

**TYPE:** Casualty  
**ISSUE:** Misrepresentation and lack of agent notes  
**RESULT:** Insurer liable / agent sued

Client built a home on the side of a hill and carried a standard homeowners policy. The policy contained a common exclusion landslide damage. However, client alleged that agent told him “if a landslide made contact with your home, you’re covered”. Three years later, client filed a landslide claim. Agent advised client he was NOT covered for landslide. Lack of notes in agent’s file to support earlier conversations with client forced court to hold that the policy was misrepresented when purchased. The insurance company was liable and bound by the agent’s action.

Steadman vs McConnell (1957)

**TYPE:** Life Insurance
Agent sold multiple life contracts called “Bank Loan Life Insurance Plans” where clients paid the first annual premium on a ten-payment life insurance policy. The policy is subsequently assigned as collateral a bank loan. Proceeds of the loan are applied to payment of the second annual premium. On each anniversary date, a new note is executed in the amount then outstanding. The result of this process was that after ten years the cash values of the policy would be substantially less than the premiums paid. Knowing this fact, agent continued to promise clients that cash values, sufficient to meet their financial planning needs, would be available. They were not. The insurance commissioner accused the agent with misrepresentation, dishonest conduct and other counts which resulted in the suspension of the agent’s license for one year.

Stuart vs National Indemnity (1982)

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

Tillman vs Short (1973)

Client owned a business and purchased a group medical plan. Client sold business but continued to pay his portion of premiums with full knowledge of agent. A subsequent car accident caused client to submit a medical claim which the insurance company denied upon learning he was no longer a full-time employee (a requirement for coverage). Even though the agent seemed to be doing the client a favor client sued agent, but the court ruled that BOTH agent and client were equally at fault. It doesn’t pay to “cross the line”.

Todd vs Malafronte (1984)

Client maintained a business insurance policy through agent that did NOT include worker’s compensation coverage even though the agent knew that client hired a part-time summer employee. The agent had assured client that it was not necessary to cover this employee who was later injured. The client sued the agent for the damages and the courts agreed that it was the responsibility of the agent to be sure the client had proper coverage for this condition.

United Farm Mutual Insurance vs Cook (1984)

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

**Wal-Mart Stores vs Crist (1988)**

**TYPE:** Worker’s comp  
**ISSUE:** Agent exceeded authority / insolvent insurer  
**RESULT:** Agent not liable but incurred major legal expenses

Client (Wal-Mart) asked for bids on worker’s comp coverage. Agent submitted a $3.5 million premium offer which client accepted. After issuance, the high claims experience did not seem to match the payroll. Then it was discovered that a Wal-Mart employee intentionally misrepresented the payroll amounts to secure a better insurance bid. Thereafter, the insurance company refused to pay claims and demanded Wal-Mart pay premiums that matched its actual payroll. Just about that time, the insurance company became insolvent. A lawsuit followed that involved the agent. Through testimony, the courts determined that the agent and insurance company were equally at fault as Wal-Mart. In essence, all parties had sufficient information to know that the premium deal was “too good to be true”. No one was liable to the other, but all parties incurred huge legal bills.

**Ward vs Durham Life Insurance (1989)**

**TYPE:** Life  
**ISSUE:** Failure to disclose information on app  
**RESULT:** Agent potentially liable

Client purchased a life insurance policy from agent and later died. The insurance company denied benefits because certain health history information was left out of the application. The client’s widow sued on the basis that the agent told her and her husband that the missing information did not need to be disclosed on the application. The court ruled a new trial indicating possible collusion between agent and the client where no agent notes of the conversation could be produced.

**Watts vs Talladega Savings & Loan (1984)**

**TYPE:** Casualty  
**ISSUE:** Failure to notify premium due  
**RESULT:** Agent liable

For years agent worked with client by sending notice of payment due for real estate fire insurance coverage. The mortgage company would then draw a check from the escrow account and pay agent. The policy would automatically renew upon payment. For some reason, agent failed to send premium notice and the policy was canceled, despite a call to the agent by the mortgage company regarding coverage. A claim caused client to sue agent. The courts felt that agent had a duty to notify client that premium was due as he had in the past. A phone call from the mortgage company was further proof of agent’s negligence.

**Westrick vs State Farm (1982)**

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

White vs Calley (1960)

Client maintained a “builder’s risk” policy covering a rental home that was set to expire on April 16. In March, client requested that agent increase the insurance limits of the rental. Agent verbally agreed that she would “take care of increasing the insurance”. A few days later the agent delivered to client a routine rider that contained a mortgage clause to be endorsed on the new policy which commenced April 16. When the building was destroyed by fire on March 30, the insurance company paid ONLY the old value. Client’s lawsuit to obtain the new value from agent was successful even though agent testified that the client’s real intent was to increase limits for the new policy.

Williams Agency vs Dee-Bee Contracting (1984)

Agent discovered that client’s apartment building was underinsured. Unable to reach client about this situation agent left on a trip and took no further action. During agent’s absence, the client also learned about the valuation problem but was unable to reach agent. Agent’s secretary indicated that “the matter would be taken care of”. The client took no further action but a major fire destroyed his building. Agent was sued for failure to fully insure the property and the courts determined that agent was negligent.

A client maintained a comprehensive business policy with agent for her marina complex. The insurance company notified agent that this policy would no longer cover ice and snow damage but agent failed to advise client of this fact when the policy was renewed. When the next storm hit the area, the client lost 18 covered wooden docks which collapsed under the weight of snow and ice. The insurance company denied coverage and the client sued all parties. The courts determined the agent was negligent and liable for not advising client of this lost coverage even though her knowledge of same might not have changed the outcome, i.e., she would have suffered loss from the damage anyway because NO snow and ice coverage was available from any source.

**Wright Bodyworks vs Columbus Agency (1974)**

*TYPE: Casualty*

*ISSUE: Dual agency / lack of coverage*

*RESULT: Agent liable*

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

Coming from a decade of insolvency threats and major misconduct claims is it possible that future agent conflicts can get worse before they get better? Well, when courts and juries are involved, it can always get worse and it can always fail to improve. However, there is little to gain by wholesale pessimism. We prefer to say that the insurance business will put problems of the past aside and forge ahead . . . actually there is little choice, and our Country is based on this kind of self-healing. For example, when rising property taxes threatened California homeowners in the late 1970’s they pushed back with an initiative to limit taxes. When doctors were threatened by record-setting malpractice claims they pushed-back by placing limits on the claims, and when insurance companies got tired of settling every frivolous claim that came along they pushed back by taking them to trial. Of course, it will take time for these “push-back” efforts by the industry to build a defense against the tide of litigation. Along the way, new legal challenges will also need to be swatted down.

The purpose of this chapter is to suggest possible areas of legal and sales conduct exposure that agents may face in the future. Some of the issues proposed may seem too large to “suck-in” an individual agent, but that is probably what all of the agents in our “blunder’s” chapter thought. The fact is, you can be affected by these future conflicts. Your best defense, is to know about the “triggers” or events that create liability, i.e., stay on top of the issues, and manage potential conflicts using techniques similar to those we discussed in an earlier section.

CLASS ACTION PROBLEMS

A disturbing trend is the severity of individual claims and wholesale growth in class-action lawsuits. The cost of the American civil liability system ran $161 billion in 1995. That represented 2.3% of the nation’s gross domestic product, compared with 1.4% in 1970 and 0.6% in 1950. These rising costs have spurred efforts for tort reform, which have passed in almost every state. However, not enough to ebb the growth of suits.

Lawyers say the industry should expect new cases to attract massive numbers of complaintants and have a wider scope, reaching beyond manufacturers and sellers, to building owners, landlords, contractors and public housing authorities. The base is getting broader, touching every aspects of our lives.

Technology is also playing a role here. A case in point: Two Illinois residents recently filed a class action lawsuit against State Farm concerning the use of non-factory authorized parts to repair their vehicles. Their lawyers established a website to recruit additional litigants. Other lawyers say they use the Internet to look for opportunities in class action insurance claims.

In essence, people today are not waiting for something to happen to sue, they’re out looking for vulnerabilities.

In some cases, the insurers themselves are taking pro-active roles in mounting multi-million-dollar lawsuits against their own policyholders as in the case of manufacturers of polybutylene pipes for residential and commercial construction projects.

LIFE & HEALTH CHALLENGES

Sales Conduct

It will take years for the current wave of market misconduct lawsuits to settle down. Before it is all over, however, there will probably be a few more companies and agents fall. The claims will probably be similar to those we are now experiencing: insurance sold as an investment, non-performing vanishing premium policies, churning policies, misrepresentation for life insurance sold as a pension plan, interest rate and investment performance falling short of projections and more.
Currently, insurance companies are settling these suits even though claims are wildly exaggerated or untrue. As of the printing of this book, for example, major settlements are in the works for **Crown Life, Equitable Life, Metropolitan Life, National Benefit Life, New York Life, Phoenix Home Life and Prudential**. Pending cases are ongoing with **Allianz Life, Cigna, Jackson National Life, Manufacturers Life, Northwestern Mutual Life and Paine Webber**. Agents by the hundreds, who were involved with specific offerings of these companies, are being investigated. Already, more than 100 Met Life representatives (the first misconduct case filed in 1994) are charged with deceptive sales practice and at least one has been asked to leave the insurance business.

One of the most important lessons to be learned from these sales misconduct lawsuits is the need to conduct personal due diligence. Don’t always assume that sales literature from your insurer is without fault. The consumer protection issues presented in Chapter 4 discuss this as well as other matters critical to sales conduct.

**American Disabilities Act**

Insurance companies and their agents may see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA). In **Parker vs. Metropolitan Life (1995)** a client alleged unlawful ADA discrimination because the disability plan, administered by Metropolitan Life, distinguished between benefits for mental and physical disabilities. The client had already received the maximum two years of benefit for a mental disorder although the plan provided for payments to age sixty-five for individuals with physical disorders. Although the client did not prevail, the courts would have allowed these benefits for someone else who was ADA “eligible”.

**AIDs / HIV**

Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled “Schedule of Benefits”. The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable. **(Gonzales vs American Life - 1994)**.

**Defining Occupation**

In **Oglesby vs Penn Mutual Life (1995)** the insurer denied a disability claim to a client radiologist (vascular interventional radiologist) since a spine and neck problem still allowed him to practice within the same specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as “radiologist” then later narrowed it to “vascular interventional radiologist”. In essence, they could not deny benefits. Look for more of these “narrow definition” conflicts which may involve agents.

**Psychologically Induced Illness**

In **Rizk vs Dun & Bradstreet / Met Life (1994)** the client claimed he was unable to perform certain work tasks due to back injuries. The insurer denied claims because they felt that client’s injuries were at least partially *psychologically induced*. The courts, ruled in favor of the client because his disability was “total” as defined by the policy regardless of whether the illness was psychologically stimulated.

**Experimental Treatment**

There will undoubtedly be many cases defining what is *experimental treatment* under health policies in the years ahead. Recent cases have “tested” policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Clients have lost their claim for coverage on the basis of a legitimate denial based on policy terms **(Wolf vs. Prudential)**.
Insurance - 1995) and Hendricks vs Central Reserve Life Insurance - 1994) and (Barnett vs Kaiser Foundation Health Plan - 1994). Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner (Gonzales vs Associates Life Insurance - 1994) or where policy language was considered ambiguous (Fredericks vs Blue Cross of Michigan - 1995) and (Bailey vs Blue Cross of Virginia - 1994).

Language Barriers

There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. In Parsaie vs United Olympic Life Insurance (1994) a client prevailed in her action against a health insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.

Defining Accidental

Policy language often limits coverage for “accidentally sustained” injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who attempted suicide because “accidental” was NOT defined in the plan documents (Casey vs Uddeholm Corp - 1994). In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by an attempted suicide (Lutheran Medical Center vs Contractors Health Plan - 1994). Finally an insurer was prohibited from withholding a claim because the client had a “subjective expectation of survival”, thus even though his injuries were self-inflicted it was still deemed an accident (Todd vs AIF Life Insurance - 1995).

CASUALTY CHALLENGES

Some of the agent challenges above also have application to the casualty agent. There will also be new “legal” conduct issues related to fiduciary duties of agents as well as some unusual problems in the areas listed below:

Tenants As Implied Beneficiaries

The courts are leaning more and more to the proposition that tenant’s are implied beneficiaries under a landlord’s policy. In Bannock vs Sahlberry - 1994 the tenant and landlord had only an oral lease agreement. Even though the tenant was responsible for the fire, the landlord’s insurer could not recover from the tenant since he was an implied “additional insured”. However, in the reverse situation, a landlord could not be construed to be an implied beneficiary of the tenant’s policy (American National Fire Insurance vs A. Secondino - 1995). More bizarre is the case of Cigna Fire vs Leonard (1994). Here, the tenant was required to obtain fire insurance naming the landlord and mortgagee as additional insureds. However, he only purchased insurance on himself and then proceeded to intentionally burn his business to the ground along with the landlord’s building. The courts denied the landlord and mortgagee’s claim against the tenant’s insurer because there was “no clear intention to cover the lessor or the mortgagee”. Only the tenant was named in the policy but his claim was denied under the policy’s arson provision.

EIL vs CGL

Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are claims-made policies, while CGL policies are occurrence-
Based. The introduction of EIL insurance provided clients an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry’s position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would no be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.

One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. In Rhone-Poulenc vs International Insurance (1994), the client owned both EIL and CGL policies. However, the EIL policy contained a provision that loss or damage could not be recoverable as long as other insurance was in force. The courts ruled that the EIL was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.

Recent court decisions have and will greatly effect CGL policies. In the past two decades, a precedent case (International Surplus Lines vs Devonshire) held that CGLs cover only those liabilities arising from torts. New cases (Vanderberg vs Superior Court of California) now say that CGLs cover BOTH tort and contractual liability. The underlying reason that courts ruled against insurers is the CGL phrase “legally obligated to pay as damages’ describes liability based on breach of duty imposed by law, i.e.tort rather than contract.”

The courts rejected the distinction between tort and contract liability saying “A reasonable layperson would certainly understand ‘legally obligated to pay’ to refer to any obligation which is binding and enforceable under the law”. Experts feel that this decision could have far-reaching negative effects on insurers across the country, just as the International case had positive effects when it was decided in 1979.

Contamination

Despite the fact that policies have been written as “All Risk” insurers continue to deny contamination claims based on policy exclusions. In W.H. Breshears vs Federated Mutual Insurance (1994), the court rejected a client’s claim for coverage on the basis that an oil spill on his property was not “covered property” because it was “land” and “pavement” only, not considered “property”. In Conde vs State Farm Fire & Casualty (1994), a client was denied coverage, which was upheld by the court, for contamination caused to his home by an exterminator’s negligence because “contamination” was not defined in the policy. The court also rejected the client’s argument that the exterminator’s negligence (a covered peril) was the actual cause of loss.

“Sick Building” Syndrom

People have an unusual ability to acquire the problems and illnesses of others. Most “sick building” illnesses are found to be psychologically based rather than rooted in fact. In Sternmann vs May Department Stores (1994), an employee claimed a long-term disability from toxic exposure at her place of work. The company refused full disability coverage since tests showed that toxic levels did not exist in the building. The courts ruled against the client even though her physician’s diagnosis was total disability due to toxic exposure and chemical sensitivity.

Asbestos

The removal of asbestos continues to be a major source of conflict between clients and insurance companies. In University of Cincinnati vs Arkwright Insurance - 1995 asbestos was found in a dormitory that suffered a partial loss due to fire. The client’s all risk policy did not cover the removal of asbestos since it was not considered an unexpected event

Lead

New standards introduced in September 1996 require property owners who are selling or renting real
estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

**Business Interruption**

On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: “In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred”. In *American Auto Insurance vs Fisherman’s Paradise (1994)*, the client lost his argument that his store would have made huge profits in the aftermath of Hurricane Andrew if it were left undamaged. The courts disagreed indicating that hypothetical profits would have created a “windfall” not contemplated by the policy.

**Miscellaneous Actions**

In addition to the events mentioned above, experts anticipate actions in the areas of Y2K compliance, Fen-Phen and Redux diet drugs, latex gloves, construction product defects, intellectual property, tobacco and carbon monoxide.
By now, everyone has accepted the growing consumer enthusiasm for the Internet. In all areas of sales, customers are getting used to going “online” to learn more about products and services. Internet purchases are expected to rise from 123 million in 1996 to 600 billion in 2000. The growth is so rapid that consumer expectations in this area are changing about every 12 months: a cycle that is much quicker than the insurance industry is accustomed to. Some feel that agents and insurers are well behind the times in keeping up with the technology changes. Others are fighting the change, electing to stay on a paper-based system in hopes that their clients still value the “personal relationship” enough to bypass use of the Internet.

The next question is will people use the Internet to buy complicated financial products, like insurance? Some feel the a majority of the market is not ready. However, the fact is that new market groups are entering the system. People who are in their 20's – the “Nintendo generation” -- are becoming agents as well as day-to-day consumers. To them, computers and the Internet are just another tool. These people will be thinking about creative and expanding ways to use the Internet for faster, effective consumption of goods and services. As their numbers, and the generations behind them, become major players as consumers and competitors, it will be harder to ignore an Internet presence.

The biggest fear of agents is the prospect that the selling of insurance online could increasingly cut out the middleman (agents). Most experts do NOT believe this will happen since most insurance is purchased when an agent uncovers a need and encourages the consumer to take action. This prediction, however, has not stopped certain companies from trying. Direct sellers are surfacing on the Internet and competing with agents at reduced rates. Agents and brokers are fighting back by finding ways to “add value” to the equation. For example, one major broker is developing a “global brokering system” so its agents and offices around the world can trade placements electronically with carriers. Another is building its technological services and capabilities simply to expand its level of customer service.

Even if the internet does not become a vehicle for widespread direct purchasing of insurance policies there are more than a dozen reasons and ways that the industry and agents can benefit:

- 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. 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.

Still others are using the Internet to find a special niche in the market, e.g., the sale of term life insurance using instant quotes from multiple carriers. The non-standard automobile market is another area where drivers with multiple accidents can go online to research their options. Some companies already boast the ability to upload information, get a policy number and billing information, bind coverage and let the customer know they’re protected, all within minutes!

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.

**WHAT IS ELECTRONIC COMMERCE?**

Electronic commerce is a broad category of activities that allows goods and services to be selected, purchased, received or serviced using, in all or in part, electronic based technologies.

Electronic based technology means the transmitting, receiving, and storing of data in an electronic format including, but not limited to, the following:

- the electronic transmission of data including transmission via telephones, electronic mail (e-mail), facsimile, File Transfer Protocol (FTP) or any other transmission of data over communication lines;
- use of the Internet, Electronic Data Interchange (EDI), or other public or private networks;
- imaging;
- electronic funds transfer (EFT) or other established means of electronically transferring funds between two parties;
- television, radio or other broadcast media;
- interactive voice response (IVR) mechanisms;
- wireless transmissions; or any other means of conducting business by transmitting, receiving and storing data in an electronic format.

**WHAT IS THE INTERNET?**

The Internet began in 1968 when the Advance Research Projects Agency (ARPA) at the United States Department of Defense began developing ARPA.net, 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.

POTENTIAL USERS 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

The Producer Information Network (PIN) and the Producer Database (PDB) are two examples of on-line regulator systems that function as central depositories tracking producer licensing, licensing demographics, regulatory actions, agent disciplinary actions, company appointments and more.
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.

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.

SELLING 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.

**LEGAL ASPECTS OF SELLING INSURANCE OVER THE INTERNET**

**Countersignature Requirements and Other Non-resident Solicitation Restrictions**

The countersignature of a resident agent is required in some states in order for a non-resident agent to transact business within the given state. The resident agent signature is referred to as a countersignature.
Countersignatures impede the sale of insurance through traditional and electronic means. Countersignature requirements were originally intended to protect consumers under the assumption that the resident agent would be more knowledgeable about the state laws and would provide a valuable service to policyholders by reviewing the policy for compliance with state law. They were developed in a time when state jurisdiction was a concern. It is generally agreed that this requirement has served its usefulness and now only serves as a protectionist of resident agents’ commissions.

Some states also have laws, regulations or other requirements that specify that a non-resident producer must be accompanied by a resident producer to solicit insurance. While originally implemented to protect consumers, the utility of this type of requirement has passed.

Most E-commerce experts believe countersignature requirements should be eliminated, as should any requirement for a resident agent to physically accompany a nonresident agent when visiting a potential policyholder.

**Signature Requirements**

The traditional “wet” signature is used to signify several actions. It is used as a formal symbol of intent to denote an individual’s agreement to terms and conditions set forth in a document – “by my signature set forth below I hereby agree…”, or to acknowledge receipt of the item(s) in question. It is also used to convey that the signer is indeed who he/she purports to be (authentication). This latter use may be equated to a “notarized signature.”

The terms electronic and digital signatures tend to be used interchangeably but there are significant differences. An “electronic signature” may be any symbol or mark originated electronically with an intent to authenticate an action. A “digital signature” is a methodology of signing an electronic document to ensure its integrity during transmission utilizing “public key cryptography.” The individual sending a document signs and encrypts it with a private key that only he/she possesses. Once so encrypted, the resulting document is termed a “digital signature.” A recipient of the document uses a public key (which may be in the possession of multiple parties) to decrypt the document. Verification of the authenticity of the digital signature is facilitated when the signature includes a “digital certificate” issued by a “certification authority” or CA. The digital certificate is issued only after the identity of the signer seeking the certificate is verified by the CA, and, in this way, is analogous to the function performed by a notary public. The digital certificate carries the name of the subscriber and the subscriber’s private key.

Public key cryptography provides the foundation for network security through encryption and digital signatures. Together these provide the following capabilities fundamental to conducting secure electronic commerce transactions: confidentiality (data is obscured and protected from view or access by unauthorized parties); access control (data can only be accessed and decrypted by those specifically identified when the data is encrypted); authentication (users can securely identify themselves to other users and servers on a network without sending secret information about themselves); data integrity (the verifier of a digital signature can easily determine if the digitally signed data has been altered since it was signed); and non-repudiation (users who digitally sign data cannot successfully deny signing that data).1

Requirements that documents be “signed” are found in all lines of insurance. Following is a partial list of the types of “in-writing” requirements that provides some examples of the types of signature requirements that now exist:

- With respect to life and health lines, insurers are generally prohibited from asserting that an applicant materially misrepresented facts unless the facts are contained in an application signed by the applicant and attached to the policy. This effectively requires all underwritten policies to be accompanied by a signed application.

Some health insurance policies, including Medicare supplement insurance, may not be issued unless the applicant has signed the application. The purpose of the signature requirement is to protect consumers by evidencing they have read the materials accompanying the solicitation.

Property and casualty forms evidencing coverage offers must be made in writing by the insurer and often accepted or rejected by the insured in writing. Such coverage includes, but is not limited to: uninsured/underinsured motorist; personal injury protection; medical payments; deductibles; tort thresholds; extended reporting periods on claims made coverages and fraud disclosure statements. The rejection in writing has been interpreted to require the applicant or insured’s signature.

Before electronic signatures can work, we must determining what constitutes a valid signature. A review of each requirement for signature should be undertaken to determine if the requirement is necessary for consumer protection. “Electronic authentication” such as that provided by digital signatures utilizing the public key cryptography approach described above, allows commercially acceptable and reasonable security measures to take the place of “wet” signature requirements for the purpose of accommodating electronic commerce. Authorities like the National Association of Insurance Commissioners (NAIC) recommend that electronic authentication be an acceptable form of signature. However, limiting acceptable signatures to digital or digitized electronic signatures may exclude other reasonable means of authenticating one’s identity. Therefore, electronic authentication strives to allow any reasonable type of technology to fulfill the basic purpose of a “wet” signature requirement (i.e., the authentication of the signer).

A working group assembled by NAIC recommends that, where possible, the legal definition of “signature” be redefined to include all verifiable electronic signatures as follows:

1. In cases where a written signature, or other means of authentication, is required, the use of electronic means, which may include an electronic signature, to authenticate the identity of the party(ies) involved shall be acceptable as long as:
   - The means of electronic authentication is uniformly applied to the consumer; and
   - The electronic authentication is unique to the signer, is verifiable, and neither the signature nor the document to which it is affixed can be altered once signed.

2. Electronic authentication should be permitted wherever “signatures” are required, including processes such as application and claim submittal. A review of authentication requirements in all insurance transactions should be conducted to identify and remove inhibitors to electronic commerce. For example, when a consumer shops for private passenger automobile insurance, he/she may be required by state law to submit a separate form to verify that he/she was offered such benefits as uninsured or underinsured motorist coverage, certain levels of deductibles, or a warning that insurance fraud is illegal. With electronic commerce, separate forms, each signed or authenticated by the consumer, may not be necessary or even feasible. If the consumer is shopping on a web site he/she should be permitted to view a page that discusses and offers uninsured/underinsured motorist coverage and warns that insurance fraud is illegal. To continue with the online application, the consumer would have to select a link at the bottom of the page and be asked to verify that he/she had read and understood the previous page or pages. This process, with some means of authentication that it was the consumer who indeed “clicked” the “OK” button, could take the place of separate forms, being authenticated by the consumer in a way very much like signing separate forms.

The following list of documents are typically required to be accompanied by a “signature”:

- Policy application
- Warranties
- Release of confidential medical information
- License applications
- Beneficiary changes
3. Delivery of Documents

The delivery of complete documents refers to transmissions between insurers and regulators as well as the receipt of insurance policies, notices and any other documents relating to the sale of insurance, by the insured, owner and other third parties that may have a pecuniary interest.

The major concerns with electronic commerce and document delivery are the ability of regulators to verify that the policy or other insurance documents involved in a sale of insurance from an insurer were actually delivered to the consumer in the sale transaction, are maintained by the insurer in either electronic or paper format and are available to the consumer within a reasonable time upon either electronic or written request by the consumer. Records retention systems will allow regulators to verify the content of a policy or other insurance document through inspection of the policy or document, and such systems must also reasonably accommodate requests from insureds for copies of their policies or insurance documents.

In the arena of electronic commerce, many consumers will want policies and other insurance documents delivered electronically. Moreover, there are clearly advantages to electronic delivery for the consumer, mainly in the speed with which the delivery can occur. While the insurer must let the consumer know prior to the purchase of the policy how it will be delivered, laws and regulations need to allow for electronic delivery.

There is a special area where notice requirements deserve special attention. For various lines of insurance, the delivery and receipt of a notice of cancellation is important not only to the insurer and the policyholder, but various other parties that may have a pecuniary interest in the insurance contract. For example, cancellation of an auto insurance policy may not only affect the policyholder, but third party victims of the policyholder's negligence. Further, mortgage holders have an interest in property polices. The issue is whether the notice has been delivered by the insurer and whether the notice has been received by the policyholder or other party with a pecuniary interest in the policy that is entitle to receive such notice. Free look periods for life insurance are also an issue.

Following is a list of some current document delivery requirements:

- Many states require insurers to deliver hard copy (paper) versions of documents, including policies, positional letters from claims, billing notices, cancellation/non-renewal notices, certificates of insurance.

- Some proof of mailing requirements specify registered or certified mail from United States Postal Service or a verifiable courier service.

- Some states have proof of coverage laws that may be unique to different coverages.

Document delivery through electronic means should be permitted if agreed upon by the insurer and the applicant, policyholder, certificateholder, or other parties involved in the transaction, but the burden is on the insurer to meet all existing requirements for policy delivery regardless of the method in which the policy or other insurance documents are actually delivered to the insured. In addition, any policy or other insurance document delivered to an insured during the insurance transaction must be
maintained by the insurer in either electronic or paper format and the insurer must be able, in a
reasonable time period, to provide an electronic or paper copy of the policy or other insurance
document to the insured upon written or electronic request by the insured.

The NAIC working group recommends that states review and, if necessary, amend existing laws,
regulations and processes to recognize electronic notification as a valid way to notify a policyholder,
given that both parties agree to the method, and receipt of the notice by the insured is verified to the
extent required by law, and acceptable records are maintained. For purposes of delivery, and other
communications required or permitted by a state and its attendant regulations, delivery and
communication by electronic or other verifiable means shall not be precluded where agreed to by the
parties

Once again, it is preferable to specify the parameters for document delivery rather than trying to
predict all of the ways in which policies may be delivered electronically in the future, developing
requirements for each method of delivery.

4. Format of Documents

Format of documents refers to stylistic presentation requirements including font size, margins, paper
color and paper size.

Insurers are burdened by requirements that relate to font size, paper color, or other requirements that
are related to presentation on printed documents that may not be able to be met electronically. For
example, some states have required workers compensation notices to be on non-standard sized paper
and printed in red.

Because of the wide variety of operations that users can perform upon displayed and printed text in
the modern PC environment, it is impractical to hold originators responsible to insure that textual
content is displayed or printed with a specific font or size, or on a specific page size or color. On the
other hand, protection of the consumer is the paramount concern.
Therefore, to promote electronic commerce, it is recommended that existing law specifying font type
and size for printed documents be interpreted for electronically transmitted or displayed documents
as using a font with characters which are clearly discernable and understandable to a person
conversant in the written language presented, with as nearly as possible, in the given font, the same
relative character sizes for different parts of the document as are specified by current law. Any web
site containing documents covered by such laws should offer a readily-selectable large print display
option for the benefit of persons whose eyesight is diminished due to aging or for other reasons.

5. Electronic Payments

Electronic payment includes, but is not limited to any electronic means of securing payment that is
acceptable to all parties involved; such as, wire transfers, smart cards, phone cards, electronic fund
transfers, electronic checks, credit cards or debit cards.

The following text details various impediments to electronic payments that appear in state laws,
regulations or processes:

- Premium Payment

Currently, the principal statutory impediment to the use of electronic forms of premium payment
involves payment by credit card. Requirements for insurers may vary with the line of insurance.
Some state laws, regulations or processes totally prohibit the use of a credit card for payment of
life or property/casualty insurance premiums or allow those payments only if the card is issued by
a bank that is domiciled in the state.

In some states, an insurer which offers a credit card payment option must offer additional payment
options, such as advance payment by check or the “bill me” option. In addition, certain states
require that, if payment by credit card is made available to some insureds, it must be made available to all insureds on a nondiscriminatory basis.

- Claims Payment

Certain state statutes, which formerly required claims to be paid by check or draft, have expanded permitting forms of payment to include electronic funds transfer. Such statutes arguably prohibit newer forms of electronic payment, such as electronic checks.

- Settlement refunds

Refunds directed by insurance commissioners almost always require insurers to issue a check to the insured rather than a credit to his/her premium account or bank account. The most recent example is a Michigan Insurance Department directive to insurers, which stated that crediting an insured’s premium account rather than issuing a check was in violation of the spirit and intent of the mandated refund in the state.

- Payment of Taxes and Fees

Some states authorize the System for Electronic Rate Form Filings (SERFF) and permit the commissioner to accept filings in electronic form. Some states accept SERFF filings but nevertheless require that a check in payment of filing or retaliatory fees be mailed to the department of insurance.

With the implementation of the Producer Information Network (PIN), the processing of agent appointments and licenses may be done electronically. A barrier to the implementation of PIN, however, is the requirement in some states that a check in the amount of the fee be paid before the transaction may be completed.

A few states affirmatively authorize the insurance commissioner (or more commonly, the commissioner of revenue) to require or accept payments of fees or taxes by electronic funds transfer (EFT). This would suggest that the removal of statutory or regulatory barriers prohibiting payments by EFT are insufficient to allow such form of payment; specific authorization is apparently necessary. Additionally, as discussed earlier with respect to claims payments, newer forms of electronic payment, such as electronic checks, may not be permitted even under these EFT enabling statutes.

For electronic commerce to be as effective as possible within the insurance industry, the use of various electronic means, such as credit cards, debit cards, electronic funds transfer (EFT) or other means of electronic payment that is acceptable to both the insurer and the insured and is verifiable in order to meet the “Proof of Payment” requirements under the statutes must be allowed. Insurance consumers will demand that electronic payments be facilitated when using electronic systems to purchase and receive insurance products. To this end, regulators should eliminate prohibitions or restrictions against electronic payments to the fullest extent possible. This issue should be dealt with on a nondiscriminatory basis.

The NAIC working group received comment that some insurers may be reluctant to accept premium payment by credit card because there are limitations on how merchants pass fees paid to the credit card company back to the credit card users. The working group did not confirm this, but if true, it is a barrier to credit cards as a form of electronic commerce in premium payments. Any restrictions on pass through of credit card fees are most likely governed by banking laws and regulations. Insurance regulators may wish to review the interaction of banking and insurance regulation in their states as they review various forms of electronic commerce for premium payment. Therefore, the working group notes that pass-through issues resulting from the use of electronic payment options should also be considered.

Note:
A Connecticut statute applying to the Commissioner of Revenue Services might serve as a model for
payment of fees by insurers to insurance departments. The statute gives the Commissioner the authority to require “the filing, by computer transmission or by employing new technology as it is developed, of any return, statement or other document that is required by law or regulation to be filed with said commissioner...and permits any person “to pay any tax, to which such return, statement or other document pertains, by electronic funds transfer...and further permits the Commissioner to “prescribe alternative methods for the signing, subscribing or verifying of such return” and “permit the payment of any tax...by use of any new technology as it is developed.”

6. Records Retention

Records retention encompasses the requirements for length of retention and method for storing company records.

Records retention laws, requiring insurers to maintain hard copy (paper) documents for a period of years, are found in many states.

Rather than attempting to specify technical requirements for electronic records retention systems, which will continue to evolve rapidly, the NAIC working group recommends that regulators clearly enunciate the basis for records retention requirements and place the burden solely on the insurer to meet those purposes with whatever system is chosen. Following is sample language taken from the NAIC Market Conduct Record Retention Model Regulation:

“Records required to be retained …may be maintained in paper, photograph, microprocess, magnetic, mechanical or electronic media, or by any process which accurately reproduces or forms a durable medium for the reproduction of a record. A company shall be in compliance with this section if it can produce the data which was contained on the original document. In cases where there is no paper document, a company shall be in compliance if it can produce information or data which accurately represents a record of communications between the insured and the company or accurately reflects a transaction or event.”

Note: The Freedom of Information Law (FOIL) should be reviewed for further information.

7. Disclosure of License Status

License status disclosure ensures that consumers have a means of readily identifying whether an insurer or producer is authorized to transact insurance in the consumer’s location and for the insurance products being considered.

Some states currently have disclosure standards that contain stylistic requirements such as font size or other characteristics like the use of strong, bold or emphasis tags, or the use of specific heading levels.

Existing standards that apply to this type of consumer notification should apply to electronic transactions, however, additional standards should not be imposed on electronic or Internet-based transactions that do not exist for other means of delivery.

Disclosure standards should, at a minimum, continue to require disclosures to be prominently displayed and easily readable. Disclosure standards should not contain stylistic requirements that could cause impediments to electronic commerce.

To ensure that consumers are provided the data needed to make informed decisions on purchasing insurance, the NAIC working group recommends that an insurer’s web site should provide a disclaimer containing the following information: a listing of states and product lines it is authorized to conduct insurance business in; the specific name of the insurer, if it is an affiliate of a large group of insurers and the name, phone number and address for the state insurance department consumer representative that can be contacted for licensure confirmation. The working group also recommends that a producer’s web site provide a list of product lines and insurers that it is soliciting for, the
complete producer name (as registered with the state insurance department), the corporate name if applicable, the trade name if applicable, the certificate of qualification number and the complete business mailing address and telephone numbers.

8. Advertising

To advertise is to make a public announcement, regardless of the media used, to proclaim the qualities or advantages of an insurance product or service for the purpose of increasing sales.

The regulation of advertising can be a problem for insurers and producers regardless of advertising medium. The Internet complicates this issue because an individual can access an insurer or producer web site from any location. This feature makes requirements for filing and prior approval of advertising material difficult or impossible for insurers to meet. Further, the fact that an insurer or producer maintains a web site, or other electronic presence, does not, in and of itself, necessarily mean that the insurer is “advertising” insurance products or transacting the business of insurance within a state. Similar concerns exist with national media advertisements.

The NAIC working group recommends that filing and prior approval of advertising be eliminated as an inefficient use of scarce regulatory resources. The working group believes that retrospective review of advertising through market conduct examination or other state regulatory review processes will adequately and efficiently protect consumer’s interests. Further, Unfair Trade Practices Acts provide sufficient relief for consumers regardless of the medium used.

*Note: The progress of the NAIC Suitability Working Group should be monitored for further information on this issue.*

9. Compensation

For purposes of this discussion, compensation is something of value provided to an individual or business as payment for a service rendered.

A problem has been identified that hinders insurer development of electronic commerce solutions. If an insurer or producer enters into an arrangement with a third party service provider where the third party service provider is compensated based on a percentage of premium, there is a technical violation of state insurance law. The third party vendor is considered to be a “producer” under many state laws and must be licensed to sell insurance. This gets in the way of insurers and producers entering into this type of service arrangement or causes the parties to engage in creative financing to get around the law that was intended to prevent commission sharing arrangements with non-licensed insurance entities.

10. Code and Regulation Clean-up

Many existing statutes and regulations unnecessarily hinder the growth of electronic commerce. These statutes and regulations have evolved over periods of many years, and are presumed to hinder the growth of electronic commerce out of a lack of anticipation of its needs, rather than out of any intention to hold back its development.

Examples of this problem are statutes and regulations worded in such a way as to require traditional mailing of notifications, and thus precluding some form of electronic mailing which would include verifiable receipt. Another example is statutes and regulations worded in such a way as to require hand-written signatures, and thus precluding some otherwise acceptable form of electronic signature.

Rehabilitating these statutes and regulations one at a time might take as long as the original enactments, and would be extremely costly in time and resources. The recommended approach by many is to enact legislation which globally allows the interpretation of existing statutes and regulations in such a way as to embrace electronic commerce technology. For example, legislation can be enacted to allow all statutory and regulatory requirements for a handwritten signature on a paper document to be optionally satisfied by a verifiable electronic signature on an electronically transmitted document.
The State of Arkansas recently enacted legislation that may be useful to other states looking for a quick way to clean-up existing statutes and regulations to make them more compatible with industry and regulatory uses of electronic commerce. In short, the new statute allows the Commissioner to interpret the words “print,” “printed,” and “printing,” among others, to include an electronic printing or form.

11. Proof of Coverage

The ability to verify that specified coverage is in force for a given insured or risk.

In many instances, particularly with automobile, homeowners’ and health insurance, individuals are called upon to prove that they have a specific type of coverage in effect. Often, states specify the format of a proof-of-coverage form. This form can then, as an example, be used to verify automobile coverage to register the car or when stopped by a peace officer.

If proof-of-coverage is required by other codes and is maintained electronically, experts agree that the proof-of-coverage must be producible in an acceptable format to satisfy the other requirements.

12: Privacy Issues

Following are some areas that may be considered in an analysis of privacy:

- Underwriting issues related to medical information — The NAIC Health Information Privacy Model Act deals with these issues.
- Access to personal information collected including personal information, financial information, claim information and health information
- Regulator access to insurer information — There is much controversy today concerning insurers turning internal documents requested by regulators for monitoring purposes only to have it procured by a plaintiffs attorney in a class action filing against the insurer.
- The NAIC domestic violence model acts deal with issues related to the issuance of insurance policies and discrimination for victims of domestic violence.
- Compliance of electronic commerce with current federal and state laws dealing with privacy issues.
- Access to information contained in documents supporting rate and policy form filings.
- Access to statistical information that advisory or statistical organizations compile for insurance regulators to assist with providing industry statistical data.

Miscellaneous Legal Impediments

There are several areas not identified in the sections above that affect an insurer’s ability to employ electronic commerce. The following list discusses various miscellaneous impediments to electronic commerce that appear in state laws, regulations and processes:

- Approval of Electronic Policy Forms - The issue here is how can insurance regulators address “electronic” policy forms. These are forms that are stored in component parts and only become a complete contract when assembled for an individual policyholder. Recommendation: SERFF should, in a future iteration, be able to access insurer web sites to review electronic form features and notices.

- Underwriting Issues - The issue here is access to underwriting information addressed by the Health Privacy Models. The tendency is to require consumers to give their approval before an insurer can gain access to confidential health information. See consent authorization.

- Binding authority issues. Similar to proof-of-coverage.

- Overcoming lack of consumer trust in institutions and/or producers.

- Consumer complaints. Is it possible to link insurer electronic sites with state sites so the consumer
Mortgages – original certificates of insurance. Add to proof-of-coverage area.

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 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.

**SECURITY & 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.

BEYOND THE INSURANCE SALE

THE NEED TO LOOK BEYOND INSURANCE

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

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

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

- The need for a structure to protect business and property owners from new and exotic
environmental liability which may be excluded by their insurance or entirely unknown by present
standards.

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

**COST OF LIVING**

It costs a lot to live today and it will cost a lot more tomorrow. The question is: Will you miss
something? Will you guess wrong? Will you place more emphasis on covering one area of need to
the deferment of another?

There are many rules of thumb you can use to gauge the amount of life or medical coverage needed
to cover loss of life or a major health condition. But, will the $250,000 life policy you sold last month
leave enough to cover an additional eight years of medical school for the surviving dependant who
suddenly finds out he wants to be a doctor? Will the health policy you delivered this morning cover
new treatment options that might be considered “experimental” today, but standard procedure years
from now? If not, there will be a huge coverage shortfall. How about the long term care policy you sold
to a middle-aged couple. Will the $92 daily nursing home care coverage do any good when inflation
has bumped the cost of nursing homes to $250 per day in 20 years? All of these examples are
possible outcomes that you or your clients cannot anticipate; or, perhaps you did but the cost to cover
them is NOT currently affordable.

**EXPANDING LIABILITY**

The idea of using and needing additional methods to replace or augment insurance coverage has
more chance to grow today than ever before. Why? Because the ways to get to you or your clients
are constantly expanding. Consider this partial list:

- Direct liability
- Imputed liability
- Joint liability
- Excessive debt
- Negligence
- Contract disputes (oral and written)
- Ownership related liability
- Environmental hazard
- Safety issues
- High risk occupation
- Status (Officer or Director)
- Business risk
- Employees
- Market trends
- Unfair trade practices
- Partnership obligation
- Government obligations
- Code violations
- Taxes

Face it, your best efforts to limit a client’s financial and legal exposure cannot insure that policy limits
will be breached or, by exclusion or technicality, completely fail. Furthermore, our country’s *expanding*
liability policy almost guarantees that along the way you will miss something. Just think about the thousands of legal decisions each year based on precedent. A new case “borrows” something from a previous case; another viewpoint is borrowed from a different case; and so on and so on. Soon you have a completely different “spin” on the original decision. Undoubtedly, someone will tie the McDonald’s “too hot coffee” case to “hot soup” or “hot egg rolls”. These cases could be the springboard to “too cold food” or even “bad tasting food”. Under conditions like this, it will be difficult if not impossible to cover your clients for every possibility or problem.

COST OF DEFENSE

Just as important as expanding liability is the outrageous cost of defense. A single mistake or accident that exceeds policy coverage can bury a client. And, in cases where punitive damages are involved, there may be no coverage at all. Quite simply, our tort system does not favor defendants. It has been said that “once you have been sued, you’ve already lost”. A defendant can incur years of legal fees simply responding to a lawsuit -- even if he is found completely free of any liability. In his book The Litigation Explosion, Walter Olsen argues that “a litigator can come around, dump a pile of papers on your front lawn and you can go literally broke trying to respond to it”.

Deep Pocket Pursuit

Many of the risks we have discussed can be and are routinely insured by agents. However, there are conditions where this coverage is less than adequate or it simply fails to cover for one or more reasons.

Insurance can fail to insure in many ways. The source can be an agent's negligence in not providing essential coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability of the insurance company to pay, e.g. insolvency of the insurer. In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent.

Coverage Shortfalls

Many Americans consider themselves dutiful to purchase and maintain insurance often buying multiple policies with varying features and limits.

People work the first half of their life to build an estate. During the last half, they are constantly worrying about someone trying to take it away from them. It’s called “deep pockets” and it is the single greatest reason that people get sued. Today, there are lawyers and other “legal pirates” who only get paid if they find a deep pocket: be they your’s, a client’s or the deep wells of an insurance company. This is the day of the “frivolous” claim, the class action, the “suppressed” childhood memory and the “too hot coffee”. If your client has deep pockets, someone will be looking for a way to get at them and your policy may fall short or fail.

Asset Protection Planning

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

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

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

**Legal Protection Theories**

There are as many legal techniques that form the basis of asset protection as there are forms of insurance. The nucleus of these strategies, however, is focused on specific principles of legal theory. Here are a few to consider:

**Free Alienability of Property**

Our common law system favors the **free alienability of property.** In essence, this theory concludes that one who is free from creditor concerns is absolutely free to dispose of his property as he sees fit. This may include gifts to children, a spouse or a transfer to a trust. Clearly, asset protection planning is not an excuse to defraud creditors or evade taxes. Furthermore, fraudulent conveyance laws generally protect present and subsequent creditors from transfers of assets made by a person who is or foreseeably will become their debtor. In essence, asset protection should be viewed as a vaccine, not a cure. And, like a vaccine, it should be administered before a problem . . . when the legal waters are calm . . . for best results.

**Whole vs Sum of the Parts**

One of the basic premises of good asset protection is the legal assumption that "the whole is worth more than the sum of the parts". This issue takes on more meaning with the knowledge that most asset protection planning involves the intentional "breaking up" of large ownership blocks into much smaller blocks, each with its own title and life. The force and effect creates a smaller "target" for a plaintiff or large creditor to pursue.

It has long been a fundamental legal tenet that small, individual ownership can lead to better protection of assets because a third party interested in laying claim to a client's assets will consider a fractionalized interest to be worth far less than a whole. The common sense of this issue prevails: A creditor or high ticket insurance claimant, will factor in the cost, time and effort needed to force the sale of a single block of assets, under one ownership, in contrast to the much higher cost, time, effort and delay to retrieve multiple, variously titled assets. Further, in the case of some fractionalized assets that have been planned properly, there is no hope of the third party actually acquiring the asset. Rather, he would have to settle for the right to any income or benefits that might accrue from the fractionalized interest. For most, the thought of being in business with other fractionalized owners who are, for the most part, at "odds with the third party", will be a distressing issue to overcome. In such cases, third parties may be completely discouraged from pursuing such an action. This is an important element of asset protection to keep in mind when studying the forms of ownership that follow.

**Choice of Governing Law**

In the United States, individuals generally have the freedom to select the law that will govern a business transaction. Examples include the use of Delaware or Nevada corporate law by a company domiciled in California. Choice of law principles likewise allows a grantor of a trust to set up a trust that is governed by the laws of his or her home state or any other state. Taken further, there is no reason to limit one’s choice of law to a particular state, the fifty states or any one foreign country when a world of governing laws is available.

Factors to consider when choosing a governing law include the tax laws of the jurisdiction, whether laws are more favorable and protective, the political and economic climate of the jurisdiction, language
barriers, telecommunication facilities, etc.

**Free & Clear vs Encumbering**

The old school thinking -- owning "free and clear" -- is not always the best way to protect assets. By owning property free and clear, one is exposed to the potential for a large loss. In the case of real estate, a large earthquake can demolish property. Similarly, a sizeable judgment from a lawsuit can take property away. Some asset protection attorneys suggest encumbering or highly leveraging property (loans) to such an extent that a creditor will lose interest in pursuing it.

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

**Problems With Legal Entity Protection**

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

**Fraudulent Transfers**

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

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

Broadly speaking, a **fraudulent conveyance is defined as** a transfer of property without adequate consideration and with the intent that the transferee will hold the property for the benefit of the transferor, returning it when requested, so as to defraud creditors who could otherwise seize the property in payment of their debts. If a transfer is found to be fraudulent, it can be made "null and void" by a court of law.

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

The determination of whether a transfer of assets is "fraudulent" or lawful is a matter of a court's evaluating a number of factors including **intent, timing of the claim, pendency of the threat of litigation, solvency of the debtor, consideration and the relationship between the transferor and transferee, concealing the transfer, the transfer of one's entire estate, and the transferor's retention or control of benefits.**

**Intent** In general, if the courts determine that a debtor has a particular creditor or series of creditors in mind and is trying to remove his assets from their reach, his intent is "fraudulent" and could be grounds to allow a judgment to proceed or discharge a bankruptcy. If the debtor is merely looking to his future well being, the transfer would not be fraudulent.
**Timing of Claim** Specific bankruptcy laws provide that every transfer made and every obligation incurred by a debtor **within one year** prior to the filing of bankruptcy is fraudulent.

**Fair Consideration** In general, a transfer of property by a debtor is considered fraudulent if the conveyance is made without receiving reasonable consideration in exchange for the property. In essence, the transfer is a sham to avoid creditors.

**Threat of Claim** To constitute a fraudulent conveyance, there must be a creditor in existence or the debtor feels there is a threat of claim from a current or future creditor. However, where the creditor is not in existence at the time of the transfer there must be evidence presented by a damaged creditor that there was still fraudulent intent. An example might be the physician who systematically transferred assets out of his name because he was unable to secure malpractice insurance and, at the same time, restricted his practice to less risky medicine. Courts held that the doctor acted prudently to protect his assets from future, unforeseen adversity where malpractice insurance was not available. Here, future “victims” of the doctor’s medical malpractice were not identifiable or known, individually or as a class. Further, as long as no evidence proved that the doctor intended to commit malpractice, the transfer of assets was NOT legal fraud.

**Debtor Solvency** The solvency of a debtor is another factor used by the courts to determine fraudulent transfer of property. Cases where legal fraud were proved include situations where debtors were “head over heels” in debt just prior to transferring assets or where the debtor transferred assets knowing that the business venture he was starting or operating was highly speculative or financially hazardous. In other words, the courts will rule fraudulent conveyance where the debtor’s objective is “If I succeed in business, I make a fortune . . . If I fail, my creditors will bear the loss”.

Obviously, there are many facts that can determine the fraudulent nature of transferring assets. As a result, there has been significant federal and state legislation that control this area of law, each with corresponding criminal and civil penalties.

**Creditor Access**

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

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

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

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

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

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

For most other property, the general rule is that **the creditor can acquire the interest of the debtor**. And as a tenant in common, the creditor can force a sale of the common asset. For this reason, it is important to select co-tenants who appear to be relatively free from financial problems.
**Community Property** The general rule is that community property is liable for debts of either spouse during the course of the marriage.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Exemption Planning**

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

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

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

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

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

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

**Life Insurance & Annuities** Both are exempt without filing. This means a creditor cannot force a policy holder to cash-in his policy. However, a debtor can be forced to borrow against the policy. The first $4,000 in loan value is exempt ($8,000 for a husband and wife). If a policy matures, the proceeds are exempt to the extent that they are reasonably necessary for the support of the debtor, his spouse and dependents.

**Health Insurance** Benefits from a disability or health insurance policy are exempt without filing (does not apply if the creditor is a health services provider).

**Retirement Plans** In general, state laws protect most private or public retirement plans, IRAs and Keoghs from creditor claims unless they have exceeded their contribution limit or are needed for child or spousal support.

**Personal Injury or Wrongful Death Damage Awards** Most are exempt to the extent they are needed to support the debtor and his family.

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

Well known types of bankruptcy filings include:

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

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

**Medicaid / Medi-Cal Planning** A huge portion of our senior population has been caught “off-guard”. Their longevity combined with escalating costs of long term care has created a need to try and capture the benefits of Medicaid through exemption planning. If they don't, a reasonable stay in a nursing home could impoverish their entire estate.

It is a small wonder, then, why these people have turned in record numbers to lawyers and financial advisers to find Medicaid loopholes -- ways to divest themselves of income and assets in order to qualify for Medicaid.

The process by which medical and nursing home care reduces a person’s assets is known as a spenddown. In the case of Medicaid, some have referred to it as the “path to poverty”. In essence, a person can't get assistance from Medicaid until virtually all assets are depleted. Certain assets are considered noncountable or exempt. They include:

- a house used as a primary residence.
- a care for transportation to work or medical services
- a wedding ring
- a cemetery plot
- household furniture
- cash surrender value of life insurance under $1,500
- real property if it is essential for support (land to grow food) or it produces income for one’s daily activities.

Assets that are countable vary from state to state. California lets the recipient keep about $2,000 in liquid assets. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medicaid purposes. Here is a short list of what counts:

- cash, CD’s and money market accounts
- stocks, bonds, mutual funds
- treasury notes and treasury bills
- vacation homes and second vehicles
- cash value life insurance and deferred annuities
- revocable living trusts

Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living.

In addition to exempt assets like a house, car and burial plot, the amount a spouse can keep varies from state to state. The maximum in California is $80,760. The amount that can be kept is determined by adding ALL available assets of BOTH husband and wife. If one-half of the total does not exceed the amounts above, the spouse can keep them. The rest must be sold and used to pay any medical bills before Medi-Cal will participate.

In addition to asset criteria, there are guidelines for income. Generally speaking, for a person to be eligible for Medi-Cal he must spend all his income -- Social Security, pensions, interest,
dividends, and so on -- on nursing home care before Medi-Cal helps.

In other states, the income restrictions are severe. Income is “capped” at $2,019 per month, even if all assets are “spent down” and even if this income doesn’t cover the cost of the nursing home.

All of these guidelines and limits are a clear reminder that Medicaid and Medi-Cal benefits are supposed to be for low income individuals.

Offshore Protection

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

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

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

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

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

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

Multi-Entity Protection

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

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

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

Following are the entity structures involved:

**The Limited Liability Company**

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

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

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

**Corporations**

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

The downfall of the corporate format in California is that since 1962 the California Supreme Court has indicated that if it is inequitable for the business creditor, the court will not allow the corporate “veil” to protect your business or personal assets for your creditors. In essence, then, if your Corporation is sued or has an IRS problem, not only are all of your business assets completely exposed to the business liability, but your personal assets could also be completely exposed through the business liability.

**The Family Limited Partnership**

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

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

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

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

The Revocable Living Trust

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

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

Multiple Entity Structuring in Action

A possible structure for both business and personal affairs might utilize a Limited Liability Company to operate an existing or new business. The LLC is for the most part a marketing company. It enters into contracts, employs individuals, and generally absorbs all of the liability of the business. The LLC is operated as a “shell”; it owns no assets. The purpose for utilizing the LLC as a shell company is that if the LLC has creditor problems or is sued then it can file for bankruptcy protection and a new LLC can be put in its place very quickly and efficiently.

A corporation might be utilized in the business context to handle all of the advanced tax planning for the business. The Corporation is usually filed in Nevada to take advantage of the fact that
Nevada does not have state income or corporate taxes. A Nevada corporation can be set up to be either one of the partners of the LLC or can be utilized to own the equipment of the business and lease the equipment back to the LLC. The advantage of owning the equipment through the Nevada Corporation and leasing it to the LLC is that if the LLC ever has creditor problems it can file bankruptcy and the Nevada Corporation can reclaim the equipment and re-lease it to a new LLC.

With respect to personal assets, planners recommended that they be held by a Family Limited Partnership or Limited Liability Company as represented in the illustration.

**Implementing a Multi-Entity Asset Protection Plan**

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

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

**Maintaining Control of a Multi-Entity Program**

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