

Loss Control Practices



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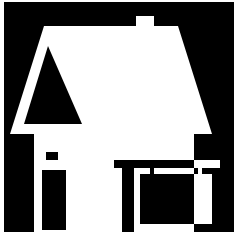


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Chapter One

Introduction to Loss Control

What is Insurance Loss Control?

The total impact of an insurance claim can devastate you, your client, his home or business. Sure, insurance indemnifies in the event of a covered loss and helps to offset. But there are other uninsured costs that have a large impact on insureds, their lifestyle and/or their company's operations, market share, and overall public perception. These costs may include emotional adjustments, relocation, rehabilitation, lost work time, production downtime resulting in excessive loss in time, loss of key employees, increased costs of selecting and training new employees, and costs to improve poor company image, just to name a few.

Loss control is a plan of action to reduce or eliminate hazards and losses to hopefully prevent the claim or accident from ever developing and/or minimize its impact. A good loss control plan might . . .

- Analyze claims experience to determine patterns and causes of losses
- Review or help client to establish risk management programs
- Evaluate current loss control measures against expected results
- Identify several alternative solutions
- Help select the most cost-effective option

While this course will touch on all of these areas, we are most concerned with identifying risks and solutions. First, however, a few basics must be understood.

Definition of Property

Because the term "property" is so general, there is no single widely accepted system for classifying different types of property. However, it is customary to draw a distinction between **real property** and **personal property**.

Real property includes unimproved land and buildings and other structures attached to land. Real estate, other than all permanent property improvements, is known as unimproved land. *Unimproved land* is classified separately because its value may be difficult to determine, and because perils that can damage unimproved land are unique.

Such land may contain water (lake, river, creek, springs, or the underground water table), mineral resources (coal, iron, oil, copper, bauxite, potash, sand, or stone), natural attractions of commercial value (a cave, therapeutic spring or pool, historic site, or artifacts), growing plants (timber, fruit trees, or pasture land), or resident wild animals. Another principal component of value in much unimproved land is its location, which may have little relationship to the physical characteristics of the property. Some perils that may strike unimproved land do not generally affect other property. Growing crops or timber are subject to brush or forest fires and plant diseases. Agricultural crops (such as vegetables and grains) may be damaged by rain, hail, snow, drought, and other weather conditions. The soil itself may be lost by erosion (caused by water or wind) and landslide.

Buildings and other structures can be subdivided into various categories. Their exposure to loss depends primarily on their type of construction, occupancy, protection against fire and other perils, and location. A sprinkled building probably is much less likely to suffer a major fire loss than an identical but unsprinkled building. Buildings and other structures under construction are subject to special hazards. Their security is relatively poor compared to that of completed structures. Fire detection and suppression devices may not be operational, and there are many open spaces through which a fire can spread.

Personal property includes all property other than real property and can be classified as either *tangible* or *intangible*. Real property is the rough legal equivalent of the more common term "real estate," meaning land and things of value permanently attached to it such as buildings, other structures, and things growing on land. Personal property is all tangible property other than real estate.

Tangible property, both real and personal, is subject to both physical damage (including destruction) and wrongful taking. When property is damaged, destroyed, or wrongfully taken, the owner or user of that property can lose much more than the value of the property itself. He or she might lose the use of that property as a way to earn income or other benefits. Tangible property includes money and securities, accounts receivable, inventory, furniture, equipment, and supplies, machinery, data processing hardware, software, and media, valuable papers, books, and documents, mobile property such as automobiles, aircraft, and boats.

Many items of *intangible property* are legal rights rather than things. For example, a copyright or a patent gives its holder the exclusive right to publish a copyrighted item or to make and sell a patented device. A license is the right to perform the licensed activity, such as engaging in a regulated business or driving an automobile. Goodwill, copyrights, patents, trademarks, trade names, leases and leasehold interests, licenses, trade secrets and prepaid expenses are generally difficult to recognize and to value.

Definition of Loss

When property is damaged, there may be both direct and indirect losses. A **direct loss** occurs when there is damage to property, as when a fire damages a home. **Indirect loss** occurs when a direct loss causes expenses to increase or revenues to decline. Because of this dual nature of property losses, many insurance contracts insure both direct and indirect losses in the same contract.

Indirect losses are more difficult to identify than direct property losses. One can see a machine and measure its value, but we cannot see the lost profits if the machine is unavailable for several months. It is difficult to estimate how long a machine or a building will be unavailable after a loss, or whether a loss will occur during a busy season or a slack period. The process begins with a forecast of expected income under normal circumstances. A second estimate of post loss income follows. The difference is the potential income loss following a direct loss. In insurance a prediction must be made from actuarial experience or statistical analysis of the number of losses to be expected within a group of exposures. The law of large numbers tells us that actual losses will more accurate as the number of units of exposure increases.

Hazards are situations or factors that increase the possibility of a loss occurring or increase the probable size of a loss should a loss occur. Hazards may be classified as physical, moral, or morale. *Peril* is the actual cause of the loss and is identified or referred to in the policy. Perils include such events as fire, wind, hail, and collision with another car. A named peril

policy will provide coverage only if the loss is caused by one of the perils specifically named or identified in the policy, such as, fire, wind, or hail.

Liability Losses

Liability insurance is designed to pay on behalf of an individual, a business, or an organization, the actual damages that the insured becomes legally obligated to pay. With the number of lawsuits filed daily and the ever-increasing size of the judgments awarded, liability insurance is a necessity for businesses and professionals, as well as for many individuals. Liability losses arise from three sources: 1) *an organization responsible for negligently injuring someone must pay legal damages awarded by a court to the injured party*, 2) *the cost of a legal defense*, and 3) *loss prevention arising from potential legal liability*.

Several types of liability losses have become of increasing concern to both profit-making and nonprofit organizations in the last ten years. *Workers' compensation* claims arise from injury to a firm's employees while they are at work, *product liability* occurs when a firm's products allegedly injure the public, *Environmental impairment liability* arises from violating federal or state statutes designed to protect the environment, or from lawsuits from parties claiming injury caused by a firm's improper handling of toxic substances. *Employment practices liability* describes the loss potential arising from lawsuits from employees or job applicants alleging wrongful hiring, promotion, demotion, termination, and sexual harassment.

One of the most serious financial risks covered by insurance is that of loss through legal liability for harm caused to others. Insurance for liability losses is more complex than property insurance, because people other than the insured and the insurer are involved. Liability is usually determined by proving negligence, a concept that is difficult for most people to understand. Negligence as a basis for determining liability for industrial accidents and illness has been eliminated by the adoption of workers' compensation laws. Public attention has recently been focused on another area of negligence, that of medical malpractice.

Definition of Loss Control

The most effective method to control insurance costs is to prevent losses from occurring ~ **preloss**--and to also contain the extent of losses after they occur--**postloss**. Any accident, fire or explosion in a home or place of business may mean family disruption or the loss of community prestige, employee morale, and customer goodwill. In addition to these intangible costs, there can be property loss and injury to employees that could add up to thousands of dollars in medical and legal expenses. By working closely with the policyholder, a loss control program can be individually planned. The object is to assist in minimizing possible accident situations and fire and explosion hazards. Improving operating efficiency and safety can also add to increased production and reduced insurance costs.

Surveys

Unsafe practices and conditions in modern operations are a major source of potential losses. Loss control studies these practices and conditions, and recommends changes that need to be made. When accidents occur, the causes should be investigated to reduce the chance of a recurrence.

Protection

Loss control assists a company in developing ways to protect from special hazards, which include:

Machine Guarding ~ Power presses and other process machines which present serious accident exposures are studied for the purpose of suggesting practical guarding techniques.

Noise Control ~ Sound measuring, noise control programs, and preliminary noise level surveys are conducted.

Industrial Hygiene ~ Loss control consultants recognize, evaluate, and recommend controls for occupational and environmental health hazards.

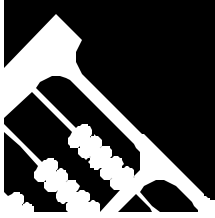
Fire and Explosion ~ Loss control consultants can recommend control measures for uncontrolled solvents, vapors, dusts, and other possible causes of fires and explosions.

Product Control ~ Loss control consultants can assist in developing product loss control programs to help a company manage their product liability exposures.

Construction Safety Surveys ~ Loss control consultants will help policyholders survey construction operations and formulate recommendations for correcting unsafe conditions and unsafe practices.

Safety award programs can be provided to encourage continued management concern and attention with loss control. Special reports designed to keep management posted on matters of immediate concern are very important information.

Loss control in homes is aided by the practice of clients developing a positive safety attitude and taking a few precautions concerning early warning devices (smoke and carbon monoxide alarms) as well as how parents deal with chemicals and products they use everyday for arts and crafts, home and automobile repairs.



Chapter Two

How to Implement Loss Control

Risk

Risk is uncertainty regarding financial loss. An integral component of loss control is risk control. Risk control is described in some theories of how accidents are caused and controlled. Even though several theories of how or why accidents occur have been proposed, no one theory has gained general consensus.

Risk Handling

Many insurance professions use the word “risk” to refer to an insured or a prospect for insurance, or to the peril that is being insured. They will say that a particular person or property is a good risk or a bad risk, meaning that they have made an evaluation of the underwriting characteristics of that person or property for a particular insurance policy. This differs from the strict insurance definition. Risk means the uncertainty regarding financial loss. For example, if an individual decides to burn down his own home and sprays gasoline on the house and applies a torch the loss is certain. The event is purposeful in nature and there is no uncertainty. In insurance terms there is no risk of loss by fire. When a house fire is started by faulty electrical circuitry or a lightning strike, the event is sudden and unexpected. The owner of the house and the financial institution that holds the loan on the house both suffer a financial loss. The loss is uncertain and accidental. **Risk is uncertainty regarding financial loss.**

Speculative risk involves the chance of both loss and profit. Investing in the stock market is an example of speculative risk. Speculative risks are not insurable. Pure risk involves only the chance of loss; there is never a possibility of gain or profit. The risk associated with the chance of being robbed is an example of pure risk. There is no opportunity for gain if the event does not occur – only an opportunity for loss if the robbery does occur. Only pure risks are insurable. The purpose of insurance is to protect the insured against **losses** caused by pure risk.

There are five basic ways to handle risk:

- Some risks, or loss exposures, may be transferred to another person or entity.
- A risk may be retained. The individual or business may choose to retain all (self-insured) or part (deductible) of that risk. Retention may be passive (the company or person is not aware that the risk exists, does not insure it and must pay if a loss occurs) or it may be active (the company or person is aware of the risk and accepts it).
- Avoid as many risks as possible. Few risks can be handled in this manner.
- Insurance is a financial device for transferring or shifting risk from an individual or entity to a large group with the same risk.
- Losses can be reduced or prevented by training, by installing safety devices, and/or by lowering the frequency and/or severity of loss. **Loss control is managing the risk.**

Risk control can be defined as any conscious action (or decision not to act) that reduces the frequency, severity, or unpredictability of accidental losses.

Actual Harm

Risk control focuses on actual harm, not on the money paid to restore, compensate for, or otherwise finance this harm, which is the concern of risk financing. For example, when a machine is destroyed or a person dies, an organization, a family or society as a whole suffers a loss of resources. Risk control strives to reduce the frequency or the severity of this loss of resources. From a risk control perspective, the extent of such a loss of resources is not changed just because, for example, inflation or deflation alters the monetary valuation of the loss. Similarly, the severity of the loss is not reduced because the owner of the machine or the family of the deceased receives financial compensation for the loss. Risk financing techniques are not risk control techniques.

Specified Exposures

A risk control measure is risk control only for one or more specified exposures. For example, fire-suppression sprinklers are risk control for fire damage, but not for loss by embezzlement. Similarly, a sprinkler system can be effective risk control for most fires. However, if the system uses water as an extinguishant, the water is a hazard rather than a safety measure for grease fires, which are spread or intensified by water. In short, specifying a risk control measure also requires specifying the exposure being controlled.

Perspective of a Given Entity

The effect of a given risk control technique can be measured only from perspective of a given entity. For example, pedestrians are exposed to bodily injury from being struck by automobiles, and drivers are exposed to the liability from such accidents. The pedestrians' exposure to injury and the drivers' exposure to liability are two different exposures growing out of the same circumstances. Any risk control technique that safeguards pedestrians from being struck by automobiles has different risk control effects for the pedestrians than for the automobile drivers. For the pedestrians, the effect is to safeguard against bodily injury; for the automobile drivers, the effect is to protect against liability. For one entity, an elevated walkway is risk control for a personnel loss; for the other, it is risk control for a liability loss.

Risk Management

A risk manager must identify, treat, and review risk management decisions concerning property and liability loss exposures every day. He must also be aware of insurance markets. Insurance markets are subject to what is often called the underwriting cycle – prices, coverages, and deductibles exist in an ever-changing market place. In hard markets, premiums increase at a very rapid rate. When premiums rise, higher deductibles are also required, contract provisions are restricted, and in some cases, coverage is not available at any price. In hard markets a risk manager's options are limited. The property and liability loss exposures can be identified and measured, but the cost and availability of insurance may complicate effective-decision-making. In soft markets, premiums may be gradually increasing or actually declining. Deductibles are lower, contract terms more attractive, and higher limits of liability are available.

One of the principal benefits of risk retention is that efforts aimed at reducing the number of loss causing events and minimizing their severity, will produce direct and immediate cost savings. In order to achieve this benefit it is necessary to have in place an effective risk management program that continually seeks to identify, assess and control areas of risk exposure. The scale of savings to be gained from effective risk management should not be underestimated and is certainly not restricted to the direct or visible costs such as compensation payment, equipment replacement etc for which insurance is often held.

The objective of a risk review is to provide a systematic evaluation of the risks that are presented by the activity of any department or service area. The process involves the assessment of the risk and the identification of action priorities, based on the potential severity of loss, the likelihood of the event occurring, and the adequacy of current control measures.

Risk reviews provide a strategic management tool, used to assist in identifying and assessing risk management issues, and in the development of departmental action plans.

Safety Management

Accident Theories

Haddon's energy-release theory--This theory views accidents as results of uncontrolled energy impinging on animate or inanimate structures that cannot withstand that energy. It suggests a number of strategies for preventing or reducing the damage that released energy might cause.

Heinrich's domino theory--This theory developed mainly from studying workplace accidents and injuries. It presumes that accidents are the end result of a chain of events (like falling dominoes), the most crucial of which represents an unsafe act or condition.

General methods of industrial hygiene control--Suggested by studies of work injuries and illness, these methods recommend substituting less hazardous materials, changing or isolating hazardous processes, wearing personal protective equipment, and using other physical and administrative controls to reduce workplace accidents and illnesses.

The system safety approach--This approach analyzes every organization, every operation within that organization, and the economy as a whole as a system of interrelated components (all needing to function properly to prevent accidents). This approach tries to predict where an accident might disrupt the system and how that accident might be prevented.

The crisis management approach -- This approach also views organizations as systems with five elements (organizational structure, personnel, production facilities, operating funds, and markets for outputs and raw materials.) These elements must be preserved by prompt, preplanned actions that are appropriate to the peril causing the crisis. These actions must be taken before and immediately after a major accident if the organization is to survive that accident.

These theories of accident causation and control were developed before, and are independent of, risk control techniques. Risk control techniques reduce accident frequency, severity, or unpredictability through exposure avoidance, loss prevention, loss reduction, segregation of exposure units through separation or duplication, and contractual transfer.

Many companies and their employees know and have testified that excellence-in-safety has proven a road to success with great returns. Those who understand the commitment have integrated safety as a process which permeates every aspect of the company's business and which is integral to its business plan. The commitment brings employees, labor, and management into a work culture of ownership, empowerment, trust, and pride where a real partnership and team exist - all working toward the same goal- an internalized excellence in safety as a way of life. Building a total safety culture process reinforces employees to actively care for the safety and health of themselves, their co-workers, and the work environment they work and live in. For all these safety best practice companies, the working together has forged a positive and productive employee relation's atmosphere in all aspects of work.

Safety as an Investment

Safety best practices represent a paradigm shift in thinking about safety. Part of this shift strongly suggests that safety should not be thought of as an **expense**, but rather as **earnings or a return on investment** vehicle, with substantial returns over the long term. Safety best practice companies who know this from experience and have reached beyond compliance swear by the difference their commitment and investment have made on bottom line results. The winners are employees, companies, and their stockholders.

Examples ~1) A manufacturer with 600 employees, has sustained lost workday case rates 73% below average for 15 years (the equivalent of preventing 600 injuries), saving an average of more than \$1 million per year in direct and indirect costs. **2)** A chemical company member with 1000 employees kept lost workday injury rates 93% below the average for its industry throughout 15 years (the equivalent of preventing 400 injures), saving more than \$10 million.

Safety as a Partnership

The Occupational Safety and Health Administration (OSHA) acknowledges that compliance alone cannot accomplish all the goals of protecting America's workforce. Safety best practices represent another paradigm shift in thinking about safety: safety belongs to everyone, bound together as partners, united in one purpose. Partnership is its heart. It moves employees and labor into a cooperative partnership with management, and vice versa. It also moves government (OSHA and DOE) from the traditionally perceived role of adversary and enforcer into the cooperative partnership with management, employees, and labor. In one company, this partnership and sense of ownership for safety is so deep that its employee handbook includes a written statement, giving employees the right and responsibility to stop unsafe work and ensure a safe work environment at all times. Safety is embraced by all as a value, and as a culture. These cooperative partnerships become central to the recognition of outstanding safety and health programs.

Creating this kind of partnership begins with employees taking care of employees. This leads to a concern for customers. Meeting customers' needs produces a better bottom line for the company. And everyone benefits from that. Success is rarely a solo performance. It's usually a joint venture. That's true of virtually every enterprise. And it's true of safety best practices. The key is partnership.

Recognizing Causes of Accidents

An unsafe act, an unsafe condition, and an accident are all symptoms of something wrong in the management system. Certain circumstances will produce severe injuries. These circumstances can be identifies and controlled. Safety should be manned like any other company function. Management should direct the safety effort by setting achievable goals and by planning, organizing, leading, and controlling to achieve them. The key to effective line safety performance is having management specify procedures for accountability. The function of safety is to locate and define the operational errors that allow accidents to occur. This can be carried out in two ways:

- by asking why accidents happen, and searching for their root causes
- by asking whether certain known effective controls are being used

The System Safety Approach

The system safety approach is based on the concept that the universe is a single system that comprises many smaller, interrelated systems (for example, the parts of an electric switch, the bones and muscles in the human body, the parts of an automobile, and the economy of a nation). An accident occurs when a human or a mechanical component of a system malfunctions. System safety forecasts how these malfunctions might occur so that appropriate action can be taken either to prevent the failure or to reduce its consequences. System safety analyzes the entire system, product, or operation by the following steps: 1) identifying potential hazards, 2) incorporating timely and effective safety-related design and operational specifications, provisions, and criteria, 3) evaluating the early stages of the design and procedures for complying with applicable safety requirements, 4) monitoring all safety aspects of the system throughout its life span, including disposal.

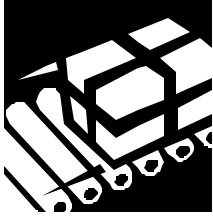
System safety relies on a number of specific techniques for identifying and evaluating hazards and determining how these hazards can lead to system breakdowns and accidents. These techniques can estimate the probability of particular kinds of breakdowns (based on the probabilities of all the events that produce the breakdown) and suggest cost-effective ways of preventing these system failures.

Crisis Management

Crisis management involves planning, organizing, leading, and controlling assets and activities in the critical period immediately before, during, and after an actual or impending catastrophic loss to reduce the loss of resources essential to the organization's eventual full recovery. In everyday language, a crisis is a turning point in a sequence of events--a point in time at which crucial actions or events significantly shape the future. In risk management, an imminent or occurring peril that can cause a catastrophic loss is a crisis, because people's actions relative to that peril can significantly shape the future by increasing or decreasing the severity of the resulting loss.

The outcome of the crisis depends on the appropriateness, effectiveness, and speed of those actions. For a positive outcome--reduction of the severity of the loss--the crisis must be well managed. This means that the response to the peril is planned in advance, thereby coordinating the actions of all personnel during the actual crisis. The plans underlying crisis management should become operational as soon as management realizes that a loss is impending and should remain in effect until the post-loss situation has stabilized.

However, crisis management does not extend to the point in time when the organization has completely recovered from the loss and returned to normalcy. Thus, in the context of the time sequence suggested by the energy-release theory of accident causation, crisis management includes the ninth strategy of taking immediate action to counter any harm already done. Crisis management does not extend, however, to the tenth, longer-term strategy of repairing any damage or rehabilitating any injured persons.



Chapter Three

Loss Control and Risk Management

Risk management occupies an important place in the broad definition of management--that devoted to *minimizing the adverse effects of accidental loss* on the organization. Given this focus on accidental losses, risk management--as a managerial or administrative process--may be defined as a process that includes the four functions of planning, organizing, leading, and controlling the activities of an organization in order to minimize the adverse effects of accidental losses on the organization at reasonable cost. This definition stresses the managerial aspects of risk management in carrying out decisions with respect to potential accidental losses.

Risk management also may be defined in terms of making these decisions. As a decision-making process, risk management is a sequence of five steps:

- Identifying exposures to accidental loss that may interfere with an organization's basic objectives
- Examining alternative risk management techniques for dealing with these exposures
- Selecting the apparently best risk management technique's
- Implementing the chosen risk management technique(s)
- Monitoring the results of the chosen technique(s) to ensure that the risk management program remains effective

Risk management focuses on accidental losses, not all losses. However, risk management professionals hold a range of viewpoints on the proper scope of the term "accidental" and, therefore, on the scope of the risk management function. In the narrowest, most traditional view, the term "accidental" limits the scope of risk management concerns to situations involving only pure risks.

Pure risk situations offer only two possible outcomes: **loss** or **no loss**. The best an individual or organization can hope for when dealing with a pure risk is to maintain one's present position in confronting such perils as fire, machinery breakdown, illness, or being named a defendant in a lawsuit. This view excludes from the scope of risk management all exposures to loss from so-called "business risks" or "speculative risks." Such exposures arise from uncertain situations in which three types of outcomes are possible: 1) gain, 2) loss, or 3) no gain or loss.

Individuals and organizations often undertake business or speculative risks willingly in the hope of gaining from their ventures. Marketing a new or redesigned product, lowering prices to attract new customers, or buying or selling a corporate bond are management decisions that individuals or organizations make in search of gain. In the traditional view, the risk management professional's responsibility is to control financial recovery from these pure risks, not to help achieve any gains from taking speculative risks.

In the broad view of risk management, fires, injuries, earthquakes, liability claims, and other sudden, destructive events are classified as **casualty risks**. The categories of loss exposures within this broader interpretation of **accidental loss** include those arising from casualty risks, liquidity risks, market risks, political risks, and technological risks.

Both safety management and insurance concentrate solely on pure risk situations that offer no opportunities for profit or other gain. Those who would eliminate all distinctions between pure and speculative risks assert that a risk management professional's fundamental concern should be an organization's overall capacity to cope with losses, regardless of whether those losses stem from such casualties as fires and lawsuits or from poor business decisions in managing speculative risks. Comprehensive risk management should pay equal attention to managing *both types* of loss exposures.

Isolated from one another, exposures to neither pure nor speculative risks can be managed properly. Making sound decisions about exposures to pure risks requires knowing an individual's or organization's activities and dealing with those potential accidental losses in ways that enhance the overall operating efficiency of the organization. While risk management focuses primarily on those loss exposures arising out of pure risks of accidental loss as a consequence, risk management enables an individual or organization to meet its business or other operating goals in ways that enhance operating efficiency.

Identifying Loss Exposures

To identify exposures, or possibilities of loss, the risk management professional must be able to do three things:

- Apply a logical classification scheme for identifying all possible exposures to loss.
- Employ proper methods for identifying those specific loss exposures that particular organization faces at a particular time.
- Test the significance of these actual loss exposures by the degree to which they may interfere with the achievement of the organization's basic objectives.

A loss exposure is a possibility of loss, or more specifically, the possibility of financial loss that a particular entity (organization or individual) faces as the result of a particular peril striking a particular thing of value. Every loss exposure has three dimensions:

- The type of value exposed to loss
- The peril causing loss
- The extent of the potential

Loss exposures are typically categorized in terms of their first dimension -- the nature of the value exposed to loss. All financial losses that are the concern of risk management, excluding losses of purely sentimental value, can be categorized as *property losses, net income loss, liability losses, or personnel losses*.

Property losses could include damage that a hospital suffers to its building, damage to a parking lot where corrosive chemical flowed, and damage that the owners of automobiles parked in the parking suffered from the chemical that had been spilled.

Net income loss is the second major type of loss exposure. The hospital suffered income loss because some of the prospective patients chose to defer elective surgery or to have it performed in some other "safer" hospital. With respect to extra expense, the hospital incurred additional costs in overtime for its maintenance crews cleaning the grounds and in making special arrangements for temporary substitute parking facilities.

Liability loss exposure is a factor here because some of the patients felt that the hospital had not taken appropriate precautions to protect its patients against foreseeable hazards from the nearby railroad tracks. The hospital employees who were injured or who suffered ill effects from the toxic chemical could bring workers' compensation claims against the hospital.

Personnel losses result from death, disability, retirement, resignation, or unemployment. A vital hospital executive or technician may have been sickened by toxic fumes and unable to come to work for the two weeks required to clean the parking lot. Then each of these two organizations would have suffered a personnel loss.

Loss histories are a record of past losses for an important indicator of accidental losses that may strike an organization. Prior accidents and lawsuits may well repeat themselves unless the organization's operations have changed in some fundamental. For many organizations, however, records of past losses and claims may be inadequate for identifying current loss exposures because the organization is too small or too young to have generated a credible loss record.

Financial statements are another method of identifying loss exposure. These financial statements must include balance sheets, profit and loss statements, and funds flow statements for a series of years. Profit and loss statements are often called income statements, and funds flow statements may be labeled sources and uses of funds.

Any document that tells something about an organization's operations, such as contracts, correspondence, minutes of meetings, and internal memoranda, also tell something about the organization's loss exposures.

Flowcharts are an approach to analyzing loss exposure by viewing an organization as a unit into which values flow, through which they are processed and increased, and out of which these greater values flow. In this perspective, an accident is an interruption of flows. The extent and duration of interruption roughly indicate the severity of the resulting loss. Flowcharts may show details of the process by which each of the organization's products is manufactured, how personnel and materials move among the organization's locations, or the flow of raw materials and finished products from suppliers through marketing channels to the final customer.

Personal inspections are done exposures to loss are the only identified by an actual inspection. For some loss exposures of any organization, no amount of theory and no set of classifications can full disclose all possibilities of loss. For some loss exposures, no amount of theory and no set of classifications can fully disclose all possibilities of loss.

Consulting with experts within and outside the organization plays a part in identifying exposure to loss. The risk management professional fro a particular organization should strive to be a generalist with a working knowledge of all the diverse loss exposures that the organization faces. However, to complement this broad knowledge of the organization, the risk management professional should be able to tap the special knowledge of experts both within and outside the organization on its particular loss exposures.

The Techniques of Risk Management

Examining Alternative Techniques

Risk management involves either stopping losses from happening or paying for those losses that inevitable do occur. Risk control techniques include risk management designed to minimize the frequency or severity of accidental losses or to make losses more predictable.

Exposure avoidance eliminates entirely any possibility of loss. It is achieved either by abandoning or never undertaking an activity or an asset. *Loss prevention* aims to reduce the frequency or the likelihood of a particular loss. *Loss reduction* aims to lower the severity of a particular loss.

Segregation of loss exposures involves arranging an organization's activities and resources so that no single event can cause simultaneous losses to all of them. *Duplication*, on the other hand, implies reliance on "back-up" -- spares or duplicates used only if primary assets or activities suffer loss. *Contractual transfer* of an asset or an activity for risk control is a transfer of legal and financial responsibility for a loss.

Selecting the Best Technique

Selecting the best risk management technique or combination of risk control and risk financing techniques, which is often the case, is a two-step activity.

- Forecast the effects the available risk management options are likely to have on the organization's ability to fulfill its objectives.
- Define and apply criteria that measure how well each alternative risk management technique contributes to each organizational objective in cost-effective ways.

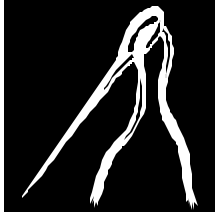
Implementing the Chosen Technique

A risk management program must from the start be planned and organized on the principle that every risk management technique an organization chooses to use must be one it can successfully implement and monitor. A technique that cannot be put into practice and then assessed for its effectiveness cannot be part of a well-managed program.

In the implementation step, a risk management professional must devote attention to both the technical risk management decisions that he or she must personally make to put a chosen technique into practice and the managerial decisions that must be made in cooperation with other managers throughout the organization to implement the chosen technique.

Monitoring and Improving the Program

Once implemented, a risk management program needs to be monitored to ensure that it is achieving the results expected of it and to adjust the program for changes in loss exposures and the availability or costs of alternative risk management techniques. The monitoring and adjusting process requires each of the following elements of the general management function: (1) standards of what constitutes acceptable performance; (2) comparison of actual results with these standards; (3) correction or substandard performance and alteration of unrealistic standards.



Chapter Four

Loss Control and Safety Management

Through targeted consulting, education, and training, instilling safety as an organizational value can significantly reduce injury experience. A company can apply proven theories and methods that have translated into positive and sustained results. Companies who live and breathe the best in safety every day, all embrace successful **safety management** that includes strategies and a process for making the essential elements of a safety program happen that is invigorated by its commitment to

- Safety
- Its partnerships with employees
- Its trust, pride, and empowerment in coming together to make a difference in safety

The savings are earned one day at a time, one employee at a time. A best practices safety management system and continuous improvement process approach can help clarify and demonstrate safety's contribution to employee value and company profitability. These practices help to position safety towards the top of an organization, integrated into the company's overall business objectives.

The outcomes of safety best practices are helping to convince skeptics that productivity, quality, profitability, and safety and health are complementary goals. Excelling in safety management also is a competitive market tool to help companies succeed in today's markets. Safety management is a long-term vehicle for "return on investment." It helps us to shift the paradigm thinking of safety as an expense and to embrace it as an investor's "initial investment" outlay for rewarding returns over the long term. Good safety management is also the right thing to do. The success stories of safety best practices companies are inspiring.

Agent/Client Communication

The agent should anticipate and work to solve customers' concerns by providing the consultancy to optimize their specific safety management system. He can do this by helping them to translate into lower incident rates and higher returns on investment. The agent should strive to be a **safety solutions provider** to his clients and this will be accomplished by:

- fostering a balance of social responsibility through ethical consciousness
- adopting the best safety practices resulting in positive financial management
- encouraging clients to develop and deliver quality innovative safety management systems and processes
- diligently studying his client's business in order to deploy customized solutions that will have the greatest return on investment for the client continuously improving his methods and resources to provide premier customer service

Industrial Hygiene Control

Asthma Management

Occupational asthma is described as the #1 leading occupational lung disorder not just in the United States but also in the industrialized world. Up to 15% of adult asthma cases are said to be "occupational asthma." It is the fourth leading cause of death in the United States. The National Institute of Occupational Safety & Health estimates that more than twenty million U.S. workers in a wide range of industries and occupations are potentially exposed to at least one of over 250 organic and inorganic substances/agents allegedly "known" to be associated with "occupational asthma."

The ability to properly *diagnose* occupational asthma is critical in identifying the need for preventive and treatment intervention. But, diagnosis of occupational asthma has not always had a clear process. It is often confounded by a number of factors. Not all asthmas are caused by occupational exposure, although many asthmas, not occupationally-caused, may be aggravated in the workplace by a number of irritants.

Issues of adequacy in the identification, diagnosis and management of asthma in the work place have concerned medical professionals. Extensive studies and research now provide a process for the identification, diagnosis, treatment, and management of workplace asthma that advocates and urges a systematic, thorough, and prompt approach with clinicians and employers both playing key roles.

Assessment of work-related asthma must start with "a thorough occupational and non-occupational history." In addition to noting several non-occupational assessment considerations, researchers advocate that the medical community includes an "investigation" of the workplace, including a walk-through, if possible, to better understand exposures, exacerbations, and an individual's work history.

Clinical tests are stressed as an important part of the diagnostic assessment so that work-related asthma is objectively confirmed by tests designed to measure expiration flow, lung capacity and lung function associated with specific exposure to causative/aggravating agents. A number of work-related assessment factors are presented for clinicians to investigate as part of the exposure history. Factors include:

- changes in work responsibilities or job duties
- changes in ventilation or other ambient conditions
- exposure to spills
- temporal patterns of respiratory symptoms and the presence of similar symptoms in coworkers

The development of occupational asthma (OA) can be temporally associated with an unusual incident at work, such as a spill or fire. As a consequence, clinicians are instructed on the importance in determining the role the worker played in the incident, the proximity to the point source, the size of the room and ventilation, the duration of exposure, and the type and efficacy of respiratory protection.

By the late 90s asthma had become such a significant public health concern that a number of national initiatives were underway to get a better handle on asthma prevalence and management. One of the most comprehensive surveys of public knowledge, attitudes and behavior toward asthma was conducted.

The survey yielded five major conclusions:

- Asthma management in America is falling far short of the National Institutes of Health goals and guidelines, "Guidelines for the Diagnosis and Management of Asthma."
- Poorly controlled asthma symptoms cause asthma sufferers to accept a much lower quality of life than need be.
- The level of care reported by patients does not meet standards.
- A widespread misunderstanding by patients exists of the underlying condition that causes asthma symptoms, as well as confusion about appropriate treatment and other aspects of asthma management.
- 71% of people with asthma feel there is a strong need for more patient education about asthma.

Asthma prevention and management belong to *workers, doctors and employers*. The widespread misunderstanding about asthma and its management, and the high-reported need for more asthma education underscore the need for **these three parties to work together** to help improve asthma understanding and management. Patient education should include information about community and self-help resources as an essential part of asthma management. In addition to written asthma management treatment plans and plan monitoring, national guidelines also expect an increase in the number of persons with asthma who receive assistance in assessing and reducing exposure to risk factors ***both in their home and work environments***.

Studies make it clear that employers have a distinct role in the managing of asthma as a workplace health issue. Work-related asthma is said to be the most common lung disease seen in occupational clinics. Work-related asthma includes both new onset asthma initiated by workplace exposures and pre-existing asthma exacerbated by workplace environments. In both cases, repeated exposure to asthmatic agents can lead to chronic pulmonary impairment. Certain substances in the occupational setting may produce hypersensitive bronchial airways and trigger asthmatic responses in sensitive individuals. Exposed workers may have symptoms even at low levels due to sensitization. Known causes of occupational asthma include (but are not limited to) isocyanates, flour/grain, glues/resins, solder and welding fumes, lab animals, and latex.

In the complex picture of asthma, researchers argue both that we are diagnosing occupational causes too often and not often enough. One side argues that employers are not paying enough attention to safety and the responsibility for disability that comes from exposure at work. The other side complains that workers unfairly blame work for medical problems that may be caused by smoking or a pre-existing disease that may be inherited.

Despite the arguments, asthma in the workplace is real. Experts agree that work-related asthma is preventable, and that workplace management practices and controls can be used to eliminate or minimize exposure. People with asthma can lead full, active lives with little disruption to work, family, or outside social activities. Experts agree that **education** for workers, medical specialists, and employers is a key first step.

Asbestos Exposures

Asbestos has moved into vermiculite concerns. The National Institute of Occupational Safety & Health (NIOSH) is targeting additional research related to occupational and potential public health risk concerns over exposure to vermiculite “contaminated with asbestos.” Past NIOSH research targeted former miners and residents of Libby, Montana and consumers and workers who came into contact with vermiculite end products, such as insulation and potting soil. NIOSH's past studies reported cancers and adverse health effects associated with asbestos exposure from the mining of asbestos-contaminated vermiculite. Future research is anticipated to help determine the distribution and concentration of asbestos contamination in vermiculite produced in various mines and used in different occupational settings.

Beryllium Exposure

Under a new law signed in October 2000, nuclear weapons workers with radiation-related cancers, lung disease, or silica-related disease (chronic silicosis), may be eligible to receive a \$150,000 disability payment plus payment of future medical expenses associated with that disease, provided they meet certain eligibility requirements. Eligible candidates include employees of the Department of Energy (DOE), DOE contractors or subcontractors, private companies that provided beryllium for use by DOE, or, in the case of deceased workers, their survivors for purposes of the lump sum disability payment. Some are hoping that OSHA will expedite the reduction of the beryllium permissible exposure limit in occupational settings. Today, beryllium is used in the production of golf clubs and dental tools and may pose a potential health risk to workers exposed to the metal dust during manufacturing.

Second-Hand Smoke Exposure

An anti-smoking group, Action on Smoking and Health (ASH), has been pressuring OSHA to move forward with a standard that would protect workers from second-hand smoke. The group has expressed that they believe second-hand smoke is a higher priority and far outweighs ergonomics. The group says that there is “clear scientific evidence” relating second-hand smoke exposures to deaths.

Safety System Approach

Cellular Phones and Wireless Technology

Cellular phone use and related health and accident research continue. The National Transportation Safety Board has held hearings on driver distractions, especially concerned with the potential for increased distractions related to newer media technologies being installed in vehicles. A National Highway Traffic Safety Administration survey found that 44% of drivers have phones available when they drive; 7% have email access; and 3% have fax capabilities. An estimated 25% of the 6.3 million crashes each year involve some form of distraction or inattention. One study reportedly found that talking on a phone while driving was almost as dangerous as driving drunk and quadrupled the risk of an accident.

Research shows that there may be a link between cell phones and headaches, memory loss, and sleeping disorders in children. Previous health warnings on cell phones have focused on microwave radiation and cancers. Studies have found “subtle effects” on brain function. England's Safety Regulation Group also conducted studies on Boeing 737 and 747 aircrafts and claim that their results show that mobile phones with an output of 1-2W can cause deviations in the aircraft instruments beyond allowable limits.

In another study researchers looked at wireless communications products in the occupational context. The study looked at a large cohort of wireless communication products workers over a 20-year period. The researchers reported that their findings did not support a link between worker radio frequency exposure and mortality from brain cancers, lymphomas, or leukemia. The researchers also say they "did not observe higher risk with increased exposure duration or latency."

Ergonomics

OSHA's new standard, which applies to general industry, has an effective date of January 16, 2001, and an enforcement date of October 16, 2001. The rule is to be phased-in over four years, unless court challenges or Congress stop the rule. A grandfather clause is included, provided certain requirements are met. The rule includes basic "screening tools." The agency also has a dedicated ergonomics web page with links designed to provide employers with an information kit, guidance, frequently asked answers and questions, and the rule itself.

Researchers continue to study and offer findings on the dynamics between computer-related work and health. In one study, researchers in Great Britain suggested a relationship between mechanical (physical motion), psychological and psychosocial factors. Among other findings, the researchers reported that dissatisfied employees were 4.7 times more likely to develop forearm pain and those with job stress had a 3.3 times higher risk. Other factors included repetitive motion of the arms and wrists, high levels of psychological distress, and boring or monotonous work.

NIOSH has been pulling together research agenda for musculoskeletal disorders. The research intends to target better surveillance tools, including outcome measures, an in-creased understanding into risk factors (biomechanical, psychological, and social)- both singly and in combination- and a better understanding of disease and disability, appropriate engineering interventions, and treatment protocols.

NIOSH also released a study in which the agency concluded that short, "strategically spaced" rest breaks could reduce musculoskeletal discomforts for computer operators. The study compared two rest-break schedules. Operators that had two conventional breaks (two 15-minute rest breaks, one in each half of the work shift) supplemented by four 5-minute breaks spaced throughout the workday, consistently reported less eye soreness, visual blurring, and upper body discomfort.

In a study involving computer operations and vision, researchers reported that 71% of participants reporting computer vision syndrome were eyeglass wearers. According to the study, eyeglasses prescribed for general use may not be adequate for computer work. The researchers suggest that eye doctors consider computer usage when determining vision correction, including prescribing special occupational lenses to meet the unique viewing distances and angles at computer stations. According to the study survey, eyeglass wearers report more neck, back, and eye/vision problems than non-wearers, due to awkward postures resulting from bi/tri-focal and progressive lenses use when viewing the computer. Vision prescriptions make it difficult for the wearer to see close up or at the typical monitor viewing distance.

Hearing Conservation

Noise-induced hearing loss (NIHL) is still one of the most written about topics in safety journals. It continues to be considered one of the most common and preventable of occupational disabilities. Recent studies show NIHL is on the rise in the construction industry, with street and

highway workers, carpenters, and concrete workers cited as the most likely to be exposed. OSHA plans to explore a more effective standard for construction.

In the meantime, NIOSH and the United Brotherhood of Carpenters convened to develop a hearing loss prevention program specifically targeting carpenter apprentices. NIOSH also is undertaking a hearing study in the mining industry, in which it has proposed studying the role of emotional messages about hearing and hearing loss in an attempt to alter “self protective” behaviors around hearing conservation. NIOSH believes that self-protective behaviors can be influenced by messages around the impact of hearing loss, such as social isolation from family and friends; diminished ability to identify warnings/dangerous situations, and unrelenting ringing in the ears that can lower quality of life.

Drug Use in the Workplace

According to the semi-annual Drug Testing Index, considered a national trend benchmark, cheating on workplace drug tests by using chemical additives called masking agents or oxidizing adulterants, declined by 48% during the first half of 2000 compared to 1999. However, illegal drug use remained unchanged, although incidence rates for cocaine and opiates declined and marijuana incidence rates increased. There is some thought that the decline in cheating “appears” to be closely linked to heightened employer surveillance.

In an effort to improve highway safety, the National Transportation Safety Board (NTSB) has recommended that the US Department of Transportation study the relationship between over-the-counter drugs, common prescriptions, and accidents, and establish a list of approved medications that can be used safely by commercial drivers.

The NTSB also recommended that the DOT prohibit the use of any medication not on the list for twice the dosage interval before or during vehicle operation, but further urged the DOT to establish criteria for exceptions so that operators who require non-listed substances may be allowed when appropriate and safe to use those medications while working. Another recommendation urges a toxicological testing requirement in fatalities to help identify the role of common prescriptions and over the counter drugs.

Transportation Safety

On March 8, 2001 the new Federal Motor Carrier Safety Agency (FMCSA) was inaugurated, charged with improving motor carrier safety and dramatically reducing truck and bus-related fatalities by 2010. Some rule revisions have included reliance on sleep studies. Revisions to the hours-of-service regulation looked to sleep studies to help decide for how many hours a trucker can stay behind the wheel safely without a rest break/sleep in order to reduce fatigue-related vehicular accidents. The changes would put commercial vehicle drivers on a 24-hour schedule that coincides with circadian rhythms (biological sleep-wake cycles).

A fairly recent study, based on six years of data of commercial driver performance, added a twist by saying that sleep might be about more than circadian rhythms. The study reports on the effects of rest and recovery cycles and partial sleep deprivation on commercial driver performance. Major findings include that statistically there are significant relationships between daytime performance on several types of tasks and the amount of sleep the prior night. There is poorer performance among drivers with slightly less sleep than population norms. Studies also showed incomplete recovery of performance where continuous sleep was reduced, even after three consecutive nights of 8-hour sleep. The report concluded that daytime alertness and performance capacity is a function not only of an individual's circadian rhythm, but also time

since the first sleep period and duration of the last sleep period, and sleep recovery history extending back for several days.

Fatigue Effects

California is so serious about fatigue, work-related performance, and safety, that under new labor regulations from the Industrial Welfare Commission (IWC), employees must be given state-mandated rest break or meal period, or the employer must pay a daily penalty equal to one hour's pay to each affected employee so deprived. It is believed that this will especially impact the health care industry where hospital understaffing has resulted in nurses regularly being unable to take rest breaks and meal periods. The concern is that more fatigued staff, when combined with mandatory overtime, can lead to increased medical errors and accidents and injuries to staff. While the IWC also adopted limitations on mandatory overtime, some say there are loopholes in the provision, which could allow employers to abuse the limitations.

Occupational Exposures

Two separate studies have reported associations between certain occupational exposures and unusual health effects. According to one study, Italian researchers reported that patients occupationally exposed in their jobs to hydrocarbon solvents were at risk for developing symptoms of Parkinson's disease. Nine jobs were identified as accounting for more than 91% of the hydrocarbon solvent exposure. The most common occupational exposures were found among petroleum, plastic and rubber workers. Others found to have frequent hydrocarbon exposure were painters, engine mechanics and lithographers.

In an unrelated study, researchers concluded that occupational exposure to lead could cause latent brain declines in workers nearly 16-20 years after exposures. According to the researchers, the declines have the effect of more rapid brain aging (five years of aging), resulting in progressive declines in memory and learning. The study compared 535 former chemical manufacturing employees exposed to lead at work to 118 non-exposed people from the same neighborhoods. This is said to be the first study to explore long-term problems caused by exposure to chemicals as adults. There is some suggestion that what we have been referring to as "normal aging" may in fact be due to past chemical/agent exposures that can affect the central nervous system.

Fire Loss Prevention

Each year more than 5,000 Americans die and more than 25,000 are injured in fires, many of which could be prevented. In less than 30 seconds a small flame can get completely out of control and turn into a major fire. It only takes minutes for thick black smoke to fill a building. In minutes it can be engulfed in flames. Fire uses up the oxygen a person needs and produces smoke and poisonous gases that kill. Breathing even small amounts of smoke and toxic gases can make one drowsy, disoriented and short of breath. The odorless, colorless fumes can lull one into a deep sleep before the flames reach them.

The U.S. has one of the highest fire death rates in the industrialized world. About 100 firefighters are killed annually in duty-related incidents. Each year, fire kills more Americans than all natural disasters combined. Fire is the third leading cause of accidental death in the home; at least 80 percent of all fire deaths occur in residences. More than 2 million fires are reported each year. Many others go unreported, causing additional injuries and property loss. Direct property loss due to fires is estimated at \$9.4 billion annually.

Causes of Fires and Fire Deaths

Causes of fire ~ Cooking is the leading cause of home fires in the U.S. It is also the leading cause of **fire injuries**. Cooking fires often result from unattended cooking and human error, rather than mechanical failure of stoves or ovens. Careless smoking is the leading cause of **fire deaths**. Smoke detectors and smolder-resistant bedding and upholstered furniture are significant **fire deterrents**. Heating is the second leading cause of residential fires and ties with arson as the second leading cause of fire deaths. However, heating fires are a larger problem in single-family homes than in apartments. Unlike apartments, the heating systems in single-family homes are often not professionally maintained. Arson is the third leading cause of residential fires and a leading cause of residential fire deaths. In commercial properties, arson is the major cause of deaths, injuries, and dollar loss.

Those at risk ~ Seniors and children under the age of five have the greatest risk of fire. The fire death risk among seniors is more than double the average population. The fire death risk for children under age five is nearly double the risk of the average population. Children under the age of ten accounted for an estimated 20 percent of all fire deaths. Children playing with fire start over 30 percent of the fires that kill young children. Men die or are injured in fires twice as often as women.

Causes of injury or death ~ A fire's heat alone can kill. Room temperatures in a fire can be 100 degrees at floor level and rise to 600 degrees at eye level. Inhaling this super hot air will scorch ones lungs. This heat can melt clothes to ones skin. In five minutes a room can get so hot that everything in it ignites at once. This is called flashover. Fire starts bright, but quickly produces black smoke and complete darkness.

Safety preventions ~ A working smoke alarm dramatically increases a person's chance of surviving a fire. Approximately 90% of U.S. homes have at least one smoke alarm. However, these alarms are not always properly maintained, and as a result might not work in an emergency. There has been a disturbing increase over the last ten years in the number of fires that occur in homes with non-functioning alarms. It is estimated that over 40% of residential fires and three-fifths of residential fatalities occur in homes with no smoke alarms. Residential sprinklers have become more cost effective for homes. Currently, they protect few homes.

Reducing Property Loss

According to the National Fire Protection Association, fires in the workplace cause more than \$1.1 billion in damage and more than 1,200 injuries each year. An average of 78 deaths each year is caused by fires in the workplace. Fires can start in any number of ways -- faulty electrical wiring or equipment, unsafe storage of combustible materials, inadequate ventilation, human error and arson. Most of these fire hazards can be corrected. By following safety procedures and recognizing potential hazards, employers and employees can prevent fires in their workplace and save lives.

Prevention Guidelines

- Keep fire exits and escape routes clear and well marked.
- Periodically inspect premises to find and correct potential fire hazards.
- Have a qualified heating mechanic check all heating, air conditioning and ventilation systems annually.
- Maintain clearances around all heating equipment to avoid ignition of combustible material.

- Keep equipment and machinery clean and in good operating condition.
- Maintain an adequate number of fire extinguishers and inspect them monthly.
- Limit the quantities of flammable materials and store them in appropriate containers, away from heat sources.
- Dispose of flammable materials according to established safety procedures.
- Keep work and storage areas clean and free of debris.
- Limit smoking to designated areas equipped with appropriate receptacles, or prohibit smoking on ones premises.
- Use caution when operating welding or other spark-producing equipment.

Preventing the Risk of Arson

About 24% of fires in the workplace have suspicious causes. Many of these fires are set intentionally by vandals, disgruntled employees or burglars attempting to cover their tracks. Here are steps a company can take to reduce the potential for arson fires:

- Stay on alert for strangers on the premises, or disgruntled employees in areas where they have no business.
- Provide around-the-clock security patrols.
- Lock gates and exterior doors.
- Secure all entrances at the end of the business day.
- Assign responsibility for periodic checks of security systems such as alarms, locks, fencing and lighting.
- Lock all sprinkler control valves in the wide-open position using sturdy locks and chains.
- Keep ignitable materials away from windows.
- Keep grass and shrubbery trimmed low near buildings so they are not a fire hazard and can't be used as cover for an intruder.
- Secure windows or skylights with boards or heavy screening.
- Keep combustible storage to a minimum in a secure area that is a safe distance from buildings.
- If practical, lock access doors to storage areas.

Reducing Risk of Faulty Wiring

Faulty wiring is a leading cause of industrial fires. By following these guidelines an employer can reduce their risks of fire:

- Properly match fuses to the size of wire being used.
- Replace all temporary wiring with approved permanent wiring properly installed to code.
- Identify the circuits served by fuses, circuit breakers or disconnected switches and record them in the panel board directory.
- Protect flexible cords and cables from physical damage.
- Keep motors clean of dust, dirt and oil accumulation so they don't overheat and burn out.
- Maintain a clear space of at least thirty inches in front of all electrical panels.

- Have a qualified electrician check flickering or dim incandescent lights, since this could indicate a damaged or overloaded circuit.
- Make sure the insulating qualities of a splice are equal to or greater than the original cord.
- Make certain there are no obstructions limiting air circulation near equipment ventilating openings.
- Locate over-current protective devices (i.e., circuit breakers or fuses) where they can be reached easily and quickly.

Fire Sprinklers

Fire sprinklers operate automatically in the area of fire origin, preventing a fire from growing undetected to a dangerous size, while simultaneously sounding an alarm. Statistics show that in fully sprinklered premises:

- 99% of fires are controlled by sprinklers
- 93% of fires are controlled within the design area of operation of the system
- 60% of fires are controlled by four sprinklers or less

Only the sprinkler that is affected by heat from the fire will operate, and it is fed from a simple connection to the mains water supply. If there is water in the mains and the stopcock is open water will be delivered to the seat of the fire. All fire safety measures have a reliability factor. Walls, ceilings and floors may have barriers penetrated by ducts, conduits and cables. Exit doors may be blocked or locked to 'improve' security. Windows may be broken. Fire sprinklers are the most reliable active fire protection system known. Detailed fire records reveal a success rate of 99.5%.

A fire sprinkler is individually heat calculated and supplied with a calculated amount of water at a predetermined pressure through a network of small bore piping in much the same way as the domestic central heating system. When the heat from a fire raises the fire sprinkler operating element to its design temperature, usually 68C (155F) either a solder link will melt or a liquid filled bulb will shatter, thus actuating that single sprinkler and releasing water in a controlled pattern directly over the source of the fire.

Fire sprinklers place less reliance upon human factors such as familiarity with escape routes or the use of manual 'first aid' fire appliances. Fire sprinklers go to work immediately to reduce the danger. Fire sprinklers prevent fast-developing fires of intense heat and smoke from trapping occupants.

The Risk of Water Damage ~ Reports of water damage arising from fires in sprinklered buildings are often exaggerated, dwelling on comparisons with the resultant small fire loss. The amount of water which is used to extinguish a fire in an **unsprinklered** building is many tens of hundreds of times more than would have been used had a sprinkler system been installed. During a fire, only those sprinklers closest to the fire operate, thus limiting the amount of water needed.

Smoke Alarms

In the 1960's, the average U. S. citizen had never heard of a smoke alarm. By 1995, an estimated 93% of all American homes ~ single, multi- family, apartments, nursing homes, dormitories, etc. – were equipped with alarms. By the mid 1980's, smoke alarm laws, requiring that alarms be placed in all new and existing residences – existed in 38 states and thousands of

municipalities nationwide. And smoke alarm provisions have been adopted by all of the model building code organizations.

Fire services across the country have played a major and influential public education role in alerting the public to the benefits of smoke alarms. Another key factor in this huge and rapid penetration of both the marketplace and the builder community has been the development and marketing of low cost alarms by commercial companies. In the early 1970's, the cost of protecting a three bedroom home with professionally installed alarms was approximately \$1,000; today the cost of owner-installed alarms in the same house has come down to as little as \$10 per alarm, or less than \$50 for the entire home. This cost structure, combined with effective public education has caused a huge percentage of America's consumers, whether they are renting or buying, to demand smoke alarm protection. The impact of smoke alarms on fire safety and protection is dramatic and can be simply stated. When fire breaks out, the smoke alarm, functioning as an early warning system, reduces the risk of dying by nearly 50%. Alarms are the most common first line of defense against fire.

Safety Violations

A number of companies, their owners, and their presidents have paid heavily with probation and prison sentences for safety violations.

Example ~ *Two contractors, one the president of a renovation company and the other a painting subcontractor, were sentenced to three years probation after pleading guilty to a criminal misdemeanor for contributing to a worker's death. One of the defendants also was ordered to perform 100 hours of community service and pay funeral expenses for the deceased worker. The case involved confined space entry violations. The president of the renovation company also pled guilty to falsifying records submitted to OSHA in an attempt to cover up the cause of the worker's death.*

Example ~ *An Alaska pulp mill company and its owner were convicted for illegal removal of asbestos. The owner faces up to 5 years in prison and a \$250,000 fine on each of seven obstruction of justice counts, as well as additional penalties for convictions under the Clean Air and Water Acts. At the owner's direction, employees knocked asbestos off pipes and boilers with high power fire hoses, washed asbestos-contaminated water down drains, and dropped dry asbestos insulation from heights of up to 60 feet, creating clouds of respirable asbestos dust. The owner also encouraged employees to turn off personal air monitoring devices to prevent regulators from detecting high asbestos fiber counts. When the EPA and OSHA came for an unannounced inspection, the owner had employees sign false statements claiming none of the asbestos-contaminated wastewater was washed down the drains.*

Example ~ *A jury for illegal asbestos abatement convicted a former owner of an environmental services company. Evidence established that the defendant's actions led to illegal removal of asbestos at more than 1000 facilities. The facilities included elementary schools, churches, nursing homes, hospitals and numerous other public buildings and private residences. Some workers were knowingly sent into "snow storms" of airborne asbestos without being directed to wear proper personal protective equipment, including respirators. The owner also conspired with accredited labs to falsify air monitoring at buildings where asbestos had been removed. The defendant faces up to sixty-five years in prison, faces up to sixty-five years in prison, up to \$4.128 million in fines or both, when sentenced.*

Example ~ *The owner of an environmental resources company in Idaho was fined \$5.9 million and sentenced to seventeen years in prison for knowingly exposing a worker to hazardous waste. The prison sentence is said to be the harshest ever imposed for an environmental crime*

in the U.S. The owner was convicted of ordering an employee to wash down a 25,000-gallon tank containing phosphoric acid and cyanide without protective equipment, no respirator, and without safety training. The chemicals when combined produce the same gas used by the Nazis in their World War II death camps. The employee suffered extensive damage, after collapsing and before being rescued, and now requires continuing medical care.

In two other cases, while prison sentences were not involved, OSHA was not hesitant in levying hefty fines for willful violations. In one, OSHA charged a manufacturer with, among others, seventeen willful violations of the lockout tag out standard. The violations were cited following finger amputations of two workers and crushing hand injuries to a third worker. The employer was aware of repeated injuries, employee complaints, and had received numerous previous OSHA citations.

OSHA fined the company over \$1.12 million. In another case, OSHA fined a steel company over \$1.7 million for 182 alleged OSHA violations. 122 were cited as willful instances regarding fraudulent record keeping. The company was found to have been “purposefully” not recording numerous injuries and illnesses from 1998 through part of 2000.

Safety Training

Safety training begins in the plant, office, job site, and boardroom. Loss control consultants can assist the management of a company in providing effective safety training for all levels of the organization. This includes providing visual aids dealing with on-the-job safety and health, safety guidebooks, posters, and audio-visual aids for use in safety training. Supervisor safety training courses and safety booklets for supervisors should be available at all times.

Safety Awards

The traditional approach to workplace safety has been to stress its importance through posters, slogans, and safety training programs, plus taking disciplinary action against those who break the rules. The better approach is to combine such traditional methods with the systematic use of positive reinforcement and extrinsic rewards using disciplinary action only to immediately stop dangerous behaviors.

Positive reinforcement and rewards come in a variety of forms. A firm might use trading stamps and/or token programs, specific verbal or written praise, short-term team competitions, and cash rewards in an effort to promote greater workplace safety.

Safety is a discipline and a value that is also its own tool for helping us protect financial results and people. Safety isn't simply about compliance and rules and science. It is about a philosophical belief in goodness and in compassion for the welfare of others- for those we love and those with whom we work. Perhaps, then, workplace safety answers do not always reside in pure science or in our reliance solely on science for answers, but rather in a certain amount of care, prudence and prudent intervention.



Chapter Five

Loss Control and the Professional

A professional act or service is one that arises out of a vocation, calling, occupation or employment involving specialized knowledge, labor, intellectual, rather than physical or manual labor.

Loss Exposures for the Professional

Legal Disaster

Professional Liability insurance protects ones business from potentially catastrophic litigation caused by charges of professional negligence or failure to perform his professional duties. Whether the claim is baseless or not, mounting a legal defense can bankrupt a company. Professional Liability insurance protects a company and its future by responding to professional liability claims and helping the professional keep his business operating as potential law suits move through the courts. Without it, a company could be financially overwhelmed.

Professional Liability insurance is especially essential in today's legal environment where the boundaries and definitions of professional requirements and duties are largely legally undefined. Unlike lawyers and other professionals who have an established body of tort, or contract law from which to draw, computer professionals are often in legally uncharted territory. What this means for the professional is that he may be liable tomorrow for actions which are today completely in line with present consulting expectations. Professional Liability insurance protects against the unknown and the unforeseeable. Professional liability insurance covers crucial aspects of ones business and his interactions with clients.

Alleged Negligent Acts

A business provides a highly specialized service that many of its clients don't fully understand. As a result, its clients may have incorrect expectations of the services the organization is providing. Professional Liability insurance protects the business against loss from a claim of alleged negligent acts. These are also known as errors or omissions in the performance of professional services.

Claims Typically Excluded from General Liability

General Liability insurance policies cover claims of bodily injury and property damage only. They typically exclude coverage for claims related to the delivery of professional services. For example, if one damages a computer while performing his job (which might fall under General Liability insurance coverage), he may be responsible simply for the finite replacement cost of a damaged computer. The financial impact of the company's professional errors and omissions and negligence is usually greater than the types of damage covered by general liability insurance.

Damage to or Loss of Client Data

An organization's projects that they work on are highly sensitive and of critical importance to their client's business. Loss of client data, software or system failure, and non-performance of their duties can drastically impact their client's ability to operate its business. This risk opens up to litigation. If one damages a company's client database, the cost to reconstruct that database may far exceed typical costs for replacing hardware and software. In fact, some client companies have won extremely large settlements when subcontractors have lost irreplaceable data.

More and more clients and consulting firms require subcontractors working on site to provide proof of insurance. The insurance most require are General Liability, as well as Professional Liability insurance. They want to know they will be covered in the event a problem occurs.

Importance of Communication

It must always be remembered that in some professional liability policies, one of the conditions of the policy may require the permission of the insured before any settlement may be negotiated. It is essential that the attorney who represents an insurance company establishes a close liaison with the insured and keeps him advised of all discussions and negotiations with the attorney for the plaintiff. As with other areas of casualty claim investigation that deal with subjects that require knowledge of the particular law, it is essential to claims involving professional liability. It is the law that determines what facts are needed and in what form these facts must be obtained in order to be admissible in evidence.

It is essential that the investigator gathers and corroborates information in a manner that can be presented in court if necessary. Factual details would include:

- the exact date, time, and place of the incident
- the complete factual details from all available sources
- the complete medical or other records that may be available, such as supervisory reports, police reports, medical records, etc. If medical or hospital malpractice is involved this investigation should cover the history of the incident, previous medical history, diagnosis, treatment rendered, x-rays taken, operations performed, consultations made and an exact list of all visits
- an itemization of the professional bill
- statements from any associates, assistants, nurses, attendants, or anyone else involved in the incident

If applicable, he should

- determine whether separate insurance is carried and, if so, obtain the name of the carriers and see that proper notification is given
- determine whether anyone made any promises or made any statement or took any action which might have broadened the scope of his or her liability
- determine whether the professional was under the influence of intoxicants or narcotics at the time of the alleged malpractice
- find out if any equipment failure was involved, and if warranted, put the retailer, wholesaler, or manufacturer on notice

- obtain the opinion of legal practitioners in the same profession in order to determine whether the services performed or the treatment rendered was in accordance with ordinary good practice. If malpractice is involved, enlist the aid of local "expert" societies. This is ordinarily more easily obtained by the defense than by the plaintiff.
- determine if the insured held out any promise of definite results and, if so, get full details

Information the investigator needs to obtain from or concerning the injured person(s) would be as follows:

- Find out who referred the doctor, surgeon, hospital, etc. to the injured.
- If surgery was performed determine whether consent was obtained and, if so, how, when, and from whom. If consent was obtained in writing, obtain a copy. If no consent was obtained, find out why.
- Find out whether the injured followed the doctor's, the surgeon's, or the nurse's instructions. Obtain complete details.
- Determine when the injured made the first complaint after the alleged malpractice and why such complaint was directed at the specific person or company.
- Determine what subsequent medical treatment was received and obtain complete medical reports from all available sources as previously outlined in making a medical investigation.
- Find out whether the injured received a settlement or was awarded compensation or a judgment as a result of an injury that necessitated the medical treatment presently being investigated. Obtain full details including copies of all releases, checks or drafts issued, court orders, or other records.
- Determine whether the injured ever made a previous malpractice claim, and, if so, obtain complete details.
- Determine the advisability of obtaining a physical examination by a specialist. Make a complete background investigation of the injured, including complete medical history as previously outlined.
- Determine if the person or company suspicion were accredited. Find out when the company /product was last inspected and get a copy of the report and recommendations. Check to see if all recommendations were complied with. Check to determine if the company's own regulations were followed. Determine the company has had previous experience with similar incidents and equipment.

Hospital records are of vital importance to any investigation where the plaintiff received care that could be involved in the liability, medical treatment, or the factual situation of a case. Other records that need to be brought under the scrutiny of investigation are

- manuals and handbooks regarding nursing procedures and regulations
- operating procedures
- any standing orders of attending doctors
- personnel records including the identity of all personnel involved in the incident
- all equipment involved
- any photographs or diagrams

Courts routinely require expert testimony to establish the standard of care in malpractice claims against physicians, lawyers, dentists, accountants, and architects. Their line of reasoning is that there are few lay people who understand professional standards of care concerning the issue of

negligence. Therefore the benefit of expert testimony is extremely important. For this same reason, courts are beginning to require expert testimony where an insurance agent's negligence is required to be shown.

General Principles and Rules

Professional liability policies are designed to protect the practitioner from liability for acts or omissions performed as a result of his or her practice. The following paragraphs tell of a few instances where the courts may closely scrutinize one's actions.

Locality Rule – Most jurisdictions have now abandoned the locality rule as a standard in judging negligence. It is generally recognized in most malpractice cases that the locality rule has become obsolete.

Expert Testimony – Generally, the only situation in which an absence of expert testimony is excused, is when the lack of skill or care of the professional is so apparent that the average layman could understand and recognize it, and where express warranties of results were made.

Wrongful Birth – These are actions brought against medical facilities and doctors by the parents of healthy, normal children who were unwanted and usually resulted from the failure of contraceptive devices, or as a result of unsuccessful sterilization operations, and even ineffective abortions. Such an action may also be brought against a doctor who negligently gives incorrect advice regarding the possibility or probability of the birth of a defective child, born as a result of failed or improperly made tests, or failure to make proper tests initially.

Wrongful Life – These claims usually involve the birth of a defective or disabled child and are ordinarily brought by the parents or guardian on behalf of the child. However, confusion reigns supreme in this. In many cases, jurists have either made on distinction in their decisions concerning wrongful birth and wrongful life or have confused them. Most jurisdictions do not even recognize an action for wrongful life or wrongful birth.

Wrongful Pregnancy – Some cases that are called wrongful pregnancy or wrongful conception have created another category of wrongful birth cases. In some courts, the physical well being of the child at the time of birth has a great bearing on how the case is decided. Most cases hold that the nonexistence of a child cannot be held to be a benefit, and do not permit recovery where the child is born normal and healthy.

Standard of Care – Initially, the standard for evaluating the conduct of a professional in a malpractice suit was the degree of skill and care of a reasonably skilled professional in the same or similar locality. The locality rule was initially promulgated in order to protect those practicing in rural communities who did not have the education or skill of their urban counterparts.

Honest Error in Judgment – It has been held that in order to fully state the standard of care applicable to a professional, the jury must be instructed that one is not responsible for an honest error in choosing accepted methods of care. Some jurisdictions, however, have discarded the honest error in judgment wording in the instructions to a jury under the belief that such wording is potentially misleading and exculpatory.

Continuing Negligence – Correcting conditions of a damaged property or the medical treatment that was subsequently received after an accident can further aggravate the initial injury. It has been held that a separate action may be brought against the owners or doctor who was guilty of negligence to repair or medical malpractice despite the fact that a previous verdict

was rendered or a settlement made of the underlying case. This doctrine was developed in cases for the purpose of tolling the applicable statute of limitations until the time when medical treatment by the defendant ceased.

Contributory and Comparative Negligence – Defenses of contributory and, more often, comparative negligence are usually available in cases involving malpractice. Professionals can also be held liable for the negligence of their employees.

Good Samaritan – Before the Good Samaritan laws were enacted, a bystander or doctor was under no duty to help an injured person in the event that he was fortuitously present when an emergency situation arose. On the contrary, if he did volunteer to help, he could be held accountable for his negligence in rendering bad assistance.

Discovery – which appears to be the majority rule, give the broadest interpretation of when the limitation period begins.

Last Act – holds that the date of the last act such as medical treatment, which can be after the regular course of treatment and post-treatment check-up have been completed, is the date from which the statute should toll.

Benefits of Parenthood – argues that the benefits of having a healthy, normal child defy precise measurement. Deciding in favor of the parents – according to the courts – would be incompatible with contemporary views concerning one of life’s most precious gifts – - the birth of a normal and healthy child.

Types of Policies

Rated Policy – An insurance policy issued at a higher-than-standard premium rate to cover a higher-than-standard risk; for example, an insured who has impaired health or hazardous occupation.

All-Risks Policy – Coverage by an insurance contract that promises to cover all losses except those losses specifically excluded in the policy. To be covered for damage or loss under a basic contract, the damage or loss must be caused by a peril that is named or listed in the contract. Consequently, if damage or loss is caused by a peril that is not named, there is no coverage. In an all-risk policy, coverage is provided unless specifically excluded. The contract’s exclusions must be considered in determining coverage.

Claims-Made Policies – This policy covers only those claims, which both occur and are reported during that policy period. In certain instances, a claims-made policy may cover claims arising prior to the policy’s inception date.

Occurrence Policy – This is a policy that covers incidents that occur during the policy coverage period regardless of when they were reported.

Commercial Package Policy (CPP) – A commercial policy that can be designed to meet the specific insurance needs of business firms. Property and liability coverage forms are combined to form a single policy.

Block Policy – A form of inland marine insurance designed to cover loss to the property of a merchant, wholesaler, or manufacturer including: property of others in the insured’s care, custody, or control, property on consignment and property sold but not delivered. Common block policies are jeweler’s block and furrier’s block policies.

Farm Owners-Ranch Owners Policy – A package policy for a farm or a ranch, providing property and liability coverages against personal and business losses.

Economic Policy – Special type of participating whole life insurance in which the dividends are used to buy term insurance or paid-up additions equal to the differences between the face amount of the policy and some guaranteed amount.

Limited Policy – An insurance contract that covers only certain specified diseases or accidents.

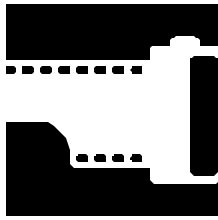
Master Policy – A policy that is issued to an employer or trustee, establishing a group insurance plan for designated member of an eligible group.

Multi-Peril Policy – A package policy which provides protection against a number of separate perils. Multi-peril policies are not necessarily multiple line policies, since the combined perils may be all within one insurance line.

Non-Occupational Policy #1 – Contract, which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Workers' Compensation. Group accident and sickness policies are frequently non-occupational.

Non-Occupational Policy #2 – One that provides off-the-job coverage only; it does not cover loss resulting from accidents or sickness arising out of or in the course of employment or covered under any workers' compensation law.

Occurrence Policy – A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim was filed.



Chapter Six

Loss Control and Errors and Omissions (E & O) Claims

Errors and omissions insurance is a basic safeguard for a business. This insurance protects technology businesses against potentially catastrophic litigation involving professional negligence or charges of failing to perform professional duties. Errors and omissions coverage can make the difference between the survival and failure of a business when faced with these types of legal threats.

Errors and omissions insurance protects technology companies if they are faced with the two most common forms of liability risks:

- Claims for "malpractice" in which companies are sued for failing to maintain accepted standards of care as a technology professional or company
- Breach of contract claims for failing to perform contracted services in a timely manner and within the contractual terms

Either one of these types of errors and omissions allegations can tie up company funds, personnel, and attention for years. E & O insurance is especially necessary in the new technology age where the law is still being formed. In many cases, courts are defining what a computer professional is and what the expectations are for services and contracts. The laws around computer consulting and contracting are too new to have established legal precedents. With no precedents, the legal waters are murky and dangerous for the company or consultant without E & O coverage.

Changing Tort Law

Tort law is established law covering contracts. It has had time to establish contractual expectations for most types of professionals and professional activities, but the cyber-service world is too new to be clearly addressed by existing law. This means that much of the tort law is still to be formed through court cases and judgments. What may not be actionable today could result in huge court awards next year. The upshot is that no one can protect against what may be decided in court cases in the near future, except with E & O insurance.

Massive software giants, multinational hardware producers, and individuals writing programs or servicing computers out of their homes are all equally at risk for E & O liability suits. Whether it is catastrophic software crash or network failure that ties up services for expensive hours, the result to the consulting firm or individual can be an unforeseen lawsuit. Errors and omissions insurance protects against the financial effects of potentially disastrous court cases.

Many computer-consulting companies are becoming aware of these legal threats and, to protect themselves and subcontractors, are requiring their subcontractors (generally those workers receiving a 1099 instead of a W-2 at the end of the year) to carry Errors and Omissions Insurance. If a client company experiences what it perceives to be an actionable error or omission, even if the problem occurs months after the initial consulting activities, both the consulting firm and subcontractors can be held liable and met with law suits. Errors and Omissions insurance protects both parties as they face the legal battles.

Errors and Omissions insurance can be highly tailored to the needs of technology firms. For example, the Errors and Omissions insurance policy can include the persons covered, exclusions, length of coverage, definitions, professional responsibilities and other information pertinent to technology businesses.

Errors and Omissions Claims

The way in which claims are handled varies from insurance carrier to insurance carrier. Some policies include a clause stating one's consent to settle, while others give the insurer to sole right to determine when to settle. Some carriers also include a clause requiring the policyholder to consent to a common defense with any other defendant insured by the same company. While this has certain advantages, it also has certain risks, and the acceptance of any such clause should be given very careful consideration.

Most professional liability policies are written on a claims-made basis, though sometimes coverage is available on an occurrence basis. **Communication** between the agent and the client can be **absolutely critical** in preventing dangerous gaps in coverage. The agent needs to understand the needs of the client, and the client needs to understand exactly what claims-made liability coverage is. Professional liability coverage is sometimes offered on a claims-made basis.

Professional liability policy coverage is sometimes provided only for work produced during the policy period and, only those claims that are first made against the business owner and are reported during the policy period will be covered under the policy when a policy is written in this manner. Claims-made coverage is most common in the computer consulting industry.

Software Errors and Omissions Claims

In today's litigious society, companies are searching for every way possible to minimize the financial consequences of a lawsuit. Even a baseless lawsuit successfully defended can cost tens of thousands of dollars in legal costs. In some situations, a standard liability product simply doesn't offer enough coverage. While both General Liability and Errors & Omissions policies cover defense and settlement costs, the manner in which the suit is brought shows the difference between the two distinct coverages.

General Liability protects a firm against lawsuit costs stemming from *bodily injury* and physical property damage. **Errors & Omissions** coverage offers protection against lawsuit costs stemming from a *product's failure to perform* as specified resulting in a client's

- Loss of use of *physical* property without *damaging* it
- Injury to the claimant's reputation
- Damage to *intangible* property
- Loss of use of *intangible* property

The Software E & O insurance market continues to evolve as the technology industry moves forward. The impact of software technology in our world, results in the need for the insurance industry to keep pace with coverage to address potential claim situations. As reliance on computers continues, there will be claims when something goes wrong. Organizations are realizing that is critical for them to secure coverage to protect their company assets. Many insurance companies have developed special technology departments and have provided the

underwriters with appropriate training to evaluate those companies requesting insurance coverage.

Specialized Coverage

Since general liability policies cover only bodily injury and tangible property damage, they don't generally insure the damage brought about by software and tailored programming. Software, in and of itself, cannot cause bodily injury, and if it does not perform, it will not likely cause *tangible* property damage. In addition, the General Liability policy only provides coverage for an *occurrence* that is defined as an *accident* and not a failure to perform. With no clear coverage under the General Liability policy, software consultants and companies are looking to Software Errors & Omissions policies to provide the insurance protection.

Some states also require that the companies writing E & O insurance as a part of a package policy, and on an admitted basis, provide defense costs outside of the policy limit, similar to the manner in which General Liability policies are written. This is important for an entity when considering the limit of liability to purchase. Many insureds purchase E & O coverage primarily for the defense provision, and it aids in the selection of limits with knowledge that defense costs are in addition to the limit of liability.

Some insurance companies write coverage on a surplus lines basis. Because their forms do not have to be filed with the respective state insurance commissioners offices, the coverage grant can usually be modified quickly and underwriters have the ability to manuscript forms. In the fast paced technology market, the ability to react to market needs is vitally important. There is typically also flexibility in the premium calculation in the surplus lines market, as the rates are not filed with the respective state insurance departments. However, when insurance is written on non-admitted paper, the insured must also pay surplus lines tax. And, the insured cannot look to the state guarantee fund in the event of insurer insolvency.

Increase in Premiums

There has been an increase in the premium volume for this class of business as companies in the software industry recognize the need to procure E & O insurance as a part of their risk management program. The increase in submissions has been seen by all of the companies. One company reports an increase of over 50% in premium written for technology accounts. For many insurers, this market is where they will experience the largest growth in underwriting. This increase in volume is very positive for the carriers from two standpoints:

- They can spread their exposure over a greater number of insureds
- There are more premium dollars from which to pay claims

For insureds, growth in this market means more competition and a focus by insurance companies **to understand the exposures** unique to their industry and **to provide the necessary coverage**.

Loss Exposures

These type of claims are not only becoming more frequent, but also costly. Typical defense costs can run in the hundreds of thousands of dollars, not to even mention the settlements. Computer related claims continue to rise, as we are increasingly dependant on technology. However, just because there are allegations of errors or omissions, the software firm is not necessarily liable. There are frivolous claims, where damages are not proven. In these cases,

however, the software entity must still address the allegation and provide a defense. Even with a well-drafted license, service agreement, or contract, a company is vulnerable to lawsuits. Attorney fees alone can seriously impact a company. For the defense costs provision alone, many companies purchase Errors & Omissions insurance.

The loss exposures for the software companies include:

- software failures, resulting in lost time and production
- virus attacks, resulting in thousands of dollars in losses
- technicians fail to make back-ups of data, and erase a client's hard-drive
- software is corrupted and data is destroyed, resulting in lost business
- hackers, resulting in penetration of prominent sites
- failure of custom-designed software, resulting in client not being able to market their product on-line
- spreadsheet error, resulting in incorrect data
- incompatible software which was recommended to client by insureds representative

Communication Issues

All policies cover

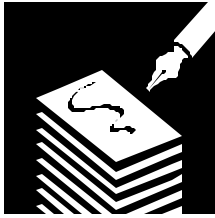
- the individual named insured
- related named partnerships and joint ventures
- corporations including executive officers, directors, and stockholders, and employees while acting within the scope of their duties

Insurers differ in their position on covering *former* partners, directors, officers and employees. The insured must decide whether it is important to include these individuals. Employment contracts may require that certain individuals be provided coverage when they no longer work for the company as a claim may occur during the time of their employment or directorship, and may not be reported until some time after they leave.

All companies either include coverage for independent contractors within the policy language or can add it by endorsement. Typically the policy stipulates the extent to which coverage is afforded the contractor, and limits it to work performed for or on behalf of the named insured. Regardless of the coverage provided for the independent contractor, policies usually will protect the named insured for claims arising out of their actions, while working on behalf of the insured.

With the increasing reliance on independent contractors and computer consulting firms, it is important to determine the company position on providing coverage. This is a management decision that should be considered before entering into a contract for services.

The insurance issue should be addressed, and made clear as to which entity is responsible for the coverage. It is very important for the insurance agent to ask detailed questions on the use of independent contractors. He and the client should discuss whether the insured requires evidence of separate errors and omissions insurance. This will help them to have a clear picture of the exposure and to be sure they are not assuming unintended risk.



Chapter Seven

Loss Control and the Employer

If one is injured on the job--or suffers a work-related illness or disease that prevents him from working—he is eligible to receive benefits from his state workers' compensation program. He is also entitled to free medical care. If his disability is classified as permanent or results in death, additional benefits are available to him and his family.

In most states, employers purchase insurance for their employees from a workers' compensation insurance company--also called an "insurance carrier." In some states, larger employers who are clearly solvent are allowed to self-insure (act as their own insurance company). When a worker is injured, his or her claim is filed with the insurance company--or self-insuring employer--who pays medical and disability benefits according to a state-approved formula.

A wise employer will involve his workers as a valuable resource for keeping the workplace safe and health. He will involve them in identifying safety and health problems and suggesting ways to solve such problems. Organizing a safety committee made up of equal numbers of employees and managers is a good starting point. If workers can voice their safety concerns to their employer and to other workers who are able to initiate changes, there is less chance that they will jump the gun and go straight to government authorities to report a complaint. Having such a safety committee can also earn the employer a break on workers' compensation insurance premiums.

The principal elements directed at coverage in workers' compensation cases are the scope of the **risk**, the relationship of employer and employee, and the factual cause. The coverage formula used in the majority of workers' compensation acts requires a *by accident arising out of and in the course of employment.*"

Risks in the Workplace

Actual Risk

The *actual risk* doctrine is a liberal approach toward the scope of the risk issue. The sole question to be answered is whether the risk realized was a risk of one's employment, regardless of whether the risk is commonly shared by the public. Heat prostration would be compensable if the nature of the employment exposed the employee to the risk. The fact that the risk is common to all who are exposed to the sun's rays on a hot day would be immaterial.

Positional Risk

The positional risk doctrine is the most liberal of the scope of the risk theories, and it has been adopted in a few jurisdictions. The only inquiry under a positional risk theory is whether one's employment was responsible for one's being at the time and place where an injury occurred. The most neutral of risks can be included under this doctrine.

Increased Risk

The *increased risk* doctrine is a modern approach that provides broader coverage than the peculiar risk test. This approach includes within the scope of the risk those risks to which an employee has been exposed for a longer period of time than the public, even though all commonly shares the risk. If one's employment results in a greater exposure to a risk there would others even though the risk is not one that is different from that share coverage. For example, the farm worker who is constantly exposed to extreme heat on the job and who suffers from heatstroke should be entitled to compensation under the increased risk theory.

Peculiar Risk

The peculiar risk doctrine was a concept that excluded coverage for injuries caused by risks which were within the course of one's employment, but which were commonly shared by others, even though the employee was exposed for a longer period of time by virtue of the nature of the employee's employment. An employee who suffered a sunstroke while cutting hay for his employer was viewed as not having been "peculiarly exposed" to the danger of sunstroke because he was not subjected to a materially greater risk of sunstroke than other outdoor workers. This theory is usually rejected in modern compensation cases because it is unrealistic and allows only limited coverage.

Proximate Cause

Judges have had difficulty separating themselves from tort law with its *proximate cause* and fault concepts. Therefore, some early cases adopted the fault-related proximate cause test for the "arising out of" concept, which required that one's employment be the proximate cause of one's injury. This approach is much too narrow, and it is incompatible and in conflict with the objectives of any statutory no-fault compensation system.

Loss Exposures in the Workplace

Acts of God

While acts of God such as windstorms, tornadoes, exposure, lightning, floods, earthquakes, etc., would at first appear to be outside the employment risk, it is generally agreed that if one's employment has enhanced or "increased" the risk of injury from these sources, the injury would be compensable. In addition to an *increased risk* approach to recovery, it may be possible to recover on the basis of *actual risk* or *positional risk* theories. The *proximate cause* or *peculiar risk* approaches would disallow compensation.

Imported Dangers

It is common for employees to be exposed to a risk of harm that they or their fellow employees have imported to the worksite. Examples of this would be matches, explosives, or firearms. Traditionally, risks imported by the injured employee were viewed as "personal" and outside of the scope of risk of employment. A danger imported by one's co-employee, while it may appear to be a neutral risk, could give rise to recovery on the basis of increased, actual or positional risk theories. Even though compensation might be denied to an employee who was killed when his hunting gun accidentally discharged while he was getting a work uniform from his car, the court could indicate that recovery would have been allowed if the gun had belonged to another employee. An employee might be able to recover for the realization of a personal risk that the

employee has imported, if it could be established that the employment had increased such a risk.

Assault

Assaults are considered to be within the scope of the risk and to arise out of one's employment when the nature of the employment increases the likelihood of such an occurrence, or if the assault has grown out of a controversy that is work related. Usually assaults are not within the scope of the risk if they have been prompted by malice or personal motives; however, even these assaults may be included if in some manner one's work has contributed to the occurrence. Assaults in some cases, such as those by stranger, lunatics, children, etc, may be viewed as neutral risks outside coverage. In the past the courts recognized the aggressor defense, which denied compensation to an aggressor in work-related assaults. The aggressor defense has been discredited today because it creates a fault-based defense in a no-fault system. A minority of jurisdictions by statute excludes from coverage those who have been harmed as a result of their willful intent to injure others.

Street Risk

In the past court decisions denied recovery to employees who were injured as a result of the risks associated with the use of streets and highways because these were viewed as common risks or hazards to the general public and not risks peculiar to one's employment. Today an employee who is subjected to a greater exposure to the risks of the street, despite the fact that such risks are common to the public, may be covered. Coverage in these cases can be provided on the basis of the increased risk approach, the actual risk, or positional risk doctrines.

Pre-Existing Injury or Disease

It is not uncommon for employees to bring pre-existing medical problems to the workplace. The difficulty posed in this area stems from the fact that pre-existing medical problems constitute personal risks, which would fall outside of coverage. However, if one is able to demonstrate that one's employment aggravated a pre-existing medical problem, recovery may be permitted. The obvious problem facing employees is that of factual cause and medical proof. One must establish through expert medical testimony the fact of aggravation and a causal connection between one's employment and the claimed injury. Some jurisdictions address this problem area through special provisions in their workers' compensation act.

Heart Cases

One of the most problematic areas in the law of workers' compensation is that of heart cases. Commonly these cases are approached on the basis of whether or not a personal injury "by accident" has occurred. This approach requires that "unusual" strain or exertion precipitate the heart attack. This is an impractical and unsatisfactory test for coverage in heart cases; distinctions between *usual* and *unusual* strains are practically impossible to make, and serve to confuse the issue.

It is better to approach this issue from a scope of risk perspective. If one's employment has contributed to the heart attack because of exertion or other work-related circumstances, the attack may be found to have arisen out of one's employment. Otherwise, heart attacks occurring on the job would involve personal risks. Because of the difficulties in this area, some jurisdictions have special provisions directed at heart and exertion cases.

Unexplained Accidents

Coverage questions arise in cases of unexplained deaths, unexplained falls, and idiopathic falls. A strict application of the neutral risk or personal risk theories could result in a denial of coverage, even if a fall or death occurred in the course of employment. An application of the positional risk doctrine can result in recovery even if the cause of a fall or death is unknown, because of the employment relation that existed at the time. The positional risk doctrine could also permit recovery in idiopathic fall situations in which the fall was the result of a purely personal condition, if, for example, the fall occurred at work.

Intentional Injury

Another rule often invoked, as an exception to the exclusivity rule is that where an **intentional** injury has been committed. Several jurisdictions have refused to allow tort actions to be brought as exceptions to the workers' compensations' exclusivity provisions unless the plaintiff has established that the employer intended the injurious results of its actions as well as the intended actions themselves. Some cases have held that although the injured worker need not prove that the employer intended to cause the injury, there must have been a "substantial certainty" of the

Sexual Harassment

Depending upon the facts giving rise to a plaintiff's claim for sexual harassment, a defendant employer may be able to characterize plaintiff's injuries as "arising out of and in the course of employment" and successfully argue that the exclusive remedy injury lies under workers' compensation.

The Occupational Safety and Health Act

In 1970, Congress passed the Occupational Safety and Health Act or OSHA that is a comprehensive law designed to reduce workplace hazards and to improve health and safety programs for workers. It broadly requires employers to provide a workplace free of physical dangers and to meet specific health and safety standards. Employers must also provide safety training to employees, inform them about hazardous chemicals, notify government administrators about serious workplace accidents, and keep detailed safety records.

Although there can be heavy penalties for not complying with OSHA, such penalties are usually reserved for extreme cases in which workplace conditions are highly dangerous and the employer has ignored warning about them. If one's workplace is inspected, OSHA will work with them to eliminate the hazards.

Usually, an employer must comply with the Act if his business affects interstate commerce. The legal definition of interstate commerce is so broad that almost all businesses are covered. OSHA does not apply to a workplace if one is self-employed and has no employees, one's business is a farm that employs only his immediate family members, or one is in a business such as mining, which is already regulated by other federal safety laws.

Safety Standards

OSHA sets a general standard for all covered businesses. The employer must provide a place of employment that is "*free from recognized hazards that are causing or are likely to cause death or serious physical harm to employees.*" Recognized hazards are not clearly defined,

which can make it difficult for the employer to know how to comply with the law. The broad language covers an almost impossible large range of potential harm—from sharp objects that might cause cuts to radiation exposure.

In the Act, Congress created the Occupational Safety and Health Administration—also called OSHA---as a unit of the U.S. Department of Labor. Congress authorized this agency to set additional workplace standards, which it has done in great profusion. The specific standards cover a wide range of workplace concerns, including:

- worker training
- workplace temperatures and ventilation
- exposure to hazardous chemicals
- first aid and medical treatment
- noise levels
- protective gear—goggles, respirators, gloves, work shoes, ear protectors
- fire protection

Administration

The employer must post a notice called “Job Safety and Health Protection,” which is available from the nearest OSHA office. If one’s business is located in a state that has its own approved OSHA program, there may be a state form for him to post instead of the national version. The employer must notify OSHA within eight hours after learning that an employee has died from a job-related accident or that three or more employees have been hospitalized because of a workplace accident.

Unless his business is exempt from OSHA record keeping requirements, he must maintain several types of records. He must keep a log of all workplace injuries and illnesses, except minor injuries requiring only first aid. He must keep up-to-date medical records and records of employee exposure to hazardous substances or harmful physical agents. He must keep records of his safety training records and make them available for review by employees. He must maintain required records for specified periods of time – sometimes as long as thirty years.

Training

The employer is responsible for safety training under OSHA. He must make sure that all employees know about the materials and equipment with which they will be working, the known hazards in his business and how he is controlling those hazards. Special attention should be given to the use of chemicals, being sure to train employees in:

- methods of detecting the release of a hazardous chemical in the work area—for example, monitoring devices or appearance or odor of chemicals when being released
- physical and health hazards of the chemicals
- measures employees can take to protect themselves from the hazards---safe work practices, emergency procedures and protective equipment
- details of the company’s labeling system and where employees can look at chemical safety data

No employee should start a job until he or she has received instructions in how to do it safely. The exact training that the employer offers will vary according to the nature of his business.

Sometimes it is helpful to call in an OSHA consultant to recommend specific training for the workplace. It is very important to train existing employees who move into new jobs or start using new equipment. All employees need refresher instruction from time to time, since it is human nature to become complacent and forget the safety rules. The employer must maintain records of his safety training efforts and be prepared to show these records to OSHA inspectors.

Inspections

OSHA inspectors can inspect one's workplace at any time without advance notice or authorization by a court and, based on what they find, can issue citations and impose penalties. It is unlikely that inspectors will make random inspections unless one is in a particularly hazardous business such as construction. OSHA has a limited number of inspectors, and must use its resources wisely.

If one has a workplace with ten or fewer employees and he is in an industry that has a low injury rate, he is exempt from random inspections by federal OSHA officials. State safety and health laws, however, may empower local inspectors to randomly inspect smaller business. If one's business is a small insurance agency, retail store, computer repair shop or similar low injury business, his chances of receiving a random inspection are remote.

Most small businesses are inspected only if:

- an employee has complained to OSHA
- a worker has died from a job-related injury
- three or more employees have been hospitalized because of a workplace condition

Even if an employer is at low risk of inspection, he is not free to ignore safety and health concerns. He is legally required to take the initiative in identifying and eliminating safety and health problems that can affect employees.

Penalties

Penalties ordered by OSHA depend on the seriousness of the violation. For willful or repeated violations, a company may have to pay thousands of dollars in penalties. If a worker has died because the employer violated OSHA standards, the employer could even be sent to prison. For less serious violations—problems that are unlikely to cause serious harm or death—the penalty may be up to \$1,000. In assessing penalties, OSHA looks at several factors, including:

- the seriousness of the hazard
- one's history of violations
- whether the employer has made a good faith effort to comply with OSHA standards
- the size of the business

There is an appeal process through which one can challenge an OSHA citation against his business. If the federal OSHA issues the citation, the employer has 15 days to file a notice of contest with the agency. If a state OSHA issues citations in one's state, he should check with that agency to confirm the filing deadline. It is wise to consult a lawyer before embarking on an appeal. After the notice of contest is filed, an administrative law judge will conduct a hearing, giving the employer and others concerned a chance to present evidence. If an employer disagrees with the decision of the administrative law judge, there is an additional appeal

process within OSHA. Fortunately, most OSHA disputes are resolved through a voluntary settlement

Workers' Rights

Workers have two basic rights under OSHA.

- Workers have a right to complain to OSHA about safety or health conditions without being penalized for doing so. Firing or discriminating against employees who have made such complaints is a violation of OSHA provisions.
- Workers have a right to refuse to work if they think the workplace is unsafe. The legal test is this: *Does the worker have a reasonable and good faith belief that there is an immediate risk of serious injury or death?*

If so, the worker can walk off the job and refuse to work. He can return after the problem has been corrected or investigated and it is determined that there is no imminent danger. While the problem is being investigated or corrected, the employer can place the worker temporarily in another job at equal pay. It is usually unwise to react by demoting or firing the complaining employee—which can be another violation of OSHA if the complaint is determined to be well founded.

If a state has a health and safety law that meets or exceeds federal OSHA standards, the state can take over enforcement of the standards from federal administrators. This means that all inspections and enforcement actions will be handled by one's state OSHA rather than its federal counterpart.

Hazardous Chemicals

The OSHA rules include a section called the Hazard Communication Standard. The standard requires employers to give information to their employees about the hazardous chemicals they handle. The requirements of informing employees vary somewhat from state to state. If one's business handles any chemicals, he must be sure to get a copy of his state's rules. Since most of the state laws are similar to the federal right to know rules, this discussion will focus on the federal law. If there are differences between the state and federal laws, it is wisest to follow the stricter standards.

The employer should become familiar with the Material Safety Data Sheets (MSDS) supplied by manufacturers of all hazardous chemicals. They contain a wealth of information, including:

- the physical hazards of the chemical such as flammability and explosiveness
- health hazards—the symptoms of exposure and the medical conditions that can be made worse by exposure
- how the chemical enters the body and the limits of safe exposure
- whether the chemical is known to cause cancer
- how to safely handle the chemical
- recommended protection methods including protective clothing and equipment
- first aid and emergency procedures should a chemical be mishandled

The law requires employers to keep the MSDS for each hazardous chemical and make it accessible to employees. He must also keep a list of all the hazardous chemicals used in his

business and label all containers. He is required to train employees in the safe use of hazardous chemicals.

Tobacco Smoke

It is well established that second-hand tobacco smoke can harm the health of non-smokers. In many states and cities, employers are legally required to limit smoking in the workplace. A proposed OSHA rule would allow only two choices:

- completely prohibit smoking in the workplace
- limit it to areas that are enclosed and ventilated directly to the outdoors

The torturous effects of tobacco smoke on human health have been clearly established and even certified by the government. A recent report by the Environmental Protection Agency, for example, estimated that secondhand tobacco smoke kills about 3,700 Americans per year. Many other estimates put the number at several times that amount. So people who smoke cigarettes, cigars or pipes at work increasingly find themselves to be an unwelcome minority--and many employers already take actions to control when and where smoking is allowed.

For example, a recent survey by Industry Week magazine found that nearly three-fourths of the 6,000 companies questioned either prohibited smoking in the workplace or restricted it to designated areas that nonsmokers can avoid. About 15% of the companies did not have a nonsmoking policy, but were considering adopting one.

Although no federal law directly controls smoking at work, a majority of states protect workers against unwanted smoke in the workplace. In addition, hundreds of city and county ordinances restrict or ban smoking in the workplace. In contrast, about half the states make it illegal to discriminate against employees or potential employees because they smoke during nonworking hours.

So the ongoing legal battle in most workplaces boils down to a question of what is more important: one person's right to preserve health by avoiding co-workers' tobacco smoke, or another's unfettered right to smoke. Because of the potentially higher costs of healthcare insurance, absenteeism, unemployment insurance and workers' compensation insurance associated with employees who smoke, some companies now refuse to hire anyone who admits to being a smoker on a job application or in pre-hiring interviews.

While most states now protect workers from unwanted smoke on the job, they follow different approaches. In several states--including California, Connecticut, New Jersey, Rhode Island and Vermont--the laws limiting smoking are aimed specifically at workplaces. A large number of other states have smoking control laws that apply to everyone in public places and specified private places. In these states, nonsmoking employees are protected only if they happen to work in a place that is specifically covered by the statute. A few state laws are all-encompassing--limiting or banning smoking in both public places and workplaces.

Where smoking is limited, some states prohibit it except in a designated area within the workplace. Other states take the opposite approach, requiring employers to set aside pristine areas for the nonsmokers in the work crowd. There are also common exceptions written into anti-smoking laws. Often, their protections do not apply to:

- places where private social functions are typically held, such as rented banquet rooms in hotels; presumably, even the most sensitive nonsmokers must brave the smoke when they frequent these places
- private offices occupied exclusively by smokers
- inmates at correctional facilities and hospital patients, who usually must comply with the rules of the institution
- employers who can show that it would be financially or physically unreasonable to comply with the legal limitations

Some workers who are irked and injured by smoke on the job have sued for their injuries under the Americans With Disabilities Act, which prohibits discrimination against people with disabilities. One is entitled to protection under this law only if he can prove that his ability to breathe is severely limited by tobacco smoke, making him physically disabled.

Workplace Violence

The workplace is becoming a dangerous place as increased violence is occurring against health care workers. A study done in Washington State found that more health care workers were being attacked at work than prison guards or police officers. The Occupational Safety and Health Administration (OSHA) developed voluntary guidelines recently to protect health care workers and consumers in the workplace, but not all employers have instituted them.

Liability for the vast majority of workplace injuries, including those due to violence, is strictly limited to worker's compensation. The injured employee is entitled to receive lifetime medical care for injuries on the job, as well as a small stipend (paid by workers comp insurance) and perhaps job retraining. Employees are able to go around workers compensation and sue for money damages only if the employer engaged in serious and willful misconduct. Examples include situations like the following:

- The employer received direct threats of violence and didn't notify or protect the target.
- An employee had a history of violence which the employer knew about but did nothing to protect others. To date, there is no legal duty to check references or criminal records of employees for violent tendencies. However, if an employer acts as a reference for a former employee who he knows was violent, he may be liable to anyone that person injures at his or her new employment.

Over the last few years there has been a dramatic increase in the use of Employer's Liability Insurance (ELI) as protection from the high cost of defending and resolving claims brought under the civil rights laws and other employment laws.

The Ergonomic Standard

Work-related musculoskeletal disorders (MSDs) currently account for one-third of all occupational injuries and illnesses reported to the Bureau of Labor Statistics (BLS) by employers every year. These disorders thus constitute the largest job-related injury and illness problem in the United States today. Employers pay more than \$15-\$20 billion in workers' compensation costs for these disorders every year, and other expenses associated with MSDs may increase this total to \$45-\$54 billion a year. Workers with severe MSDs can face permanent disability that prevents them from returning to their jobs or handling simple, everyday tasks like combing their hair, picking up a baby, or pushing a shopping cart.

Thousands of companies have taken action to address and prevent these problems. OSHA estimates that 50% of all employees but only 28% of all workplaces in general industry are already protected by an ergonomics program, because their employers have voluntarily elected to implement an ergonomics program. OSHA believes that the proposed standard is needed to bring this protection to the remaining employees in general industry workplaces that are at significant risk of incurring a work-related musculoskeletal disorder but are currently without ergonomics programs.

A substantial body of scientific evidence supports OSHA's effort to provide workers with ergonomic protection. This evidence strongly supports two basic conclusions:

- there is a positive relationship between work-related musculoskeletal disorders and workplace risk factors
- ergonomics programs and specific ergonomic interventions can reduce these injuries

Taken together, this evidence indicates that:

- High levels of exposure to ergonomic risk factors on the job lead to an increased incidence of work-related MSDs
- Reducing these exposures reduces the incidence and severity of work-related MSDs
- Work-related MSDs are preventable
- Ergonomics programs have demonstrated effectiveness in reducing risk, decreasing exposure and protecting workers against work-related MSDs

As with any scientific field, research in ergonomics is ongoing. The National Academy of Sciences is undertaking another review of the science in order to expand on its 1998 study. OSHA will examine this and all research results that become available during the rulemaking process, to ensure that the Agency's ergonomics program standard is based on the best available and most current evidence.

Employer Experience

Employers with companies of all sizes have had great success in using ergonomics programs as a cost-effective way to prevent or reduce work-related MSDs, keeping workers on the job, and boosting productivity and workplace morale.

A recent General Accounting Office (GAO) study of several companies with ergonomics programs found that their programs reduced work-related MSDs and associated costs. The study also found that the programs and controls selected by employers to address ergonomic hazards in the workplace were not necessarily costly or complex. As a result, the GAO recommended that OSHA use a flexible regulatory approach in its ergonomics standard that would enable employers to develop their own effective programs. The standard being proposed today reflects this recommendation and builds on the successful programs that thousands of proactive employers have found successful in dealing with their ergonomic problems.

Much literature and technical expertise already exists and is available to employers, both through OSHA and a variety of other sources. OSHA's state consultation programs will provide free on-site consultation services to employers requesting help in implementing their ergonomics programs; and OSHA is developing a series of compliance assistance materials and will make them available before a final ergonomics standard becomes effective.

Reporting Injuries

The workers' compensation system is designed to provide benefits to injured workers no matter whether an injury is caused by the employer or employee's negligence. But there are some limits. Generally, injuries caused as a result of an employee being intoxicated or using illegal drugs are not covered by workers' compensation. Coverage may also be denied in situations involving:

- self-inflicted injuries (including those caused by a person who starts a fight)
- injuries suffered while a worker was committing a serious crime
- injuries suffered while an employee was not on the job, and
- injuries suffered when an employee's conduct violated company policy

Most states require that the injury be reported within two to twenty days. If an injury occurs over time (for example, a breathing problem or carpal tunnel syndrome), one must report his condition soon after he discovers it. The injured worker should get the medical treatment he needs and follow the doctor's instructions exactly. This may include an off work order" or a "limited duties work order. Finally he should file a claim with his workers' compensation carrier. The employer must provide necessary forms.

In some states, one has a right to see his own doctor if he makes this request in writing before the injury occurs. More typically, however, injured workers are referred to a doctor or health plan recruited and paid for by their employer. One's doctor's report will have a big impact upon how he is treated. While it is crucial that one tells the doctor the truth about both his injury and his medical history (one's benefits may be denied based on fraud if he does not), he should be sure to clearly identify all possible job-related medical problems and sources of pain. In short, this is no time to downplay or gloss over the presence of a pain.

The injured employee needs to keep in mind that a doctor paid for by his employer's insurance company is not his friend. The desire to get future business may motivate a doctor to minimize the seriousness of the injury or to identify it as a pre-existing condition. For example, if the employee injures his back and the doctor asks him if he have ever had back problems before, it would be unwise to treat the doctor to a twenty-year history of every time he suffered a minor pain or ache.

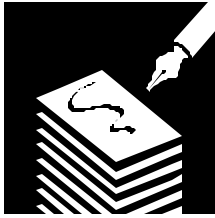
State workers' compensation systems establish technical and often tricky rules in this area. Often, one has the right to ask for another doctor at the insurance company's expense if he clearly states that he does not like the one the insurance company provides, although there is sometimes a waiting period before one can get a second doctor. Also, if one's injury is serious, he usually has the right to a second opinion. And in some states, after an insurance company's doctor treats one for a certain period (ninety days is typical), he may have the automatic right to transfer his treatment to his own doctor or health plan with the cost being paid for by the workers' compensation insurance company.

One does not usually need a lawyer unless all or part of his workers' compensation claim is denied. If this occurs the claimant will probably want to do some research to familiarize himself with his rights and duties. For example, many claims are denied based on a doctor's report claiming that the claimant is not injured. If the injured employee disputes this, he may have a right to obtain a second doctor's opinion paid for by the worker's comp insurer.

The workers' compensation system was established as part of a legal trade-off. In exchange for giving up the right to sue an employer in court, the employee gets workers' compensation benefits no matter who was at fault. Before the workers' compensation system was passed, if

one went to court, he stood to recover a large amount of money, but only if he could prove his employer caused the injury. Today, one may be able to sue in court if someone other than his employer (a visitor or outside contractor, for example) caused his injury or if it was caused by a defective product (such as a flaw in the construction of the equipment he was working with

Workplace safety and health laws establish regulations designed to eliminate personal injuries and illnesses from occurring in the workplace. The laws are primarily federal and state statutes. Federal laws and regulations preempt state ones where they overlap or contradict one another.



Chapter Eight

Loss Control and Employee Hiring

Negligent Hiring

The doctrine of negligent hiring is a broad doctrine that extends liability to employers for the injurious conduct of its employees even when the injurious acts are committed outside the scope of employment. Specifically, liability may be imposed when an employer places a person *with known propensities, or propensities that should have been discovered by a reasonable investigation, in an employment position in which, because of the circumstances of the employment, it should have been foreseeable that the hired individual posed of a threat of injury to others.*

Liability will not be imposed upon an employer who simply fails to investigate or adequately investigate the employee **unless** the investigation would have disclosed information that would have put the employer on notice that the prospective employee posed a risk of harm to others.

Legal Implications of Negligent Hiring

Litigating under the doctrine of negligent hiring may be advantageous in several circumstances. As already indicated, when the injurious activity of an employee is outside the scope of his employment, negligent hiring may permit recovery. Negligent hiring may save a case from being barred by a statute of limitations. In addition, certain defenses available under the doctrine of respondeat superior, such as guest statutes or assumption of risk, may not be applicable in a negligent hiring action.

Since negligent hiring alleges the employer hired a dangerous or incompetent employee, the person's character, reputation and criminal record may become important issues. The victim may introduce evidence of an employee's prior misconduct to illustrate the employer's failure of reasonable care.

With negligent hiring causes of action, victims may be able to seek punitive damages against an employer who was reckless or grossly negligent in the hiring of an employee. While punitive damages are generally unavailable in vicarious liability actions, punitive damages may be available in respondeat superior actions, but the victim may be required to prove the employer authorized, participated or ratified the employee's injurious conduct. However, in negligent hiring cases, some juries are quite willing to award punitive damages against employers.

Elements of Negligent Hiring

In a negligent hiring claim, courts look for a connection between the victim and the employment of the perpetrator. Essentially, the court needs to find that

- at the time of the injury an employment relationship existed between the employer and employee; the employee was unfit for the position
- the employer knew or should have known that the employee was unfit for the position
- the employee negligently or intentionally caused the victim's injury

- the employee's negligence was the proximate cause of the victim's injury

Most courts hold that the duty of the employer is to exercise reasonable care in hiring individuals who, due to the employment, may pose a threat of harm to others. The nature of the employment directly relates to the duty imposed upon the employer. In situations where the job provides access to property or homes or a special relationship exists between the employer and victim, such as customers, invitees, licensees, passengers, guests and others, the employer may have a duty to conduct a reasonable investigation into the employee's background. In addition, the employer's duty may extend only to victims within the sphere of foreseeable risks created by the employment.

Reasonable Investigation

In order to conduct a reasonable investigation, the employer must take into account the severity of the potential risk of harm the employee may pose in the employment position. Depending upon the nature of the work, employers should make an appropriate investigation into the background of the employee by going beyond the job application form and interview by making an independent background check on the employee by calling former employers and references. In addition, in some situations it may be appropriate to look at the employee's driving record, criminal record, qualifications and character, especially when the job involves security duties or the use of weapons.

However, where risks to others posed by the employment are slight, an employer may only be liable if the employer had actual prior knowledge of an employee's propensity for violence. No single standard or formula has emerged to determine the employment situations where a heightened duty to investigate exists. Most authorities suggest that the important factor is that the victim was made vulnerable because an unfit employee was in a position that facilitated the commission of the injurious conduct.

The final determination on the liability for negligent hiring is a question of fact for the jury. But, when evaluating a case for viability as a negligent hiring claim, certain aspects of an employer's hiring decision should be scrutinized. While there are many specific steps that employers could use to cut down on their possible liability for negligent hiring, did the employer utilize them?

Following are questions that the jury will consider:

- Did the employer check the employment application carefully for any discrepancies or red flags?
- Did the employer obtain the employee's consent to contact previous employers and references?
- Did the employer contact listed references and the previous employers to find out whether the employee is an honest, trustworthy and reliable applicant?
- Did the employer inquire about any gaps in the employee's work history?
- Did the employer inquire about the employee's reasons for leaving previous jobs?
- If the employee was fired from previous employment, did the employer check the validity of the employee's answer?
- Did the employer determine whether the responsibilities of the position indicate a need to investigate any possible criminal conduct or driving infractions?
- Did the employer investigate appropriate areas of the employee's background as deemed necessary by the responsibilities of the position?

- If the employee sought to change positions, did the employer reevaluate the employee's suitability for the new job's responsibilities?
- Did the employer make a reasonable decision in hiring the employee in light of the responsibilities of the job and the totality of the information learned about the employee?

The Employee's Unfitness

The victim possesses the burden of proof in regard to the unfitness of the employee and risk of harm that the employee posed to persons who might come into contact with the employee due to the job. Thus, the victim must prove that the employer had actual or constructive knowledge that the employee is unfit; the employer knew or should have known of the employee's dangerous propensities. Actual knowledge exists when the employer personally witnessed such violent propensities in the employee.

On the other hand, constructive knowledge may be found when a reasonable investigation would have put the employer on notice of the employee's criminal or tortious tendencies.

Example ~ *A restaurant was held liable for negligent hiring when it failed to investigate an employee's background, and the employee, previously convicted of child molestation, sexually assaulted a young boy.*

Example ~ *A court reversed summary judgment in favor of the employer whose employee who had violently attacked a customer when he was inside her home to pick up rental furniture. The court noted that an obvious discrepancy existed on the employee's application when the employee claimed to have worked in two different cities at the same time, and that discrepancy was a "red flag" which should have prompted the employer to contact previous employers and references. The court held that the employer was put on notice of the employee's recent discharge for drug abuse, should have conducted a reasonable investigation, and could not escape liability based on his lack of actual knowledge.*

Summary judgment in favor of a hospital was also reversed because the court found that there was sufficient evidence, by way of an affidavit, which demonstrated that the hospital could have discovered through reasonable diligence that a nurse, who repeatedly made sexual advances toward patients, had a criminal record.

A number of other factors are considered regarding the background an employer knew or should have known. Such factors include: the availability of such information; burden, cost and delay in obtaining background information; whether adequate sources exist which are sufficient to justify a finding of fitness; and, whether unanswered questions or negative indicators exist.

Proximate Cause

Not only must an employer have a duty to investigate the employee, the breach of that duty must be the proximate cause of the victim's injury. The victim must establish that his or her injuries were actually and proximately caused by propensities of the employee that the employer knew or should have known posed a risk of harm to others.

The proximate cause combines a necessary showing of cause-in-fact as well as a showing of foresees ability.

Example ~ *In one negligent hiring case, the court held that negligent hiring of the employee was not the proximate cause of a victims' injuries when the employee, an appliance delivery*

man, broke into her home late at night and raped her. The court found the employee was on his own time, not utilizing a business vehicle, and had not entered the victim's apartment at the time of the injury under the authority of the employer. In that case, the employment relationship was not instrumental to the employee committing the crime.

In the end, the responsibility for criminal acts lie with the perpetrator. Yet, when an employer puts that dangerous person in a position to harm others, the employer should be liable. The liability not only means monetary compensation to the victim, but also serves as a deterrent example to other employers when making hiring decisions. In the long run, successful recovery against employers under the doctrine of negligent hiring will greatly benefit individual victims as well as society at large.

Legal Liability

If an employer decides to hire or lease employees or use independent contractors, it is extremely important that he is aware of all the federal and state laws that can affect those relationships. Whether or not a business is subject to specific employment laws depends on how many employees that business has and for how long. There's a large array of federal and state laws and, in some states, it only takes one employee to make an employer subject to certain employment laws.

The legal liability as an employer involves four things:

- Understanding the definition of an employee
- Knowing his liability under federal employment laws
- Knowing his liability under state employment laws
- Structuring contracts for non-employees to minimize liability

Lots of business owners think that the way to get around all of the employment laws is to have no employees and instead to employ leased workers, temporary workers, or independent contractors. In some cases, this works, but how well it works depends on what the worker actually does and how the contracts are structured.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. The employer is responsible for their health and safety while they are at work. If one is injured as a result of an accident at work, or becomes ill as a result of his work, and if he believes his employer is responsible, he may seek compensation from them. In order for the employer to pay the compensation they must take out an insurance policy. This is employers' liability insurance.

Employers' Liability

Employers' liability insurance will provide compensation for injuries or illnesses caused on or off site. Any injuries or illnesses relating to motor accidents, which occur as a result of one's employment, may be covered separately by his employer's motor insurance.

Public liability insurance is different. It covers employers for claims made against them by members of the public or other businesses, but not for claims made by employees. While public liability insurance is generally voluntary, employers' liability insurance is compulsory. An employer can be fined if they do not hold a current employers' liability insurance policy, which

complies with the law. All employers must have employers' liability insurance except the following:

- most public organizations including government departments and agencies
- local authorities
- police authorities and nationalized industries
- health service bodies including National Health Service trusts, health authorities, Family Health Services Authorities and Scottish Health Boards and State Hospital Management Committees
- some other organizations which are financed through public funds, such as passenger transport executives and magistrates' courts committees

If one works for one of these public sector organizations, he can still claim compensation if he is injured at work or becomes ill as a result of his work and his employer is to blame. Any compensation will be paid directly from public funds.

Family businesses are also exempt. One's employer will not need employers' liability insurance to cover him if he is closely related, that is if the employer is his husband, wife, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother or half-sister. However, this exemption does not apply to family businesses that are incorporated as limited companies.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. When thinking about workers' compensation insurance, most employers, agents/brokers, and insurers tend to focus on the fact that a standard workers' compensation policy provides employer coverage for statutory benefits that an employee is entitled to for injuries that are sustained during the course of employment. This type of coverage is typically found in Part One of a standard policy. When purchasing a workers' compensation policy, however, an employer may also obtain Employers Liability ("EL") coverage, which is written under Part Two of the standard policy. EL insurance provides coverage for claims which arise from injuries suffered by employees in the course of their employment that are not otherwise covered by Part One under the policy.

In most cases, a workers' compensation carrier is not subject to a significant risk of loss arising from EL coverage. Stating the obvious, the overwhelming majority of claims arise under Part One of the policy. However, due to the erosion of the exclusive remedy doctrine in certain states, the frequency of EL claims has become more prevalent in such states.

The Exclusive Remedy Doctrine

Generally, once an employer's obligation to an employee to provide workers' compensation benefits is established, an employee (or his estate) cannot sue an employer based upon common law claims for damages sustained as a result of an injury or death that arose out of and in the course of employment (even if the damages result from the negligence or recklessness of an employer). This exclusive remedy also applies to situations in which an employee's injury or death results from the negligence of a co-employee.

Some state law does provide for three principal exceptions to this exclusive remedy doctrine:

- If an employer fails to provide coverage as required by the Workers' Compensation Law (WCL), an employee is allowed to either sue for damages that were sustained as a result of

the injury or seek benefits provided under the WCL. Obviously, this exception does not implicate EL coverage since an employer has not procured a policy of workers' compensation insurance to cover its employees.

- If an employee's injury arises as a result of an intentional act, which *is perpetrated by the employer, or perpetrated by an employee at the direction or instigation of the employer*, then the employee has a common law right for damages against the employer. In order to prevail, an employee needs to prove that the employer's acts were deliberate and intentional, not merely reckless. Given this standard, EL coverage under Part 2 likely would be excluded for these claims. The standard policy form, upon which most companies policies are based, specifically excludes EL coverage for bodily injury intentionally caused or aggravated by the employee. In view of this exclusion, the loss exposure for these intentional-act based claims should be limited.
- A third exception has developed out of common law and appears to provide a significant risk exposure in connection with EL coverage, commonly referred to as the **Dole exception**. Originally, this exception allowed a third party, that was sued by an employee for injuries sustained in the course of the employee's employment, to implead the employer for contribution or indemnification if the third party was found liable for the employee's injuries. In 1996, however, this exception was limited through an amendment to Section 11 of the WCL. The amended Section 11 language now only allows a third party to implead an employer for contribution or indemnification when an employee suffers a "grave" injury (this term is defined to include death, permanent and total loss injuries, and brain injuries resulting in total disability). Even in view of the recently enacted limitation, the Dole exception could provide a significant risk of loss for a carrier providing EL coverage to the insureds as described below.

Example ~ *An employee suffers a grave injury in the course of his employment due to actions or negligence of a third party. Although the employer was negligent in connection with the incident (for example, not providing proper safety devices or a vehicle was negligently maintained), the employee recognizes that his only remedy against the employer is workers' compensation benefits. However, the employee's attorney recognizes that the employee has a cause of action against the negligent third party for damages arising from the incident based upon common law principles. Under Dole, as limited by the amended Section 11 of the WCL, the third party will likely implead the employer for contribution or indemnification in the event the court or jury finds the third party liable for damages. Consequently, an employer could be subject to defense costs and ultimate liability to the third party, even though its liability to the employee is limited to statutorily defined benefits.*

In spite of the recent limitation of the Dole exception to situations in which an employee suffers a "grave" injury, the implications of this risk are still significant with respect to an insurer's EL loss exposure. The first factor in this regard concerns the potential unlimited liability an insurer faces under EL claims. Assuming an employer is made subject to a third party action via the Dole exception, if the employer is found liable for contribution or indemnification, the loss exposure for the employer's insurer will therefore only be limited by the amount of damages found attributable to the employer.

Absolute Liability

It is wise for an employer to carry Absolute Liability if his employees are working in extremely dangerous situations. An example would be in the use of explosives. A contractor would almost certainly be liable for damages caused by vibrations of the earth following an explosive detonation. With absolute liability it is usually not necessary for a claimant to establish that the operation is dangerous.

Employment Practices Liability

This protects the corporation, directors & officers and employees for claims resulting from wrongful termination, discrimination, sexual harassment, wrongful discipline and failure to employ or promote. Whether one is right or wrong in the eyes of the jury, the typical defense costs alone average \$100,000 - \$200,000 per case! Over the past several years, jury verdicts and legislative enactment's regarding employment law have greatly altered the approach taken by corporate entities as it relates to the employer/employee relationship.

Employment law cases have fast become one of the largest components of the civil dockets of federal courts, rising 125% over the past 20 years. Current trends are showing the majority of employment practices cases are now going into state courts, and therefore, federal court cases are only the tip of the iceberg. In recent years, the average award for a sexual harassment suit was \$225,800 and the defense costs on these cases are averaging \$100,000-\$125,000 each.

It was never the intent of the general liability policy to cover employment practices claims. Most employment related claims are not within the scope of the general liability coverage and are excluded by the expected or intended injury exclusion the employer's liability exclusion, or because the damages sought are neither bodily injury or property damage.

However, insurance providers defense obligation is triggered when at least one of the claim allegations falls within the scope of coverage provided by the policy. The most common allegation is libel or slander, which falls within the definition of personal injury. Although insurers may avoid paying for the indemnity portion of the claim, defense costs are unlimited in the CGL policy and can reach extremely high levels for employment practices cases.

As a consequence of the routine use of an exclusionary endorsement and in response to the growing liability presented by employment practices, a new insurance product has emerged which is specifically designed to response to these exposures. Employment Practices Liability (EPL) coverage has become one of the most visible new products to emerge in the insurance industry in many years. It covers claims due to employment practices. Employment practices means any of the following practices directed against any current or former employee, leased worker or temporary worker, or applicant for employment:

- Wrongful refusal to employ a qualified applicant for employment
- Wrongful failure to promote a qualified "employee" or "leased worker"
- Wrongful demotion, negligent evaluation, negligent reassignment, or wrongful discipline
- Wrongful termination of employment, including retaliatory or constructive discharge
- Harassment, coercion, discrimination, or humiliation, as a consequence of race, color, creed, national origin, marital status, medical condition, gender, age, physical or mental impairments, pregnancy, sexual orientation, or sexual preference
- Oral or written publication of material that slanders, defames, or libels and "employee", "leased worker" or "temporary worker" or violates or invades and "employee's", "leased worker's" or "temporary worker's" right to privacy

Virtually every commercial entity has an EPL exposure making the breadth of the potential market enormous. While there are currently a relatively limited number of carriers offering this product and most are in the specialty marketplace, standard insurance companies, are beginning to enter the market. This claims-made policy is designed to address the needs of eligible commercial insurance firms as respects coverage for employment practices

The last decade saw an astonishing rise in the incidence of claims alleging wrongful employment practices. The increase in claims is attributable to many factors, including a drastic corporate downsizing, new federal legislation directly affecting employment practices and an increased presence of women and minorities in the workplace. EPLI has emerged within the last few years to address the avalanche of claims that have been financially devastating to corporations.

According to surveys, employees bring 22% of all director and officer claims, and employment related litigation is rapidly growing. Even the best-managed companies can be sued, and sometimes successfully for employment-related practices. The management of people is such a complex and demanding task that it creates numerous opportunities to make mistakes.

Further continued strains on the economy and increased performance demands on employees can heighten tensions between supervisors and employees. Increasing legislation and regulatory requirements on employers serves only to add to the already antagonistic employer/employee relationship.

As more lawsuits are filed, corporate America has sent sexual harassment insurance sales catapulting. An estimated 60% of companies have been the target of at least one employment-related lawsuit in the past five years and more businesses are turning to a relatively new form of insurance designed to protect them against workplace liability. Employment Practices Liability Insurance (EPLI) was developed in the 1980's to protect employers who find themselves the target of work-related lawsuits, including harassment, wrongful termination and discrimination.

EPLI covers defense costs, judgments and settlements for the corporate entity, employees, former employees as well as directors and officers. Depending on the type of business, coverage is provided up to a limit of \$50 million. Deductibles range from \$10,000 to \$25,000. On the average, companies are spending \$100,000 annually for EPLI coverage. Workers' compensation, bodily injury and property damage are not covered by EPLI.

Here are some tips to limit EPLI exposures in one's business:

- Instill tough "no tolerance" policies toward workplace harassment, discrimination and drug or alcohol abuse
- Develop an employee standards handbook that defines the skills and performance expected for each position

Being unjustly accused of discrimination or sexual harassment can seem like a "no win" situation. Making a mistake, terminating or laying off an employee can result in damaging headlines and potential lawsuits, which are costly and demoralizing. EPLI coverage protects business assets against defense expenses and damages resulting from wrongful employment practices. This coverage protects employers against the risks and liabilities that arise out of their employment practices in relation to tests on employee. EPL covers for negligent actions arising out of other parts of program administration such as a supervisor's handling of a reasonable suspicion test.

EPLI policies today remain a mixed bag, and it is unclear whether such policies will become the rule or remain the exception. It is clear, however, that the number of employment-related lawsuits continues to increase, and that insurance companies are increasing their marketing efforts of these policies. Given these facts, and the fact that employment claims are typically excluded from general liability policies, many employers will consider whether purchasing an EPLI policy makes business sense. Because of the flexible and complex nature of EPLI,

employers considering purchasing such a policy, or renewing an existing policy, must be aware of and understand the myriad of issues involved.

One of the most important issues, which must be considered, is whether the employer or the insurer will have control over selection of counsel. Failure to address this issue prior to obtaining a policy may result in a situation in which the employer's long-term attorneys, those most familiar with its operations and policies, and who perhaps even represented the employer with respect to a claim at the stage of an EEOC charge, cannot represent it once litigation is filed.

Employers should be aware that EPLI carriers tend to be flexible prior to acceptance of a policy and may permit employers to modify provisions in proposed policies to address these concerns. This flexibility, however, can have the effect of creating uncertainty regarding the scope of coverage; and it is, therefore, important that employers understand what type of lawsuits are covered by the wide variety of EPLI policies, as well as the policy deductibles and policy limits.

If the employer is not insured his liability hereunder shall be primary and direct. If he is insured his liability shall be secondary and indirect, and his insurer shall be primarily and directly liable hereunder to the injured employee, his dependents or other persons entitled to rights hereunder. On the request of the division or the commission and at every hearing the employer shall produce and furnish it with a copy of his policy of insurance, and on demand the employer shall furnish the injured employee, or his dependents, with the correct name and address of his insurer, and his failure to do so shall be prima facie evidence of his failure to insure, but the presumption shall be conclusively rebutted by an entry of appearance of his insurer.

Both the employer and his insurer shall be parties to all agreements or awards of compensation, but the same shall not be enforceable against the employer, except on motion and proof of default by the insurer. Service on the employer shall be sufficient to give the division or the commission jurisdiction over the person of both the employer and his insurer, and the appearance of the employer in any proceeding shall also constitute the appearance of his insurer, provided that after appearance by an insurer, the insurer shall be entitled to notice of all proceedings hereunder.

General Liability

General Liability policies were not specifically designed to cover today's discrimination, breach of contract, and wrongful discharge claims. Numerous courts have held that such employer conduct does not constitute an "occurrence", but is deemed an "intentional act" that falls outside the coverage provided by the standard GL policy.

Most GL policies exclude wrongful discharge and discrimination claims brought by past, present, or prospective employees. In addition, many GL carriers exclude bodily injury claims by employees and consider employment-related emotional injuries to bodily injury. Likewise, umbrella policies frequently contain exclusions relating to termination or failure to promote an employee or failure to hire a prospective employee.



Chapter Nine

Loss Control and the Business Owner

A business owner has several loss exposures to control. These include business income loss, business interruption, extra expense, time element loss, and commercial crime. Let's take a look at each of these.

Business Income Loss

Business income loss will result from little or no direct damage many times. Without electricity, an entire plant is shut down. Even though the direct damage may not cost much to repair, the loss of production could cost thousands of dollars. On the other hand, an apartment building is destroyed by fire, and the owner is unable to collect rental income from the tenants because of the destruction of the building. His loss includes direct damage to property as well as loss of income. The profit, or net income, the business could have earned will be reduced if a business must close temporarily because of direct property damage. Even if the business is closed temporarily, it must continue to pay most, if not all, of its normal operating expenses. The business also may incur extra expenses. Therefore, continuing expenses and extra expenses are considered when measuring a business income loss.

Payroll of key employees, debt service, taxes, insurance, and many other expenses **continue** whether or not the business is open. In the event of a longer interruption of business, many expenses can be reduced or eliminated. Production line workers can be furloughed, debt can be refinanced, and insurance premiums are smaller. It is often difficult to predict which expenses will continue and which will not since there are so many different kinds of loss that might occur. However, the impact of **continuing expenses** on a business income loss may be substantial. In many cases, these expenses may be much greater than the profit earned by a business organization.

For business income losses associated with property exposures, the causes of loss are typically the same as those for direct damage losses. Thus, a fire or a windstorm that damages property also may cause a business income loss. As noted earlier, however, a business income loss can result when there has been no physical damage to buildings or personal property. The closing of a road or the shutdown of a telephone system can cause a business income loss. A business cannot generate income if it cannot continue to operate after a direct property loss. A restaurant, for example, is likely to close if there has been a fire in its kitchen. If the restaurant is closed, its net income will be reduced because revenue falls to zero and some expenses cannot be reduced. For businesses such as the restaurant, the measure of the business income loss exposure is an estimate of the lost profit plus the operating expenses that will continue during the repair period.

Business Interruption Loss

A business interruption loss is equal to the reduction in profits that result from the interruption plus the expenses that necessarily continue during the interruption. The period of loss runs from the time the organization is partially or fully shut down until the time at which normal volume of business is restored after business resumes. Normal business volume is not often reached again until sometime after the organization reopens, usually because some former customers do not return immediately.

Extra Expense Loss

Two basic types of extra expenses may be incurred as the result of a business income loss. These are 1) those extra expenses that ultimately reduce the loss and also 2) those that enable the business to remain in operation. **Extra expense insurance** is designed for those businesses that simply cannot allow a physical damage loss to cause a shutdown of operations. A business that needs such coverage consists of enterprises that will suffer a permanent loss of customer goodwill as a result of even the temporary curtailment of operations. **Continuity of service** is the key to success for those businesses, because an interruption will immediately send clients to the firm's competitors, and a number of these clients may never return.

"**Extra Expense**" itself is a defined term. The term "extra expense" means the excess (if any) of the total cost incurred during the period of restoration chargeable to the operation of the insured's business, over and above the total cost that would normally have been incurred to conduct the business during the same period had no damage or destruction occurred.

The insurer is entitled to take into consideration any salvage value of the property obtained for temporary use during the restoration period. The carrier is liable for extra expense incurred during the period of restoration, which is defined in precisely the same terms as the period of indemnity under a contract of business interruption insurance. The period of restoration is the time necessary "with the exercise of due diligence and dispatch" to rebuild, repair or replace damaged or destroyed property.

Coverage for Extra Expense and/or Business Interruption

Business interruption insurance substitutes for or replaces the ordinary income derived from the operations of the business during a period when normal operations cannot be continued. **Extra expense coverage**, on the other hand, provides the funds necessary to insure that operations can be continued, thus allowing the business to continue to generate the earnings needed to cover fixed expenses and provide a profit.

Extra expense insurance reimburses the insured for those expenditures in excess of normal operating costs that are required to keep the business going while repairs to physical property damage are made. This would include the cost of renting temporary quarters and substitute equipment, the cost of overtime for employees, and any extra transportation expenses required to relocate the business.

If the business must continue to function, then extra expense insurance may well be more important than business interruption coverage. A business interruption policy has a certain amount of "extra expense" coverage built in under a provision for expenses to reduce loss. The insured will be reimbursed for some of the same expenses as are reimbursed under extra expense insurance, but only to the extent that the overall business interruption loss is actually reduced. When the business must keep its doors open, however, the extraordinary expenses necessary to do so may outstrip not only any reduction in the business interruption loss, but the entire business interruption loss itself.

Adequate Coverage

Extra expense insurance needs should be reviewed periodically to insure that the amount of coverage is sufficient, because changes in the local situation may dictate a revision of the policy. Some extra expenses exceed any revenue they produce but are necessary because the business must continue to operate. Payment for overtime work and the cost of bringing in

temporary employees are other examples of this kind of extra expense. Businesses such as banks, insurance agencies, and newspapers could incur such extra expenses.

Contingent Extra Expense Coverage

There are situations in which an insured may sustain an extra expense loss when property of others sustains physical damage. For example, a newspaper company may use a printer that is located on another property that is not owned by the newspaper company. A fire that shuts down the printer will cause the newspaper to sustain precisely the same type of extra expense as discussed, but a standard extra expense policy will not cover this exposure, for it requires that physical damage occur "on premises occupied by the insured.

The newspaper needs *contingent extra expense* insurance. The insured is covered for an extra expense loss occasioned by physical damage from an insured peril on premises that are not operated by the policyholder. An endorsement is added to a standard extra expense policy, and this modifies the insuring agreement. The non-owned property is designated as the contributing property, and it must be identified in the policy by name, location and type of occupancy.

The insured recovers for extra expense necessary to continue operations when a physical damage loss by an insured peril at the contributing property wholly or partially prevents delivery of materials or services to the insured or to others for the account of the insured. The period of restoration is the time necessary with the exercise of due diligence and dispatch to effect repairs to the contributing property. All other terms and conditions of the basic extra expense insurance remain unchanged by the endorsement.

Time Element Loss

Many business income losses may result as a consequence of direct damage. One example is the loss faced by businesses that have only one source of off-premises power or communications. If the electricity goes off, the business cannot function and there is a loss of business income.

A seasonal business like a ski lodge or a private school does not have a full year in which to earn a profit. A fire at the beginning of ski season or just prior to the opening of school could mean the loss of a whole year of revenue, even if the shutdown is relatively short.

Some businesses are dependent upon another property either as a major customer or as a sole supplier. It also is possible that a business is dependent simply because it is near a key facility or leader property. If any or these dependent locations are damaged, the effect could include a business income loss at the location where there was no direct damage.

Commercial Crime Loss

A crime is a violation of law punishable by some governmental body. Commercial crime includes **two kinds** of crimes: those committed by **employees** of the insured and those committed by **outsiders**. Exposures to crime losses have three elements for types of loss exposures. The three elements are 1) the item(s) subject to loss, 2) the covered causes of loss, and 3) the financial impact of the loss.

Item(s) Subject to Loss

Commercial crime insurance policies cover three broad categories of property. These categories of property are money, securities, and property other than money and securities. As used in crime coverage forms, **money** is currency, coins, and bank notes that are in use and have a face value, or travelers checks, register checks, and money orders held for sale to the public. **Securities** are negotiable instruments, nonnegotiable instruments, or contracts representing either money or other property. Also included in the definition of **securities** are tokens, tickets, and stamps in use, or charge slips issued in connection with charge cards, provided the charge cards were not issued by the named insured. **Securities do not include money.**

In the crime coverage forms, “property other than money and securities” is tangible property that has intrinsic value. However, the term does not include money, securities, or property listed in any crime coverage form as property not covered. Crime coverage forms do not cover certain types of property, such as motor vehicles, because such property is covered under other forms of insurance.

Causes of Loss

Employee Dishonesty ~ Employee dishonesty is a criminal act committed by an employee acting alone or in collusion with others. There must be intent by the employee to cause the employer a loss and to obtain a financial benefit for the employee or someone else.

Forgery and Alteration ~ Forgery is generating a document or signature that is not genuine. Alteration is changing a document in a manner that is neither authorized nor intended.

Robbery ~ Robbery is the taking of property from a person by one who has caused or threatened to cause that person harm or who has committed an unlawful act witnessed by that person.

Burglary ~ Burglary is the taking of property from inside a building by unlawful entry or departure from the building. Marks of forcible entry or exit must be evident. Normally, burglary is accomplished when the business is closed, whereas robbery most often occurs when the business is open.

Safe Burglary ~ This is a specific kind of burglary meaning the taking of property from a safe or vault accompanied by visible signs of forcible entry on the safe. It includes removal of the safe itself from inside a building.

Theft ~ Theft means any act of stealing. It includes robbery and burglary in addition to other forms of stealing. Unobserved shoplifting is a form of theft. It is not robbery because there is no threat of personal injury; and it is not burglary because there is no breaking and entering.

Disappearance ~ Disappearance can include not only a crime but also unknown causes of loss. Theft, burglary, and robbery tend to be losses from a known location at a known time; disappearance may lack these elements.

Destruction ~ Destruction is the loss of certain property. It does not have to be intended. Instead, destruction is a result. For example, if money were destroyed in a fire at the insured's building, the loss would likely be covered by at least one of the crime forms.

Computer Fraud ~ Computer fraud is a specialized kind of theft. That is, a thief uses a computer to steal property from its rightful owner.

Extortion ~ Extortion is the surrender of property away from the premises as a result of a threat of bodily harm to someone who is, or allegedly is, being held captive.

Some of the crime coverage forms insure against only one cause of loss; other forms cover more than one. In the context of crime coverage, the definitions of these causes of loss may differ somewhat from the usual definitions of these terms. It is important to remember this point during the study of commercial crime insurance.

Financial Impact of a Crime Loss

As the result of a crime loss, the owner no longer has the property - such as a safe damaged during a burglary. The value of the loss is determined differently for each type of property covered by crime insurance. Money is valued at its face value. If foreign money is lost, it is valued at its own face value or at its equivalent in United States money on the day the loss is discovered. Securities are valued as of the close of business on the day the loss is discovered. The amount of loss may include the premium on a bond required to issue duplicates of the securities.

There are **two** ways of determining the value of property other than money or securities. If such property is lost or damaged, its value is 1) either the *actual cash value* on the day the loss was discovered or 2) the *cost to repair or replace* the property.

Commercial Crime Insurance

There are two declaration forms for commercial crime insurance.

- Form A is used with monoline crime policies
- Form B is used when crime coverage is included in a commercial package policy.

The provisions in the crime general provisions form apply to all coverage forms included in the crime coverage part. These provisions fall into three categories: general exclusions, general conditions, and general definitions.

General Exclusions

Dishonest Acts Committed by Business Partners ~ The insurer will not pay for dishonest acts of the named insured or, if the named insured is a partnership, any partner. The exclusion applies whether the dishonest act is committed by the named insured or partner acting alone or in collusion with others.

Government Action ~ There is no coverage for loss resulting from the seizure or destruction of property by order of governmental authority. The impact of this exclusion appears to be small, since such losses are not likely to result from the covered causes of loss.

Indirect Loss ~ The policy does not cover any indirect loss resulting from a covered loss. Three specific kinds of indirect loss are listed in the exclusion, but the exclusion applies to all indirect loss and not just to those listed.

Legal Expenses ~ The insurer will not pay expenses related to any legal action. Unlike liability policies, crime policies generally do not provide coverage for defense costs.

Other Exclusions--The general provisions form also contains the war and nuclear exclusions common to commercial property policies. Additional exclusions appear in the various crime coverage forms.

General Conditions For Crime

Duties in Event of Loss ~ The insured's duties after loss under a crime policy are essentially the same as under any other property policy.

Loss Sustained Under Prior Insurance ~ The crime general provisions form includes two conditions that relate to loss sustained under prior insurance. The first, Condition Eight, applies to prior insurance *written by the current insurer* or an affiliate. The provisions of Condition Nine relate to loss *covered partly by the present insurance and partly by prior insurance written by the current insurer of a recoverable under the present insurance or under the prior insurance.*

Consolidation-Merger Conditions ~ This states that if the insured obtains additional employees or premises by consolidation or merger, the coverage under the policy will be extended automatically to the new employees or premises. The insured must notify the insurer of the acquisition within thirty days and pay the appropriate additional premium.

Joint Insured Condition ~ This appoints the first insured named in the policy as agent for all other insureds with regard to all transactions under the policy. The condition also states that knowledge possessed by any insured or any partner or officer of any insured is considered to be known to all insureds.

Non-Cumulation of Limits of Insurance Condition ~ This provides that the limit stated in the declarations is the most the insurer will pay regardless of the number of years the insurance has been in force or the number of premiums paid. A policy in force ten years with a \$5,000 limit will pay a maximum of \$5,000, not ten times \$5,000.

Other Insurance Condition ~ This makes the crime insurance excess over any other insurance available to the insured to cover a loss.

Ownership of Property - Interests Covered" Conditions ~ This limits policy coverage to property owned by the named insured of, or for which the named insured is legally liable.

Records Condition ~ This requires the insured to keep sufficient records to enable the insurer to verify the amount of loss.

Legal Action Against Us Condition ~ Under this condition the insured may not bring legal action against the insurer until the insured has complied with all policy conditions, until ninety days after the insured has filed proof of loss, or more than two years after the discovery of the loss.

Recoveries Condition ~ This condition specifies the method used to divide any subrogation or salvage recoveries between the insurer and the insured. Any recoveries, less the cost of recovering them, go first to the insured until the insured has recovered any loss sustained in excess of the sum of the policy limits and the deductible. If any amount of recovery is left after the first step, it goes to the insurer until the insurer has recovered all that it paid. The remainder, if any, goes to the insured to cover the deductible amount.

Policy Period Condition ~ This is the period shown in the declarations. The "policy period" condition is important because, except for losses subject to the "loss sustained during prior insurance" condition, the insurer will pay only for losses that occur during the policy period.

Valuation--Settlement Condition ~ This condition explains the valuation of money, securities, and property other than money and securities. The methods of valuation were described earlier. This condition also includes provisions regarding loss settlement.

General Definitions

The crime general provisions form includes definitions of four terms as those terms used in crime insurance. The definitions of "money," "securities," and "property other than money and securities" have been discussed. "Employee" is the fourth term defined in the form.

Employee means any individual (1) who is in the service of the named insured, (2) whom the named insured compensates directly by salary, wages, or commissions, and (3) whom the insured has the right to direct and control.

All three of these conditions must be met. In addition, a person will be considered to be an employee of the named insured if an employment contractor employs him or her, and he or she performs services for the named insured under the control and direction of the named insured.

Crime Coverage Forms

Letters A through Q identifies the crime coverage forms. The Surety Association of America developed Forms A, B, O, and P. The Insurance Services Office (ISO) developed the other coverage forms. Although each coverage form insures against a specific type of crime loss, many of the additional conditions, exclusions, and definitions are the same in all forms. These similar provisions are described as follows:

The limit of insurance applicable to a coverage form is the most that will be paid for an "occurrence," which is an act or a series of related acts. The territory covered by the crime coverage forms is stated in the crime general provisions form, but individual forms may include additional conditions regarding the territory in which property is covered. All of the crime coverage forms exclude losses caused by the named insured, a director, a trustee, or an authorized representative of the named insured. Forms A, O, and P cover only losses caused by employees of the named insured; the other forms exclude such losses. Most of the coverage forms require the insured to notify the insurer if there is reason to believe the loss involves a violation of law.

If coverage is provided for property other than money and securities, such property does not include motor vehicles, trailers, semi trailers, or equipment and accessories attached to any of the above. The definitions of terms are the same in all forms using the terms. Six of the crime coverage forms used often are:

Form A--Employee Dishonesty ~ The only covered cause of loss under the employee dishonesty coverage form is dishonest acts of employees of the named insured.

Form B--Forgery or Alteration ~ The forgery or alteration coverage form insures against loss caused by the forgery or alterations of a "covered instrument" drawn against the insured's accounts.

Form C--Theft, Disappearance and Destruction ~ This form covers money and securities against loss by theft, disappearance, or destruction. There are two insuring agreements in the theft, disappearance and destruction coverage form. *Section 1--Inside the Premises* covers money and securities inside the "premises" or a "banking premises." *Section 2--Outside the Premises* covers money and securities in the care and custody of a "messenger."

Form D--Robbery and Safe Burglary ~ Property Other than Money and Securities ~ This form covers property other than money and securities both inside and outside the premises.

Form E--Premises Burglary ~ Like Form D, the premises burglary coverage form also does not cover money and securities. This form covers property other than money and securities inside the premises. It also covers damage to the insured's premises resulting from a covered cause of loss.

Form H--Premises Theft and Robbery Outside the Premises ~ Coverage Form H can be used as an alternative to the coverage provided by Forms D and E. *Section 1 of Form H* covers property other than money and securities inside the premises for loss caused by actual or attempted theft. *Section 2* covers property other than money and securities while it is outside the premises in the care and custody of a messenger or, through a coverage extension, an armored car service. The covered cause of loss under Section 2 is actual or attempted robbery.

Rating Commercial Crime Coverage

All of the coverage forms included in a crime coverage part of a monoline policy must be rated separately. The Surety Association of America, the organization having jurisdiction over fidelity bond forms, develops rules and statistics used for rating employee dishonesty coverage and forgery or alteration coverage. The Insurance Services Office (ISO) develops the rules and statistics for rating of all other crime coverages.

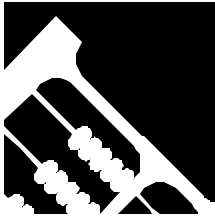
Rating Guidelines

Form A--Employee Dishonesty Coverage ~ Rating employee dishonesty coverage written on a scheduled basis is governed by the number of individual employees or positions to be covered and the amount of coverage applicable to each.

Form B--Forgery or Alteration Coverage ~ Rates for forgery or alteration coverage are determined in a manner similar to that used for blanket employee dishonesty coverage. The basic premium is determined by the limit of insurance for forgery or alteration coverage, however, and is modified by a discount factor.

Forms C and D --Theft, Disappearance and Destruction ~ Robbery and Safe Burglary are rated with similar factors. For each form, separate premiums are developed for coverage inside and outside the premises. Premium discounts are available for Form C or Form D if the insured has an approved alarm system.

Form E--Premises Burglary Coverage ~ The rating of premises burglary coverage is based on many of the factors used to rate inside the premises coverage in Forms C and D. However, since coverage is for property other than money and securities, there is no consideration given to safes or vaults. Premises burglary coverage must be written for at least a specified minimum limit of insurance (the "class limit") that varies according to the business class of the insured. Rates are applied to either the class limit or the actual limit of insurance, whichever is greater. Premium discounts may be offered for an approved alarm system or for security guards on the premises when the business is closed.



Chapter Ten

Loss Control and Reinsurance

Basic Principles of Insurance

Insurance involves the transfer of potential losses to an insurance pool. The pool combines all of the potential losses and then transfers the cost of the predicted losses back to those exposed. Insurance involves the transfer of loss exposures to an insurance pool, and the redistribution of losses among the members of the pool. Through the operation of an insurance system, combined losses can be predicted. The predictability of losses is basic to an insurance system's operations. Because insurance allows a group's losses to be predicted accurately, it allows the cost of losses to be financed and redistributed in advance.

An insurance system redistributes the cost of losses by collecting a premium payment from every participant in the system. In exchange for the premium payment, the insurer promises to pay the insured's claims in the event of a covered loss. Usually, only a small percentage of insureds suffer losses. So an insurance system redistributes the costs of losses from the unfortunate few members experiencing them to all the members of the insurance system who pay premiums. Like banks, insurance companies borrow, invest, and lend money. An insurance company can be viewed as an investment firm that borrows capital from its policyholders. A reinsurance company can be viewed the same way, the only distinction between them being that the policyholders are themselves insurance companies.

Unlike most borrowing, insurance does not return the borrowed capital to each policyholder but rather reimburses those ones who have suffered loss, as defined in the insurance contract. To the policyholder who suffers a loss, insurance indemnification is similar to a loan - but, in this case, one that doesn't have to be repaid. **Insurance** is a contractual arrangement whereby one party agrees to compensate another party for losses. The party agreeing to pay for the losses is the **insurer**. The party whose loss causes the insurer to make a claims payment is the **insured**. The payment that the insurer receives is a **premium**. The insurance contract is a **policy**. The insured's possibility of loss is his **exposure to loss**. The insured transfers the exposure to loss to the insurer by purchasing an insurance policy.

Basics of Reinsurance

Reinsurance is a transaction whereby one insurance company - the reinsurer - agrees to indemnify another insurance company - the ceding or primary - against all or part of the loss that the latter sustains under a policy or policies that it has issued. For this service, the ceding company pays the reinsurer a premium. The purpose of reinsurance is the same as that of insurance: to spread risk. By spreading risk within the insurance industry, reinsurance is a mechanism that enables the insurance industry to function more efficiently. Reinsurance is a creative process and each client's requirements are unique. The reinsurer will identify a client's financial and reinsurance needs and opportunities, and then bring together a team of specialists to create customized products and services for that client.

Reinsurance is the insurance of an insurance company.

Example ~ As the result of an automobile accident, a court orders a driver to pay \$2 million US dollars to a pedestrian. An airplane is totally destroyed in a crash, and hundred of people die. The total loss of lives and property is valued at \$50 million. To a large extent, the above losses are covered by insurance policies. Large loss payments can negatively affect an insurance company's financial results. To mitigate the potentially adverse financial effect of a single large loss or many smaller losses, an insurance company might pay a premium to another insurance company and, in exchange, is indemnified for some or all of its loss payments. When a loss occurs, the second insurance company pays its share to the first insurance company, which remains responsible to the insured for the entire amount of the loss. This transaction between the two insurance companies is called reinsurance. By sharing losses with another insurer, an insurance company can increase its capacity to underwrite risks and better control its underwriting results.

An insurance company that issues insurance policies is called a **primary insurer**, and an insurance company that indemnifies another insurer for losses is called a **reinsurer**. A reinsurer may even indemnify another reinsurer for losses. A ceding company is an insurance company that purchases reinsurance and cedes, or transfers, premium and losses to a reinsurer.

Benefits of Reinsurance

Reinsurance protects against a single, catastrophic loss of multiple large losses. Reinsurance helps to smooth the overall operating results from year to year and easing the strain on the reinsured's surplus during rapid premium growth. It provides a means for the reinsured to withdraw from a line of business or geographic area or production source.

Another benefit of reinsurance is that it helps the reinsured spread the risk on new lines of business until premium volume reaches a certain point of maturity and it can add confidence when in unfamiliar coverage areas. It provides the reinsured with a source of underwriting information when entering a new line of insurance or a new market.

Types of Reinsurance

Facultative Reinsurance is transacted on an individual risk basis. The ceding company has the option to offer an individual risk to the reinsurer and the reinsurer retains the right to accept or reject the risk. **Treaty Reinsurance** is a transaction encompassing a block of the ceding company's book of business. The reinsurer must accept all business included within the terms of the reinsurance contract.

Facultative Reinsurance is the reinsurance of part or all of the insurance provided by a single policy, with separate negotiation for each cession. The word "facultative" connotes that both the primary insurer and the reinsurer have the faculty or option of accepting or rejecting the individual submission (as distinguished from the obligation to cede and accept, to which the parties agree in treaty reinsurance).

A Facultative Semi-obligatory Treaty is a reinsurance contract under which the ceding company may or may not cede exposures or risks of a defined class to the reinsurer, which is obligated to accept if ceded. A Facultative Treaty is a reinsurance contract under which the ceding company has the option to cede and the reinsurer has the option to accept or decline individual risks. The contract describes how individual facultative reinsurances shall be handled. Facultative and treaty reinsurance can be written on either a pro rata or excess-of-loss basis.

Pro Rata

This is a term describing all forms of quota share and surplus reinsurance in which the reinsurer shares the same proportion of the premium and losses of the ceding company. This also is called a "proportional" agreement. The operative relationship is one of sharing. The advantages to the pro rata basis are that it provides good protection against frequency/severity potential, protection of net retention on first-dollar basis, and permits recovery on smaller losses.

Excess of Loss

This requires an analysis of potential severity of losses. The ceding company selects a loss level compatible with net and treaty guidelines and uses this as its retention. The facultative reinsurer provides a limit of reinsurance in excess of this retention. Unlike pro rata premium determination, where premium to the reinsurer is the same as the percentage of risk assumed, excess layer pricing is based on various formula guidelines, the underwriter's evaluation of risk, primary rates, increased limits rates, and market conditions. Excess pricing may be net of commission or gross, depending on the arrangements between the ceding company and reinsurer.

Results of Reinsurance

Financial Capacity

The primary insurer is often asked to assume liability for loss in excess of the amount that its financial capacity permits. Instead of accepting only a portion of the risk and thus causing inconvenience to and even ill will on the part of its customer, the company accepts all the risk, knowing that it can pass on to the reinsurer the part that it does not care to bear. Using a single policy with a single premium also simplifies insurance management procedures. The policy coverage is not only more uniform and easier to comprehend, but the added guaranty of the reinsurer also makes it that much safer.

Stabilized Profits

Stabilized profit and loss ratios are an important advantage in the use of reinsurance. Good business must often be shared with others, but in return some bad business is also shared. It is usually considered more desirable to have a somewhat lower but stable level of profits and underwriting losses than it is to have a higher but unstable level. Reinsurance arrangements do not necessarily reduce average profit levels, but they do smooth out the fluctuations that normally occur. Reinsurance does not always mean the loss of premium volume, because one of the results of reinsurance is the procurement of new business. As a member of a group of ceding companies organized to share mutual risks, one ceding company must usually accept the business of other insurers. Some companies obtain a large portion of their total premium volume in this manner, and others engage exclusively in the reinsurance business.

Premium Reserve

For new, small companies one of the limiting factors in the rate of growth is the legal requirement that the company set aside premiums received as unearned premium reserves for policyholders. Since no allowance is made in these requirements for expenses incurred, the insurer must pay for producers' commissions and for other expenses out of surplus. As the premiums are earned over the life of the policy, these amounts are restored to surplus. Through reinsurance, the firm can accept all the business it can obtain from its agency force and then

pass on to the reinsurer part of the liability for loss, and with it the loss and unearned premium reserve requirement.

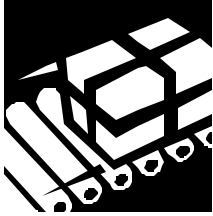
Underwriting

If a firm wished to liquidate its business, it could conceivably cancel all its policies that are subject to cancellation and return the unearned premiums to the policyholders. This would be quite unusual in actual practice because of the necessity of sacrificing the profit that would normally be earned on such business. It would most likely be impossible to recover in full the amount of expense that had been incurred in putting the business on the books. Through reinsurance the liabilities for existing insurance can be transferred, and the policyholders' coverage's remain undisturbed. If an insurer desires to retire its insurance business and to cease underwriting, it may do so through reinsurance. A life insurance policy is non-cancelable, and the policyholder has the right to continued protection. Without reinsurance, the insurer would find it difficult, if not impossible to achieve its objective of relieving itself from the obligation of seeing that the insured's coverage is continued.

Providers of Reinsurance

Professional reinsurance companies engage only in reinsurance transactions. These companies provide a large share of the reinsurance market. Many primary insurers also accept reinsurance from other primary insurers. Self-insurance subsidiaries of non-insurance companies provide insurance for the parent company as well as reinsurance facilities. International insurance firms also provide reinsurance.

A reinsurance relationship exists when an insurance company in turn purchases insurance on some exposure. It is a standing agreement between a primary insurer and a reinsurer to reinsure all the formers contracts a treaty reinsurance arrangement. A reinsurance agreement requiring separate negotiations for each case is called facultative reinsurance. Reinsurance in amounts greater than \$50 million is referred to as catastrophic reinsurance.



Chapter Eleven

Loss Control and Fraud

Workers' Compensation Fraud

A lot of effort has been invested in trying to combat financial difficulties by reducing workers' benefits, but if everybody paid the correct premium there would be sufficient revenue to adopt a different approach. Workers have been fined for fraud, but little has been done against employers who are committing corporate crime. Investigations have found many companies who have no workers' compensation insurance whatsoever and many others who under-insure by false declaration of wage levels or by providing misleading information concerning their industry classification. Premium levels are generally calculated as a percentage of total wages and are also influenced by the type of industry an employer is competing in.

The best evidence from the states that have pursued fraud and generated detailed records indicates that for every \$1 lost in claimant fraud, at least \$4 to \$5 (and in some states as much as \$10) is lost through premium fraud.

Premium Fraud

Premium fraud includes a number of schemes used by employers to reduce the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experience. Let's look at the most common premium frauds.

Underreporting payroll. Employers reduce their premiums by not reporting parts of the work force, paying workers off the books or creating a companion corporation to hide a portion of the employees.

Declaring independent contractors. Employers avoid premium payments for employees by classifying them as independent contractors even though they are legally employees.

Misclassifying workers. Employers intentionally misrepresent the work employees do to put them in less hazardous occupational categories and reduce their premiums.

Misrepresenting claims experience. Employers hide previous claims by classifying employees as independent contractors or leased employees or creating a new company on paper.

Employers deliberately underestimate employment projections at the beginning of the premium year and essentially receive an interest-free loan from the insurance company for the amount that would have been required to insure new employees.

In addition to premium fraud, employers often fail to purchase workers' compensation insurance, despite state laws mandating that they do so. There are also reports of employers:

- Instructing injured workers to seek treatment under group health insurance rather than workers' compensation

- Discouraging workers from filing workers' compensation claims
- Firing workers who file claims

The number one answer to this situation is *a focus on prompt rehabilitation and return to work*. It is an enormously complicated assignment, as anybody participating in the industry would be aware. While some states and the media continue to focus on claimant fraud, states that have pursued workers' compensation fraud in a serious way are now concluding that the emphasis on claimant fraud is misplaced, and employer fraud is by far the greater problem. Experts report that historically, there has been a common presumption that those committing the most costly type of workers' compensation fraud have been claimants whose actions, such as double-dipping or claims for false injuries, drove up the cost of workers' compensation insurance.

Premium fraud scams are costly to companies causing workers compensation insurance rates to escalate and legitimate companies to lose business because they are less able to compete with companies shirking the system.

Examples ~ *One case involved underreporting of payroll at a large fruit harvesting company, with fraud charges totaling \$3.5 million. Another employer was charged with defrauding insurers of \$2 million while operating one of the largest temporary employment agencies in his state. The employer disguised the high-risk nature of the work done by many of the employees, concealed its claims history, prevented insurance companies from conducting audits and lied on applications for workers' compensation insurance. Two insurance executives and their attorney were charged with multiple criminal counts in connection with the \$100 million collapse of two insurance companies caused by kickbacks to reduce workers' compensation premiums.*

There is no question that **employer fraud** today costs more dollars to carriers and to the industry than **employee fraud**. A recent study calculated that 19% of employers - nearly one out of every five - either underreport payroll or have no workers' compensation insurance. The study concluded that losses on premium fraud can and usually do exceed the amount of loss in claimant fraud, and, in some instances, medical mill fraud. For example, in several cases where criminal charges have already been filed, losses due to premium fraud for each case are estimated to be in excess of \$5 million.

Employers also abuse the system when they fail to provide workers' compensation insurance for their employees or take out a policy but then fail to pay the premiums. California has been investigating employers who fail to provide workers' compensation insurance. In March of 1998, California launched a three-part pilot project to match computer databases from various state agencies to identify employers who are illegally uninsured for workers' compensation. The project is designed to level the playing field for law-abiding insured employers and reduce the taxpayer burden created by those who are not. In industries with high premium rates, the illegally uninsured employer is able to underbid the insured employer. Insured employers are again disadvantaged when taxes are raised to cover costs shifted to government services to assist the injured workers of employers who are illegally uninsured.

Several other states are also using proactive programs to identify uninsured employers using computerized lists of employers and workers' compensation policies. A audit by one state's comptroller's office revealed that employers owe more than \$500 million in overdue unpaid workers' compensation insurance premiums to the State Insurance Fund.

Medical Provider Fraud

Workers' compensation fraud also occurs among medical providers. These forms of fraud evolve as the nature of medical care changes over time. Outright fraud occurs when providers bill for treatments that never occurred or were blatantly unnecessary. Some of the newer forms of medical provider fraud include kickbacks from specialists and other treatment providers to referring physicians, and provider up-coding, where provider charges exceed the scheduled amount. Providers also shift from the less expensive, all-inclusive patient report to supplemental reports, which add evaluations and incur separate charges.

Medical provider schemes include:

- *Creative billing* - billing for services not performed
- *Self-referrals* - medical providers who inappropriately refer a patient to a clinic or laboratory in which the provider has an interest
- *Upcoding* - billing for a more expensive treatment than the one performed
- *Unbundling* - performing a single service but billing it as a series of separate procedures
- *Product switching* - a pharmacy or other provider bills for one type of product but dispenses a cheaper version, such as a generic drug

Newer forms of fraud and abuse occurring under managed care arrangements include:

- *Underutilization* - doctors receiving a fixed fee per patient may not provide a sufficient level of treatment
- *Overutilization* - unnecessary treatments or tests given to justify higher patient fees in a new contract year
- *Kickbacks* - incentives for patient referrals
- *Internal fraud* - providers collude with the medical plan or insurance company to defraud the employer through a number of schemes

According to the National Council on Compensation the increased use of managed care for workers' compensation, as well as for other insurance lines, is bringing new twists to old schemes. Managed care creates more opportunities for fraud because of the financial relationships and incentives between players.

Example ~ *A pharmacist pleads guilty to twenty-one counts of fraudulent workers' compensation insurance billing. The pharmacist increased his revenues by up to 500% per prescription on more than \$600,000 of drugs sold over a four-year period.*

Insult Added to Injury

Because of the assumption of widespread claimant fraud, injured workers who file a workers' compensation claim may be subjected to insulting questions and treated as malingerers and cheats. Under the auspices of "fraud prevention," they may face endless questioning and unnecessary medical examinations. They may be subjected to constant video surveillance by private investors hired to follow their every move. Their employer may refuse to provide light duty work, or take retaliatory actions against them when they return to work. If they look for another job, their application may be screened for prior workers' compensation claims.

Although some of these tactics are used in legitimate attempts to investigate questionable claims, they have also become part of a broad employer attempt to intimidate workers from filing workers' compensation claims. Under the pretext of controlling what has been falsely presented as rampant claimant fraud, injured workers are discouraged from exercising their legitimate rights to workers' compensation benefits.

As a recent study demonstrated, the real problem in workers' compensation is not that too many workers claim benefits, but that too few do so. The study found that only one in four workers with occupational diseases file for workers' compensation. Unsubstantiated charges of rampant claimant fraud undermine public confidence in the system and discourage legitimately injured workers from seeking the benefits they need and deserve.

The grossly overstated estimates of claimant fraud have not only subjected injured workers with legitimate claims to fear and intimidation, but have also obscured a more serious look at the workers' compensation system and the benefits it provides. In most states, workers' compensation benefits provide little more than poverty-level existence. Workers often wait weeks and months for payments.

Many employers refuse to provide light duty or alternative jobs for workers who might be able to go back to work in a modified capacity while they continue to recover, so workers are forced to continue on inadequate benefit payments even though they may be able to work in some capacity. Some injured workers lose their jobs or are only offered positions at much lower pay. It is little wonder that so many claimant fraud cases involve workers illegally continuing to accept benefits when they are in fact working at another establishment. Inadequate benefits put people in desperate straits, and they take desperate measures as a result. A system that leaves people in poverty invites abuse.

Fighting Insurance Fraud

High workers' compensation costs has led to more anti-fraud efforts. Some states have created special fraud investigation units in response to escalating workers' compensation costs. These units have discovered that the real drain on the system stems from employer and provider fraud.

Workers' compensation fraud occurs when a person knowingly or intentionally conceals, misrepresents, or makes a false statement to either deny or obtain workers' compensation benefits or insurance coverage, or otherwise profit from the deceit. The most common type of fraud discovered and investigated is injured worker benefit fraud. More cases involving health care provider fraud were referred to district attorneys for criminal prosecution than injured worker benefit fraud cases -- even though injured worker benefit fraud investigations outnumbered provider fraud investigations by more than four to one.

Investigators have found that health care provider fraud was often the most expensive type of fraud in the workers' compensation system.

Trickle-Down Effect

Stealing from large, faceless insurance companies seems harmless at first. One should consider the trickle-down effect of workers' compensation fraud. Insurance companies pass on the costs of fraud to employers as higher premiums. These employers in turn pass on the costs to consumers for goods and services. Employers who can't afford the costs are sometimes forced to move to a state with lower compensation premiums, taking their jobs and income with them. But employees aren't the only people committing fraud.

- Employers have neglected to carry workers' compensation coverage.
- Doctors have falsified bills to insurers.
- Attorneys have committed forgery.
- Insurance agents have neglected to send premiums to insurers, pocketing the money.
- Employers that don't carry workers' compensation coverage operate their businesses with a lower overhead, giving them the opportunity to underbid businesses with the proper coverage.
- Uninsured employers can run honest employers out of business, again resulting in a loss of jobs.
- Health care professionals, attorneys and insurance agents -- professions often regarded as being owned by individuals of high moral fiber -- are also under scrutiny.

If one is aware of someone who is abusing the workers' compensation system, he should realize that it does affect him and his community. While his neighbor next door sits home and collects fraudulently obtained benefits, he will be working harder to support his family. Those benefits are coming out of his pocket.

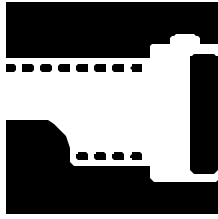
The Self-Insured

While vigilance against fraud by employees must be maintained as a deterrent to systemic abuse, and fraud prevention strategies should continue to be developed, it seems that the attention of insurers might be beneficially invested in other directions. Further lessons can be learnt from a section of the industry not contributing to the problem of premium non-compliance: **the self-insured.**

Study reports a "negligible" occurrence of workers' compensation fraud in a self-insured company. As a result of their strong prevention record they have 60% less claims than the rest of their industry. As a self-insurer they have management and ownership of all claims and they can deliver benefits within twenty-four hours. The closeness of their involvement with the worker in terms of early post-injury intervention produces an environment not conducive to fraud.

While current regulations limiting self-insurance could be looked at more closely, it is not a realistically viable option across the board. Experts agree with arguments for self-insurance but believe the same positive principles can be applied to broader schemes.

The self-insurer certainly has the capacity to be closer to the worker but other employers can replicate that in the broader workforce by seriously practicing early intervention. That is the self-insurer's greatest advantage against fraud. Other employers should take the view that all injuries are legitimate on the first day and get the system intervening very quickly. If they can get people looked after and set on the road back to work straight away, thoughts of exaggerating incapacity fall away.



Chapter Twelve

Loss Control and Communication

The starting point for the development of any solution must be **dialogue**. All clients have a unique set of risks and the agent will need to work with each one to obtain a clear picture of their risk exposure and an overview of their circumstances. This will include information on claims history, financial environment, and loss control activities.

One of the most effective ways to reduce the cost of risk is to **prevent** losses occurring. The agent will work with the client to create a loss control program. It does not always cost a great deal of money to improve risk. Often an improvement in the way resources are employed can bring a noticeable reduction in losses. Once a loss has occurred, there is still scope for reducing the overall cost of risk by **effective claims management**. Claims management is more than simply handling a claim. The cost of the loss may depend on how a claim is managed and it may have consequences, which are not financial. An effective claims management approach is to aim to minimize the cost of losses, while ensuring that the final result is fair for all parties.

Developing the best way to finance the losses that are unavoidable will entail a flexible mixture of self-insurance and purchased insurance together with aggregate protection. The agent should present clients with a number of options to choose from which have been developed especially with their circumstances in mind, not by the rigid application of a pre-determined formula. The client's ultimate financial liability for his losses will be determined at the outset and guaranteed by aggregate stop loss protection set at a realistic level.

A Loss Control Department

To be effective a loss control department should operate as a full-fledged department rather than as simply an adjunct to the underwriting or claims department. This is indicative of the priority given to the services provided by this segment of the risk management process. The primary function of this department is to provide **consultative** loss control assistance. In order to keep abreast of client needs and situations where loss control assistance is required, the department should maintain close **communication** with the claims departments.

Loss control is an innovative approach to reducing the potential for property damage, employee injuries or other losses in the business environment. A well-designed loss control program can contribute to a businesses bottom line, through enhanced corporate productivity and profits, while offering customers and employees a safer environment. An evaluation of how an organization's loss control procedures commingle with their overall operation could make it possible for the company to:

- Be more pro-active in controlling or lowering their insurance costs
- Reduce their exposure to uninsurable losses
- Lessen the threat of a catastrophic loss that might interrupt their business operation
- Provide a safer environment for their employees and customers

An insurance company that provides consultative loss control services can assist clients by conducting physical surveys of their business operation. Surveys are conducted as deemed necessary by the department, and/or requested by clients.

Physical surveys may point out potentially hazardous conditions that presently exist in a business such as: insufficient and or blocked emergency exits, material handling problems, exposed machinery parts, incorrectly stored chemicals, or a sprinkler system that is not adequately designed for their occupancy.

Ergonomic reviews examine material handling procedures, product flow, and corresponding lifting tasks. Often times this analysis can suggest ways that an organization can reduce the potential for back injuries in their business with a few, relatively inexpensive corrective measures.

Loss Control Assistance

General Safety Reviews

Assistance in the development of effective loss control programs can include plant inspection procedures. Communication can include the following:

- Advising on OSHA regulation compliance
- Assistance in reviewing machine guarding, lock out /tag out procedures
- Suggestions on proper personal protective equipment and material handling equipment
- Ergonomic procedures for various job assignments to reduce injuries
- Assistance in developing a Hazard Communication Program Outline of Loss Control Services
- Occupational health hazard reviews
- Assistance with accident investigation procedures which follow-up on the cause and remedy of accidents
- Assistance with periodic safety meetings, providing appropriate handouts and/or make suggestions for video or other training methods

An important part of safety reviews is conducting an accident analysis for all lines of coverage using in house or insurance carrier loss runs. The purpose of this analysis is to identify loss trends and root causes, and point out the uninsured costs associated with the loss experience. Then the agent can make suggestions for developing internal accident analysis procedures, and monitoring the effectiveness of present loss control efforts.

Property Protection

The agent can assist in helping the client to protect their property by coordinating the following communication:

- Conduct property surveys to assist accounts with identifying possible fire hazards
- Assist clients in reviewing product storage methods and heights to mitigate fire potential
- Evaluate all types of sprinkler systems for various occupancies, i.e. warehousing, cooking/kitchens, computer rooms, etc. to determine adequacy
- Assist clients with interpretation of various fire codes and standards

- Develop specific self inspection forms to assist clients in conducting scheduled property inspections or to maintain fire protection equipment
- Assist clients with pre-emergency planning

Fleet Operations

Many businesses lose sight of the fact that the vehicles they use in their operation enable them to operate more efficiently, enhancing profits. If these vehicles were eliminated from a companies operation, the overall operations would either be hindered or non-existent. For this reason, fleet safety must be part of a corporations loss control program. Through the following communication techniques the agent can assist the client in improving their loss control:

- Assist all clients with incorporating fleet safety into their overall corporate safety program.
- Assist clients in developing proper procedures for driver selection and training.
- Conduct comprehensive audits of fleet safety programs to pinpoint deficiencies and areas that do not conform to corporate culture.
- Assist clients with the development of forms and programs to facilitate vehicle maintenance, accident reporting and investigation, and driver supervision
- Assist clients with route analysis and product delivery, pick up scheduling.
- Assist clients with interpretation of state and federal DOT regulations.

Products Liability

Social and economic trends, ever increasing consumer awareness and the doctrine of the " strict liability " doctrine by the courts contributes to a "pro claimant" atmosphere for product liability claims. As a result, a wide range of real and imagined product defects have been brought before the courts. Product liability claims can impair a corporation's bottom line by way of actual claim settlement costs, losses due to product recalls, increased production costs to comply with product safety requirements and loss of sales due to negative publicity.

The insurance agent can help with Products Loss Control by communicating in the following ways:

- Assistance with the product design phase to analyze product hazards
- Assistance with product quality control and performance control
- Assistance with developing user information, labeling, instructions and advertising material
- Evaluate the record keeping procedures used in conjunction with the product, which assists with complaint and claims handling
- Analyze product packaging and shipping materials

General Liability and Security

Injuries to the public can impact a company's bottom line, either from the actual cost of the accident, or the negative communication and goodwill. A loss control department can help by:

- Conducting premises surveys to assess hazardous conditions and identify areas where the public could be injured

- Reviewing procedures for controlling visitors on premise, and off premise exposures to the company
- Conducting assessments of the overall security in all areas of premises, i.e. buildings, parking areas, off site locations etc., to determine premises vulnerability and the probability of burglary/robbery occurrences

Strategies for Effective Communication

Effective Verbal Communication

Verbal communication is critical to effective loss control. Many claims can be avoided if the agent will take the time to confirm all parties' understanding in each transaction.

In order to do this the agent should always **repeat** his understanding to the client when handling an instruction or request. The agent should never assume any detail about the insured property. When he is recommending certain coverage, he must thoroughly **explain** the options and the consequences of each decision. He must be sure that the client **understands** his current coverage.

Effective Written Communication

Documentation is written confirmation on all verbal instructions. It is also a written record of all that that has been done, and what needs to be done in the future. Lawyers are always instructing their clients to document.

Methods ~ Insurance agents should document all instructions and transactions. He should be sure and obtain the client's signature whenever necessary, even if it has to be on a piece of scratch paper. The note should be specific with details, date and time, and then signed by both the insured and the agent.

Normally **standardized forms** are the preferred method of documentation. These should all have a section for remarks and the insured's signature. **Letters** are another way of written communication with the client. The letter reinforces or acknowledges what has already been discussed verbally. Many times this can alert either the agent or the client to an error or misunderstanding in their communication. A signed release from the insured should be used for special requests or rejections of coverage.

Purpose ~ If an **insurer refuses to provide coverage**, the agent should communicate that information in writing so that the client does not assume that he has coverage when he does not. If a **client rejects coverage** by the insurer, that rejection should be confirmed in writing from the insurance agency.

Coverage limits especially for bodily injury or property damage limits should be in writing on a sign-off form. These forms are a communication device to indicate to the client that higher limits are available. They should be signed at every renewal for every level of coverage. A signed application is no longer sufficient proof that the limits are the insured's intent.

The agent should discuss the limitations of the coverage in writing. This can be done with a phrase such as "If there are any other exclusions or limitations in the policy that you would like

A **quote** is an estimate of the price for coverage the insured needs or wants. It is a statement of options available and the decisions made by the insured. It describes in detail the offer of coverage by a particular insurer. It is not evidence that coverage is in effect or a substitute for a signed application. A quote, known also as a proposal, will communicate what the insurer is recommending, and what the cost of the coverage will be.

The quote or proposal should be in standard format and language. It should communicate specifically to the client what he should do to effect coverage. All options and limitations should be listed clearly. There should be a disclaimer regarding the purpose of the quote included.

Effective Fax Machine Communication

It is very important for the agent to understand the loss exposures involved with communicating via a fax machine. These exposures depend upon how faxes are transmitted and received.

Both the agent and the client should communicate about the confidentiality level of the information being faxed. Both should approve the sending of the material, and be notified ahead of time that confidential material is being faxed. The faxes should be delivered immediately to the appropriate person, and responded to. Important documents require a confirmation of receipt.

All forms should have original signatures. Faxed signatures may be accepted temporarily in an emergency, but should be replaced by an original signature as soon as possible. Fax confirmation of date and time can be critical; so they should always be stapled to the document or the document should be stamped with the date. The sender should be notified if a fax does not come through properly.

A **faxed** request for coverage that is received in the agent's office after hours does not confirm coverage. Even though the fax may communicate an offer of a risk, the insurer has not accepted that offer. Because of this potential in miscommunication, it is wise to leave the fax machine on even when the insurance agency is closed.

Effective Telephone Communication

Speaking over the telephone has become so common that it is easy to forget that it can be the cause of serious errors in communication. One of the ways to avoid misunderstanding is to document telephone conversations. Activity records of all telephone conversations can be an effective tool in defending an agency against lawsuits. The agent should never depend solely upon answering machines or voice mail for records of communication. There is too much room for error. Pocket recorders are the most reliable means of verbal records.

Documentation is especially critical in conversations requiring action. No action should be taken based merely on a telephone conversation. If a change in coverage has been discussed, no action should be taken until a signed and dated confirmation is received from the insured.

Another danger in telephone communication is incomplete information. The agent should have a standard form that he follows in leaving telephone messages which includes all the necessary information such as date, time, name of caller and company, purpose of the call, request for return call, etc. and a return phone number.

Communication and Customer Service

Consistent professional customer service is critical if the insurance agency is going to control their errors and omissions. As we have already discussed verbal and written communication is a big part of customer relations. Technology is constantly giving us new means of communication that sometimes can threaten the humanness of the agent/client relationship. Automated phone systems cannot take the place of communicating with one's agent. Advertising on the Internet can seem impersonal to one who is looking for a live person to explain his product.

We will look at some areas of customer service that can affect not only the relationship of the agent and the client, but also the loss exposures, and the profits for the insurer.

Billing and Collecting

The opportunity of more efficient and effective billing and collections, in order to increase investment income, is overlooked by many insurance companies. Accelerating the collection of premiums and non-premium revenue, such as service fees and loss-sensitive rating plan reimbursements makes funds available more quickly for investment. This generates additional investment income. The ability to increase earnings through better billing and collections can increase the profits of an insurance company as much as if they wrote several million dollars in profitable new business premiums.

The average amount of premiums that flows through an insurance company is several billion dollars annually. If insurance companies would be as aggressive as banks are in their billing and collection procedures, they could increase their profits greatly. Surveys show that banks have consistent, well-managed collection procedures. Insurance companies use a variety of practices, which leads to different results.

Surveys have revealed that insurance companies could reduce problems with billing was to convert as many accounts as possible to **direct billing**. Most insurance carriers offer commercial-lines direct-bill services, but they have not been as aggressive with the commercial accounts as with personal-lines. This is not going to change unless companies move from their traditional billing processes. Increased direct bill usage would increase the productivity of any company in a very significant way. Experts feel that the benefits far outweigh the costs and challenges involved.

Top-performing organizations have recognized the connection between collection performance and product standardization. They offer fewer options both in payment plans as well as products. Fewer options lead to more efficiency in customer service and less confusion on the part of the client. As companies have studied how to better identify customer needs and improve customer service, there has been a rise in creating programs designed to meet the specialized needs of each segment. High-performing insurance companies align their bill-payment options with agency status to improve customer service for their key agents. They tier payment options by segment. This results in the company's resources being allocated to their most profitable segments. This also simplifies and reduces processing costs and lowers risk for the smaller segments of the company.

Surveys have also proved that there are significant benefits to having a **centralized** location for billing and collection procedures. This is consistent with the principle of standardization. Not only does it enhance the efficiency of customer service, but also attracts clients. Teamwork is vital to productivity. A centralized structure with aligned billing and collection service teams can increase effective communication throughout the organization.

One of the most important factors in efficient and effective billing and collection procedures is the timeliness of the **collection follow-up** activities on past-due balances. To stress importance of billing and collections, but fail to reinforce the rules can be devastating to the effectiveness of the process. Past-due notices should be sent consistently. Agents should be required to collect partial payments for disputed bills. This reinforces the understanding of clients that billing is being closely monitored.

Efficient staffing is imperative if the above strategies are going to be put into practice. One reason that small accounts don't grow is because of inefficient customer service. Effective hiring and training of competent employees is of utmost importance. Personality, as well as skills, needs to be considered in choosing persons for this extremely important part of marketing insurance. Creating a team of workers moves all of the responsibility from one or two people to a group who are working together. This is a way of using a variety of skills and yet not sacrificing quality. Accountability will also increase the initiative of employees. This is accomplished by monitoring their performance with payment results.

Proper compensation will also promote positive productivity. History has proved again and again that one gets what he pays for. If insurance companies want to provide top-quality customer service, they will have to be willing to invest time and money in hiring and building a competent staff force.

Communication and Marketing

Setting up Accounts

Targeting the small-business customer requires a new model, the right staffing and a disciplined approach to sales and marketing. This effort can bring in many new customers who can grow with the insurance agency and help recruit new producers. Agents know the potential in the small-business market segment. There are over two million small businesses today with fewer than 100 employees, and 100,000 new businesses are started each year. Businesses with fewer than nine employees are expected to increase to almost two million within the next year. Every small account can become a large account. 20% of these small businesses are increasing their employee base by 20 % each year.

The perception that small accounts cannot be profitable is beginning to change. With the right staffing, compensation, and effective use of automation, these accounts can be quite profitable. Growth is going to depend on how these accounts are handled. Experts agree that many problems have existed because of poor customer service techniques. Customer service representatives working in these smaller accounts are often less technically proficient than counterparts who handle the middle-market segment, and they lack the sales aptitude to cross-sell or make outbound sales calls. Some employees have had to work without an automated database, and have struggled with paper processing and unnecessary procedures. They do not have the benefit of customer centers. These inefficiencies have developed a situation of low productivity.

Another problem has been compensation. Many of the middle-market producers on small accounts receive no commission. So these accounts are turned over to a customer service representative who already is overworked. As a result, there is no clear sales responsibility or accountability for these accounts. The secret to creating productivity in these small accounts and then growth is **effective communication** between the underwriter and the agent, and between the agent and the client. If the small-account producer is supported, he can sell enough new business to cover salary and benefits and still generate a profit for the agency.

Cross-Selling

Most agents understand the value of cross-selling automobile, homeowner's, umbrella, and watercraft coverage. Yet many fail to consistently market in all areas. An effective cross-selling program will not only benefit one's clients, but also grow revenues and reduce competition. Success in this area of marketing is going to depend greatly on the work of the customer service representatives. They must be trained to understand the concept, and also realize that they are responsible to sell the concept. Everyone in the agency must understand how the program works, and what their role is in it.

Not only must everyone in the agency understand the cross-selling program and their responsibility, but also it is critical that each one is compensated for their efforts in the process. Agencies have found that incentive awards and cash awards are very effective in recognizing contributions of employees. After settling a claim to a client's satisfaction, the agent should ask them if they would like to purchase additional coverage. Office staff can question clients at time of annual service calls with questions such as:

- Have you bought a new home or car?
- Have you installed a pool?
- Has your son or daughter started driving?

The agency should send mailings out describing the range of products available on a regular basis. It will take a lot of hard work and consistent effort on the part of all agency employees to increase cross-selling policies, but it is a necessary ingredient for the long-term success of companies and agents.

Communication and the Internet

As all eyes are on the Internet, some have criticized the insurance industry for being slow in moving online. Insurers' presence on the Internet is evolving in many ways. Two areas that are going to be greatly benefited are:

- Policyholder services
- Claims processing

One of the top complaints issued against insurance companies through the years has been in relation to claims handling. Customers have been unhappy with the time that it has taken, and felt that the communication was poor. Many insurers now offer many services, including online claims reporting and e-mail links. Some insurers are providing tracking systems so that clients can track the progress of claims online in much the same way that United Parcel Service customers can track the movement of packages.

Even though online shopping for an insurance policy does not take as long as visiting an agent's office, many times clients get bogged down because of the choices that they have to make. Experts feel that many people will shop online like they shop from a catalog. Many will still prefer to go to the agent in person. But just as a catalog may draw customers to the retail store, so a Web site may draw clients to an agency. Surveys have shown that most Americans still prefer to purchase insurance from an agent because:

- They value personal contact
- Insurance is difficult for them to understand

As time passes, people will turn more and more to the Internet to do their shopping for insurance. There is no doubt that e-commerce is going to change the way people relate to the insurance industry.



Chapter Thirteen

Loss Control and Home Safety

places. Approximately 24,000 individuals are killed each year in home accidents--an average of about 65 deaths per day. The National Safety Council reports that about 3.6 million people are injured in home accidents, which means that one person in 60 was disabled for one or more days in a home accident. About 100,000 of these injuries resulted in permanent impairment.

Although most loss control programs focus on commercial / professional elements, agents can help their personal lines clients reduce claims in the home with some education on a few simple concepts and procedures.

Positive Safety Attitude

You cannot oversee your client's activities at home, but you may share with him some ideas on developing a positive safety attitude. Let's see how this works. First, some examples . . .

Example: *A father making a plumbing repair in his kitchen finds that he does not have the correct tool for the next job step. He really needs a strong utility knife to cut the trim off a plastic pipe, but he left it back in the garage. There are only two choices: Should he improvise and use a substitute tool, like his small pocket knife? Or, should he take a little extra time and get the right tool? The father with a strong, positive safety attitude certainly will take the time and do the job properly and safely by going back to the tool shed and getting the correct tool.*

What A First Aid Kit Should Include

Box of nonporous disposable gloves
Sealed packages of alcohol wipes or antiseptic
Small Scissors
Tweezers (for removing splinters)
Thermometer
Adhesive bandage tape
Sterile gauze squares (2" and 3")
Triangular bandages
Flexible roller gauze (1" and 2" widths)
Triangular bandages
Safety pins
Eye dressing
Insect sting preparation
Pencil and notepad
Syrup of ipecac
Cold pack
Small splints
Sealable plastic bags for soiled materials

Here's another example . . .

A mother is running errands on a hot day with her baby. She needs to stop at a friend's house to pick-up a pan she needs for a recipe. It will only take a minute or two to get the pan she needs. Does she park the car in the driveway with the baby inside? Maybe she can leave the motor and air conditioner running while she pops inside for just a minute. The mother who takes the time to remove the baby from the car is making the correct decision. It is the only way to guarantee that something won't happen (heat stroke, a stolen car, exhaust fumes, etc) to the baby while she is out of sight – even for just a minute.

In both of these examples, there was an easy way out . . . a short-cut . . . a quick solution. But, by adopting a **positive safety attitude**, your clients can make better, more consistent

decisions for greater safety. It may be a little harder this way, but at the end of the day, you and your clients will have peace of mind and a greater sense of accomplishment.

Parents have the unique opportunity to help their children develop a **positive safety attitude** at an early age by setting a good safety example? When they do jobs around the house, make kids see them wear safety glasses, gloves, protective clothing, etc. Make sure they see them handle household tools like knives, scissors, chemicals and appliances with extreme caution. Encourage them to take the time to explain to them that the reason for wearing safety gear and following safe procedures is to make sure that they are not injured.

Emergency Preparation and Procedures

In any emergency, clients should: ¹

- 1) Stay Calm.
- 2) Check for life-threatening situations (choking, severe bleeding, or shock). Do not move a seriously injured child.
- 3) Call 911 or your local emergency number if the child is seriously hurt. Have emergency numbers posted by the phone--police, ambulance (911), and poison control center.
- 4) Give CPR or first aid, if necessary (if you know what you are doing).
- 5) Know where the nearest hospital or urgent care center is located. Are they open 24 hours a day? Do they have an emergency room? (Not all hospitals or clinics have emergency services).
- 6) Keep consent forms for emergency treatment (in case someone else is watching your child when he is injured) and numbers for emergency contacts near the phone. These forms can save you child's life since they give the person in charge of your child the immediate right to authorize emergency medical treatment if you are not around.
- 7) Keep a fully stocked first aid kit in easy reach, but out of reach of children. Check the first aid kit regularly and restock it as necessary. (See box for what your kit should contain.) In addition to the supplies listed for your first aid kit, you should also keep ice cubes or ice bags in the freezer to use to reduce swelling of some injuries.
- 8) Place a stocked first aid kit in every vehicle used to transport your children. In addition to the items in first aid kit, your vehicle kit should also include a bottle of water, soap, coins for a pay telephone, and a first aid guide.

First Aid Procedures

There are many injuries where people in the home need some first aid right away. Encourage clients to go take a Red Cross class in first aid training to get this knowledge.

Another part of managing risks at home is to do as much as possible to **prevent them from happening** in the first place. There are probably dozens of changes that anyone could make to their home or apartment to make them safer. You are not trying to be an authority here, but there are some good suggestions from some people who are considered experts.

Preventing Common Household Injuries

Here is a few simple precautions can help to prevent many common household accidents. Start today to make your home safe using these tips: ²

- Make sure stairs are clearly lit.
- Install light switches at the top and bottom of stairways.

¹ The ABC's of Safe and Health Child Care, www.cdc.gov, 12/2000

² Farmers' Insurance website, www.farmersinsurance.com, Preventing Accident at Home, 12/2000

- Keep exits and passageways free of boxes, furniture and other tripping hazards.
- Regularly clear the floor of toys, games, magazines and other obstructions.
- Make sure you can see over the top of what you're carrying to avoid tripping.
- Make sure that all of your small rugs have slip-resistant backing.
- Put cut-to-fit rubber matting or two-sided tape on rugs that don't have their own backing.
- Mark sliding glass doors with decals or decorations. Someone could easily walk through what looks like an open door.
- Wipe up spilled water, grease or food peelings immediately to prevent slipping.
- Place a rubber mat or adhesive strip on the bathtub floor. This will reduce the possibility of slipping in the bathtub.
- Purchase bedroom night-lights for children and elderly people. Falls can happen easily in a dark bedroom.
- Wear shatter proof safety glasses when operating any power tool. If you wear eyeglasses, use safety glasses that fit over them.
- Never store inedible products in the same place as food. This may result in an accidental poisoning.
- Don't save medicine. Discard all leftover medications by flushing them down the toilet.
- Avoid using the basement, attic or utility room for a dumping ground, especially for combustible materials.
- The yard should be kept clear of broken glass, nail-studded boards, and other litter. Electric utensils or tools should be properly grounded if they are not of the "double insulated" type and should always be disconnected when not in use.
- You should always tag and identify your main gas and water valves and electrical cut-offs. Be sure that others in your family know where they are located and how to cut the supply in the event of an emergency.
- Fuses or circuit breakers should be labeled to identify outlets and fixtures they protect. Good lighting should be available for work areas, stairways, and in the bedrooms of children and elderly persons.
- Keep emergency phone numbers like police, fire, doctor, utilities, handy by your telephone.
- Falls are the greatest killers in the home. Always have non-skid backing on small rugs and avoid using them at the top of stairs.
- Use a step stool or utility ladder--never a chair or table--when reaching into high cupboards or shelves. Keep ladders in good condition by replacing loose rungs, worn ladder shoes, and frayed ropes on extension ladders.
- Replace cracked or frayed electrical appliance and extension cords.
- Don't use aerosols near open flames or while smoking.
- Keep firearms secure in a locked rack or cabinet and ammunition stored separately from the firearms.
- As on the job, always use the right tool for the job and always get help from a neighbor or friend for heavy or difficult jobs.
- Prepare and practice a family escape plan in case of a fire that might occur during the day or night.
- This plan should include two ways out of every area and a pre-determined meeting place outside of the home.

- Smoke detectors of an approved type are a good investment to provide early warning of a fire in the home.
- Motor-vehicle accidents are the #1 accidental killers of our children ages 5 and under. Using a child safety seat is estimated to be 80 to 90 percent effective in preventing fatalities.
- Look for the UL label whenever you buy appliances.
- Wipe up liquid spills immediately.
- Turn hot handles away from the stove front so that they don't tempt little children, but don't place them over another burner.
- Keep in mind that water should never be poured on a grease fire.
- Washers and dryers should be electrically grounded.
- Always keep household cleaners, disinfectants, insecticides, drain openers, and medicines in their original labeled containers--separate from food--and preferably locked up and out of reach from small children.
- Read the label before taking any medicine.
- Keep emergency phone numbers like police, fire, doctors, utilities, handy by your telephone.
- Keep all tools properly guarded and out of reach of small children.
- Flammable paint thinners and solvents should be kept in metal cans. Their vapors will travel along the ground, so it is important to keep them stored away from gas hot-water tanks, heaters, or other sources of ignition.
- When operating a power mower, keep children and pets a safe distance away. Always shut off the mower and make sure the blades are stopped before adjusting the blade or emptying the grass catcher.
- Keep the garage door open while running the car engine inside to avoid asphyxiation.

Fire Safety & Prevention

If a fire broke out in the middle of the night, would your client's family be able to escape safely? Although most Americans believe they could get out alive, according to NFPA's 1997 Home Fire Escape Survey, only a small number (16%) have actually developed and practiced a home fire escape plan to ensure they could escape quickly and safely.

Some 4,000 fire deaths occur in U.S. homes every year, and too often it's because people did not, or could not, get out of a burning home in time. Developing and practicing a home fire escape plan is the key to survival.

According to the National Fire Prevention Association, the elements of an effective home fire escape plan include the following:³

- Working smoke alarms on every level of the home and outside all sleeping areas
- Two ways out of each room
- Unobstructed and easy-to-use exits
- A meeting place outside
- A posted emergency phone number for the fire department
- Practicing the plan at least twice a year with every member of the household

³ Fire Escape Planning & Practice, www.nfpa.org

Everyone, including preschoolers, can be taught the basics of fire escape. If there are infants or family members with mobility limitations, someone in the household should plan to assist them. Also make sure that doors needed for escape can be opened easily, and that windows are not nailed or painted shut. The most important thing to remember is to react to the sound of a smoke alarm immediately and make getting out your top priority.

Some other tips helpful in fire safety include the following:⁴

- Once you are out, stay out! Call the fire department from a neighbor's home.
- If you must exit through smoke, crawl low under the smoke to your exit.
- If you are escaping through a closed door, feel the floor before opening it. If it is warm, use your second way out.
- If smoke or heat blocks your exit, stay in the room with the door closed. Signal for help using a bright-colored cloth at the window. If there is a phone in the room, call the fire department and tell them where you are.

One of the worst things that can happen, of course, is an emergency where you or your clothes catch on fire. Each year more than 15,000 people are seriously burned when their clothes catch on fire. In more than half of the incidents, flammable liquids or vapors were present on or around the person's clothing. But it can happen in many ways. A person's loose sleeve may catch fire on a hot stove. Someone may be working with gasoline or some other flammable liquid and then light a cigarette. They might spray lighter fluid on a smoldering barbecue fire and the resulting flames could catch their clothes on fire. When a person's clothing catches on fire, action must be instinctive and immediate. There is no time to think.

The one thing you should never do is run.

To minimize a burn injury when your clothes catch fire, **STOP, DROP and ROLL**. Burns are among the most painful of injuries and the third leading cause of unintentional death in the United States. The hands, groin, face and lungs are at particular risk because they are delicate structures and easily injured. The healing process is slow and painful, resulting in enormous personal suffering.

Certain types of clothing are less flammable and resist flames more than other types of clothing. Heavier clothing and fabrics with a tight knit weave burn more slowly compared with loose knit clothing. Fabrics with a loose fit or a fluffy pile will ignite more readily than tight-fitting, dense fabric clothing. Synthetic fibers, such as nylon, once ignited, melt and burn causing severe burns. Natural fibers, such as cotton and wool, tend to burn more slowly than synthetic fibers. However, fibers that combine both synthetic and natural fibers may be of greater hazard than either fabric alone. Curtains and draperies can be sprayed with flame retardants to reduce their rate of burning. However, these chemicals should not be applied to clothing.

The principles of STOP, DROP and ROLL are simple:

- Stop, do not run, if your clothes catch on fire.
- Drop to the floor in a prone position.
- Cover your face with your hands to protect it from the flames.
- Roll over and over to smother the fire. Don't stop until the flames have been extinguished.

⁴ Ibid

If you are near someone whose clothing catches on fire, be sure to stop them from running and make them STOP, DROP and ROLL. Once the fire is out, you must treat a burn injury. Cool a burn with water. Then call 9-1-1

Earthquake Safety

Are your clients ready for an earthquake? Here's what the Red Cross says they can do to prepare.⁵

Prepare a Home Earthquake Plan

- Choose a safe place in every room--under a sturdy table or desk or against an inside wall where nothing can fall on you.
- Practice DROP, COVER, AND HOLD ON at least twice a year. Drop under a sturdy desk or table, hold on, and protect your eyes by pressing your face against your arm. If there's no table or desk nearby, sit on the floor against an interior wall away from windows, bookcases, or tall furniture that could fall on you. Teach children to DROP, COVER, AND HOLD ON!
- Choose an out-of-town family contact.
- Consult a professional to find out additional ways you can protect your home, such as bolting the house to its foundation and other structural mitigation techniques.
- Take a first aid class from your local Red Cross chapter. Keep your training current.
- Get training in how to use a fire extinguisher from your local fire department.
- Inform babysitters and caregivers of your plan.

Eliminate Hazards, Including--

- Bolting bookcases, china cabinets, and other tall furniture to wall studs.
- Installing strong latches on cupboards.
- Strapping the water heater to wall studs.

Prepare a Disaster Supplies Kit For Home and Car, Including--

- First aid kit and essential medications.
- Canned food and can opener.
- At least three gallons of water per person.
- Protective clothing, rainwear, and bedding or sleeping bags.
- Battery-powered radio, flashlight, and extra batteries.
- Special items for infant, elderly, or disabled family members.
- Written instructions for how to turn off gas, electricity, and water if authorities advise you to do so. (Remember, you'll need a professional to turn natural gas service back on.)
- Keeping essentials, such as a flashlight and sturdy shoes, by your bedside.

Know What to Do When the Shaking Begins

⁵ Are You Ready For an Earthquake?, www.redcross.org

- DROP, COVER, AND HOLD ON! Move only a few steps to a nearby safe place. Stay indoors until the shaking stops and you're sure it's safe to exit.
- Stay away from windows. In a high-rise building, expect the fire alarms and sprinklers to go off during a quake.
- If you are in bed, hold on and stay there, protecting your head with a pillow.
- If you are outdoors, find a clear spot away from buildings, trees, and power lines. Drop to the ground.
- If you are in a car, slow down and drive to a clear place (as described above). Stay in the car until the shaking stops.

Identify What to Do After the Shaking Stops

- Check yourself for injuries. Protect yourself from further danger by putting on long pants, a long-sleeved shirt, sturdy shoes, and work gloves.
- Check others for injuries. Give first aid for serious injuries.
- Look for and extinguish small fires. Eliminate fire hazards. Turn off the gas if you smell gas or think it's leaking. (Remember, only a professional should turn it back on.)
- Listen to the radio for instructions.
- Expect aftershocks. Each time you feel one, DROP, COVER, AND HOLD ON!
- Inspect your home for damage. Get everyone out if your home is unsafe.
- Use the telephone only to report life threatening emergencies.

Hazardous Materials Awareness

Many people don't realize it but there are a lot of common household items that are considered to be hazardous materials. These include medications, paint, motor oil, antifreeze, auto batteries, lawn care products, pest control products, drain cleaners, pool care products such as chlorine and acids, and household cleaners. Some household cleaners may be harmful separately or when combined such as ammonia and bleach. In extreme cases, people and children have died when exposed to improperly mixed household chemicals.

How do clients manage this risk?

- Be alert
- Take the time to ask questions
- Look for labels

To help, most fire departments provide some very good pamphlets and other materials for identifying dangerous and hazardous materials, including potential health effects. Here are some examples of their advice:⁶

Arts & Crafts

A good percentage of your clients engage in some form of art or craft as a vocation or hobby. While art is a creative, individualistic pursuit, the materials used may pose a risk to individual

⁶ Household Hazardous Materials, Eastside Fire Department, www.esfd.org

health and the environment. Knowledge about the materials and processes is the best protection against the major and minor health effects of the art or craft.

A wide range of health effects are linked to materials used in the arts and crafts, depending on the substance, the dose, the duration of exposure, and the susceptibility of the person exposed. Many solvents affect the central nervous system and are skin and eye irritants. Most are flammable; many are linked to long-term adverse health effects such as liver damage. Several are known or suspected carcinogens such as benzene and toluene.

Dusts/fibers created from crafts are eye and respiratory irritants, and may aggravate asthma and provoke allergies. Specific hazards: **silica in clay** dust causes lung disease over years of exposure; **talca (white clays)** may be contaminated with asbestos a known carcinogen; some hardwood dusts lead to nasal and sinus cancers in woodworkers. **Heavy metals** are hazardous

both as dusts and as fumes. Lead affects the nerves, digestive system, muscles and joints. Arsenic, cadmium and chromium are known carcinogens. Mercury, copper, cobalt, silver, manganese, selenium and zinc are all acutely toxic.

Acids are corrosive to skin and eyes. Acid vapors are irritating to the lungs and inhalation of small amounts may damage lung tissue. Concentrated acids can react with many other materials.

Gases generated from kilns, welding or

<p>Basic Safety Rules For Arts & Crafts</p> <ol style="list-style-type: none">1. Know the hazards of the materials you're working with. Read the labels, request material safety data sheets (MSDS) on new products, know what precautions, safety gear and clean up procedures are advised. When buying arts and crafts materials look for these key words or symbols:<ul style="list-style-type: none">• Non-toxic - item will not cause immediate poisoning.• AP - approved product; item does not contain sufficient quantities of a material to be toxic or harmful to the body, even if eaten or swallowed.• CP - certified product; meets AP standards as well as standards for product quality, color, etc. Be especially cautious using discarded materials such as wood (what chemicals might it be treated with?) or scrap metal (what alloy is it?).2. Use the safest materials and procedures possible. Stay current on the new developments in your art or craft. Safer, less-toxic alternatives are being devised for many activities.3. Use good ventilation at all times. Local exhaust is the best, such as a hood or spray booth that vents to the outside. Next best is to use exhaust fans that pull the contaminated air away from you and exhaust it outside (an air-conditioning system is not adequate, since it re-circulates most of the air). An open window usually does not provide adequate ventilation; toxins may be blown back into your face.4. Use good hygiene and good housekeeping habits. Separate work and living areas; avoid eating, drinking or smoking in the work area; don't store materials in food containers; and wash and change clothes after working. Wet mop or vacuum for cleanup of dusts.5. Special precautions are needed for children's art. In general, children over the age of 12 can understand and consistently follow safety instructions for the more toxic materials; younger children cannot and should use only the safest materials.

sculpting with plastics are acutely toxic; some may lead to long-term lung damage with repeated exposure.

Pesticides

Pesticides are chemicals designed to kill rodents and insects. Herbicides are used to kill plants and micro-organisms. **They can injure or potentially kill people by inhalation, ingestion and absorption through the skin.** Exposure can affect the respiratory and nervous systems, and cause skin and organ damage. If improperly used, these chemicals can also injure or kill plants or animals that are not intended to be controlled. Certain pesticides that don't readily break down can accumulate in the food chain.

Unless otherwise directed, don't water an area immediately after applying these chemicals to it. This might cause them to run off with the extra water into a storm sewer or stream. Don't throw pesticides or herbicides in the trash, or pour them on the ground or down a drain. Don't burn or bury them either. These methods of disposal can pollute groundwater, lakes, rivers, and water supplies.

The best way to get rid of these chemicals is to use them up unless they are banned. When mixing these chemicals, follow the directions on the label. Read the label to determine if protective clothing such as wraparound goggles, gloves or a respirator are needed. When finished, wash protective clothing separately from other laundry in hot water.

If you can't use the chemicals, see if friends, neighbors, greenhouse, or city park departments need them. Don't give away pesticides or herbicides that are banned, damaged, or unlabeled.

After using all the pesticide or herbicide from a container wash it three times and use the rinse water as pesticides. Throw the rinsed-out container in the trash. Don't burn or reuse old containers. Safely store pesticides in their original container. Protect the label and make sure the word DANGER appears on the container. If the chemical is flammable, keep it away from heat, flames, and spark sources. Also, store it where it won't freeze. Always store chemicals out of the reach of children.

Before purchasing a pesticide or herbicide, make sure you need one. Contact the local agricultural extension service for information on when to use pesticides/herbicides. If you need to use these chemicals, buy only the amount you need. Try using up leftover pesticides/herbicides before purchasing more.

Automobiles

Automobiles consume vast quantities of gasoline, motor oil, antifreeze, car batteries, degreasing agents, windshield washing fluid, car waxes, and cleaners. While most of these products are necessary for proper operation and maintenance, they are all toxic.

Any oil that has been refined from crude oil and has been used is "used oil." The term "used oil" also applies to any oil that is no longer useful to the original purchaser as a consequence of extended storage, spillage or contamination with non-hazardous impurities such as dirt and water. Used oil is a hazardous waste. The hazards associated with used oil result from the various additives used in its manufacture and from the heavy metal contaminants picked up from use in the internal combustion engine.

Oil poured down household drains or directly onto the ground can reach the lakes, rivers and ground water. It can pollute the groundwater with contaminants such as lead, magnesium, copper, zinc, chromium, arsenic, chlorides, cadmium and polychlorinated biphenyl (PCBs). ***One quart of oil can pollute 250,000 gallons of drinking water.***

Used oil is recyclable. Two and one half quarts of lubricating oil is gained by re-refining one gallon of used oil. You can participate in oil recycling by draining the used oil into a clean container with a tight fitting cap. Do not mix the recovered oil with any other liquid and make sure the oil is free from dirt, leaves and other debris. Many auto parts stores will accept your oil for recycling. Check the Yellow Pages or contact stores such as Jiffy Lube or Auto Zone for used motor oil recycling.

Automobiles use lead-acid batteries. Lead-acid batteries contain lead and sulfuric acid. The lead can contaminate water and the acid can burn skin. These batteries have approximately 18 pounds of toxic metals and a gallon of corrosive acids.

If lead-acid batteries are improperly disposed of, such as dumped in a non-hazardous landfill or an empty field, the lead and sulfuric acid can seep into the ground, contaminating the environment and ground-water supply. Damaged, leaking batteries improperly disposed of in the regular trash also pose a danger to refuse collectors who can come in direct contact with sulfuric acid. They are also a fire hazard.

Symptoms of severe lead poisoning include coma, convulsions, irreversible mental retardation, seizures and even death. Even low levels of lead exposure can result in fatigue, impaired central nervous system functions and impaired hearing.

Lead-acid batteries are recyclable. Many places that sell batteries will take the battery. Also some garages and scrap metal dealers will take the battery. If you have a used battery at home, store it safely until you can take it somewhere to recycle. For safe storage, keep the battery in a dry place inside or a lead-proof container outside. Store batteries out of the reach of children and pets.

Nationwide, 70 percent of spent lead-acid batteries are recycled. After the lead is separated from the non-metallic components of the battery, it then is smelted to produce soft lead and lead alloys. Most of these lead products are used to make new lead-acid batteries.

Antifreeze is made up mainly of water and ethylene glycol and added to the radiator water in a car to lower the freezing point and raise the boiling point of radiator fluid. In other words, it keeps the water from freezing on very cold days and boiling over on hot days.

Auto maintenance experts recommend that radiators should be flushed every one to two years. This presents a question of what to do with the radiator fluid. You have to be careful not only to store new antifreeze safely, but also to dispose of used antifreeze properly.

Because ethylene glycol is a clear, colorless and sweet-tasting liquid, it is very attractive to pets and small children. Pets will lap up an antifreeze puddle because it tastes sweet. Young children are also at risk. If swallowed, ethylene glycol may cause depression, followed by respiratory and cardiac failure, renal and brain damage. It is often fatal.

Antifreeze that is carelessly disposed of, such as poured into a storm drain or ditch, a river or stream, onto the ground, or into the trash, presents a health threat to humans, animals and the environment.

Flush antifreeze down the toilet or sink with plenty of water if your house connects to a sanitary sewer system. The sewage treatment plant will break down hazardous chemicals in antifreeze. Used antifreeze can be recycled for use by the mining industry (sprayed on coal to keep it from sticking together) and the glycol industry (used for airplane de-icing solution). It also is used in cement grinding and brake fluid.

Gasoline is toxic and extremely flammable, and never should be used as a cleanser. Always store gasoline in a cool, well-vented area away from electrical sources. Gasoline should be kept only in a metal, stopper-topped container made specifically for gasoline.

Cleaners

Some chemicals in **cleansers** may be hazardous to your health during routine use even though exposure is only to small amounts in the air or on your skin. You can reduce the risk to your health by avoiding products containing toxic chemicals. Or, if you must use toxic chemicals, be sure to follow the manufacturers' directions.

Organic solvents affect the central nervous system, liver and kidneys. Many are flammable and a few are suspected carcinogens. Petroleum distillates in **polishes and sprays**, perchloroethylene in spot removers, mineral spirits in paint thinner and p-dichlorobenzene in mothballs are all examples of organic solvents.

Strong acids or bases are corrosive to skin, eyes and mucous membranes, and can react with other household chemicals. **Acids are found in tub, tile and toilet cleaners and in rust removers.** Lye in oven cleaners and hypochlorites in **chlorine bleach** are examples of high-pH corrosive substances.

Phenols and alcohol are poisonous and flammable chemicals and active ingredients in most **disinfectant products.**

Although not highly toxic, synthetic detergents are the household chemicals most frequently ingested by children. "Real" soaps made from animal fat or vegetable oil are less toxic. Cleansers also may contain added dyes, perfumes, fillers, aerosol propellants, and traces of ammonia and formaldehyde. Keep in mind that hazardous wastes are produced in manufacturing all the different chemicals contained in these elaborate formulas. They generate waste problems even before you buy them.

Paint

Leftover oil or solvent-based paint is a hazardous waste. Toxic, dangerous chemicals used in the production of oil-based paint can pose serious threats to human health and the natural environment if handled or disposed of improperly.

A Johns Hopkins University study found 300 toxic chemicals and 150 carcinogens that may be present in paint. Hazardous chemicals can be found in each of the four basic components that make up oil-based paint: resins, solvents, pigments and additives.

Resins that cover the surface may contain ethylene, which may cause headaches, dizziness and loss of consciousness. Ethylene also is flammable and can be toxic to aquatic wildlife. Urethane alkyds, which cause nausea, vomiting, and drowsiness, also may be present. Solvents that keep the resin liquefied contain aromatic hydrocarbons such as mineral spirits and toluene. Mineral spirits can be a skin, eye, nose, throat and lung irritant, as well as flammable. Very **high air concentration may cause unconsciousness and death.** Toluene may irritate the eyes, respiratory tract and skin. Acute exposure results in central nervous system depression.

Pigments that provide the color may contain heavy metals such as cadmium and chromium. Cadmium irritates the respiratory tract while chromium is an eye and skin irritant. Pigments also may be made with zinc oxide, which can cause flu-like symptoms. Additives, such as thickeners and fungicides, may contain heavy metals such as mercury compounds, which can irritate the skin and mucous membranes.

If oil-based paint is thrown into the trash and ends up in a sanitary landfill, there is the potential health hazard of the chemicals seeping into the groundwater and possibly being consumed by

animals or people. In addition, since oil-based paint is flammable, refuse workers may be injured and equipment may be damaged during trash collection.

If you must use oil-based paint, buy only the quantity needed. Measure the space you wish to paint and ask for help from the retailer to purchase the right amount.

Reuse or recycle leftover paint by giving it to someone who can use it, such as a neighbor or friend, theater group, school, or other community organization.

If possible, use latex or water-based paint instead because they are made up of less hazardous ingredients. Latex paint is easy to apply and can be cleaned with soap and water. Latex paint also is less harmful to the environment than oil-based paint, which contains more hazardous ingredients.

Definitions

Corrosive: A chemical, (solid, liquid or gas), that can cause destructive damage to body tissues at the site of contact. It can cause severe burns to the skin and can "eat through" clothing, metal and other materials.

Flammable: Can be ignited at almost any temperature. Spontaneously react with oxides.

Irritant: Causes soreness or inflammation of the skin, eyes, mucous membranes or respiratory system.

Oxidizer: An unstable chemical that can spontaneously react with flammables and releases oxygen.

Toxic: May cause injury or death upon ingestion (eating/drinking), absorption (touching) or inhalation (breathing into lungs).

Carbon Monoxide Poisoning ⁷

You can't see or smell carbon monoxide, but at high levels it can kill a person in minutes. Carbon monoxide (CO) is produced whenever any fuel such as gas, oil, kerosene, wood, or charcoal is burned. If appliances that burn fuel are maintained and used properly, the amount of CO produced is usually not hazardous. However, if appliances are not working properly or are used incorrectly, dangerous levels of CO can result. Hundreds of people die accidentally every year from CO poisoning caused by malfunctioning or improperly used fuel-burning appliances. Even more die from CO produced by idling cars. Fetuses, infants, elderly people, and people with anemia or with a history of heart or respiratory disease can be especially susceptible. Be safe. Practice the DO's and DON'Ts of carbon monoxide.

Know the **symptoms of CO poisoning**. At moderate levels, you or your family can get severe headaches, become dizzy, mentally confused, nauseated, or faint. You can even die if these levels persist for a long time. Low levels can cause shortness of breath, mild nausea, and mild headaches, and may have longer term effects on your health. Since many of these symptoms are similar to those of the flu, food poisoning, or other illnesses, you may not think that CO poisoning could be the cause.

Play it Safe. If you experience symptoms that you think could be from CO poisoning:

⁷ Protect Your Family from Carbon Monoxide Poisoning, The environmental Protection Agency, www.epa.gov

- DO GET FRESH AIR IMMEDIATELY. Open doors and windows, turn off combustion appliances and leave the house.
- DO GO TO AN EMERGENCY ROOM and tell the physician you suspect CO poisoning. If CO poisoning has occurred, it can often be diagnosed by a blood test done soon after exposure.
- DO Be prepared to answer the following questions for the doctor: Do your symptoms occur only in the house? Do they disappear or decrease when you leave home and reappear when you return? Is anyone else in your household complaining of similar symptoms? Did everyone's symptoms appear about the same time? Are you using any fuel-burning appliances in the home? Has anyone inspected your appliances lately? Are you certain they are working properly?

Prevention is the Key to Avoiding Carbon Monoxide Poisoning

- DO have your fuel-burning appliances -- including oil and gas furnaces, gas water heaters, gas ranges and ovens, gas dryers, gas or kerosene space heaters, fireplaces, and wood stoves -- inspected by a trained professional at the beginning of every heating season. Make certain that the flues and chimneys are connected, in good condition, and not blocked.
- DO choose appliances that vent their fumes to the outside whenever possible, have properly installed, and maintain them according to manufacturers' instructions.
- DO read and follow all of the instructions that accompany any fuel-burning device. If you cannot avoid using an unvented gas or kerosene space heater, carefully follow the cautions that come with the device. Use the proper fuel and keep doors to the rest of the house open. Crack a window to ensure enough air for ventilation and proper fuel-burning.
- DO call EPA's IAQ INFO Clearinghouse (1-800-438-4318) or the Consumer Product Safety Commission (1-800-638-2772) for more information on how to reduce your risks from CO and other combustion gases and particles.
- DON'T idle the car in a garage -- even if the garage door to the outside is open. Fumes can build up very quickly in the garage and living area of your home.
- DON'T use a gas oven to heat your home, even for a short time.
- DON'T ever use a charcoal grill indoors -- even in a fireplace.
- DON'T sleep in any room with an unvented gas or kerosene space heater.
- DON'T use any gasoline-powered engines (mowers, weed trimmers, snow blowers, chain saws, small engines or generators) in enclosed spaces.
- DON'T ignore symptoms, particularly if more than one person is feeling them. You could lose consciousness and die if you do nothing.

Pesticide Poisoning⁸

Although pesticides can be beneficial to society, they can be dangerous if used carelessly or if they are not stored properly and out of the reach of children. According to data collected from the American Association of Poison Control Centers, in 1995 alone, an estimated 79,000 children were involved in common household pesticide-related poisonings or exposures in the United States. An additional 19,837 children were exposed to or poisoned by household chlorine bleach.

⁸ Pesticides and Child Safety, The Environmental Protection Agency, www.epa.gov

A survey by the U.S. Environmental Protection Agency regarding pesticides used in and around the home revealed some significant findings:

- Almost half -- 47% -- of all households with children under the age of five had at least one pesticide stored in an unlocked cabinet, less than 4 feet off the ground (i.e., within the reach of children).
- Approximately 75% of households without children under the age of five also stored pesticides in an unlocked cabinet, less than 4 feet off the ground (i.e., within the reach of children). This number is especially significant because 13% of all pesticide poisoning incidents occur in homes other than the child's home.

Bathrooms and kitchens were cited as the areas in the home most likely to have improperly stored pesticides. Examples of some common household pesticides found in bathrooms and kitchens include roach sprays; chlorine bleach; kitchen and bath disinfectants; rat poison; insect and wasp sprays, repellents and baits; and, flea and tick shampoos and dips for pets. Other household pesticides include swimming pool chemicals and weed killers.

EPA regulates pesticides in the United States under the pesticide law (the Federal Insecticide, Fungicide, and Rodenticide Act). Since 1981, the law has required most residential-use pesticides with a signal word of "danger" or "warning" to be in child-resistant packaging. These are the pesticides which are most toxic to children. Child-resistant packaging is designed to prevent most children under the age of five from gaining access to the pesticide, or at least delay their access. However, individuals must also take precautions to protect children from accidental pesticide poisonings or exposures.

Recommendations for preventing accidental poisoning include the following:

- Always store pesticides away from children's reach, in a locked cabinet or garden shed. Child-proof safety latches may also be installed on cabinets and can be purchased at your local hardware stores;
- Read the label first and follow the directions to the letter, including all precautions and restrictions;
- Before applying pesticides (indoors or outdoors), remove children and their toys as well as pets from the area and keep them away until the pesticide has dried or as long as is recommended by the label;
- If your use of a pesticide is interrupted (perhaps by a phone call), properly reclose the package and be sure to leave the container out of the reach of children while you are gone;
- Never transfer pesticides to other containers that children may associate with food or drink;
- Never place rodent or insect baits where small children can get to them;
- Use child-resistant packaging properly by closing the container tightly after use;
- Alert others to the potential hazard of pesticides, especially caregivers and grandparents;
- Teach children that "pesticides are poisons" -- something they should not touch;
- Keep the telephone number of your area Poison Control Center near your telephone.

IN CASE OF AN EMERGENCY, try to determine what the person was exposed to and what part of the body was affected before you take action, since taking the right action is as important as taking immediate action. If the person is unconscious, having trouble breathing, or having convulsions, give needed first aid immediately. Call 911 or your local emergency service.

If the person is awake, conscious, not having trouble breathing, and not having convulsions, read the label for first aid instructions and contact your local Poison Control Center, physician, 911 or your local emergency number -- remember to act fast because speed is crucial! In most cases, the pesticide products label provides you with a "Statement of Treatment" to follow in emergencies.

Lead Poisoning⁹

Lead has long been recognized as a harmful environmental pollutant. In late 1991, the Secretary of the Department of Health and Human Services called lead the "number one environmental threat to the health of children and others in the United States." There are many ways in which humans are exposed to lead: through air, drinking water, food, contaminated soil, deteriorating paint, and dust. Airborne lead enters the body when an individual breathes or swallows lead particles or dust once it has settled. Before it was known how harmful lead could be, it was used in paint, gasoline, water pipes, and many other products.

Old lead-based paint is the most significant source of lead exposure in the U.S. today. Harmful exposures to lead can be created when lead-based paint is improperly removed from surfaces by dry scraping, sanding, or open-flame burning. High concentrations of airborne lead particles in homes can also result from lead dust from outdoor sources, including contaminated soil tracked inside, and use of lead in certain indoor activities such as soldering and stained-glass making.

Health Effects: Lead affects practically all systems within the body. Lead at high levels (lead levels at or above 80 micrograms per deciliter (80 µg/dl) of blood) can cause convulsions, coma, and even death. Lower levels of lead can cause adverse health effects on the central nervous system, kidney, blood cells. Blood lead levels as low as 10 µg/dl can impair mental and physical development.

Steps to Reduce Exposure:

- Keep areas where children play as dust-free and clean as possible.
- Leave lead-based paint undisturbed if it is in good condition; do not sand or burn off paint that may contain lead.
- Do not remove lead paint yourself.
- Do not bring lead dust into the home.
- If your work or hobby involves lead, change clothes and use doormats before entering your home.
- Eat a balanced diet, rich in calcium and iron.

The effects of lead exposure on fetuses and young children can be severe. They include delays in physical and mental development, lower IQ levels, shortened attention spans, and increased behavioral problems. Fetuses, infants, and children are more vulnerable to lead exposure than adults since lead is more easily absorbed into growing bodies, and the tissues of small children are more sensitive to the damaging effects of lead. Children may have higher exposures since they are more likely to get lead dust on their hands and then put their fingers or other lead-contaminated objects into their mouths.

⁹ Lead, The Environmental Protection Agency, www.epa.gov

Get your child tested for lead exposure. To find out where to do this, call your doctor or local health clinic. For more information on health effects, get a copy of the Centers for Disease Control's, Preventing Lead Poisoning in Young Children (October 1991).

Secondhand Smoke¹⁰

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, pipe, or cigar, and the smoke that is exhaled from the lungs of the smoker. Secondhand smoke is also called environmental tobacco smoke (ETS); exposure to secondhand smoke is often called involuntary smoking or passive smoking.

Why Should Homeowners Be Concerned About Secondhand Smoke?

- Effect on Lungs...people who breathe secondhand smoke are more likely to suffer from pneumonia, bronchitis, and other lung diseases.
- Ear Infections...people who breathe secondhand smoke can have more ear infections.
- Asthma...people who breathe secondhand smoke can have more asthma attacks and the episodes can be more severe. In fact, secondhand smoke is believed to cause thousands of healthy children to develop asthma each year. Infants and very young children who breathe secondhand smoke are more likely to get lung infections, resulting in thousands of hospitalizations each year.

What Can I Do to Reduce Health Risks from Secondhand Smoke?

- Choose not to smoke in your home and don't permit others to do so.
- Choose not to smoke if children are present, especially infants and toddlers. They are particularly susceptible to the effects of passive smoking.
- Don't allow baby-sitters or others who work in your home to smoke in the house or near your children.
- Choose not to smoke in your car.
- Find out about the smoking policies of the day care providers, pre-schools, schools, and other care-givers for your children. Help other parents understand the serious health risks to children from secondhand smoke. Work with parent/teacher associations, your school board and school administrators, community leaders, and other concerned citizens to make your child's environment smoke free.

Where Can I Get More Information on Secondhand Smoke?

All of EPA's publications are available from the: National Service Center for Environmental Publications (NSCEP) <http://www.epa.gov/ncepihom/> (to order EPA documents online)

Or call 1-800-490-9198/(513) 489-8695 (fax), or write to:

U.S. Environmental Protection Agency
National Center for Environmental Publications (NSCEP)
P.O. Box 42419
Cincinnati, OH 45242

¹⁰ Secondhand Smoke, The Environmental Protection Agency, www.epa.gov

Indoor Pollution ¹¹

Indoor pollution sources that release gases or particles into the air are the primary cause of indoor air quality problems in homes. Inadequate ventilation can increase indoor pollutant levels by not bringing in enough outdoor air to dilute emissions from indoor sources and by not carrying indoor air pollutants out of the home. High temperature and humidity levels can also increase concentrations of some pollutants.

Pollutant Sources

There are many sources of indoor air pollution in any home. These include combustion sources such as oil, gas, kerosene, coal, wood, and tobacco products; building materials and furnishings as diverse as deteriorated, asbestos-containing insulation, wet or damp carpet, and cabinetry or furniture made of certain pressed wood products; products for household cleaning and maintenance, personal care, or hobbies; central heating and cooling systems and humidification devices; and outdoor sources such as radon, pesticides, and outdoor air pollution.

The relative importance of any single source depends on how much of a given pollutant it emits and how hazardous those emissions are. In some cases, factors such as how old the source is and whether it is properly maintained are significant. For example, an improperly adjusted gas stove can emit significantly more carbon monoxide than one that is properly adjusted.

Some sources, such as building materials, furnishings, and household products like air fresheners, release pollutants more or less continuously. Other sources, related to activities carried out in the home, release pollutants intermittently. These include smoking, the use of unvented or malfunctioning stoves, furnaces, or space heaters, the use of solvents in cleaning and hobby activities, the use of paint strippers in redecorating activities, and the use of cleaning products and pesticides in house-keeping. High pollutant concentrations can remain in the air for long periods after some of these activities.

Ventilation

If too little outdoor air enters a home, pollutants can accumulate to levels that can pose health and comfort problems. Unless they are built with special mechanical means of ventilation, homes that are designed and constructed to minimize the amount of outdoor air that can "leak" into and out of the home may have higher pollutant levels than other homes. However, because some weather conditions can drastically reduce the amount of outdoor air that enters a home, pollutants can build up even in homes that are normally considered "leaky".

Outdoor Air

Outdoor air enters and leaves a house by: infiltration, natural ventilation, and mechanical ventilation. In a process known as infiltration, outdoor air flows into the house through openings, joints, and cracks in walls, floors, and ceilings, and around windows and doors. In natural ventilation, air moves through opened windows and doors. Air movement associated with infiltration and natural ventilation is caused by air temperature differences between indoors and outdoors and by wind. Finally, there are a number of mechanical ventilation devices, from outdoor-vented fans that intermittently remove air from a single room, such as bathrooms and kitchen, to air handling systems that use fans and duct work to continuously remove indoor air and distribute filtered and conditioned outdoor air to strategic points throughout the house. The rate at which outdoor air replaces indoor air is described as the air exchange rate. When there

¹¹ What Causes Indoor Air Pollution?, The Environmental Protection Agency, www.epa.gov

is little infiltration, natural ventilation, or mechanical ventilation, the air exchange rate is low and pollutant levels can increase.

Indoor Air

Health effects from indoor air pollutants may be experienced soon after exposure or, possibly, years later.

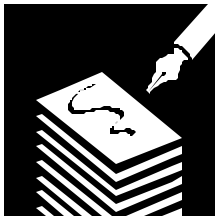
Immediate effects may show up after a single exposure or repeated exposures. These include irritation of the eyes, nose, and throat, headaches, dizziness, and fatigue. Such immediate effects are usually short-term and treatable. Sometimes the treatment is simply eliminating the person's exposure to the source of the pollution, if it can be identified. Symptoms of some diseases, including asthma, hypersensitivity pneumonitis, and humidifier fever, may also show up soon after exposure to some indoor air pollutants.

The likelihood of immediate reactions to indoor air pollutants depends on several factors. Age and preexisting medical conditions are two important influences. In other cases, whether a person reacts to a pollutant depends on individual sensitivity, which varies tremendously from person to person. Some people can become sensitized to biological pollutants after repeated exposures, and it appears that some people can become sensitized to chemical pollutants as well.

Certain immediate effects are similar to those from colds or other viral diseases, so it is often difficult to determine if the symptoms are a result of exposure to indoor air pollution. For this reason, it is important to pay attention to the time and place symptoms occur. If the symptoms fade or go away when a person is away from home, for example, an effort should be made to identify indoor air sources that may be possible causes. Some effects may be made worse by an inadequate supply of outdoor air or from the heating, cooling, or humidity conditions prevalent in the home.

Other health effects may show up either years after exposure has occurred or only after long or repeated periods of exposure. These effects, which include some respiratory diseases, heart disease, and cancer, can be severely debilitating or fatal. It is prudent to try to improve the indoor air quality in your home even if symptoms are not noticeable.

While pollutants commonly found in indoor air are responsible for many harmful effects, there is considerable uncertainty about what concentrations or periods of exposure are necessary to produce specific health problems. People also react very differently to exposure to indoor air pollutants. Further research is needed to better understand which health effects occur after exposure to the average pollutant concentrations found in homes and which occurs from the higher concentrations that occur for short periods of time.



Chapter Fourteen

Loss Control For Agents

The term “buyer beware” may have been around since ancient Rome, but it means little to the legality of insurance. Why? Because no matter how agents try to avoid it, they are principals to every insurance transaction. Furthermore, courts recognize the severity of “botched” insurance. Face it, an unsuspecting client, who on the advice of his agent buys the wrong retirement plan or building coverage is hurt a lot more than someone who buys a fake Rolex for \$20 on the street corner. Consequences to the agent for his negligent acts are similarly severe when one considers malpractice judgments in today’s litigious society. These are reasons why agents need to practice loss control for themselves and their agency.

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

Agent Responsibilities

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

Do You Cross The Line?

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

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

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

For the more lucrative cases, attorneys are pushing back. Others are looking for greener pastures . . . directions where there is less resistance. In the case of insurance conflicts, can you think of anyone these attorneys might pursue who might be easier to get at than a major

insurance company? Someone without staff attorneys, little time to spare and a lacking a huge legal pocketbook. Are there individuals who might fold quicker than a big insurer and “belly-to-the-bar” to settle a claim to avoid a long and protracted trial? If you haven’t guessed by now . . . **its you, the working insurance agent!** You could be the next victim of a clever attorney looking to cash-in on a quick settlement when something goes slightly astray with your client’s coverage.

Even if you are lucky enough to avoid a claim for now, every time another agent is sued, it gets closer to you because our court system makes **legal decisions based on precedents**. 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 (page 104) 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.

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

Agent Liability

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

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

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

Cases can be built around issues of legal conduct as well as sales conduct. Throughout this book you will learn the “triggers” that launch insurance related lawsuits. They can be as basic as failure to secure the type or amount of coverage requested by the client to more complex and

seemingly "blue sky" claims where clients demand recoupment of losses and damages simply because of a relationship that existed between agent and client. Other claims span the gamut from client losses due to an insurance company failure to refusal to pay a claim.

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

Agents who have never been sued are sometimes lulled into believing that the way they do business must be working. Unfortunately, this ignores the real possibility that the same events of the past, that weren't a problem, can now become a problem. It is a world of legal rights and little trust. The long-term client who you trusted, can change. Also, regulations change, industries change, economies change and no one can really keep up or control every aspect of their present business, let alone the future. Can you imagine, for example, the changes that will occur over the life span of a whole life policy between today and when it endows in fifty or sixty years? Will a state or federal regulation change the way automobile or health policy benefits are triggered? Will the IRS retroactively disallow tax benefits for 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 section, 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.

Basic Agent Duties

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

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

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

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

An insured is entitled to rely on an agent/broker's advice on the content and meaning of policy provisions. In **Perelman vs Fisher - 1998**, the insured sued an agent for not informing him about the lack of cost of living benefits even though the agent advised the insured to review the policy which clearly did not provide it. In **Stivers vs National American Insurance - 1957**, it is suggested that client reliance may sometimes be unjustified, as when the advice given by the agent "is in patent conflict with the terms of the policy".

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

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

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

simply promoted a **family insurance checkup**. A special duty might have been imposed if the agent held himself out to be an expert in umbrella coverage.

Another area of legal conduct involves the Law of Agency.

The Law of Agency

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

An **agency relationship** begins when agents are granted authority to operate by expressed, implied or apparent agreement. This can be **created by contract or agreement** or it can take the form of casual mutual consent. What is interesting about the business of insurance is that most agents start out as an agent for the client, when coverage is requested, and then become an agent for the company, when business is placed. As you will see later, the exact status you occupy when a problem occurs affects your liability exposure.

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

General Agents

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

Local Agents

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

Brokers

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

matters thereby aiding clients to secure a lower premium. In a sense, these brokerage firms act as insurance and risk managers.

Surplus Brokers / Agents

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

Solicitors

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

Marketing Organization & Clusters

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

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

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

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

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

In cases where the producer's status is unknown at the time a problem occurs, the courts have the difficult task of trying to determine **who initiated the relationship**. Here again, when in doubt the law leans to the assumption that the **majority** of insurance transactions are **agency relationships** even though the client may have called the insurance agent first. Otherwise, the mere fact that clients request coverage . . . which they do in virtually every instance . . . would establish a principal-agent status every time. The courts feel this is NOT an appropriate conclusion.

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

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

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

Producer status problems also occur when **unlicensed employees** of the agent are found to be doing the work of a licensee. A small mistake here can become a big deal (**Williams Insurance Agency vs Dee-Bee Contracting Co -1984**). You can be held responsible for any claim or

shortfall and it will likely void your errors and omission coverage. Insurance department sanctions, fines and possible revocation of license could also follow.

Agent vs. Broker

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

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

An insurance **broker** is "a person who, for compensation on behalf of another person, transacts insurance, ***other than life*** with, but not on behalf of, an insurer". Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer's agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file.

In **Kioutas vs Life Insurance Co of Virginia – 1998**, the agent was deemed to be a "broker" representing the insured to obtain the most suitable and affordable life insurance from among various insurers. Specific rules that determined this status included: 1) who set the agent in motion (who called the agent); 2) who controlled the agent's actions; 3) who pad the agent; and 4) whose interest did the agent represent.

Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance (**Maloney vs Rhode Island Insurance Company**).

Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them.

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

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

Where an agent is acting properly, a person wronged by an agent's negligence has a cause of action against the **principal or insurance company**, although this does NOT preclude clients from naming the producing agent also. Another general rule of agency law states that if an

insurance agent acts as the agent of a disclosed principal, the principal -- NOT THE AGENT -- is liable to the client (**Lippert vs Bailey - 1966**).

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

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

Agent vs. Professional

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

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

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

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAls, ARMs and more, who practice **due care** for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional

designations for fear that the added exposure can't be managed. Perhaps there is room toward the middle. A position we call **responsible agent**. These individuals also practice due care, yet operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but "pass" on outside inquiries, not because they don't know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

Contract Disputes

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

Failure to Act/Procure Coverage

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

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

Failure To Notify Lack of Coverage

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

Failure To Place Coverage At Best Available Terms

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

Failure To Renew / Notify

If an agent has a history with a client of automatically and voluntarily renewing or reminding them to renew a policy, he can assume exposure for the "one and only" time he forgot (**Siemorama vs Davis Manufacturing Co - 1988**). With the trend toward "direct billing" of clients by insurers, agents are not as close in contact as before. However, agents may still have renewal responsibility if the client depended on this service in the past.

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

Other issues concerning breach of contract include the following:

Policy Promises & Provisions

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

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

Agent Promises

From time to time, agents make promises that EXCEED what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverages and exclusions. Agent liability also existed in a case where a producer promised to arrange "complete insurance protection" for a business or where an agent promised, but never did, to evaluate an appraisal of an individual's property or to determine its "insurable value" in order insure a certain percentage of that value. In **Blumber vs Paul revere Life – 1998**, the

agent went so far as to market **guaranteed disability insurance** to a company regardless of previous medical history. He was found liable for covering new employees.

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

Advertising Promises

Advertising violations are among the most costly mistakes. Regulators have been known to levy stiff fines of \$1,000 or more **per violation**. In other words, 1,000 non-compliant flyers distributed in the mail or otherwise could amount to a fine of **\$1 million or more** (\$1,000 X 1,000 flyers). 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**).

Agent Torts

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

Negligence & Misrepresentation

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

Bad Faith

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

Agents must remember that the number one reason that people purchase insurance policies through agents is for service. When an insured makes a request to procure coverage or turns in

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

In the property/casualty arena, many bad faith issues surface under the title of "claim avoidance". Some agents play judge and jury with client claims by advising them to NOT submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a breach of his fiduciary duty to the insured as well as a breach of the implied-in-law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages (**Independent Life & Accident Ins Co vs Peavy - 1988**).

Client / Agent Relationships

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

Contributory Liability

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

Lack of Client Knowledge

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

Improper Advertising

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

Dual Agency

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

Errors & Omissions Insurance

The availability and wide subscription of errors and omissions insurance for agents creates an argument that agents can be liability targets in any insurance disputes. In some cases, the absence of errors and omissions coverage has practically absolved the agent of liability where attorneys assume there is nothing 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 . . .

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 exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer. **Glenn vs Leaman & Reynolds - 1983**).

Another area of fiduciary responsibility concerns disputes dealing with **Employment Retirement Income Security Act (ERISA)** qualified funds. Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An **ERISA fiduciary** has been interpreted to be **any person exercising managerial control over the plan or its assets, regardless of their formal titles**. In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers be labeled ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries. The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that a commissioned agent who helps establish a retirement plan and recommends products to fund the plan violates these rules? The answer lies in whether the agent is actually deemed a fiduciary. **If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary. If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent's proposals without advice from other consultants, he can be classed as a fiduciary of the plan.** On the other hand, where the agent is only acting in the capacity of an agent, offering a choice of products from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan "relied" heavily on the agent's advice in the purchase of insurance contracts. In **Brink vs Dalesio - 1981**, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In **Reich vs Lancaster - 1993**, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In **Kerns vs Benefit Trust Life**, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible. In yet another case, a Louisiana district court held that an insurance agent was a fiduciary a profit sharing plan, even though he only **sold** a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (**Schoegal vs Boswell**), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was **"...clearly more than a mere salesman"**. In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that agent Boswell lacked the necessary authority and control over the plan investments and because there was no underlying agreement that his advice would serve as

the primary basis for investment decisions for the pension plan. While this is a favorable decision for agents, it demonstrates the extremes and aggressive legal action to which agents are vulnerable, **particularly if the insurance transaction does NOT produce the anticipated or desired results for plan participants.**

New fiduciary conflicts may also develop in the area of **Medicaid planning**. Agents who routinely counsel clients on methods of transferring assets so as 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 to five years in prison. Many agents recommend that clients purchase annuities, previously "exempt" in calculating assets that qualify for Medicaid. Under these new rules, if the payout of the annuity contract does not match the payout schedules established by the Department of Health (most don't) a disqualification of asset transfer and ineligibility period can be established. Look for future court cases here.

Insurer Claims Against Agents

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

Following are some examples:

Basic Agency Violations

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

Misappropriating Premiums

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

Failure To Disclose Risk Factors

An agent has a duty of good faith and loyalty to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss (**Clausen vs Industrial Indemnity - 1966**). In this case, it was successfully argued that an insurer may obtain indemnity from a broker, if the broker knows or should know that insurer is relying on the broker to supply information about the client; the information furnished is incomplete or incorrect; the incomplete or incorrect information is material to the decision accept or decline the risk; and the insurer is forced to pay a loss under a policy that the insurer would NOT have issued if complete and accurate information had been provided by the broker. In a similar case (**New Hampshire Insurance Co vs Sauer - 1978**), the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to the agent's negligence. In similar cases the insured sued the agent for failure to ask if the insured had been cancelled (**Smith vs Dodgeville - 1997**); or failed to indicate a known pre-existing heart condition (**Life Investors vs Young - 1999**); or failed to accurately disclose a client's prior loss history (**Soho Generation vs Tri City Brokers - 1998**).

Failure To Cancel or Notify of Cancellation

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

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

Authority To Bind

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

Legally, the agent possesses the powers that have been conferred by the company or those powers that a third party has a right to assume he possesses under the circumstances of the case. In **Troost vs Estate of DeBoer - 1984** the agent exceeded his binding authority yet his

acts and representations were relied upon by the insured. The agent was held liable for the insurers' losses.

Premium Financing Activities

Frequently, brokers play a role in helping clients finance their insurance premiums by bringing the insured and the financing entity together. There have been cases where the financing company has been the victim of fraudulent schemes misleading them into issuing loans to nonexistent insureds. In an effort to recover its losses, the financing entity may look to the insurer on grounds that the broker was acting on the insurer's behalf in arranging the financing, even though the insurer may not have given the agent explicit authority 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 by Insurance Company Failures

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

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

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

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

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried and a trend is developing that places greater legal responsibility on agents concerning insurer insolvency. In **Wilson vs All Service Insurance**, for example, the client commenced a lawsuit in 1975 and even though the agent prevailed, the decision was not rendered until 1979 -- that's four years of attorney and court fees! So aggressive was the client that two different appeals the State Supreme Court were attempted involving more defense fees. One must also ask . . . If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies **REFUSE to defend and REFUSE indemnify** agents where an insurer insolvency arises?

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

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

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

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

In addition to these known precedents and cases, agents are continually subjected to harassment suits from disgruntled clients and others that are settled out of court. Because these settlements are not published, it is impossible to know the depth and breadth of the problem. Most agents, however, know someone or has had some personal experience realize they occur frequently. One such case involved an Oregon couple who invested their \$26,000

retirement fund in an annuity with Pacific Standard Life in 1987. About three years later, they attended a financial planning seminar where they learned that their insurance company had been taken over by the California State Insurance Department due to losses in "junk bond" holdings. The couple immediately demanded a surrender of their policy. Of course, they were blocked from withdrawing their money by the conservators and the six-month payment delay provision in their policy. Seven months later they received a check for about 70 percent of their annuity value. The agent was threatened with legal recourse to pay the deficiency. After weighing the possibility of a lengthy court case and to keep an action from going public, the agent agreed pay. From the above court recitals, this agent clearly had no exposure. The least path of resistance, however, was to pay the client and move on. Fortunately, the dollars involved were controllable. But what of the situation where multiple clients are seeking reimbursement or the numbers are significant? The answer is not easy to predict, but the solution involves a multi-faceted approach to managing exposure while still providing service.

Misrepresentation & Insurer Failures

Insurer insolvency cases against agents may be based on ***misrepresentations*** by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds. An even worse situation occurs where an agent knowingly distorts actual capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a ***detailed investigation*** of the insurer when, in fact, he did not. Examples where agent liability is not so clear, however, include cases where an agent convinces a client to surrender or cancel a policy from one company for a policy of another company and it is determined that the second insurer is weaker and maybe even be liquidated at some later date. In this instance, the law might interpret the agent actions to be more than just a "usual transaction", where a policy product is simply "sold". Here, the agent acted more as an ***advisor***. His actions might appear to be assurances that the new company is better than the old company when, in fact it was not, for purposes of generating a commission.

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

Claims of Regulation by the State Insurance Department

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

Claims of Minimum Capital and Surplus Requirements

"Among the requirements imposed by state laws are minimum capital and surplus requirements. These provide that an insurer or reinsurer will not be allowed to do business unless it is adequately capitalized and has sufficient available surplus funds with which 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 an 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 periodic audits of the company they reinsure. Finally, an annual audit is also conducted by a public accounting firm."

Claims of Statutory Accounting

"In reporting to 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."

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

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

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

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

industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."

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

Congress has also chimed in by suggesting that:

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

Why Insurance Fails

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

What goes wrong?

Coverage Shortfalls

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

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

Coverage Disputes

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

One form of coverage dispute results when the agent fails to secure the promised coverage (**Bell vs. O’Leary - 1984**). The courts have found that when an insurance broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client’s agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

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

Legal Maneuvers -- Attorneys at Work

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

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

Another valuable source used by attorneys is ***reinsurance documents***. Communications between an insurance company and its reinsurer can provide information on whether and how policies may apply to underlying claims and may offer assessment of the insurance company’s

coverage obligations. Access to reinsurance documents is a hotly contested issue in insurance litigation discovery, and some courts have refused access to such documents.

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

Agent Records

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in **the ordinary course of business**. In other words, if you use as operations manual or stick "post-it" notes in you client files as **standard operating procedure** they are generally admissible. The test will be: Do you use these methods for **every** client? An example might be a standard checklist of coverages that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available.

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

Agent Cooperation

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

Insurance Litigation

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

Triggers of Coverage

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

In a life policy, the trigger seems clear: death. However, issues of whether the death was an accident or suicide within the incontestable period is often up for debate. Disability and health policies, however, have a higher propensity for dispute: What is a permanent disability? Are

there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In long term care policies, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient's inability to care for himself: the prerequisite for insurance benefits.

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

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

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

Definitions

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

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

Property Damage - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property 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 proceeds.

Rules of Construction

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

Duty to Defend

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

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer. A **PRP letter (Potentially Responsible Party)**, received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple *demand letter* which only exposes one to a potential threat of future litigation.

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

Breach of Contract / Refusal of Coverage

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

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

Bad Faith

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

Choice of Law / Venue

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

Lost Policies

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

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

Environmental Litigation

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 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.

In more recent years, new court cases are again changing interpretations of CGL. Past court cases held that CGLs covered only those liabilities arising from torts. The new precedents (**Vandenberg vs Devonshire**) now say that CGLs cover BOTH tort and contractual liability. Experts say that this decision has far-reaching negative effects on insurers across the country.

Excess Insurance Claims

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

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

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

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

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 an life

insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to disclose a medical condition that is critical to the insurer's risk decision.

The burden of proof as to fraud in concealment falls on the insurance company. In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was NOT made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information. Again, the issue of bad faith enters the picture. Only when the insured conceals a fact in bad faith, **knowing the fact to be material**, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for what causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered **material** and grounds for avoidance 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 avoidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to **facts, and not to mere fears or concerns** of the insured about his health or the subject matter of the policy. There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

Misrepresentations

A representation by the insured that is **untrue or misleading, material** to the risk, and is **relied** upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for avoidance 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 avoidance 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 avoidance could occur when the insured has reason to believe that the agent will not pass information on to the insurance company.

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

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems

is where such representations are made with the intent to deceive and defraud. The burden of proving a representation *to be material* falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

Warranties & Conditions

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

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

Limitations on Coverage

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

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

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

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

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

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

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

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

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

Settlement Disputes

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

Reproduction Cost Less Depreciation

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

Market Value

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

Insurer Insolvency

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

If an insurer is liquidated, all policy owners and other potential claimants **MUST** be informed and permitted to file a **proof of claim** with the insolvent estate. These claims will then be evaluated and a value established. Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

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

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

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

State Guaranty Funds

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

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

Exclusions

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

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

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

Limits of Protection

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

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

Other states, like Alabama, still follow an older model act and guaranty benefits of impaired or insolvent insurers domiciled in their own state, no matter where the policyholders live, and also

cover their own residents who are policyholders of licensed companies domiciled in other states, unless coverage is provided by the state of domicile.

Dollar Limits

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

Life and Health Guaranty Funds

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

Property/Casualty Guaranty Funds

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

Triggers

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

Coverage Options

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

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

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

Reinsurance

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

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

Reinsurance Defined

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

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

Sources & Reasons For Reinsurance

Reinsurance can be obtained through **three distinct sources** : professional reinsurers, reinsurance departments of primary insurance companies and unauthorized alien reinsurers. The insurance premium charged policy holders by insurers includes the cost of reinsuring the risk. In other words, there is **no added charge to the policy holder**. The primary company calculates the premium on a gross basis and all reinsurance expenses are incorporated in the premium. The insurer has the responsibility to evaluate the risk in its totality and to price the risk according to the potential loss exposures. The distribution of the **reinsurance premium**

between the insurer and the reinsurer is a separate transaction which ***does not involve the policy holder.***

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

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

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

Another approach often used by companies to limit their potential liabilities attempts to cap the aggregate losses which may be sustained over a specific period -- say one year -- either with respect to its total combined losses for the period or the combined losses for certain lines of insurance. The important reason an insurer may want to purchase aggregate loss reinsurance is to stabilize its operations from year to year.

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

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

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

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

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

Limitations of Reinsurance

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

Regulation of Reinsurance

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

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

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

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

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

Managing Conflicts

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

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

Step 1

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

Step 2

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

Step 3

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

Step 4

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

Step 5

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

Step 6

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

Step 7

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

Step 8

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

Step 9

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

Step 10

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

Now let's expand on some of these steps:

Know Your Agent Responsibilities

The Agent & Client Duties

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

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

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

The Agent & Company Duties

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

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

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

Agent Integrity

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

Qualifications

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

Lack of Business Skills or Reputation

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

Activities Circumventing The Law

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

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property. Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted. In **McConnell vs. Ehrlich (1963)**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers 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 and Marketing Practices

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

Applications

Proper attention to the completion and submission of applications cannot be stressed enough. Spend at least 50% more time than you do now on applications. Mistakes by you or a client can void, decline or reduce coverage. Be accurate, timely and explain to clients the serious nature of misrepresenting information they provide. **Tip:** Use mini-disclosures in applications to note the source of suspicious information or to justify your reasoning, e.g., if you are basing an exchange on an IRS code, include the code section in the application.

Concealment

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

Presentations, Illustrations & Quotes

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

Misrepresentations

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

Twisting & Churning

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

Redlining

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

False Claims

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

Unfair Business Practices

It is a violation in most states for agent/brokers to fail to act promptly and in good faith regarding an insurance claim, fail to confirm or deny coverage applied for within a reasonable time, dissuade a claimant from filing a claim, persuading a client to take less of a claim than he or she is entitled to, fail to inform and forward claim payment to a client or a beneficiary, fail to promptly relay reasons why a claim was denied, specifically advise a client NOT to seek an attorney when seeking claim relief, mislead clients concerning time limits or applicable statutes of limitation concerning their policy, advertising insurance that the agent does NOT have or intend to sell, use any method of marketing designed to induce a client to purchase through the use of force, threat or undue pressure, use any marketing method that fails to disclose (in a conspicuous manner) that the agent is soliciting insurance and/or that an agent will make contact.

Policy Replacement (*Certain states*)

Agents must clearly disclose in writing, signed by the client, their intention to replace insurance with a new policy and that the existing insurance will lapse, be forfeited, surrendered or terminated, converted to a paid-up or reduced paid-up contract, etc. A copy of this

"replacement notice" shall be sent to the existing insurer (by the new insurer). Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement.

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 ethics. Take the case of **Grace vs Interstate Life (1996)**. An agent sold his client a health insurance policy while in her 50's. After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court did not look favorably on the agent's lack of duty to notify his client.

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

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

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

Disclosure

Client Disclosure

Without a proper disclosure of facts and terms, it will be impossible for your clients to make informed decisions. Not surprising, failure to disclose important policy or product information is a major area of conflict leading to denied claims and lawsuits involving agents and insurers alike. What can you do to minimize disclosure conflicts? First off, make sure you tell the truth;

the whole truth; and nothing but the truth when selling product. To make sure that you clients have understood what you said, develop a standard procedure (backed up in writing) of asking the **3 closing questions**:

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

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

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

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

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

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

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

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

Insurer Disclosures

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

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

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

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

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

Agency Relationship

Without specific contractual ties, the agent's primary duty to the insurer is to collect premiums and 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.

Ratification

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

Errors & Omissions Insurance

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

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

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

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

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

Exclusions

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

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

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

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

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

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of **even one** protected client claim and any subsequent judgement requiring an agent to pay any deficiencies and possible attorney/court fees. The cost of the average errors and omissions policy is cheap when compared to these costs.

If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy **options** that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits (\$1 million minimum), the availability of prior-acts coverage and coverage carrier solvency.

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

E&O Claims

If you feel you have a potential errors and omissions claim, you should first review your policy to follow the reporting requirements that need to meet. Most E & O carriers want you to report an

incident right away. However, it is important to know what your company determines to be an "incident". Is it an actual claim? Is it a threat of a claim? If in doubt, you might want to call the company anyway and discuss it with them.

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

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can't afford to "prejudice" your case in any way. Violating this errors and omissions contractual promise is the sure way for coverage to be canceled.

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

Office Protocol

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

Put It In Writing

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

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

Automated Equipment

Computers and the diary capabilities they present provide up-to-date documentation that can be used to verify an agent's defense. Electronic "date-stamping" can also be valuable as can fax

messages concerning any client/agent contact concerning the dispute. We use a program called "Maximizer" which allows a quick location of a client file and fast entry of the conversation. Retrieval is a snap.

Applications For Insurance

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

The Agent's File

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

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

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

Correspondence

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

Operations Manual

As you read above, **standard operating procedures** are steps that you follow consistently in selling and serving 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. Chapter 2 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.

The Agent Call Center

Some of the biggest conflicts with customers occur over communication or lack thereof. And, the problem compounds as the world finds more ways to communicate. The insurance client of the new millennium may wish to reach you in several ways . . . phone, cell phone, PDAs, voice mail, fax, mail, e-mail, internet text chat, and voice over Internet protocol. Truly, this is an era of

the "multi-channel" customer experience. As an agent who wants and needs to serve his customers, there is little you can do to keep from participating in some or all of these communication systems. However, there is much you must do for proper loss control.

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

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

Principles of Communication

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

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

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

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

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

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

Telephones

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

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

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

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

- Hire customer service people who have insurance knowledge and a pleasant phone voice. Clients are more likely to trust a friendly, confident person on the other end of the line over one who is abrupt, uninterested or combative.

Cell Phones

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

Automated Messaging

Answering machines and voice mail systems are inexpensive methods to take calls in your absence. Newer systems are capable of documenting the time and date a call was received. However, all such systems are capable of breaking down when you most need them and/or distorting a message. Answering machines in an agency should not take messages. They should be limited to listing agency hours and an emergency number if needed. If you use one, your outgoing message should clearly state that your machine does not take messages. Claims and coverage issues must ONLY be handled during normal business hours with a "live" person.

Fax Messaging

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

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

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

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

Online Communications

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

Online communications are evolving rapidly. Unfortunately, customer care is moving at a much slower pace. Recent studies, for example, have found that only a small percentage of

customers who sent an e-mail regarding an inquiry or purchase receive a follow-up e-mail. The same customer who telephoned their agent would be outraged to NOT receive a return call. To avoid this, your **e-mails should be treated like a phone call**. Check them often and return them promptly.

E-mail messages and correspondence is fast replacing written memos, faxes, 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. That is why it is imperative to have *use guidelines* for E-Mail.

For liability purposes, all parties who have access to E-Mail in your company should apply good judgment. They should communicate with E-Mail as they would in a public meeting. Sensitive information should be encrypted to protect it from being transmitted via the Internet. For the best protection, use software that requires passwords.

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

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

Customer Handling

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

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

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

- A **totally satisfied customer** contributes 2.6 times as much revenue to a company as a *somewhat satisfied customer*.

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

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

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

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

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

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

What Is Customer Satisfaction

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

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

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

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

Better Service

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

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

Handling Tough Customers

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

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

If Customers Leave

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

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

Never Say . . .

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

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

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

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

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

"I don't know . . . "

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

Elements of Good Service

Following are the elements of good service.

- Reliability. Consistent service the customer can rely on.
- Quality performance. Make sure you do things well.
- Worthwhile outcome for the customer.
- Overall service. The ability to provide good service in **all** your dealing with clients.

Poor Service

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

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

Best Practices

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

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

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

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

1. **Focus on customer service and satisfaction.** This means not only providing good service but looking into what the customer needs and expects.
2. **Maintain good customer contact.** Best Practice agencies use customer contacts to educate the customer, serve as the client's advocate and problem solver, and make every transaction as easy as possible. They also tend to be pro-active on pricing and introducing new products
3. **Valued staff.** Agencies' staff are continuously provided education, training and tools to do a good job. The expectation of high performance and professional growth is often rewarded with recognition, better salaries and better benefits.
4. **Participatory management.** Top managers are very active in day-to-day operations. Managers regularly seek employee input, especially about planning and budgeting processes. Fiscal information is not a secret and profit expectations are clear.
5. **Vision.** Best Practice agencies have a very clear vision of where they are and where they intend to go in the future.
6. **Win/Win supplier relationships.** Successful agencies seek to do business with companies that have a vision and embrace values like theirs. A Best Practice agency engages in joint planning.
7. **Efficiency.** Though not all agencies are completely automated, use of efficient processes and systems is common. Best Practice agencies strive to improve work flows to add value for their customers.
8. **Total account development.** Best Practice agencies seek to grow through total account development. They are looking to develop a larger share of the customers' accounts.
9. **Continuous improvement.** These agencies constantly work to improve themselves. They measure and compare themselves to peers and their own past performances.

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

Customer Retention

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

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

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

To keep more of your customers sticking around longer, with fewer complaints, you need to invest in a system of **customer retention.** This goes beyond simple customer servicing or a monthly newsletter. It means building a relationship with clients and giving them the

encouragement to remain active in choosing your business. The ultimate goal is keep them happy and involved long enough that their devotion to you is ingrained. Who would think of leaving a trusted advisor or friend?

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

How do you get to know customers and what do you do with the results? Conduct a customer satisfaction survey and compare the results with the length of time each customer has been with your agency. Ideally, you may also have some information in their file as to how long they were with their previous agent as well. Once gathered, you should be able to use this information to classify your clients into specific categories as follows:

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

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

Communicating and Keeping Customers Involved

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

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

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

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

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

Matching Client Needs With Product

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

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

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

Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as you will see in this chapter. Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. 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 life, 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 waived? If waived, 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, otitis 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 counseling, 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"

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 importance 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?

Long Term Care Insurance

Long-term care is the kind of help your client needs if he is unable to care for himself because of a chronic illness or disability. Most policies and state regulations define a “chronically ill” individual as someone unable to perform at least two activities of daily living for a period of at least 90 days and/or someone who requires “substantial supervision” to protect themselves from threats to health and safety due to severe cognitive impairment. Long term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

The long term care continuum is the ever-expanding and multi-faceted range of services needed by the long term care market. Today’s continuum might consist of the following:

Chore services: Volunteers buy groceries, mow lawns, vacuum, run errands, etc.

Home visitors: Meals-on-Wheels, story reading, companionship, etc.

Senior centers: Social activities, dances, bus tours, etc.

Adult day care: Daytime activities, lunches, therapy, games, etc.

Home health care: In-home services by nurses, physical therapists and dieticians, etc.

Rehabilitation programs: Provide extensive physical therapy, occupational therapy and speech therapy.

Respite care: Individuals provide relief to aid primary caregivers.

Retirement housing communities: For the independent elderly, offering individual units, security, social activities, etc.

Continuing care communities and centers: Designed to meet residents’ changing needs from retirement housing through skilled care.

Assisted living centers: Offer medical attention, as well as assistance with eating, bathing and other activities of daily living.

Nursing facilities / skilled nursing: Provide intensive nursing care around the clock.

Subacute care: Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.

Acute care: Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.

The continuum is in a constant flux as it responds to new terms, new legislation, coverage limitations, medical breakthroughs and other market-driven demands. Similarly, long term care policies, both old and new, must be placed in the context of continuum changes. Residential Care Facilities and Adult Day Care, for example, are increasingly covered in today’s newer policies. Earlier policies restricted benefit payments to only those facilities that offered Adult Day Care, a much more restrictive definition. Another example is policies that covered home care, but required that services were needed because the person would require institutional care without them. Agents need to understand how the policies they offer relate to Continuum

of Care services in from the standpoint of policy triggers, ADLs, mental deterioration, etc. This can only be accomplished by evaluating individual policies and client needs.

Essential Long-Term Care Policy Questions

- ✓ Is the benefit amount enough to meet the cost of local nursing homes? Costs can range from \$90 in the mid-west to \$300 in New York City. Be sure to advise clients that costs may exceed benefits.
- ✓ Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs? Most policies are indemnity plans which can cover incidental costs versus reimbursement contracts which cover actual costs. Reimbursement plans generally pay less, but cost less.
- ✓ What is the daily benefit for home care and assisted living? Typical policies cover these conditions at 50 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.
- ✓ Can benefits be used as a pool of money for both nursing and assisted living / home care? A pool of money may use the maximum benefits of the policy sooner but at least the cost of BOTH assisted living and home care is covered for the meantime.
- ✓ Can the benefit amount be increased later? If so, will underwriting be required? This can be a valuable option for meeting unanticipated care down the road. However, added benefits are usually associated with higher premiums, especially if the new insurance is written at the insured's attained age.
- ✓ Can the benefits be decreased if the cost of the policy becomes too much to pay? Coverage will drop, but at least some benefits will be paid.
- ✓ Can benefits be purchased jointly for a married couple? The discount is typically 10 to 15 percent
- ✓ Is a survivorship benefit available? Some insurance policies that cover both spouses have a "survivorship" benefit. Under a survivorship benefit, when one spouse dies, the other owes no further payments, as long as the policy has been in force for at least ten years.
- ✓ Will benefits be paid if the caregiver is a friend or family member? What about caregiver training? Some policies allow this under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.
- ✓ How much does home care coverage add to the premium? Home care benefits are typically one-half the nursing home benefit but could raise premiums by 30 percent or more. Policies where home care benefits equal nursing benefits will probably increase rates about 50 percent.
- ✓ Is the premium for benefits more than 5 percent of the client's income? Some industry analysts believe that the cost of long term care should not exceed this threshold.
- ✓ Are premiums guaranteed to stay level? It's doubtful. Clients should know that rates can increase by state residency or by class of policyholder. Some say that clients should prepare for an average 50 percent increase over time. Remember, extremely low premiums today, might guarantee rate increases later.
- ✓ Is there a limited pay or "paid-up" feature? Nonforfeiture or paid-up features are an option that clients should know about. They can be expensive now but useful later, e.g., a working couple with strong income today can retire with a paid-up policy.
- ✓ Is there a restoration of benefits clause? If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.
- ✓ Does the insurer count days or years? Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.
- ✓ Do benefits paid through an HMO count as a full day? Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.

- ✓ Do home health care and adult day care benefits pay for a full day? This can be important to the relief and effectiveness of the primary caregiver.
- ✓ Do nursing home / home health care benefits increase automatically? Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of \$110 per day today will run up to \$513 in 20 years at 8 percent inflation.
- ✓ Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed? No one knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.
- ✓ Is there a “cap” on the amount benefits can increase? Beware of companies that “cap” their inflation increases to two or three times the base benefits.
- ✓ Are future benefit increases available on demand? Some policies offer the option to increase benefits every so often at the client’s attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.
- ✓ What kind of inflation protection is offered? Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of \$110 today will grow to \$292 in 20 years at 5% compounded vs \$220 under 5% simple.
- ✓ What is the cost of waiting to buy inflation protection later? Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only \$770 today for a policy with optional increases compared to \$1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over \$5,000 compared to the same \$1,598 for automatic benefit increase protection.
- ✓ If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels? Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.
- ✓ Are bathing and dressing on the list of daily activities? If a bathing or dressing disability is a trigger of coverage, policyholders will have a much easier qualification and will qualify sooner since these are two of the first daily activities that chronically ill people are likely to fail.
- ✓ Are activities explained in different ways than other policies? Some define an eating disability as the inability to feed oneself while another may define it as the need for someone to watch over the party eating. Look for clarification on all activities of daily living as well as terms like: assisted living, walking or wheeling, cognitive impairment, ambulating, transferring, etc.
- ✓ Does the policy assess physical activities on a “standby” or “hands-on” basis? IRS 97-31 rules clarify the difference: “Hands on” assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL. More on this in Section 6.8. Suffice to say, policies that cover only individuals requiring “hands-on” assistance would generally provide fewer benefits than one that included “standby assistance”.
- ✓ Will the policy pay on a “medical necessity”? Patients can be too frail to care for themselves from a medical condition like coronary disease, yet still able to perform daily activities. “Tax qualified” plans do not recognize medical necessity.
- ✓ Are there special underwriting definitions? One company uses the term “standard” to describe its worst class. For another, it means mid-grade.

- ✓ Is there “lifestyle” underwriting that will automatically cause an application denial? One company says that anyone who needs assistance with housekeeping, shopping and household finances is simply unacceptable.
- ✓ Does the policy require special equipment installation before benefits can begin? Some insurers may require the insured to install grab bars or a shower stall in place of a tub before they will pay benefits. These restrictions are not favorable to the policyholder.
- ✓ What are the measures of cognitive impairment? Look for methods that fairly measure cognitive impairment using terms like thinking, reasoning, remembering, memory, etc. HIPPA provisions measure cognitive ability based on whether the individual needs “substantial supervision” to protect himself from threats to health and safety.
- ✓ Is cognitive impairment measured separately from physical measures of ability? A company that uses physical methods to determine cognitive assessment may overlook people who can pass the test or perform daily activities but forget how or why they did them. Worse yet, their mental impairment could become a threat to how they do them in the future.
- ✓ Does the policy pay for home care alterations? Some will pay for stair lifts, ramps, grab bars, etc; allowing an insured to receive care at home.
- ✓ Is there a return of premium or nonforfeiture option and how much does it cost? Clients are always concerned about paying insurance premiums and getting nothing in return. Offering them this option may increase premiums by 30 to 50 percent, but they will be certain to get something out of the policy.
- ✓ Is there a vesting schedule on any return of premium? Return of premium riders typically start or “vest” after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death.
- ✓ Determine how the policy’s nonforfeiture options work. Nonforfeiture options will either return premiums or pay benefits. The benefit may be purchased as “full” (it accrues regardless of claims paid) or “limited” (claims are subtracted from any premiums or benefits paid).
- ✓ Nonforfeiture and return of premium options may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options represent a potential loss in the time value of money.
- ✓ Is there a cognitive reinstatement option? Where mental impairment has set in, policyholders may forget to make premiums payments and risk cancellation. This clause allows reinstatement for up to five months so long as all back payments and proof of cognitive impairment is made.
- ✓ What about other useful policy features? Some examples of options to discuss with clients include bed reservation (If an insured goes home, bed space is reserved in case he returns within a specified period) for nursing homes, waiver of premium, respite care and survivorship benefit.

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

Clients 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

Clients 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 need 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?

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, lightning 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.

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 the insurer to pay a claim?

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, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

Liability & Liability Exclusions

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

Auto Insurance

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

Policy Limits

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

Policy Eligibility

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

Policy Conditions

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

Policy Endorsements

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

Policy Exclusions

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

Policy Effective Date

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

Named Insured

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

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

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

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

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

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process, i.e., *you have more control over the sales process and less compliance.*
- Sales conduct violations drive up the cost of doing business which could effect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation, i.e., *violations can mean less money.*
- Sales conduct problems erode the public trust and *that can cut into your sales.*
- Sales conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

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

Ethical Selling

Do you think you're an honest agent? Could you prove it to a jury? What would your mother say about your sales practices? In the end, how will you judge your sales career? By how much money you made? By how many customers you helped? By what you accomplished for your family and your community? The answer lies within you. And, you are not alone if you are

not 100% sure. There are many people and industries trying to grapple with the solution to "truth in selling".

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

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

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

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

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

- The capital needs of a family are met by a \$1 million life insurance policy when the breadwinner dies prematurely
- The estate of an entire family is left intact because an umbrella liability policy sheltered against a major accident claim
- A business is able to survive after the death of a partner because a life policy payment provided necessary capital to replace the devastating loss
- The retirement plans of a once young married couple are made possible through investments in pensions and annuities
- The owner of income property financially survives a major fire because his liability policy included "loss of income" provisions
- A family survives a mother's long term bout with cancer because their health insurance carried a sufficient "lifetime" benefit

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

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

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

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

Ethics From The Start

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

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

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

Ethics For Life

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

Ethics From Education

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

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

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

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

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

Integrity

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

Qualifications

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

Lack of Business Skills or Reputation

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

Activities Circumventing Laws

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

Agent Dishonesty

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

Catchall Category

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

Business Conduct

Business conduct is the behavior you ***chose to uphold*** to be a better agent. It is also a great tool for loss control. Business conduct involves more than legal compliance and more than maintaining a code of ethics. Business conduct is the adherence to procedures that make you the most responsible agent you can be. As a positive side effect, following better procedures also helps mitigate the legal exposure you carry as an agent and should yield greater respect

from your clients. Ultimately, the combination of these two aspects will lead to a higher level of success in your insurance practice.

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

Solutions

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

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

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

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

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

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

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

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

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

Applications

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

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

Agents should ensure that the applicant understands the questions in the application and ask the prospective insured to read it to confirm that everything is answered correctly and completely. Only then should it be signed. Under no circumstances should applicants sign blank forms. In **Smith vs Dodgeville (1997)** the agent was sued for failing to answer a standard question on the application regarding "previous cancellations". The client indicated he would have answered the question truthfully if asked. In **Ward vs Durham Life (1989)** the agent assured the applicant that missing health history information on the application did not need to be disclosed. Coverage was denied.

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

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

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

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

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

Agency Agreements

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

Your agency agreement, if you follow its provisions, can protect your **agent status** in a lawsuit between your client and the insurer. Most insurers will attempt to focus or narrow the authority of agents to limit their exposure to agent wrongdoing. In practice, however, the law **generally** considers the agent and the insurer as one and the same so the insurer is the ultimate “deep pocket” for problems – in essence an **agency relationship** is established. While this may help to insulate, agents are regularly and routinely named in suits against an insurer. Agents are also sued by their own insurers looking for reimbursement for violations of agency agreements.

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

was approved and the courts made the agent responsible for the applicant's losses as those he was the insurer.

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

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

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

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

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

Communications

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

In practicing better business conduct, it is important that any communication with your client (written, verbal or electronic) be clear, complete and balanced in providing benefits, costs, limitations, and contract terms of products you present or service. Remember, even though people today are generally more sophisticated and have access to more information, most clients still have trouble understanding the terminology of insurance, determining appropriate

product and the amount of coverage to buy. They look to you NOT to make those decisions for them, but to guide them through the process so they can make informed decisions based on their own best interests.

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

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

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

Replacements & Exchanges

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

- Provide and **carefully review with the client** information to help the client understand the advantages and disadvantages of replacing an existing policy; and
- **Document why** the purchase of a new policy serves the client's needs and objectives better than does the maintenance of existing coverage

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

- Suicide or contestability limitations in a new policy
- Higher premiums for new coverage at current attained age;
- Diminished value of the existing policy where unpaid loans will be deducted
- New acquisition expense charges may result in lower future cash values (assuming the same face amount)
- New possible surrender charges

- Loss of privileges and options under the old policy which may not be available in the new one

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

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

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

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

Know Your Own Product

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

Disclosures

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

- Have I given you all the information you need to make a decision?
- Does this information or policy make sense?

- Is there something else I can answer for you to assure you that this is the right solution based on your needs and objectives?

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

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

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

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

Illustrations and Quotes

Agents should follow strict procedures when using illustrations, including:

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

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

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

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

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

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

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

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

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

Correct Coverage

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

The **Bayley vs Pete Satire (1987)** case is a prime example of what can go wrong. A client owned a bar-lounge and was assured by the agent that his business was "covered" by a policy purchased. The policy contained an ***exclusion*** for alcohol-related lawsuits. An accident caused by a patron of the bar caused a lawsuit to end up on the agent's doorstep. The court concluded that the agent was indeed negligent. In an extreme lesson, the judge also ruled that the agent was held liable for all ***future*** alcohol-related lawsuits until proper coverage could be secured. In another case, **Free vs Republic (1992)**, an agent was asked by a client if his homeowner policy limits were sufficient to rebuild his home. The agent assured the client they were. A subsequent fire and quote to rebuild proved otherwise. The client brought suit against the agent and his insurer for failing to inform him of the inadequate limits of coverage. Even though the courts held that the agent had no legal duty to advise the client about sufficiency of coverage,

once he elected to respond to the client's inquiries he acquired a special duty to use reasonable care.

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

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

Standard Procedures

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

- Create consistent and comprehensive steps for every sale. The offer of a special endorsement or rider, for example, should be offered to everyone and their acceptance or denial noted.
- Reduce oral agreements, scattered notes and conversations to a formal writing as soon as possible.
- Use automated equipment with database capabilities for up-to-date documentation and "date stamping" features.
- Note and file client needs and requests.
- Create a "follow-up" or "hot list" system for notifying clients about important dates, renewals and endorsements.
- Lay out set procedures for handling and logging phone messages, faxes, copies, e-mails, photographs, microfilm, proof of mailing receipts, records storage, etc.
- Review policies received to be sure they are meeting client needs.
- Complies with application and cancellation procedures with the ability to track notices sent.
- Provide quick, easy access to claim processing and claim procedures.

Mishandling Money

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

Underwriting & More

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

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

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

In another example, **Jarvis vs Modern Woodmen (1991)**, an agent encouraged the client to drop an incontestable policy and purchase a new policy even after being advised about certain mental and financial problems. When these facts were found missing from the application the new policy was cancelled leaving the client bare. The courts awarded \$500,000 in punitive damages.

These are all cases where agent knowledge of underwriting and facts of the case would have retained coverage for the client. There are also occasions where you need to assess underwriting facts and suggest a different tact. Take the case of “Mark”. His application for life insurance included several notes to recent tests run by his doctor. They include three routine enzyme tests: GGT, AST and ALT. Mark’s GGT test, which is the most sensitive to alcohol and accounts for 99% of most declines, was high. He claimed that he simply had too much to drink the night before. The AST and ALT tests, however, were also high indicating the

likelihood of liver impairment. Again, Mark had some excuse. Further, Mark had refused his doctor's request to take additional tests including a scope and liver biopsy. When clients refuse these tests it always results in an automatic decline, which is exactly what happened with Mark. The point is, if you know more about reading test results, you can better counsel your client on how to save further delays in processing (during which time he could deteriorate further). In this case, you could advise Mark that he is likely to be declined no matter how many times and how many places you submit his application. The problem with continuing is that something could happen in the meantime, leaving him no coverage at all. From here, your skill in placing him can depend on your knowledge of the impairment or suggest an alternative path like a different rating class or in Mark's case converting existing term coverage to permanent coverage without medical underwriting, etc. Look for the "tell-tale" signs and discuss them with clients instead of incurring repeated underwriting rejections.

Conditional Coverage / Binding Authority

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

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

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

Referrals

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

Insurer Solvency

Always verify the ***current financial condition*** of insurers at the time of coverage. There are clear and certain legal penalties for placing coverage with an insolvent insurer or for having knowledge of pending insurer problems at the time coverage is placed. More importantly, there are severe financial consequences for your client. In the **Moss vs Appell (1998)** case, the agent sold annuities to a client and placed them with a company that ultimately became insolvent. The client contended that the agent knew of pending problems with the insurer when he received a letter from them indicating they needed to find capital to bolster reserves. The courts determined that a breach of fiduciary duty had occurred. The agent's liability hinges on the outcome of the insurer insolvency.

Liquidity

Determining and abiding by the client's need for liquidity is a basic agent function. You need to practice reasonable care in the products you choose to be sure your client's liquidity is

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

Privacy

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

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

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

Policy Delivery

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

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

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

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

Complaints and Claims

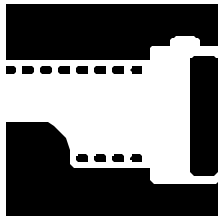
Quality customer service and customer satisfaction should be important to you. You must **take all customer concerns very seriously and be sure that you and your insurer resolve them fairly and quickly.**

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

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

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

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



Chapter Fifteen

Loss Control Beyond Insurance

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

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

The Need to Look Beyond Insurance

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

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

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.**

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 order it sold to receive the debtors share.

Tenancy in Common

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

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

Community Property

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

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

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

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

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

Partnerships

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

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

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

Corporations

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

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

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

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

Limited Liability Companies (LLC)

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

Trusts

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

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

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

Exemption Planning

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

Civil Codes

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

The Homestead

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

Personal Property

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

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

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

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 Medicaid will participate.

In addition to asset criteria, there are guidelines for income. Generally speaking, for a person to be eligible for Medicaid he must spend all his income -- Social Security, pensions, interest, dividends, and so on -- on nursing home care before Medicaid helps.

In other states, the income restrictions are severe. Income is "capped" at around \$2,000+ 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, for example, one person may be the sole Shareholder, sole Director and sole Officer of the company.

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

The Family Limited Partnership

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

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

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

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

- First, you may make pro-rata distributions from your Family Limited Partnership to the partners. Distributions will flow from the assets of the Family Limited Partnership to you or to your Revocable Living Trust, which would be recommended.
- Second, your Family Limited Partnership may pay a management fee to your Corporation. The amount of the management fee is determined by you and the terms of this fee can be

very flexible. Income from that fee can be used to pay a variety of corporate expenses such as salaries, employee benefits, retirement plans, etc.

- Third, your Family Limited Partnership can loan money to you, your spouse, or other family members. Repayment of the loan is effectively repayment to yourself.
- Fourth, the Family Limited Partnership is totally revocable by you, your fellow shareholders and Limited Partners at any time. In the unlikely event that you would ever need to dismantle and revoke the Family Limited Partnership, the Corporation or the Trust, it simply takes unanimous vote by you and your spouse to do so. If this happens, title of your assets can be transferred back to your direct ownership without penalties or tax consequences.

The Revocable Living Trust

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

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

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, it might be recommended that they be held by a Family Limited Partnership or Limited Liability Company as represented in the illustration.

What Does Multi-Entity Structuring Accomplish

Taxes

With respect to the Limited Liability Company from which the business is operated, a possible illustration might be a \$60,000 per-year net income being paid to the LLC from the operation of the business. From the \$60,000 net income, \$25,000 per year would be paid to the client in the form of a salary. The remaining \$35,000 would be payable to the client through a beneficial distribution of income from operations on either a monthly, quarterly or annual basis.

Without a Limited Liability Company, you would pay approximately \$9,180 in self-employment taxes based upon a \$60,000 per year business income at the current 15.3% self-employment tax rate as seen in the Figure.

With the implementation of the LLC and a beneficial distribution of \$35,000 per year, you would save \$5,355.00.

Utilizing a Corporation in the business plan allows the business owner to receive a variety of benefits through the Corporation. The expenses involved in providing such benefits may be deductible to the Corporation and not includable in the taxable income of the client. These benefits include health, accident insurance, payment of unreimbursed medical and dental expenses, disability insurance and group term life insurance. In addition, automobile expenses can be reimbursed and/or paid through the Corporation. The Corporation can also reimburse and/or pay the entertainment expenses made on behalf of the client or the clients family.

Pension Planning

Utilizing the corporate format, business owners can set up their own corporate pension plan which they can control as both the administrator and trustee. Therefore, the business owner or individual can contribute up to 15% of their net taxable income in said plan in any given year. Once the money is contributed to the plan, it grows tax-deferred but is completely taxable upon retirement.

The significant advantage of the Corporate Pension Plan is that the Internal Revenue Code allows for business owners to borrow from their own corporate pension plan of up to 50% of the pension plan assets not to exceed \$50,000. This benefit allows business owners to contribute 15% of their gross salary every year to a corporate pension plan and still allows said business owner to obtain a certain amount of liquidity with respect to pension plan contributions.

As you may be aware, there are certainly some problems with Qualified Pension Plans which include but are not limited to the following:

- ***PENALTIES FOR EARLY WITHDRAWAL***
- ***DISTRIBUTIONS MUST BE TAKEN AT AGE 70***
- ***DISTRIBUTIONS ARE FULLY TAXABLE WHEN THEY ARE WITHDRAWN***
- ***ANNUAL REPORTING AND ADMINISTRATIVE COSTS***
- ***QUALIFIED PENSION PLANS ARE ACCESSIBLE TO LAWSUITS AND TAX LIENS***

Alternative Pension Planning

Because of the problems above, Multi-Entity Planners offer alternative methods to better facilitate retirement planning. A highly recommended method utilizes various sections of the

Internal Revenue Code . . . specifically Sections 79,162, 419A(f)(6), 501(c)(9) and ERISA . . . a specific insurance product and trust to overcome the problem areas indicated above.

Alternative pension planning utilizes the concept of an Irrevocable Trust which receives all of the client's contributions. An employer's contributions are made to the Irrevocable Trust which is managed by a multi-billion dollar financial institution. The client's business has no control over the Trust nor does the owner have any control over assets until such time as the business owner decides to terminate his plan contributions and obtain it back on a tax-free withdrawal basis!

These pension plan alternatives allow business owners or other professionals to deduct 100% of their contribution as a business fringe benefit (expense) and receive 100% tax-free withdrawals (income)! This method also enables clients to enjoy the flexibility of early retirement as well as the comfort of knowing:

- **THE FUNDS CAN BE USED FOR OFFSETTING ESTATE TAXES**

Since the method of vesting is through an Irrevocable Life insurance Trust or Family Limited Partnership, the client does not personally own the contribution funds. As a result, upon the client's death, all contributions would be payable to the Trust or FLP and not the client's estate.

- **THE FUNDS ARE COMPLETELY PROTECTED FROM CREDITORS DURING THE ACCUMULATION PERIOD**

Statutory and case law protect the client's contributions. In addition, the Irrevocable Trust structure is considered virtually impenetrable.

- **THERE IS LITTLE OR NO ANNUAL REPORTING**

- **THERE ARE NO MANDATORY DISTRIBUTIONS**

Another area of concern that can be solved by using the alternative pensions is that of converting distributions from **EXISTING** qualified pension plans into totally tax-free withdrawals in your retirement years. Consult a professional in this area before making any decisions.

Estate Planning

Advanced Multi-Entity Structuring can provide the following estate planning advantages:

- The market value of your estate is lowered due to well-established principles granting discounts for lack of marketability and fractional ownership of an asset. You save up to fifty-five percent (55%) in estate taxes for every dollar your taxable estate is lowered through the implementation of a Family Limited Partnership. The Internal Revenue Service allows a minimum of a twenty-five to forty percent (25%-40%) discount on all the assets placed in a Family Limited Partnership. In a typical illustration, a \$2,000,000 estate could receive a 40% discount thereby excluding \$800,000 of assets from estate valuation. This \$800,000 exclusion would represent an approximate **\$400,000** in estate tax savings to the heirs of the client.
- The estate plan allows for lifetime gifts of Limited Partnership interests to your children, grandchildren, other loved ones or charities while you maintain control over the assets. You can begin to reduce your estate by making gifts of fractional interests in your Family Limited

your interest in your Family Limited Partnership or Business Limited Partnership. A charging order is similar to a garnishment of wages and requires that all distributions from your Family Limited Partnership which would have gone to you must now be paid to the third party creditor.

THE CHARGING ORDER CANNOT FORCE ANY DISTRIBUTIONS TO BE MADE FROM THE LIMITED PARTNERSHIP!

If you or your Corporation, as General Partner, decides not to distribute any income to the limited partners, then the creditor does not receive any money. At the same time, the **creditor is responsible for all of the income tax responsibility or liability** from the Limited Partnership. Assuming your Limited Partnership has taxable income and no pro rata distributions are made to the partners, the creditor becomes liable for “phantom income”. In other words, **the creditor must pay income tax on money earned by the Partnership but for which it did not receive any distribution.** This unfavorable result dramatically improves your negotiating position against any creditors and helps to level the playing field.

An asset protection plan developed by a professional provides the following asset protection advantages for your business and family:

- It shields your assets from the ever-expanding damage awards for personal injury and professional liability and it protects your assets from unfair or outrageous financial claims of

judgment creditors.

- It insulates your assets from the effects of death or bankruptcy of your co-guarantors, co-makers of debts and fellow General Partners. With the asset protection plan, the problems of your partners do not become your problems.
- It provides an entity you control to be the beneficiary of the estate from which you anticipate an inheritance. Parents redraw their Wills or Trusts to leave their estate not to their children directly, but to their children's Family Limited Partnership so that the children's inheritance is protected from creditors.
- It provides protection for your legacy. If a son or daughter is in a high-risk occupation, you can implement an asset protection plan and thereby leave your children a Limited Partnership interest as their inheritance. This protects the assets of the parents while they are alive and passes on the same protection to their children.

Charitable Remainder Trust Planning

Although most people do not think of gifting assets to charities, the gifting of assets to a Charitable Remainder Trust is oftentimes an effective tax avoidance and asset protection.

An advanced protection program designed by a multi-entity planner provides the following charitable advantages for your family:

- By transferring the family business, ranch, farm or other family asset into a Family Limited Partnership, a gift of a Limited Partnership interest to a charitable organization can be made while the family business, ranch, farm or other family asset remains intact to produce income for the benefits of all partners.
- As a Limited Partner, a Charitable Remainder Trust or organization has no control over the daily management of the Family Limited Partnership so that the family business, ranch, farm or other family asset may be operated essentially the same as before the transfer of Limited Partnership interest.
- The value of the Limited Partnership interest that is given to the Charitable Remainder Trust or organization can be taken as an immediate tax deduction on your current year's income taxes. In some cases, this may provide you liquidity that you previously did not have.
- By requiring the vote of all Limited Partners of the Family Limited Partnership and all the shareholders of the corporate General Partners, including the charitable organization, to liquidate the entities, you have optimized your potential to obtain a reduction in the valuation of your taxable estate.

In a typical case, a client could contribute \$1,000,000 in appreciated real estate to a Limited Partnership and thereafter gift Limited Partnership interests to a Charitable Remainder Trust. By doing so, the client can take an immediate \$1,000,000 charitable deduction which he or she can use over six years to reduce his or her taxable income.

An even greater benefit is the fact that that \$1,000,000 piece of property can now be sold and the \$1,000,000 in proceeds can be reinvested in the Limited Partnership for the entire term of the partnership (usually 25 to 55 years). Accordingly, some clients can buy and sell real estate as well as other capital appreciated assets such as stocks and bonds, etc. during their entire lifetime and never pay any tax on the income received from said sales.

Upon death, all of the Limited Partnership assets could be transferred to a Charitable Remainder Trust which could have as its beneficiary a Family Foundation thereby allowing your children or designated beneficiaries to continue to operate the Limited Partnership for their

lifetime and the lifetime of all generations in perpetuity. As you can imagine, the tremendous tax and asset protection benefits of the program cannot be overstated. The bottom line is that you can own and control your assets in perpetuity without ever paying any taxes on them or losing them to the Internal Revenue Service or other creditors.

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.

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

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

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

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

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

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