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222

THE ETHICAL ADVANTAGE

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Are There Advantages To Being Ethical?

YES! It's not always easy to do the right thing, especially when taking an alternative path can result in a quicker payday or a bigger commission. But choosing to do as many things right as you can is the premise of ***being ethical***, and, in general, society tends to favor good, ethical behavior. In fact, small business owners, like insurance agencies, generally find that building a reputation for consistently ethical behavior can have positive long-run effects on their financial performance.

Here are just a few of the ways that ***being ethical pays:***

- ***Customer Loyalty***. When your customers are happy, they come back. Part of making them happy is to treat them fair, just like you like to be treated when your the customer. Finding new customers is expensive. Repeat business from the same customer is a major savings in direct marketing

- ***Referrals***. Customers who are satisfied are likely to share their positive experiences with others. Good ethical behavior is typically rewarded by favorable word-of-mouth advertising, which, in turn, is much less expensive than generating new clients from scratch.

- ***Reduce legal costs.*** Companies and agents caught in bad ethical behavior are prone to the higher cost of litigation, settlements and fines. It's much cheaper to simply do the right thing.

- ***Good publicity***. Everyone likes to be treated fairly and the word spreads. Have favorable ratings, through new social media outlets like yelp, create positive publicity. Good news is sometimes hard to generate at any cost.

- ***Access To Capital.*** Investors and banks often make some of their decisions to loan/invest based on the integrity and honesty of a borrower. So, being ethical might help you secure that loan you need to expand your business.

If none of this convinces you, Kim Cameron, Professor of Organizational Behavior at the University of Michigan, has proved that businesses with high scores on virtuousness significantly outperformed those with low scores. It pays to have a strong moral compass!

Example: You investigate two proposal quotes for a client. Proposal A is the least expensive policy, but it meets the client's needs. Proposal B also meets the client's needs with a few bells and whistles added at a much higher premium. The client relies entirely on your recommendation and doesn't have a clue what a competitive premium might be for a comparable policy. What do you do? As an agent with a strong moral compass, you present Policy A, but explain the options available on Policy B and the fact that premiums and commissions are higher. If the client wants

Policy B the honest response is that it is not the one you want him to buy as long as Policy A meets his protection needs.

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

A Note On Court Cases Found In This Course . . .

Please do not take offense to the many court cases cited in this course. This is not an attempt to scare or intimate you. Just like ethical behavior has its rewards, as mentioned above, unethical behavior has consequences too. Part of being ethical is to know when you have crossed the line into unethical behavior, especially where this behavior can result in you being sued. Court cases are a very effective, real world, way to demonstrate this. It is the perfect opportunity to learn from the mistakes of others.

Being Ethical

Ethical Standards

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?

By what standards do you measure ethics? The answer lies within you. And, you are not alone if you are not 100% sure. There are many people and industries trying to grapple with the solution to "truth in selling".

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

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

Possessing a moral code is not all that is needed to set a professional apart from a salesperson. However, maintaining a Code of Ethics can inspire us to do better — especially if the breach of the code means we will lose our membership or be scrutinized by our peers.

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

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

- The capital needs of a family are met by a $1 million life insurance policy when

the breadwinner dies prematurely
- The estate of an entire family is left intact because an umbrella liability policy sheltered against a major accident claim
- A business is able to survive after the death of a partner because a life policy payment provided necessary capital to replace the devastating loss
- The retirement plans of a once young married couple are made possible through investments in pensions and annuities
- The owner of income property financially survives a major fire because his liability policy included "loss of income" provisions
- A family survives a mother's long term bout with cancer because their health insurance carried a sufficient "lifetime" benefit

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

Being ethical is indeed professional but the gesture goes beyond the mere compliance with law. It ***means*** being completely honest concerning ALL FACTS. It means more than merely NOT telling lies because an incomplete answer can be more deceptive than a lie. It means more than being silent when something needs to be said, because saying nothing can be the same as a lie.
Take the case of ***Bell vs. O'Leary***. An agent took an application for flood insurance but failed to notify the client that his mobile home was located in unincorporated areas that were ineligible for any coverage under the National Flood Insurance Plan. A loss occurred and the agent was sued. ***The courts determined that the agent had superior knowledge and failure to give the client a complete answer about the unavailability of coverage*** took precedence over the fact that coverage for the property was not available from anyone.

Someday, it may be real important for a court and jury to hear that you have a history of serving clients without consideration for how much commission you made or how busy you were, i.e., you are a person with good ethics. In Grace v. Interstate Life, 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 AgentsJ, The American Society of CLU and ChFC, Chartered Property and Casualty Underwriters the International Association of Financial Planning and the Million Dollar Round Table. We summarized many of these in the box on the next page titled simply . . . ***An Agent's Code of Ethics***

Ethics From The Start

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

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

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

Ethics For Life

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

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

Ethics Defined

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

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

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

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

Shades of Grey

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

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

More specifically, the agents explained that what they were offering was not an ordinary life insurance policy; rather, it was a ***supplemental retirement program***

with a death benefit and an "immediate cash benefit plan" containing a $ 1,000 "check" which, in the event of an insured's death, could be cashed immediately to pay for such burdensome expenses as funeral arrangements. Of critical significance, the agents assured that employees who decide to enroll in this "retirement program": (1) could allow their current policies to lapse, and (2) would be covered (insured) "immediately" and unconditionally upon completing an application and "upon signing . . . the[ir] payroll deduction card."

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

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

Moral and Market Values

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

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

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

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

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

The Coopers asserted that the ***assumptions*** underlying Berkshire's illustrations of the premiums that the Coopers would have to pay were inconsistent with Berkshire's own internal forecasts and estimates, and were based on abnormally high dividends that, to the defendants' knowledge, Berkshire could not sustain. If the illustration had been based on Berkshire's real investment earnings rate, the Coopers claim, it would have shown the "disappear year" to be ***later than*** the ten years represented to Cooper.

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

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

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

Will tougher laws and longer prison sentences be a deterrent. It can't hurt. But, the fact is bubbles burst quicker than a business climate can change. If a crooked

practice doesn't pay off, a lot fewer people will take the risk of using them. So, the real challenge is to create a new business culture that matches the market. Think about a system that rewards and reinforces the honest and careful agents and businessmen just like the bubble economies made heroes out of the gamblers.

Moral Compass

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

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

A strong moral compass is maintained by having a strong, unfailing sense of what is right and stay focused on it at all times. It's called ***integrity***. When you have it, it allows others to trust you, even when things go bad.

Moral Distress

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

What can you do?

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

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

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

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

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.

Ethics Are Not Laws

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

Laws in the United States are abundant, growing in numbers every day. The courts attempt to legislate protections from those without values or with values in opposition to what most of us would consider right and wrong. We have more laws than any one lawyer can ever know. And more and more lawyers seem to be necessary to handle the litigation that results from what seems to be a trend in "making others pay".

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

Ethics for Insurance Agents

Ethical and Unethical Behavior

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".

Understanding insurance ethics is sometimes the study of what is unethical. In essence, knowing what another agent did wrong is important so as not to repeat it. We will spend a lot of this course analyzing rights, wrongs and issues in between. The take away is hopefully that you strive to be as ethical as you can. What is the advantage for you? Well, as we explained int eh first chapter, you can make more money. Also, someday, it may be real important for a court or 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***. 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.

Ethical Selling

Less-than-honest selling is nothing new: ***Caveat Emptor*** *(buyer beware)* is said to have appeared on buildings in ancient Rome. But in the insurance business, it is the magnitude of damage that heightens the dishonesty. An unsuspecting client

who buys the wrong retirement plan or building coverage is hurt a lot more than someone who buys a fake Rolex for $20 on the street corner. This is why agents need to practice ethical sales conduct.

But what exactly is ethical selling?

Ethical sales conduct is a higher level of responsibility you ***choose to uphold*** in order to do a better job for your client. If you need more reasons why you should 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 ethical sales conduct, including: A Code of Ethics, Proper Disclosure, Client Protection (E&O Insurance), Applications, The Agent's File, Communications, Following Protocol, Integrity, Choosing Product, Choosing Companies and Presentations of Quotes and Illustrations and much more. We will delve into many of these in this chapter.

A Code of Ethics

Learning anything new is always easy if you have a road map or guide. The Agent Code of Ethics on the next page is one such guide. It's not everything you need to be the most ethical agent you can be, but it's a start.

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?

AN AGENT CODE OF ETHICS

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

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

Client Disclosure

Many agents have also 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.

Sample Agent / Client Disclosure
(Speak to an attorney before using ANY disclosure form)

Dear Client:

As you know, we are an insurance agency and not an insurance company. Our service to you includes the pricing and presentation of various insurance programs which may fit your needs, and the transmittal of your application to the insurance company. There are, however, limitations to our service, including the following:

1) Premium quotation and coverage are controlled by the insurance company and may be subject to change. We do not warrant or guarantee that a premium or coverage quoted by an insurance company will be identical to the ultimate premiums or coverage of the policy as issued by the company. There is no coverage promised or implied beyond the policy as written and endorsed. Your acceptance of the policy replaces all other agreements, either oral or written.

2) While we are pleased to provide to you and explain the industry ratings of a particular company or alternate insurers, we do not make any independent investigation of a specific company's solvency or financial stability. We do not warrant or guarantee that any insurance company will remain solvent, and we will not be liable to any insurance applicant or insured for the failure or inability of an insurance company to pay claims.

3) Insurance companies rely on the truthfulness and accuracy of information provided in the application. It is your sole responsibility to complete the application accurately, and if the insurance company should deny a claim based on its contention that the application has not been truthfully or accurately completed, we take no responsibility for such inaccuracy.

We ask that our client applicants signify their understanding of the foregoing points and their agreement to defend, indemnify, and hold us harmless against any loss or liability which may arise from the applicant's failure to truthfully and accurately complete the application, by signing and dating this letter in the place provided below and returning the copy to us. Kindly do so at your earliest convenience.

Accepted by _____

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 v Fireman's Fund Insuranc**. 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** 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 was found liable for client losses because his proposal*** also listed eight specific exclusions of the policy. Unfortunately, he ***left out the peril that damaged the client's property***.

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. Besides, keeping your client fully informed is the ethical thing to do. 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 who have adopted a policy of ethical behavior 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!***

How can you say you are doing the job you promised to do if you don't take the time and effort to read and understand the terms of your insurer's agreements. Agents and brokers have been sued by their insurers for failure to comply with terms of agency agreements ranging from gross misappropriation of premiums to seemingly small violations involving clerical errors. In many of these cases, the attorney for the defense had to go beyond the written disclosure by defending the agent or broker on the following points of law:

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

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

Estoppel: An insurer who has had a long course of dealing with a given broker/agent may well have been willing, over the years, to overlook shortcomings in the information a broker provided the insurer. In some cases, brokers are

allowed to "bind" coverage and later provide additional information. If the same insurer brings an action against the broker after a loss has occurred, the broker may be able to point to the insurer's past practices as the basis for an estoppel argument.

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

Errors & Omissions Insurance

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

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

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

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

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

banks or association groups, this often leads to the agent accepting many ***policy exclusions.***

Exclusions

Again, knowing your contracts is a responsibility you have to your insurer and clients. If you are unaware of a major exclusion, you may not have coverage, which means your clients and insurer may be out as well.

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***.

An *E&O 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 you need to meet. This is a responsibility and duty you assume if you are doing a good job for clients and insurers alike. 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. For example, in **McDaniel v Sheperd**, an agent approached an injured insured, told her not to get an attorney, offered to get her

an attorney, and offered her money in exchange for a release of liability for all known and unknown personal injuries she incurred in an accident. The court pursued him for constructive fraud. This type of activity is a clear violation of an errors and omissions contractual promise and a sure way for coverage to be canceled.

Also remember that cooperation extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you publicly disagree with, and the case ended with a higher judgement, 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 clients decision to reject a recommended coverage. The client would have a hard time proving otherwise. Some liability claims have hinged on a hastily scribbled note confirming that a disputed conversation took place.

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

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

Following are some areas of office protocol that may make or break a claim against an agent:

Automated Equipment

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

Application For Insurance

Insurance applications are among the most important documents you use. Your client's coverage can be covered or lost in the application. There is no standard higher than true and accurate answers. In fact, that is why most successful agents spend more time and care in filling out applications than other agent activities. 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 v Bowser)**

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 vs. Gros, lack of notation regarding a client conversation three years before the loss was evidence 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 and ethical 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.

Effective Verbal Communication

Verbal communication is critical to effective loss control. Many claims and lost coverage 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

Ethical behavior is demonstrated in many ways. Documentation of client verbal instructions, for example, is a service you should provide and not the responsibility of the client. It is also serve as 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.

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.

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 to have explained, please call me".

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 or illustration, 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.

Fax signatures may be considered legal, but whenever possible all forms should have original signatures. 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. However, 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.

E-Mail

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

E-Mail communications are just as binding, admissible and prohibitive in court as other communications. Attorneys are finding damaging information in E-Mail files that they can't find elsewhere. 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.

Operations Manual

As you read above, ***standard operating procedures*** are steps that you follow ***consistently in selling and serving clients*** to be sure that ***that all clients are treated the same***. Also, establishing your notes and records is 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 and ethical 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 plaintiff's vantage, non-compliance of policy procedures that you establish may work against you.

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

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

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

Privacy

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

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

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

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

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

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

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

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

Nationwide recognizes and respects your right as a citizen to communicate with government agencies and the public. However, you do not have the right to make false statements or accuse Nationwide of wrongdoing, unless your allegations are reasonably supported by the facts and the law. Such actions will not be tolerated,

and if they occur in the future, Nationwide intends to exercise its legal rights, which could include legal proceedings in addition to canceling your Agent's Agreement.

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

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

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

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

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

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

Fraser's second claim involved his right to ***free speech***. The court's decision, however, was that Nationwide is a private corporation and a private actor under the law. Therefore, Nationwide's decision to terminate Fraser's Agent's Agreement is not subject to constitutional requirements of free speech. Further, the court stated

that even if it is true that Nationwide terminated Fraser for reporting to government authorities Nationwide's alleged unlawful practices, for drafting the letter to Nationwide's competitors, or for associating with NIICA, Nationwide is not liable under the constitution.

Confidentiality

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

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

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

Opt-In / Opt-Out

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

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

Opt-in does not enhance consumer privacy. Since it is the consumer who makes the final and binding decision regarding the use, non-use, or misuse of his personal information under either "opt-in" or "opt-out", there is no privacy advantage to "opt-in". Neither approach provides the consumer with greater or lesser rights than the other. If this argument is valid, and both "opt-in" and "opt-out" fully reflect consumer preferences regarding the use of their personal information, then all the other arguments are invalid – sellers would receive the same amount of information under either approach. Thus, implementing "opt-in" would not impose any additional costs on either producers or consumers, as compared with implementing "opt-out". However, the choice of scheme – "opt-in" or "opt-out" – does distort consumer preferences by imposing transaction costs on one choice or the other. After acknowledging that transaction costs cause both "opt-in" and "opt-out" schemes to reflect imperfectly the "true" privacy preferences of the consumer, the policy debate can move forward and tackle the next question. Does "opt-in" or "opt-out" reflect the true preferences of the consumer better? Presumably, transaction costs under "opt-in" lead consumers to provide less information than their true privacy preferences would suggest; conversely, transaction costs under "opt-out" lead consumers to provide too much information.

The structure of the seller-producer relationship suggests one reason why "opt-in" might represent the consumer's true privacy preference better. The seller can adjust the level of transaction costs involved in "opting" in or out, whereas the consumer cannot. Since the seller has an obvious interest in collecting information, it has an incentive to make it easy and simple to opt in, under an "opt-in" system, and an incentive to make it difficult and time-consuming to opt out, under an "opt-out" system. Whatever regulations exist to make opting out easier, the seller has an incentive to push the envelope, to make opting out as difficult as possible within the letter of the law. Thus, transaction costs under an "opt-out" scheme are likely to be higher than under an "opt-in" scheme, and the outcome under "opt-out" is likely to be concomitantly farther away from the correct outcome than under "opt-in".

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

Opt-in imposes significant costs on sellers, which are then passed on to consumers. Opt-in increases the costs to a seller of expanding its range of services, because of the necessary expenditure of resources to obtain consumer permission to use the additional personal information that enables the better service. *Opt-in also*

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

Opt-in reduces the amount of competition in the market. By raising costs of operation, "opt-in" will drive marginally profitable companies out of the market altogether. By requiring new entrants to go through a laborious process of obtaining personal data permits from each new consumer, "opt-in" creates a barrier to entry into the market. Market incumbents, on the other hand, will benefit from an established consumer base that has already given permits. Essentially, "opt-in" helps entrench market incumbents. Since consumers are more likely to "opt-in" to companies they know and trust, such a scheme will favor large firms with established brand names over smaller firms. Competition is most reduced in the industries that rely the most on expensive means of obtaining permission, such as telephone or paper-mail, rather than on website-notices and e-mail. As e-commerce continues to grow, and technology becomes more pervasive, there is likely to be a shift from the former to the latter, and a reduction in the height of the entry barrier. A new entrant, though forced to beseech consumers for information-permission, could do so inexpensively through mass e-mailing.

Opt-in costs to sellers will be passed on disproportionately to less wealthy consumers. A study of distance shopping in the apparel market (catalogs, online

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

Misuse of Position

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

Campbell v. Valley State Agency

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

Europeon Bakers v. Holman

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

Seascape vs. Associated Insurance

Agents held themselves out to be "professional insurance planners". They had served client for several years. Client came to them to get specific advice regarding "seawall insurance". ***Agents advised client that seawall insurance was NOT available to them, but it was***. Later, a storm damaged client's seawall and clients learned that seawall insurance could have been purchased. Clients sued

agent alleging that their relationship was such that agent owed a duty to exercise reasonable care in rendering advice on insurance matters. The courts agreed.

Sobotor vs. Prudential Property & Casualty

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

Wright Bodyworks vs. Columbus Agency

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

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

Loss Control

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

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

- Know your basic ***legal responsibilities*** as an agent and only exceed them when you are absolutely sure what you're doing. Then, pull out your agency agreement and ***read it . . . right now***!!! And, when you decide that you want

to be more than an agent, i.e., ***a specialist or expert***, understand that it comes with a high price tag -- ***added liability***. Also, make sure you are complying with basic license responsibilities to keep you and your company from becoming a commissioner's target for suspension or revocation.

- Learn from other agent mistakes. The best school in town is the one taught by agents who have already had a problem. Study their errors, learn from them and make sure you don't repeat them. Countless lawsuits, for instance, surface due to something an agent wrote down in an application causing the policy to void or a claim denied. The insured typically denies they responded in that manner. If applications were made out in an insured's own handwriting, however, there is little they can say.

- Be aware of and avoid current industry conflicts that could develop into problems for your agency, e.g., mold prevention, viatical settlements, life insurance acting as retirement plans, etc. There are hundreds of professional industry publications and online sources that will help you keep abreast. Once you are aware of a potential problem, take action to make sure it doesn't end up at your doorstep.

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

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

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

- Use client disclosures whenever possible. There is nothing more convincing than a client's own signature witnessing his knowledge of the situation or a note in an application offering an explanation. And while we're on the subject, ***spend more time with client applications***. The information provided in an application is serious business. Mistakes, whether intentional or not, can void a policy or reduce benefits and lead to a lot of trouble for your client and you. Use mini-disclosures to evidence a position and reasoning. For instance, assuming your state regulator and company approve, the applicant could be asked to write "I have read everything on this page. The answers are true".

- Get connected to the latest office protocol systems. The ability to access a note concerning a client conversation or the way you "package" correspondence can

make a big difference in the outcome of a claim or avoiding one at the outset. You want a system that will produce solid evidence not "hearsay".

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

Ethics and Client Suitability

What is the ethical advantage agents have when helping clients choose insurance products? Well, a client views policies in terms of obtaining ***reduced uncertainty***, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. Agents are vital players in solving client needs. The greater agent due care exercised, the more valuable this or her service. The more valuable the agent becomes to a client the more he depends on the agent and the more business he is likely to do with that agent.

Background

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

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

Before we further discuss the role agents ***should play*** in the process of helping clients, let's talk about the role agent's must play . . . your suitability duties.

Suitability Duties

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

For a majority of suitability lawsuits, the basis of liability is relationship and purpose. Legally a ***personal relationship is created*** when a prospective insured consults an insurance agent, provides that agent with specific information about his unique circumstances and relies on the agent to obtain appropriate coverage tailored to these circumstances. Courts have recognized that the relationship between a prospective insured and an insurance agent (like the relationship of attorney and client) is that of principal and agent, for the purpose of negotiating a

policy suitable to the client's needs (Nu-Air Manufacturing Co. V. Frank B. Hall & Co.). Further, an insurance agent owes the prospective insured a duty of unwavering loyalty similar to that owed by an attorney to a client. It is the special ***fiduciary nature*** of the relationship between a prospective insured and an insurer that lends the relationship a ***personal character*** similar in scope to the lawyer-client relationship. For this reason, alleged acts of negligence on the part of an insurance agent who has been consulted for the ***express purpose*** of meeting a client's unique needs create a ***personal tort***.

In ***Forgione vs. State Farm***, it was determined that the insureds made ***express representations*** to the agent about the importance of arranging a set of policies that would prevent a gap in coverage. ***The insureds relied on these agents to obtain the appropriate gap coverage coverage, and the agents failed to use reasonable care, skill and diligence to procure suitable policies***. The allegations in the complaint make clear that the insureds ***expected*** the agents to respond to the couple's unique, personal insurance needs. A $600,000 claim proved that a gap in coverage existed and therefore it was not a suitable policy.

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

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

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

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

Was Anderson guilty of a breach of duty in a failure to make disclosure of certain

facts? Was this product suitable? What about the rather large commissions, not ordinarily possible with a client in this income category?

The trial began by with a citation from another case, Steadman v. McConnell, where and agent's license was suspended for making false and fraudulent representations in selling bank financed life insurance. The court in this trial said:

'The appellant was an experienced expert in the field; the insured a mere layman who was led to believe that the bank plan would meet certain expressed objectives. Certainly the relationship was a fiduciary one in which the plaintiffs were entitled to believe the agent's material statements.'

The court determined that Knox ***did rely*** upon Anderson's statements and that it would be unreasonable to argue that Knox should have found out for himself, because of some principle of caveat emptor, that the program was not at all what it was represented to be. Knox testified:
'I had my faith in him because he was recommended by a leading business man in the Territory. I figured he knew what he was talking about. He had all the facts in my case. I figured he was giving me something that was designed for me.'

It was also uncovered at trial that the Knoxes inquired about ***reducing*** or dropping the program after they started it, in case they found it burdensome. Anderson ***assured*** them they could do so. What he ***neglected*** to tell them was that they could do so only at a very ***substantial loss***. The court believed that Knox has a right, as a matter of law, to rely on these representations as to suitability, if, as the court found, the representations were false, and were made with intent to deceive.

This brings us to the next inquiry which is: does the record support the court's finding that the program sold to Knox was in fact ***not suitable***?

Insurance experts were brought in on both sides of the argument to prove or disprove suitability. Both those for the plaintiff and for the defendant, were in substantial agreement as to what would constitute a suitable insurance plan for Knox and his family and as to what factors would have to be considered in order to determine such suitability.

'*It was necessary to know (i) the details of the existing insurance program; (ii) its values and benefits, (iii) the cost of continuing the old program, (iv) the additional cash outlay for the new program, (v) loss of values and benefits, if any, under the old program and (vi) the additional values and benefits of the new program.*

Next it was Anderson's turn to take the stand. Imagine yourself in this predicament. Imagine what it would be like answering questions from a hostile attorney about the suitability of your own product suggestions:

'Q. Mr. Anderson, do you agree that in determining the suitability of a program of insurance such as the one that you were presenting to Mr. Knox to be financed by bank finance plan, that first you would have to know the existing program, what

was provided, what it will cost to continue the program, and also the benefits of the existing program? Do you agree with that?

A. *I am sure those are factors. But all of these points don't mention the right of the individual to make his choice.*

'Q. I will get back to that. That certainly is a necessary element in the consideration of suitability, is it not?

A. Yes, with qualifications. There are certain things you must also take into consideration.

'Q. I know that is just one of the elements, isn't that right, what I have recited in my question to you?

A. Not one. You recited several elements.

'Q. Shall I go over it again?

'The Court: Wait. Try to stop guessing as to why he is asking these questions or anticipating his point. Just answer the question and we will get along better.

'Q. In determining the suitability of a program such as the one that you were presenting to the Knoxes to be financed by the bank loan plan of finance, -- take one element at a time -- it would be one of the elements to be considered or one of the elements to be considered is, was there an existing program? Just stop there. Isn't that right?

A. Yes, I think that is true.

'Q. All right. Number 2, you would want to know what the existing program was, what it provided, what coverage it provided, is that right?

A. Yes. Our schedule called for that.

'Q. You would want to know, would you not, what the cost was of the existing program?

A. Yes, our schedules require that.

'Q. Just answer the question and we will get on better. We will get to the schedules afterwards. Third or fourth -- whatever it is -- you would also want to know the benefits that were contained in the existing program, isn't that right?

A. Yes, our schedule calls for that.

'Q. Then you would want to know what additional cash outlay there would have to be for the new program and what additional benefits you would get out of the new program, isn't that right?

A. Yes, the policies and the schedules call for that and show that.

'Q. Then you would next want to know what the variables and the risks of the new program were so that you could appraise whether it was suitable to answer, suitable or desirable to enter into the program, isn't that right?

A. Yes. I like the term 'variable' much more as simplifying 'risks'.

'Q. That is another thing that would have to be known, what the variables of risks were. All right. You would also want to know what the loss was of benefits under the old program if there were any loss, isn't that right?

A. Yes, but there were no losses.

'Q. I am not asking you about this program for the minute. I am just asking you generally. If there any losses under the old program, you would want to know what they were?

A. Oh, yes, if there were.

'Q. Next and finally, in order for it to be suitable there would have to be some reasonable understanding on the part of the man that was buying it, how the program works, isn't that right?

A. Yes, I would say so. This was done also.'
The ***expert*** for Knox was up next. He demonstrated with a great degree of clarity and reference to specific details, the reasons why the Anderson program was ***not suitable*** for Knox. With the use of figures and amounts he demonstrated that the program ***failed to provide*** the protection Knox was led to think he was getting; that it in fact destroyed some protections he already had; that the program was ***not worth*** the money it would cost; that Knox ***could not afford it***; and that he did not understand it.

He also testified that the usually accepted practice among good life underwriters was not to permit a policy holder to contract for more insurance than he could comfortably afford. He explained that in the event of an emergency policies often lapsed to the detriment of both the policy holder and the company; that the usually accepted safe limit for a man in his 30's, with a family to support, would be a life insurance plan calling for some 10 or 12 per cent of his income,

'Ten or twelve percent should be about the maximum you should go.'

He also testified that it is a standard rule among most insurance companies not to write insurance more than ten times a man's annual income; however, when Knox had ordered his $100,000 policy, that brought his insurance to approximately fifteen times his income.

'Frankly in reviewing this, I was surprised that $100,000 was obtainable. It would have been a difficult job to get I would think.'

Another portion of the expert's testimony dealt with the problem of suitability of the Anderson program as an investment or for retirement. According to the witnesses, Anderson undertook to sell Knox's program on the basis of it providing retirement funds when he reached age 65. The record does not show how much in the way of retirement benefits Anderson and Kreidler represented the plan would produce. Mrs. Knox testified that when the other policy was sold Anderson said the retirement benefits would be 'around' $ 600 per month. The inference is plain that the plan was sold as suitable and valuable for that purpose. The expert concluded that the plan sold to Knox was an ***unsuitable*** one because it provided ***neither*** desirable investment savings nor retirement benefits.

The next issue for the court to decide was whether the representation made by Anderson as to the suitability of this program a ***representation of fact*** and ***not a mere expression of opinion***? The second question is: assuming that they find here a statement or representation of fact, was it ***made falsely and fraudulently*** with intent to deceive, or was the representation made with reckless disregard whether it was true or false?

The plaintiff's attorney set about his task to prove that Anderson knew or should have known that his insurance plan was falsely represented and relied upon by Knox. Bank financed plans in general were not under attack. However, the use here, for this particular insured should be considered unreasonable. In short, any insurance agent using this system and familiar with it must be aware of the fact that in employing it he must resist any temptation to overreach a purchaser. Anderson must have known that an indiscriminate use of the bank loan plan was fraught with hazards.

Anderson's own testimony helped the court decide that he was unconcerned about these matters. The cross-examination of Anderson by counsel for Knox endeavored to find out his thoughts and mental attitude with respect to the suitability of this program at the time of sale. For a considerable period of his testimony Anderson ***evaded*** the question. The court intervened telling him that

'Counsel is trying to find out how you felt at the time of this transaction, specifically whether or not you felt that you owed a duty to protect the Knoxes against what in your opinion might be poor judgment in deciding how much insurance to take under this proposed loan financed plan.'

He evaded this question by stating that he went to the time and expense to prepare the schedules so that the Knoxes ***themselves*** could decide. It was the following testimony, however, that was the most convincing to the court:

'<u>The Court</u>: Let's go over it again. From the answers you have given me, I take it that you are saying, no, that you felt you owed them no duty to protect them against any bad judgment that in your opinion they might be exercising in relation to the insurance that they had decided to purchase? <u>The witness</u>. I guess that's

right with this qualification, that it was their responsibility to determine what they should buy and could buy. I was selling life insurance. But at the time I felt I was using the judgment of the insuring company in the amount that would be issued. As to what they decide, what they should buy, is their responsibility.'

This answer alone would be sufficient to warrant the trial judge in finding that Anderson, in making his representations respecting the suitability of the program, did so with ***reckless disregard*** as to whether his representation was true or false.

In this same connection Anderson's own testimony is that he did not undertake to draw up a suitable program of insurance for the Knoxes.

'I didn't do any extensive planning because that was not my field. I simply submitted the policies that were applied for and they made the decision as to what they wanted to purchase.'

He did little personally to inform himself as to the facts relating to Knox, his income, his resources and his old insurance program before he undertook to sell the plan to him.

After many pages of questioning, the plaintiff's counsel finally elicited the following equivocal testimony:

Q. Did you express a judgment that it was a suitable plan for them or an opinion?

A. Oh, I may have expressed an opinion as a salesman, yes. I believe in insurance and I believe it was necessary and they believed it was necessary. There was a meeting of minds.'

Based on this response the court concluded that

One who undertakes to make statements under circumstances such as this, is bound not only to state truly what he tells, but also ***not to suppress or conceal*** *any facts within in his knowledge which* ***materially*** *qualify those statements. If he speaks at all he must make a full and fair disclosure. This is particularly true where one party to a deal, though in no sense a fiduciary, is possessed of* ***superior knowledge*** *as to facts material and important to the transaction which he* ***fails to disclose*** *to the other party.*
Fragmentary information *may be as misleading and as deceptive as active misrepresentation, and half-truths may be as actionable as whole lies and sometimes properly be regarded as actual concealment.'*

The decision came swiftly:

With a record such as this we find it impossible to hold clearly erroneous the finding of trial judge that Anderson's expressed opinion of suitability was not an honest one but was made fraudulently and with intent to deceive; particularly because the facts clearly warrant a determination that Anderson made his representations recklessly in disregard of whether they were true or false.

The court could fairly infer from the circumstances here that Anderson's sole interest was in collecting his immense commission; that he felt no responsibility whatever, as he himself indicated, with respect to the truth or falsity of his representation of suitability. Indeed, the court might well regard seriously the argument that any insurance agent who would sell a man with Knox's limited income and prospects an insurance program that involved saddling him with a bank indebtedness of $125,000, an essentially term insurance type of protection, and dissipation of the accumulated cash values of his old insurance, must have known that he was not acing honestly in making the sale.

The court awarded Knox compensatory damages, exemplary and punitive damages and damages for 'grievous mental anguish and great distress of body and mind'.

Meaning of Suitability Conduct

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

To really uncover as many of these client needs as possible, you must know more about your clients. Of course, a client profile is the best way to accomplish this. Customer profiles can provide a lot more information than you would gleam from an application. You must also ***ask*** clients what about their needs. Three important questions might be:

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

In addition, you should do research about their needs as a group so you can ***better anticipate insurance needs***. (Discussed in the next chapter).

Every additional bit of information you learn about your client helps you get closer to knowing what makes him "tick" and how he ticks could be a best indicator of how you need to insure him. Are you uncovering his or her "core beliefs"? Is he or she following generational trends? Where do they see themselves five years from now? How will they get there? These are not questions you will find on insurance applications nor many client profiles. In some cases, your clients will not know the

answers to these questions themselves -- you may need to interpret for them. But, by all means never do this without involving them in the process.

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

Ethical Decision-Making

Your ethical advantage is improved when you make better ethical decisions. So, let's discuss ethical decision making.

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

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

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

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

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

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

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

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

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

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

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

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

Confronting Unethical Conduct

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

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

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

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

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

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

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

Ratification of Misconduct

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

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

That's how ethics in insurance work!

A Moral Agency Climate

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

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

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

Integrity

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

Qualifications

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

Lack of Business Skills or Reputation

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

Activities Circumventing Laws

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

Agent Dishonesty

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

Catchall Category

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

Choosing A Company

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

No doubt, it will be the same attorneys who expect an agent to quote code and verse about the company, a policy or illustration when something goes wrong. There is no question that young lawyers, and some very rich lawyers alike, are increasingly aware of the numerous legal theories available to hold the insurance producer liable for failing to meet some kind of professional standard. Could a jury be convinced, for example, that an insurance professional, especially one who has earned a designation such as CLU or CFP, neglected his professional duties in not explaining the full impact of estate taxation to a now deceased, but underinsured client? Is a casualty agent, possibly a CIC or CPCU, liable for placing a client with a B-rated carrier that liquidates at the very time a client files a claim or failing to recommend a specific policy option that later involves losses?

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

Company Choices

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

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

An agent is engaged by a client because of his knowledge. Clients should expect to be placed with financially reliable insurers. Too often, it is believed that state regulators are monitoring solvency closely and will advise agents and brokers by some mysterious "hot line" — it just doesn't happen that way — and we have recent examples to prove this is not the case. Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations could initiate a complete collapse similar

to what happened with Mutual Benefit Life years ago. By stepping in without public warning or fanfare, regulators hope to avoid the severity of a takeover and minimize consumer panic. That is why an agent will not receive advance warning from regulators. Unless the agent is tracking solvency by demanding full disclosure from an insurer BEFORE AND AFTER involving a client, he may experience the unpleasant experience of dealing with a disgruntled client or his attorney who just read about an insurer's demise, complaints filed with the insurance commissioner, or worse, a surprise visit from the "60 Minutes" investigative team!

There are NO set rules on ***solvency due care*** techniques since the actual process must consider the risk capacity of a client, the current economy and the specific financial result or exposure needing coverage. However, there are some steps that agents might take to help mitigate bad choices. It is hoped that at least a few of the following sources and considerations will have application and will involve the agent in an area of due care that has been largely ignored. If this is considered too time consuming, an agent would be advised to concentrate only on those companies where this information can be acquired. In some cases, due care is not simply a matter of collecting a financial ratio. The story behind the numbers is often as important.

Using the Rating Services

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

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

One consultant suggests a way to determine if an insurer is running into ***difficulty*** is to ***monitor several ratings sources***. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. An

example is United Pacific Life. In 1992 it was rated A-Plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

For more information, consult the section called ***The Rating Services***.

On-Going Monitoring and Policy Replacement

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

Company Deals

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

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

Company Diversification, Business Lines & Parent Affiliation

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

The insurance consumer should also be educated by agents about the different types of insurers, i.e., stock versus mutual company, although it might be considered an error to generalize about the safety of an insurer or the price of its coverage or the service it provides, based solely on the insurer's legal structure.

This disclosure may be particularly appropriate where an insurer, due to its legal structure, may NOT be covered by state guaranty fund protection, e.g., non-profit Blue Cross and Blue Shield. Or, where the legal structure of the product offered may NOT be "insured" by state funds, e.g., variable annuities.

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

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

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

Conflicts of Interest

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

Reinsurance

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

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

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows: " . . . If the reinsurance agreement is entered into for the principal purpose of providing

significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged". The reinsurance market has taken some heavy blows in past years.

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

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

Size of Company & Loan Portfolio

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

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

State Admission

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

Risked Based Capital

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

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

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

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

It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an ***asset-default test*** under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages. Industry critics say that the ***C-1 surplus requirements*** alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks. Since the 1994 Risked Based Capital reports are based on 1993

financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings. Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios. In many cases, companies have very few options to unload foreclosed real estate as long as the market continues soft. A Saloman Brothers Inc study of almost 500 insurance companies clarifies the problem. Using 1992 financial reports for these insurers, the median level of surplus capital was found to be at 189 percent of their respective Risked Based Capital levels. Even though, a majority of companies exceeded the 150 percent threshold — thus, not requiring regulatory correction — the results indicate that hundreds of companies did not measure up. The concern by industry groups is that when Risked Based Capital is enacted, the results could generate significant "bad press" which could weaken demand for individual company and industry products. There is also speculation that companies will change investment portfolios to achieve higher Risked Based Capital ratios. This may critically hamper real estate investing for a some time to come.

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

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

Choosing Product

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

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

- Monitor policy needs on a continuing basis. Regardless of the sequence of policy decisions, agents must recognize that the choice of a policy is viewed differently between agent and client.

An agent seeks coverage as a means of transferring pure risk. A client views a policy in terms of obtaining reduced uncertainty, i.e., in most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in any insurance purchase. The greater agent due care exercised, the more valuable the service. Agent choices were at the heart of the issue in recent class-action suits involving pensions and life products. Allegations that agents marketed life policies and annuities to tax-qualified pension plans have led to multi-million dollar settlements. Even though the insurance industry defends the choice of this product, the courts say that placing a tax-deferred product inside a tax-deferred retirement plan is redundant, unnecessary and costly to consumers. The critics say that mortality and expense costs associated with life products, like variable annuities, make them a poor choice compared to mutual funds. In addition, the tax-deferral feature is unnecessary. Oddly enough, the issue here does not focus on performance, where some variable annuities inside pensions have outperformed mutual funds. Rather, the focus is on disclosure and suitability.

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

Policy Choices & Risk Management

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

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

The agent must also consider a client's ***pure risk* vs *speculative risk***. Both pure risk and speculative risk involve uncertainty, but in pure risk, the uncertainty relates only to the occurrence of the loss. In other words, there is no chance for a profit to be made. Speculative risk offers the opportunity for both gain and loss. An example of a speculative risk is when a dilapidated apartments burns and is replaced with new housing. Society can gain from speculative risk. However, the agent would do better to concern himself with the pure risk losses of the client. In

the above case, for example, does the apartment policy provide pure risk provisions, such as a "lost rent clause" to provide the client and his family sufficient cash flow while the new apartment is being built?

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

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

In the case Aetna v. Rodriguez the agent chose a policy based on what he ***believed*** his client was saying. The courts determined that even though the client used words that could have been interpreted two ways the agent should have investigated the "real" need and not simply wrote the policy in a manner that was legally advantageous to the insurance company.

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

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

Factors to consider include personal and business resources the client may wish to devote to covering losses (cash, assets, bonds, etc), available credit resources, the use of higher than average deductibles and any possible claims for reimbursement the client may make against outside parties who may be legally responsible to help

pay all or part of the loss. Of course, it is likely that the major transference of risk, or the final source of loss coverage, is the insurance contract.

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

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

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

Too Good To Be True

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

Ethical Decision Making – Life & Health

Questionable market conduct in the 1980's and early 1990's created new demands for today's agent. For life and health agents, past abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been further tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together -- less support in marketing and support materials. The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive. Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as 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 live, modified whole life, single premium whole life, universal life, variable life, etc. The attributes of these different policies are best left to a course on basic life insurance. However, it is critical, under due care, that agents recognize the "pure risk" need of clients and counsel them on the proper choice. For example, persuading a client to accept a high monthly premium whole life policy with a settlement payoff that leaves a significant financial gap at the death of a breadwinner, is NOT exercising due care. This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations here a client's age and situation call for the agent to consider future estate settlement costs and liquidity as prime directives in making policy choices. There may even be conditions where due care by the agent might involve a recommendation for a client to carry little or no life insurance at all. Issues regarding life insurance needs for singles, non working spouses and children are often debated among financial planners and agents alike.

One process for determining an estimate of the amount of life insurance needed is called ***capital needs analysis.*** Financial planning courses cover this process in considerable detail and typically include a sample capital needs worksheet. For purposes of proper sales conduct by agents, factors to consider by agents include:

- **Family Capital needs**. *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 (for plans outside Obamacare) prohibited or waivered? If waivered, for how long? Is there a waiting period for unknown pre-existing conditions? Some policies specify a 6 to 12 month waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins, nasal surgeries, foot and toe surgeries, breast reductions, otis media (ear problems),etc.

Exclusions

Possible policy exclusions or highly limited protection might include conditions and services as follows: medical costs exceeding limits, unlisted services, service covered by occupational insurance (worker's compensation, etc), health problems due to acts of war, government provided services, Medicare benefits, services from relatives, private nursing fees, custodial care, long-term care, inpatient diagnostics (x-rays not related to specific surgery), dental and hearing aids, vision care, speech therapy, cosmetic sex changes, infertility, weight reduction, orthopedic devices, maternity care, outpatient drugs, acupuncture, nutritional 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"

Multiple lines insurance agents (life, health, disability, property/casualty) should prioritize the impact of health insurance on a client's financial

planning. A medical catastrophe can permanently devastate a family. Despite the important of life insurance, disability protection and certain property/casualty coverage, health insurance is a clear priority. It would NOT be considered due care for an agent who handles different product lines to market a $250 per month whole life insurance plan to a financially limited client when there was NO health insurance in place. A more prudent approach would combine a "basic hospital plan" for major medical emergencies at $150 per month and a term life plan for $100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.

Essential Health Coverage Due Care Questions

- ✓ What available sources of health care are available to your client -- group plans (employer provided), HMO's, Medicare, other?
- ✓ Does your client have enough medical expense benefits to meet basic hospital needs or major medical expenses?
- ✓ What family members of the client require coverage and are they eligible? Does the client or family member need supplemental coverage?
- ✓ Should the client terminate any existing or duplicate medical expense premiums?
- ✓ Does the client have dependents who have or will soon terminate coverage under the family plan? If so, can they purchase their own? What conversion rights do they have?
- ✓ Is your client's policy guaranteed renewable?
- ✓ Does the client's health care continue to protect dependents in the event of his or her death?
- ✓ Does the client have a substandard rating or waiver of coverage? Will the insurer remove it? When? Will another company write without the waiver or rating?

Annuity Analysis

Sales conduct concerning annuity investing first involves fact finding to determine what portion, if any, annuities should play in a client's overall financial plan. Next, a needs analysis should be conducted to uncover growth vs. income requirements, risk tolerance, liquidity specifications, now and in the future, and whether tax deferral benefits are worthwhile to pursue.

Who should invest in annuities? One rule of thumb follows that a client looking for a long-term investment with a tax bracket greater than 15 percent might consider annuities. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time, i.e., retirement monies.

Fixed rate annuities might be an alternative for CDS, GNMAs (Ginnie Maes), T-Bills or other similar obligations. Variable annuities are better geared to individuals who seek tax deferral, yet willing to ride with the ups and downs that accompany stock and mutual fund investments.

Once an annuity can be established as an appropriate investment opportunity, agents must carefully weigh the following choices and discuss same with each client:

Immediate Annuity vs. Deferred Annuity

Clients may have current income needs or the desire to defer income for greater growth. Perhaps a combination is appropriate. Tax planning and liquidity are key considerations for the agent.

Single Premium vs. Flexible Premium

Client's generally have a lump sum to invest or need to accumulate by paying into a savings plan. Short and long-term liquidity is an important consideration.

Fixed Rate vs. Variable Rate

Client's may have needs to lock-in their yields or go for growth. One group is typically a CD type investor as opposed to those who are willing and able to incur greater risk. Agents needs to carefully explain the potential loss of principal possible in variable plans. Agents should review potential interruptions in return of principal and yield that can develop with either fixed or variable contracts.

Yield vs. Guarantees

It is logical that the stronger the guarantee the lower the yield. Agents must explain that a higher first year yield may include bonuses or special incentives to invest that later disappear. This type of contract should be compared to other contracts that may offer a slightly lower yield that is locked in for a specific period, i.e., determining overall predictable yield over time is important due diligence. In the same vein, a disclosure would be appropriate as to the method used by the insurer to adjust yield. A contract with a guaranteed yield spread may be more appropriate for some clients than a yield that is adjusted by the insurer's board of directors. Equally important is whether yield is banded, i.e., are yields adjusted separately for certain blocks of investors or are investors who entered five years ago given the same yield as new investors.

Yield vs. Liquidity

Clients demanding easy access to their money should be prepared to settle for lower overall yields. Agents need to go farther to determine special needs such as the potential for large sums of money to pay for a potential illness or nursing home. Certain contracts allow penalty free withdrawals for special circumstances. Due care dictates that agents carefully and clearly explain all surrender charges associated with the contract and when they occur.

Maturity options

Annuity contracts may mature at specific ages. This can affect BOTH a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85. Further, agents MUST disclose the potential tax affect of a maturing annuity. Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal. Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

Withdrawals & IRS Penalties

Where the client is withdrawing all or part of an annuity contract PRIOR to age 59.5, he should be apprised of the ten percent IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies or becomes substantially disabled or, where annuitization is chosen within one year of investing in the annuity contract.

Guaranteed Death Benefits

Where agents assist in estate planning, due care would involve a disclosure concerning death benefits. Most fixed rate contracts guarantee the return of principal and any appreciation (interest left to grow). However, agents should uncover and review factors concerning potential surrender penalties or how they may be avoided, as well as the basis of the guarantee. Is the death benefit guarantee, for example, the greater of ALL contributions of principal OR simply the value of the contract on the date of the annuitant's death?

Settlement Options & Taxes

Clients should be made to understand that, at best, annuities represent tax deferral, not tax free income. Unless the beneficiary of the annuity is a surviving spouse, taxes on the accumulated growth will be due -- there is NO step-up in basis. The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket. Options to mitigate this include five year or lifetime annuitization of the contract.

Other settlement options that should be discussed with the client include possible options such as life annuity, joint and last survivor, lifetime with period certain, etc.

State Guaranty Fund Coverage

Rules governing state guaranty coverage should be disclosed to the client. If the State does NOT permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases. The primary concern? Is the full amount of the annuity covered against insurer failure.

Perhaps due care is served by diversifying among several insurers and/or between fixed AND variable contracts to take full advantage of guaranty protection.

Titling Options

If the agent is advertising tax and estate planning advice he should disclose the consequences of titling contracts. Where no tax or estate counseling is provided, the agent should still exercise due care by disclosing the fact that titling consequences may result and offer to refer a competent attorney or tax expert before any purchasing decisions. As a general rule, the death of an owner or annuitant triggers a death benefit which carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary must take a lump sum and pay the tax or annuitize over a minimum five-year period. An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

Essential Annuity Due Care Questions

- ✓ Is the client interested in growth or income?
- ✓ Is the client interested in current income or retirement income? How soon does he need to start receiving income?
- ✓ How much risk is the client ready to accept today and in the future? Could he stand the loss of his entire investment? How would an interruption in income affect him?
- ✓ What are the client's liquidity needs in the short-, intermediate- and long-term?
- ✓ What is the client's federal/state tax bracket? Does tax deferral through annuities make sense?
- ✓ Is the client under age 60, and is it likely that he will need to withdraw major portions of the annuity in the future? Will the ten percent penalty offset the benefits of tax deferral?
- ✓ Does the client demand full and complete protection of principal? Or, can the client afford to take risk in hopes of greater appreciation using variable contracts?
- ✓ Is the preservation of principal more important to the client than the effects inflation may have against a fixed yield?
- ✓ What are the survivor spouse/family needs in the event the client dies? How can these needs be accomplished?

Business Insurance

The risk managing agent recognizes that due care extends to businesses as well as individuals, since businesses are composed of the same people. The illness, disability or death of these people represent an exposure to businesses in terms of their survivability and commitments to principals, employees and their families. ***Sales conduct in business analysis*** involves a determination of the reduced revenues and increased expenses that may result from the death or disability of a key person in the business, including the possible costs to replace or sell the

business, if necessary. The degree of risk protection in business insurance varies by the person who is affected and the legal structure of the company. Following are some due care considerations for three major forms of ownership -- sole proprietors, partners and corporations:

Sole Proprietorships

There is no legal distinction between personal and business assets . . . debts of the business are debts of the sole proprietor's estate. Agents should determine needs or ***preloss arrangements*** of the surviving family to continue the business, sell it or liquidate it in the event of the owners death and disability. Capital deficiencies can be filled through the appropriate insurance line.

Partnerships

The legal relationship between partners is personal . . . each is fully responsible for acts of the business and business debts of all others. If a partner withdraws or dies, the partnership must be terminated or reorganized. The disability of one partner can also create a significant financial strain on the entire business. Due care planning here involves learning the wishes of the surviving family and surviving partners. Where a deceased or disabled partner's family wishes to exit the business a ***buy-sell agreement*** provides ***insurance to purchase the deceased's share*** with the business passing to the surviving partner. Alternatively, the heirs of the deceased may become partners or sell the lost partner's interest, assuming this is permitted in the partnership agreement. Again, preloss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

Corporations

Most agents will deal with the "close corporation" where the stock is closely held by a few individuals and not offered for public sale. Typically, the stockholders are also employees of the company. In this case, situations similar to the partnership can develop. A key employee or stockholder can become disabled or die creating additional financial burdens on the company. Most corporation charters provide that remaining stockholders can purchase the share of the withdrawing or deceased shareholder. The risk manager needs to uncover the "formula" for purchase and plan available funds via buy-sell policies, disability protection, health care, etc.

Other significant due care factors concerning business insurance include planning for taxes and liability. For planning purposes, most transfers or sales of business interest become part of your client's gross taxable estate for purposes of death taxes. Income taxes become a factor in corporations where the challenge is to transfer assets out of the corporation without claims of dividend. This is a very complicated area of planning best left to other courses. The issue of liability will be discussed in sections below.

Essential Business Insurance Due Care Questions

- ✓ Who will control the business when your client dies or becomes ill for an

extended period?
- ✓ Will there be a market for the business if it has to be sold?
- ✓ Will the business provide adequate income for the heirs of your client?
- ✓ How will the value of the business affect the taxes and liquidity needs of your client's estate?
- ✓ Will the client be able to continue in business if one of his associates dies?
- ✓ How will working capital be kept intact where a partner or owner dies or is seriously disabled?
- ✓ How can a business be transferred to a new owner without shrinkage in value?
- ✓ What will become of your client's interest in the business if he or she retires?

Sales Conduct – Property & Casualty

Risk management in the property/casualty arena is extremely complicated, yet the primary goal is the same as other forms of insurance -- the transfer of risk. However, a higher standard of due care and agent liability exist in property/casualty because of binders, indemnity disputes and redlining.

A ***binder*** can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible. Abuses occur where agents do NOT have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

Property and casualty insurance contracts are ***contracts of indemnity*** in that they provide for compensating the insured for the amount of loss or damage. Due care is accomplished when an adequate amount of compensation is provided that will avoid profit or loss from a peril or hazard.

Elementary insurance defines a ***peril*** as the cause of a loss. Fire, lightening and collision are all examples of perils. A ***hazard*** is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard. Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard.

While there are, as yet, no formal rules on ***insurance redlining***, there is pending legislation that would force insurers to comply with rules similar to Community Reinvestment requirements now imposed on banks. If passed, a majority of the burden would fall on underwriters. However, agents should be aware that clients living in inferior, low income or minority communities should NOT be denied application for coverage. The logic behind this is obvious -- without access to insurance, clients would not be able to buy housing.

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 attractibility, 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 expanded within the policy or through the addition of umbrella coverage, that applies to all covered liability losses arising out of an accident regardless of the number of persons injured or the amount of separate property damage. Minimum due care considerations in this area include:

Policy Limits

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

Policy Eligibility

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

Policy Conditions

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

Policy Endorsements

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

Policy Exclusions

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

Policy Effective Date

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

Named Insured

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

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

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

Commercial & Professional Lines

Commercial and professional insurance takes many forms: investment and commercial property coverage, business owners insurance, farm coverage, commercial auto plans, commercial liability policies, for directors, officers and professionals, workers compensation and more. A full discussion of each goes beyond the scope of this course. However, there are some important due care factors for agents to disclose and discuss with clients.

Policy Limits

As with most other forms of insurance, a client needs analysis should determine the extent of assets to protect, including any personal exposures. Policy endorsements and/or commercial umbrella protection may be considered as options. Special occurrences may have individual limits which must be evaluated for each client. For example, a "products-completed" limit may be small for a bakery but should be expanded for a lawnmower repair service.

Eligibility

Rules of eligibility in the commercial arena are very complex. Suffice to day, clients should be aware of ALL limitations that might exclude coverage, including: building

size or height restrictions, e.g., buildings not exceeding 15,000 square feet and no more than four stories; business class restrictions, e.g., office uses permitted / manufacturing prohibited or retail permitted / restaurants prohibited, etc. Where liability is concerned, is the policy based on a "claims made" basis or a "claims occurred" basis? Clients should be well informed that coverage may exist ONLY while they are in business and paying premiums. A claim made ten years after a client retires can be financially devastating.

Policy Endorsements

Due care should involve the listing of available options to extend coverage, reimburse for loss of use, loss of rents, loss of income, business expense coverage, builders risk protection, for buildings under construction, add or exclude specific accidents, products, work or locations, employment occurrences (termination, defamation, discipline, discrimination, etc), liquor liability, products completed protection, pollution liability, malpractice, errors and omissions, personal and advertising violations, contractual liability, employee use of vehicles coverage, product defects or deficiencies, product recall protections, inflation upgrade protection, replacement cost coverage, personal effects protection, debris removal, etc.

Scheduled Losses

The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises. In the case of liability policies, premises and operations exposure is the heart of coverage. Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage, etc.

Policy Exclusions

As important as what is covered, clients should understand exactly what is excluded: Building ordinances, government actions, power failure, water damage, bursting pipes, explosion of steam boilers, mechanical breakdown, money, animals, autos for sale, illegal property, underground pipes, fences, antennas, signs, etc.

Named Insured

Since multiple parties may share insurable interest, it is important that ALL parties understand that the "first insured" is typically the "notified insurance partner". In the event of cancellation and policy changes, the conditions of the policy normally name the first insured to be responsible to notify other named insureds. In essence, the first insured is the "point man" for most policy transactions.

Sales Conduct – Quotes & Illustrations

In the past few years, media "sound bites" and state regulator attention concerning the financial stability of insurers and sales misrepresentations have been the primary focus of sales conduct. Not far behind are the issues and supporters demanding agent due care in choosing the right policy -- after all, an industry cannot rise to responsible status, perhaps even survive, if its members take a "sale at all cost" attitude. Both these issues have and will be the target of new company compliance procedures and new regulatory standards. These efforts, however, have been pursued more in a "broad brush" fashion with an emphasis on concerns such as fraud, misrepresentation and twisting.

Many professional agent groups feel that sales conduct should include a new dimension: ***fair and understandable illustrations and quotes***. The reason? Most insurance purchasing decisions are made by clients and agents using illustrations and quotes. Minor variations in the assumptions that go into these projections can produce dramatically different results -- especially if they are spread over long periods of time.

With the advent of computers, multiple page illustrations, some with graphics, literally predict results a client can expect from almost any given product, at any given time in the future using an almost unlimited choice of assumptions. Agents also use mass mailing technology that can tap public records, such as property values, ages, names to personalize and customize a quote without even visiting the property or client. Stiff competition has made the use of computerized quotes and illustrations widespread. Given the sophistication and high quality of these proposals, agents and clients are depending more and more on the face value of the illustration, rather than the actual policy itself. In many instances, clients and agents alike completely pass on reading the policy. This, in turn, has resulted in some surprises for clients and the call for greater scrutiny of sales presentations from professional associations and some regulators.

The problems that surface with most illustration sales relate to the disclosure of assumptions made in illustrations, e.g., interest rates that went down instead of up, insurer insolvencies that could not meet minimum policy rates and/or return of principal, surrender values well below projected results, premiums that were expected to "vanish" simply continued, premium quotes well below replacement value of the property, quotes that do not reflect necessary endorsements, etc. For the most part, the responsibility of misleading illustrations lie with insurer actuaries and marketing departments that produce them. Some agents have also manipulated quotes to specifically avoid true comparisons, i.e., presenting only projected cash values NOT guaranteed values OR quoting skeleton plans void of necessary endorsements.

In recent cases, the misuse of illustrations has led to significant charges of questionable sales tactics by state regulators. The MetLife case involved fines totaling $20 million among 40 state agencies and $75 million in restitution to as many as 60,000 customers. Shortly after these fines were levied, the Florida department of insurance filed charges against the company's top agent, and at least 100 more, accusing them of fraudulent sales practices.

While there is no one single solution to the problem, some remedies are underway in the areas of education, disclosure and better illustration design. In the MetLife case, the company has created a corporate ethics and compliance department which will audit agent offices in the area of sales techniques, including the use of illustrations. Regulators have threatened to prohibit certain proposal techniques altogether, require specific "full disclosure" requirements. Others are launching new compliance orders like requiring insurers to conduct internal investigations designed to uncover illegal illustration marketing practices. Further, the National Association of Insurance Commissioners has outlined the misuse of policy illustrations as a violation of their **Unfair Trade and Practices Act** and Congress has proposed the **Insurance Marketing and Sales Reform Act** to strengthen consumer protection laws concerning advertising and illustration mishandling by agents, brokers and insurers.

Currently, illustration disclosure is different from company to company. Certain professional organizations and government agencies, such as the National Association of Insurance Commissioners, are proposing "model" illustration disclosures. In the mean time, some states have already passed laws requiring agent due care to disclose all assumptions of the quote and/or highlight or bold the guaranteed portions of these proposals to contrast the "anticipated" results. Further, life insurance companies are required to answer certain questions in their annual statement filings pertaining to the "basis" of dividend and interest rate projections. These questions include:

- What is the company's opinion of its ability to continue supporting current dividends and nonguaranteed elements (interest rates).

- Are company assumptions of these factors exceeding the company's current experience level.

To a great extent, the answers to these questions fall on the shoulders of company actuaries. These individuals maintain personal standards of practice that require full and complete disclosure. The Society of Actuaries has also promoted education of this problem to its members and the Academy of Actuaries has made recommendations to the National Association of Insurance Commissioners (NAIC) on possible regulatory actions that could be useful now and in the long term.

Some industry groups, feel that much of the pressure to greatly restrict or eliminate the use of illustrations is unwarranted. They believe that illustrations can be a valuable tool to educate clients with visual interpretations of their options. Rather than scrap the entire illustration system, for example, it is suggested that, as a minimum, ***agent illustration sales conduct*** can focus on treating the client fairly by implementing the following considerations:

- Specimen policies should be on file to compare with specific illustration issues and/or client questions.
- Before doing business with a specific company, request a copy of illustrations for policies the agent intends to handle. Clear up any questions as soon as possible. If the company's management say they don't know the answer, or they avoid

requests altogether, it may be a clue that they will handle client policies in a similar way.

- Agents should be certain that all illustration pages are printed and that all projected interest rates are disclosed and discussed with the client. In casualty quotes, if an "All Risk" policy is presented list ANY & ALL exclusions.
- Particular attention should focus on matters of age, gender, classification, avocations, past experience and other "default" conditions of the life illustration. For casualty, does the quote match the requested coverage, is the principal disclosed, do words imply that client is bound?
- Be sure that the client receives all pages and disclosures.
- On the life side, look for sudden jumps in cash values or premiums -- especially in later years.

Crossing The Line

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

If you are worried about this happening to you, you won't be able to put this book 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-fourths 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 "LA LAW".

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*** case decision automatically creates added exposure for MOST agents, i.e. ***a legal precedent is established***. Agents who fail to comply, are potentially closer to a lawsuit than others. This, coupled with the willingness of judges and

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

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

Finally, don't depend on this book to be a universal solution for avoiding litigation or handling your own defense, rather it is a big, bright ***WARNING BEACON***. ***Study it, learn from it, but get legal advice before taking any action to reduce or defend a possible insurance conflict.***

Agent Responsibilities

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

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

Claims against you may surface as a result of events that occur ***before or after*** a policy is issued, and they may involve you and a client, your insurer or a third party who is an ***intended beneficiary***. Cases can be built around issues of legal conduct (the subject of this section) as well as sales conduct (discussed earlier). 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 subsequent chapters, we suggest several steps to help you reduce and manage this exposure.

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

Liability Based on Agent Duties & Status

The most critical questions in determining agent liability is the extent to which accepted legal standards, state licensing and agency status obligates the agent. This process involves the investigation of many areas, including: Basic Agent Duties, The Law of Agency, Producer's Status (relationship to the client/insurer) and the classification of the producer as Agent/Broker or Agent/Professional.

Basic Agent Duties

The agent/broker generally assumes duties normally found in any agency relationship. The primary obligation here is to ***select a company and coverage and bind the coverage*** (if the agent has binding authority, i.e., property/casualty agents). However, since clients typically ***request*** coverage, the basic duty may expand to include the agent deciding whether the requested coverage is ***available*** and whether the insured ***qualifies*** for it **(Harnett, Responsibilities of Insurance Agents)**.

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)**. 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)**. 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)**. In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a ***specific type of coverage***, the agent is responsible to see if it is available and determine if the client qualifies.

An insured is entitled to rely on an agent/broker's advice on the meaning of policy provisions. In **Stivers vs. National American Insurance**, 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)**. 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)**.

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)**. 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)**. 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)**, i.e., agent duties may also include informing clients their coverage is appropriate ***after the sale***. Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent, e.g., an agent handling the client's business for an extended period of time may assume a higher standard of care.

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however, it is the client's burden to show that **greater duty** is the result of an express or implied agreement between agent and client **(Jones vs. Grewe)** 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.

Another area of legal conduct involves the Law of Agency.

The Law of Agency

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

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

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

General Agents

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

Local Agents

The local agent represents the insurer. He or she may represent more than one company. Commission schedules are typically lower for local agents because they

do not usually perform technical services usually reserved for the general agent or branch/regional office; such as underwriting, policy implementation, claims support, etc., and are subject to a lower level of liability than other agent categories. The local agent is principally a sales representative of the insurer who acquires business and counsels clients.

Brokers

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

Surplus Brokers / Agents

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

Solicitors

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

Marketing Organization & Clusters

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

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**).

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)** and, perhaps, contract and statute duties to the insurer. (**Kurtz, Richards, Wilson & Co vs. Insurance Commun Marketing Corp**).

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.

If you are somewhat confused about this agent / professional controversy you are not alone. There are many agents of professional status, such as CLUs, CPCUs, CICs, AAIs, ARMs and more, who practice ***due care*** for all the right reasons. Most stay clear of conflict by managing it. There may also be an entire army of extremely qualified agents who stay clear of professional designations for fear that the added exposure can't be managed. Perhaps there is room toward the middle. A position we call ***responsible agent***. These individuals also practice due care, yet

operate strictly within the bounds of agency. They accurately describe policy options that are widely available, but "pass" on outside inquiries, not because they don't know, rather the request goes beyond the scope of their authority. They do not profess to be experts but know their product better than anyone. Their goal is simply to be the most responsible agent possible.

Conflicts Through Contract Disputes

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

Failure to Act/Procure Coverage

This is one of the most important areas of agent/broker liability because an estimated 60 percent of all claims result from agent malpractice in failing to procure coverage. In a typical transaction, a broker or agent agrees to procure a certain type of coverage for an insured. It is well established that the broker has a duty to exercise ***reasonable care*** in procuring that coverage. Consider the following cases: (**Jones vs. Grewe**); a failure to actually procure coverage (**Keller Lorenze Company vs. Insurance Associates Corp**); or, a failure to perform some function related to the insurance coverage -- failure to see that policy was actually provided (**Port Clyde Foods vs. Holiday Syrups**); or, failure to forward premiums to prevent lapse (**Spiegal 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)**. Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate (**Hamacher vs. Tumy**). Prior knowledge of an insured's condition is also considered failure to procure coverage **(Soho vs. Tri City Brokers)**.

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 the he is ***unable*** obtain insurance (**Bell vs. O'Leary**). 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.

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**). 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**).

Failure To Renew

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)**. 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.

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**) and point out the difference between different products he is selling **Benton vs. Paul Revere Life)**.

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**).

Agent Promises

From time to time, agents make promises that EXCEED what the actual policy promises. Obvious violations and examples 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.

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 to advertising in the section 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. Violations that result in claims 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)** or **Greenfield vs. Insurance inc)**. 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**).

Conflicts Created By Agent Torts

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

Negligence & Misrepresentation

Agents and brokers can be liable for failure to procure the requested coverage (**Mayo vs. American Fire & Casualty**). 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**). 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**). In **Walker vs.. Pacific Indemnity Co**, 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**). 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**). Finally, in **Anderson vs. Knox**, 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)**.

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)** or in the making of false and fraudulent representations about the total cash that would be available from a policy **(Steadman vs. McConnnell)**.

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**).

Conflicts Created by Client/Agent

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**) and **(United Farm Bureau Mutual Insurance vs. Cook)**. 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)**.

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 to "get it right" the first time. Some feel that the close ties often stop a lawsuit in its track . . . after all, they say, who wants to sue a friend!

Agents as Fiduciaries

New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable "deep pocket". A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent's contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent's liability as a fiduciary simply comes with the territory . . . ***it's part of selling insurance***. In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies **Glenn vs. Leaman)**. 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)**. 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)** / **Kurtz vs. Insurance Communicators)**, or when an agent promises to provide "complete coverage" **(Magnavox Co of Tennessee vs. Boles & Hite).** 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)**.

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**, the agent was found liable for unsound insurance purchases because the plan trustees relied on his advice. In **Reich vs. Lancaster**, the agent was again found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary. In **Kerns vs. Benefit Trust Life**, an agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible. In yet another case, a Louisiana district court held that an insurance agent was a fiduciary a profit sharing plan, even though he only ***sold*** a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is provide retirement benefits. The plan can provide life insurance death benefits only if those benefits are incidental to the retirement benefits. "Incidental", under IRS guidelines, would allow for premium payments LESS THAN 50% of the aggregate employer contributions to the plan. In the Louisiana Case (**Schoegal vs. Boswell**), the plan had purchased life insurance on a plan participant IN EXCESS of 50%. Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was

*"...**clearly more than a mere salesman**"*. In the court's view, he had sufficient discretionary authority and control to be a plan fiduciary. Fortunately, the court's ruling has recently been appealed and reversed on the basis that agent Boswell lacked the necessary authority and control over the plan investments and because there was no underlying agreement that his advice would serve as the primary basis for investment decisions for the pension plan. While this is a favorable decision for agents, it demonstrates the extremes and aggressive legal action to which agents are vulnerable, ***particularly if the insurance transaction does NOT produce the anticipated or desired results for plan participants.***

New fiduciary conflicts may also develop in the area of ***Medicaid Planning***. Agents who routinely counsel clients on methods of transferring assets so as qualify for Medicaid benefits may be subject to fines and penalties. 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 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)**. Beyond fiduciary matters, agents are bound to his insurer by other ***statutory duties***. They include Duty of Care and Skill, *using standard care and skill*; Duty of Good Conduct *or acting so as not to bring disrepute the principal*; Duty

To Give Information *by communicating with the principle and clients*; Duty To Keep Accounts *by keeping track of money*; Duty To Act as Authorized; Duty To Be Practical *not attempt the impossible*; and Duty To Obey or *comply with the principal's directions*. A violation of these duties can be considered grounds for termination and represent legal exposure for the agent.

Following are some examples:

Basic Agency Violations

When an agency agreement exists between agent and insurer, the agent/broker has a duty to exercise reasonable care. The agent is considered a fiduciary of the insurer. He or she must exercise skill and diligence and is liable for negligence that induces the insurer to assume coverage on which it suffers a loss. Brokers who have agency agreements with insurers have been found liable to the insurer for clerical mistakes -- incorrect policy dates, erroneous limits of liability and omissions of endorsements.

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**, 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**. 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**), 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.

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)** 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**, 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** the agent exceeded his binding authority. 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**, 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**, 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 (agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or

maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

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

Liability Created By Insurer Failures

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

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

In an actual case against a California agent, **Wilson vs. All Service Insurance Corp** 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 to indemnify*** agents where an insurer insolvency arises?

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the result of **Williams-Berryman Insurance vs. Morphis**. 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**, 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."

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

Claims of Regulation by the State Insurance Department

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

Claims of Minimum Capital and Surplus Requirements

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

Claims of Minimum Reserve Requirements

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

Claims of Annual Statements

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

Claims of Periodic Examinations

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

Claims of Statutory Accounting

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

Claims of Investment Restrictions

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

Guaranty Fund Claims

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

Virtually every state has enacted what are commonly know as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policy owners, wherever located, of insurers

domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there. The law in some states, however, limits protection on several fronts: There are coverage limits or caps ranging from $50,000 to $1 million per claim; some completely eliminate claims or place severe restrictions on certain policies including life, variable life blends, disability, mortgage guaranty, ocean marine, surplus lines, HMOs, PPOs and other non-traditional markets. Learn more about guaranty funds in a later section.

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.).**

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:

"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).*

Managing Agent Conflicts

An ***ethical advantage*** will be gained if agents choose to manage ***client conflicts before they occur***.

It is estimated that one in seven agents face an errors and omissions claim each year. Charges like these will challenge your reputation, waste enormous time and could threaten your financial well-being. ***Basic measures*** to limit liability always begin by ***avoiding claims at the outset***. Of course, this is easier said than done, since there is NO foolproof method to sidetrack a lawsuit from a client or an insurer. There are, however, some suggestions that agents can use to help reduce the possibility of a claim developing and present a reasonable defense if one does. ***Of course, this can NOT be considered a complete list since special circumstances may require additional precautions.***

Step 1

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

Step 2

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

Step 3

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

Step 4

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

Step 5

Be consistent in your level of "due care" (see Sales Conduct, first section). Write a procedures manual that forces you to treat client situations the same way every

time. Courts and attorneys alike are quick to point out any inconsistency or lack of standard operating procedures where the client with a problem was handled different than another client.

Step 6

Know every trade practice and consumer protection rule you can (Consumer Protection, the next section will help). The violation of "unfair practice rules" is a really big deal to lawyers. They will portray you as something short of a "master criminal" for the smallest of violations.

Step 7

Use client disclosures whenever possible (see this section). There is nothing more convincing than a client's own signature witnessing his knowledge of the situation.

Step 8

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

Step 9

Maintain and understand your errors and omission insurance (see this section). This policy is your "first line of defense", but know its limitations and gaps. The discussions that follow will expand on most of the steps we just mentioned.

Know Your Agent & License Responsibilities

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

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

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

Agent Duties To His Insurer

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), an ***agent's fiduciary duty to his insurer*** prevents him from ***competing with the insurer*** 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, an ***agent's statutory duties to his insurer*** include: a ***Duty of 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**, 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**, 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**, 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**, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers whose license 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

I
n 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". Being ethical requires an agent to comply with all areas of the law to be sure his

client's business is not disrupted by a glitch in licensing. Here are some areas of compliance for ethical agents:

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 many times 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 (check your own state requirements).

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

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

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

Notice of Appointment

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

License Domicile

Agent domicile is a rapidly changing area of law. Currently, many states will grant non-residents a producer license. The rules are fairly straightforward: Agents and brokers of insureds with exposures in several states must be licensed in those states before they can collect a commission for the coverage they have written. However, since a non-resident agent "exports" premiums and business outside a

given state, many states are beginning to erect barriers to prevent outside solicitation. One state (Texas) has strictly prohibited agents and firms from entering to solicit property/casualty insurance business (life and health sales are permitted) without forming a corporation or agency and physically opening a Texas office. Soliciting is defined as direct mail, telephone or any other form of communication, such as fax.

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

Display of License

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

Records

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

Agent Files

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

Agent Business & Marketing Practices

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

Concealment

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

Presentations, Illustrations & Quotes

It is illegal to induce a client to purchase or replace a policy by use of presentation materials, illustrations or quotes that are materially inaccurate. (See Sales Conduct, first section).

Misrepresentations

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

Twisting & Churning

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

Redlining

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

False Claims

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

Unfair Business Practices

It is a violation in most states for agent/brokers to fail to act promptly and in good faith regarding an insurance claim, fail to confirm or deny coverage applied for within a reasonable time, dissuade a claimant from filing a claim, persuading a client to take less of a claim than he or she is entitled to, fail to inform and forward claim payment to a client or a beneficiary, fail to promptly relay reasons why a claim was denied, specifically advise a client NOT to seek an attorney when seeking claim relief, mislead clients concerning time limits or applicable statutes of limitation concerning their policy, advertising insurance that the agent does NOT have or intend to sell, use any method of marketing designed to induce a client to purchase through the use of force, threat or undue pressure, use any marketing method that fails to disclose (in a conspicuous manner) that the agent is soliciting insurance and/or that an agent will make contact.

Policy Replacement *(Specific states only)*

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

Privacy

Information gathered in connection with an insurance transaction should be confidential and have specific purpose. Clients are entitled to know why information is needed and have access to verifying its accuracy where a claim or application is denied.

Consumer Protection

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

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

Insurance Advertising

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

What is Advertising?

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

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

What Isn't Advertising*?*

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

Advertising Compliance

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

Identity of Insurer or Product

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

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

Accuracy and Truthfulness

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

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

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

Illustrations and Quotes

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

Comparisons, Ratings and Competition References

Comparisons made between policies and investment products, e.g., comparing an annuity to a savings account or a split limit quote to a single limit estimate, must be complete, accurate and not misleading. Agents have lost their license by using solicitations and letters that inferred that insurance is available at lower rates than others because of a special "volume plan". All statistical information should be recent, relevant and the source and date identified. Any reference to a commercial rating should be clear in describing the scope and extent of the rating. If an A.M. Best, S&P, Moody's or other rating is advertised, the appropriate disclosures should be given.

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

Disclosures

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

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

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

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

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

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

Testimonials and Endorsements

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

More Unfair Insurance Practices

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

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

Identification

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

Defamation

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

Boycott, Coercion & Intimidation

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

False Financial Statements

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

Stock Operations

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

Discrimination

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

Rebates

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

Deceptive Name or Symbol

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

Deceptive or Unfair Business Practices

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

The Uniform Consumer Sales Practices Act

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

Unlawful Trade Practices

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

- Passing off services as those of another.
- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered.
- Causing confusion or misunderstanding as to affiliation, connection or association with another.
- Using deceptive representations or designations of geographic origin in connection with services.
- Representing that services have sponsorship, approval, characteristics or benefits which they do not have.
- Disparaging services or the business of another by a false or misleading representation of facts.
- Advertising services with intent not to sell them as advertised.

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

Burden of Proof

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

Legal Remedies

Whenever the courts or consumer protection division of an insurance department have reason to believe that any person is engaging in, has engaged in, or is about to engage in any act or practice that may violate a trade or practices act, and that proceedings would be in the public interest, the division may bring action in the name of the state against the person to restrain by temporary restraining order, temporary injunction, or permanent injunction the use of such method, act or practice. In addition, there may be a request by the consumer protection division, requesting a civil penalty for each violation, possibly $2,000, with a maximum total

not exceed an established amount (typically $10,000). These procedures may be taken without notification to such person that court action is or may be under consideration. Usually, however, there is a small waiting period, seven days or more, prior to instituting court actions.

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

The United States Post Office

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

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

Unfair Competition and Business Practices By Insurers

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

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

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

Unauthorized Insurer False Advertising

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

Unfair Settlement Practices

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

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

Discrimination by Handicap

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

Discrimination by HIV Testing

In recent years, HIV-related testing in connection with an application for insurance has become commonplace. If an insurer requests or requires applicants to take an HIV-related test, he must do so on a nondiscriminatory basis. An HIV-related test may be required only if the test is based on the person's current medical condition

or medical history or if the underwriting guidelines for the coverage amounts require all persons within the risk class to be tested. Additional stipulations require that an insurer may not make a decision to require or request an HIV-related test based solely on marital status, occupation, gender, beneficiary designation or zip code. Further, the uses that will be made of the test must be explained to the proposed insured or any other person legally authorized to consent to the test and a written authorization must be obtained from that person by the insurer.

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

Discrimination in Rates or Renewal

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

Benefits Protection

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

Health Policy Benefits

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

Contract Entirety

Every policy of insurance issued or delivered within the state by any insurance company doing business in the state shall contain the entire contract between the parties. Furthermore, ***applications used to secure (purchase) insurance are made part of the contract.***

Insurer Mergers

The conditions and regulations necessary for two insurance companies to merge or consolidate are well documented in state insurance codes. Concerning consumer protection, however, it is important to know that all policies of insurance outstanding against an insurer must be assumed by the new or surviving corporation on the same terms and under the same conditions as if the policies had continued in force with the original insurer.

Reinsurance Assumptions

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

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

Beyond Insurance

Being ethical, may someday require you to go above and beyond your role as an agent. Let's explore this: Your first duty is to make sure that you sell insurance that ***really insures.*** The meaning behind this is that insurance can fail to insure for many reasons (see below). The exposure this creates for you and your client, is something ethical agents need to consider. You need to help prepare your clients for this contingency. This can be the most critical service you offer, and it can result in a lot of goodwill for you and your company..

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***. Agents should look beyond insurance because there are times when clients are underinsured; there are clients who cannot be fully insured; and there are times when insurance simply fails to insure***. Add to this a bevy of carriers, who withdraw or are unwillingly forced from the marketplace, a few insolvencies here an there, and you know why a growing band of attorneys and financial advisers are starting to look ***beyond insurance***; supplementing insurance coverage with multiple legal strategies, i.e., ***asset protection planning***.

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

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

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

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 $140 daily nursing home care coverage do any good when inflation has bumped the cost of nursing homes to $350 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 "legal pirates" who only get paid if they find a deep pocket: be they yours, 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.

When Insurance Fails to Insure

Many of the risks we have discussed can be and are routinely insured by agents. However, there are conditions where this coverage is less than adequate or it simply fails to cover for one or more reasons.

Insurance can fail to insure in many ways. The source can be an agent's negligence in not providing essential coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability of

the insurance company to pay, e.g. insolvency of the insurer. In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent.

Coverage shortfalls

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

Sometimes, insurance shortfall cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference 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 The result can be disappointing to BOTH client and agent. 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 you may already know, 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.

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. In the event of ***a lost or stolen policy***, the policy holder must satisfy ***two requirements to prove coverage***. First, the policy holder must prove that the policy was, in fact, lost or otherwise unavailable by showing that he made a ***diligent search*** for the policy in all places where it can likely be found. Second, the policy holder must ***prove the existence and the contents of the policy by identifying the parties to the contract***, the policy period and the subject matter of the policy. Secondary evidence includes any correspondence, certificates of insurance, claim files, management reports, corporate records, ledger entries, receipts, licenses and agent files and agent testimony.

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

Environmental Litigation There are numerous actions pending in state and federal court concerning the interpretation of commercial liability policies and environmental claims. Much of the confusion was started by the insurance companies themselves when they first marketed the 1966 standard form ***Comprehensive General Liability (C.G.L.)*** policy which represented coverage for environmental hazards. Some companies went so far as to refer to environmental problems, in their sales literature and presentations, as a "hidden exposure" that policy holders should consider. Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure.

Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost $4 billion in settlements from waste generators, disposers and transporters of hazardous materials. Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.
In response to a flood of litigation, the insurance industry began making adjustments. In 1973, certain terms in the C.G.L. policy were revised. For example, the 1973 C.G.L. policy defines "occurrence" as "an accident,, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured." Obviously, an occurrence under the 1973 definition required exposure to conditions over a period of time. "Property damage" was also changed to read "physical injury to or destruction of tangible property which occurs during the policy period . . . or, the loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period." Thus, compared to the pre-1973 contracts, "property damage" now requires ***physical injury*** to tangible property. This distinction may be critical in certain hazardous waste cases and in asbestos property damage cases. In fact, courts have held that some insurers are not required to provide a defense in suits

where the there was no covered "occurrence" or "property damage" as defined in the C.G.L..

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the omission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents. A growing number of courts are siding with insurers where the absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates.

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

In coverage disputes where the insured is bringing action against BOTH a primary and excess insurer, the excess carriers sometimes 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 still to disclose a medical condition that is critical to the insurer's risk decision.

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

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 waivered. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

Misrepresentations A representation by the insured that is ***untrue or misleading***, ***material*** to the risk, and is ***relied*** upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for voidance of the policy, unless the policy is beyond the incontestable period. This is true even if the misrepresentation was made by the insured innocently, with no intent to defraud. A minority of courts, however, take a somewhat less severe

position limiting or prohibiting voidance where the insured's misrepresentation was NOT an intent to deceive the insurer.

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

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

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

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

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

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

An agent's or client's greatest fear would be realized when a perfectly good policy fails because the company behind it cannot pay. 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 of a troubled insurance company can be extremely involved and lengthy. This is the reason that ***state guaranty funds*** were established. ***They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation of an insurer***. Yet, they may still not fully restore a client or move fast enough to replace lost coverage because they have many exclusions, limits and triggers that are not widely known.

Generally speaking, 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.

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

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

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

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

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

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

Dollar Limits As we have discussed in an earlier section, typical pay outs to policyholders who are victims of failed or financially strapped insurance companies might range from $100, 000 to $300,000 for life and health policies and from $300,000 to $500,000 for casualty failures.

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, 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.

Asset Protection Planning / More 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 unforseen 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 form 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 hew 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 Tenenacy There are many ways that creditors can reach a joint tenancy.

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

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

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

Tenancy in Common In the case of a dwelling, a creditor attempting to reach the interest of a tenant in common can cause ONLY the interest of the debtor to be

sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment.

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

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

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

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

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

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

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

Alternatively, the creditor can look to attach the 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.

Spendown is the process by which medical and nursing home care reduces a person's assets. 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 prinicipal 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 statue 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***

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 Partnership which will further reduce the estate taxes due upon your death.
- This estate plan creates a way for you to manage your family assets. This is accomplished by setting up your Corporation as the General Partner of your Family Limited Partnership which will continue to manage your Family Limited Partnership despite the death or disability of any of the shareholders.

- This estate plan eliminates the need for probating your estate since a trust will transfer all assets to your children or grandchildren without court intervention even beyond the death of you or your spouse.

- This estate plan will clarify, prioritize and systemize your entire estate by (1) compiling all the essential information regarding your estate into one complete

source; (2) reorganizing your financial paperwork into a single comprehensive file; and (3) transferring your diversified investment portfolio into a single, easier-to-manage asset -- your Family Limited Partnership.

Asset Protection Plans

What happens today if a third party gets a judgment against you, your spouse or your business?

Without implementing an asset protection plan, the majority of your assets are subject to seizure by third party creditors. Your creditors can pick and choose whatever they please in order to execute upon a judgment taken against either you or your business. Without an asset protection plan, almost all of your personal and business assets will be exposed to execution by a potential creditor.

After implementing an asset protection plan, the majority of your assets are owned by a Family Limited Partnership and are safe from seizure by creditors. Once your assets are transferred to a Limited Partnership format or a series of Limited Partnerships, the third party creditor cannot seize or obtain any portion of your estate. The creditor's only recourse is to obtain a "charging order" against **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 of 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.

Other Ethical Challenges

The purpose of this chapter is suggest possible areas of legal, sales and ethical issues that agents may face in the future. Some may seem too large to have an effect on an individual agent, although there will always be plenty of lawsuits against individual agents to prove this wrong. The fact is, ***you can be affected*** by many different events and changes in the insurance industry. Your best defense, is to know about the "triggers" or issues that create problems, stay on top of trends, manage potential conflicts using ethical techniques similar to those we discussed earlier.

Let's look at some areas of future challenge . . .

Sales Conduct

Future claims against agents will probably be similar to those we are now experiencing: ***insurance sold as an investment, non-performing vanishing premium policies, churning policies, misrepresentation for life insurance sold as a pension plan, interest rate and investment performance falling short of projections and more.***

One of the most important lessons to be learned from these sales misconduct lawsuits is the need to conduct personal due diligence. Don't always assume that sales literature from your insurer is without fault. If it's too good to be true, it probably is.

American Disabilities Act

Insurance companies and their agents may see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA). In **Parker vs. Metropolitan Life** a client alleged unlawful ADA discrimination because the disability plan, administered by Metropolitan Life, distinguished between benefits for mental and physical disabilities. The client had already received the maximum two years of benefit for a mental disorder although the plan provided for payments to age sixty-five for individuals with physical disorders. Although the client did not prevail, the courts would have allowed these benefits for someone else who was ADA "eligible".

AIDs / HIV

Cases are surfacing that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled "Schedule of Benefits". The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable. **(Gonzales vs. American Life)**.

Defining Occupation

In **Oglesby vs. Penn Mutual Life** the insurer denied a disability claim to a client radiologist (vascular interventional radiologist) since a spine and neck problem still allowed him to practice within the same specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as "radiologist" then later narrowed it to "vascular interventional radiologist". In essence, they could not deny benefits. Look for more of these "narrow definition" conflicts which may involve agents.

Psychologically Induced Illness

In **Rizk vs. Dun & Bradstreet / Met Life** the client claimed he was unable to perform certain work tasks due to back injuries. The insurer denied claims because they felt that client's injuries were at least partially ***psychologically induced***. The courts, ruled in favor of the client because his disability was "total" as defined by the policy regardless of whether the illness was psychologically stimulated.

Experimental Treatment

There will undoubtedly be many cases defining what is ***experimental treatment*** under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants, etc. Clients have lost their claim for coverage on the basis of a legitimate denial based on policy terms **(Wolf vs. Prudential Insurance)** and **Hendricks vs. Central Reserve Life Insurance)** and **(Barnett vs. Kaiser Foundation Health Plan)**. Insurance companies have lost their cases where an exclusion about experimental treatment was NOT highlighted in a conspicuous manner **(Gonzales vs. Associates Life Insurance)** or where policy language was considered ambiguous **(Fredericks vs. Blue Cross of Michigan)** and **(Bailey vs. Blue Cross of Virginia)**.

Language Barriers

There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand***. In Parsaie vs. United Olympic Life Insurance a client prevailed in her action against a health insurer because she understood little English and could not read the application.*** She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.

Defining Accidental

Policy language often limits coverage for "accidentally sustained" injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who

attempted suicide because "accidental" was NOT defined in the plan documents **(Casey vs. Uddeholm Corp)**. In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by an attempted suicide **(Lutheran Medical Center vs. Contractors Health Plan)**. Finally an insurer was prohibited from withholding a claim because the client had a "subjective expectation of survival", thus even though his injuries were self-inflicted it was still deemed an accident **(Todd vs. AIF Life Insurance)**.

Tenants As Implied Beneficiaries

The courts are leaning more and more to the proposition that tenant's are ***implied beneficiaries*** under a landlord's policy. In **Bannock vs. Sahlberry** the tenant and landlord had only an oral lease agreement. Even though the tenant was responsible for the fire, the landlord's insurer could not recover from the tenant since he was an implied "additional insured". However, in the reverse situation, a landlord could not be construed to be an implied beneficiary of the tenant's policy **(American National Fire Insurance vs. A. Secondino)**. More bizarre is the case of **Cigna Fire vs. Leonard**. Here, the tenant was required to obtain fire insurance naming the landlord and mortgagee as additional insureds. However, he only purchased insurance on himself and then proceeded to intentionally burn his business to the ground along with the landlord's building. The courts denied the landlord and mortgagee's claim against the tenant's insurer because there was "no clear intention to cover the lessor or the mortgagee". Only the tenant was named in the policy but his claim was denied under the policy's arson provision.

EIL vs CGL

Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are ***claims-made*** policies, while CGL policies are ***occurrence-based***. The introduction of EIL insurance provided clients an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry's position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would no be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.

One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. In **Rhone-Poulenc vs. International Insurance (1994)**, the client owned both EIL and CGL policies. However, the EIL policy contained a provision that loss or damage could not be recoverable as long as other insurance was in force. The courts ruled that the EIL

was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.

Contamination

Despite the fact that policies have been written as "All Risk" insurers continue to deny contamination claims based on policy exclusions. In **W.H. Breshears vs. Federated Mutual Insurance (1994)**, the court rejected a client's claim for coverage on the basis that an oil spill on his property was not "covered property" because it was "land" and "pavement" only, not considered "property". In **Conde vs. State Farm Fire & Casualty (1994)**, a client was denied coverage, which was upheld by the court, for contamination caused to his home by an exterminator's negligence because "contamination" was not defined in the policy. The court also rejected the client's argument that the exterminator's negligence (a covered peril) was the actual cause of loss.

"Sick Building" Syndrome

People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact. In **Sternmann vs. May Department Stores (1994)**, an employee claimed a long-term disability from toxic exposure at her place of work. The company refused full disability coverage since tests showed that toxic levels did not exist in the building. The courts ruled against the client even though her physician's diagnosis was total disability due to toxic exposure and chemical sensitivity.

Asbestos

The removal of asbestos continues to be a major source of conflict between clients and insurance companies. In **University of Cincinnati vs. Arkwright Insurance - 1995** asbestos was found in a dormitory that suffered a partial loss due to fire. The client's all risk policy did not cover the removal of asbestos since it was not considered an unexpected event

Lead

New standards introduced in require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.

Business Interruption

On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what

your situation would probably have been if the loss had not occurred". In **American Auto Insurance vs. Fisherman's Paradise (1994)**, the client lost his argument that his store would have made huge profits in the aftermath of Hurricane Andrew if it were left undamaged. The courts disagreed indicating that hypothetical profits would have created a "windfall" not contemplated by the policy.

ADDENDUM: REQUIRED ANTI-FRAUD TRAINING

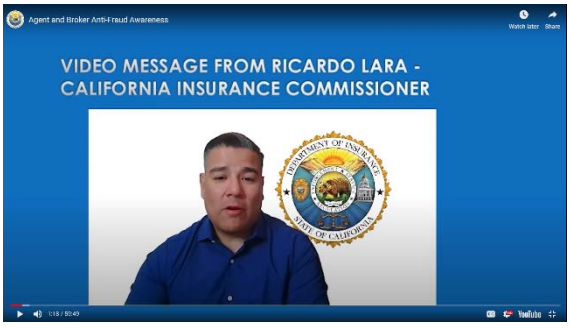
This course INCLUDES the 1-hour required Anti-Fraud Training. When done, you will see a link for a separate Anti-Fraud Certificate that you must open, approve and email to the State. You can send this email through our system. Details will be provided at completion.

INTRODUCTION

Hello and welcome to the required one hour anti-fraud awareness training.

You are participating in this training because you are either working toward obtaining your agent or broker license in the State of California, or you already have your license and are in need of this requirement to renew it.

In the next hour, you will hear from Commissioner Ricardo Lara and several Enforcement Branch personnel as we walk you through who we are, what we do and what your obligations are if you suspect potential insurance fraud may be occurring.



Hello and welcome to the California Insurance Agents and Brokers Anti-Fraud Awareness Training. I'm California Insurance Commissioner Ricardo Lara.

As insurance agents and brokers you provide an essential service and serve as an important resource for homeowners, renters, drivers and consumers across the state.

You also play a key role in anti-fraud effort for the insurance industry as you are in a unique position to detect suspicious insurance applications, potential fraudulent transactions, and claims, and stop them before the fraud is committed.

Because of the change in state law, beginning in 2023, agents and brokers now have a duty to report suspected fraud. The new requirement will assist investigators in our Department to do our job to protect consumers.

To help you comply with this law, our Department of Insurance has put together this training.

This training is really aimed at helping you identify red flags for potential fraud so you can meet your reporting duty. In doing so, you are helping prevent fraudulent insurance transactions and sending a strong deterrent message.

Our enforcement team is the largest branch in the Department, with more than 300 staff dedicated to protecting Californians and stopping fraud. Our team includes Detectives,

Investigators, and support staff who work everyday to meet the Department's mission of insurance protection for all Californians.

Fraud hurts all of us, but by working together to fight fraudulent claims we can better serve our consumers. Thank you, thank you for choosing a career in insurance and doing your part to keep California's insurance marketplace the strongest in the nation.

Thank you again, Muchas Gracias!

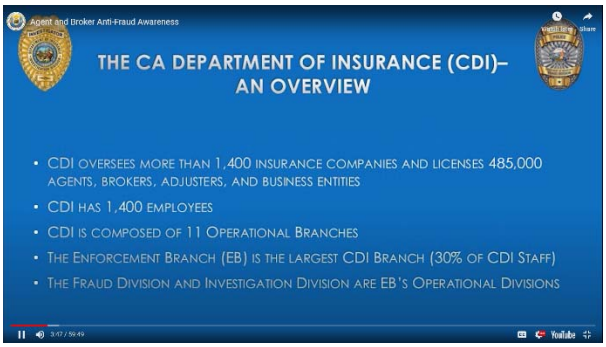
COALITION AGAINST FRAUD

The Coalition against insurance fraud is a group comprised of 281 member organizations that include both private and public groups. The Coalition was formed in 1993 and has dedicated nearly 30 years of work and research in the fight against insurance fraud.

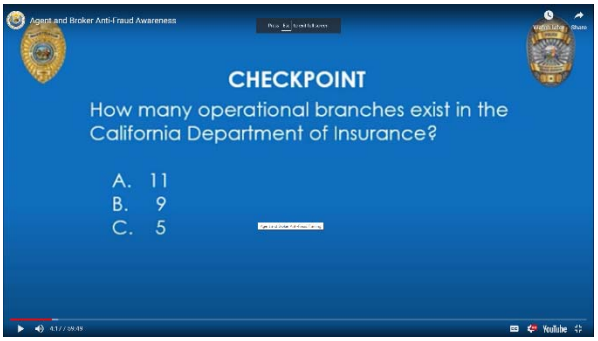
The Coalition conducted a massive study that concluded with a report issued in 2022. The results of the study indicate there to be at a minimum $308 billion lost to insurance fraud each year. And it is estimated that about 10 percent of losses in property and casualty involve some element of fraud.

For agents and brokers, this is a significant number and can impact your profitability.

For more information about the Coalition Against Insurance Fraud, please visit their website at www.insurancefraud.org.

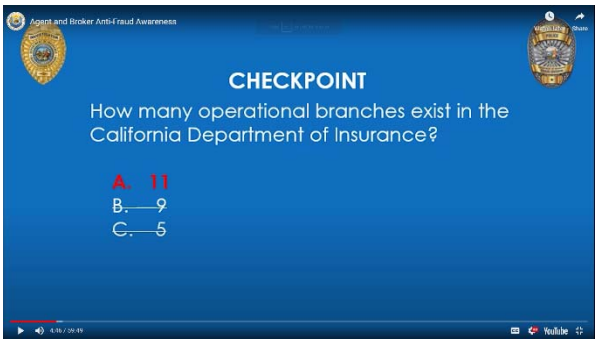


Here are some highlights of the California Department of Insurance. If I may draw your attention to bullet points number 2 and number 4 here. The CDI has roughly 1,400 employees and 30 percent of those work in the Enforcement Branch. That is a lot of resources dedicated to the fight against insurance fraud. In fact, of the 11 branches within the California Department of Insurance, the Enforcement Branch is the largest. In a few moments, you will see why those resources are needed and some of the phenomenal work that our branch does.



Here is a quick checkpoint question, and this is the first of many. The Departments goal is to provide training and form a partnership with you.

To effectively do that, we wanted to ensure that certain elements throughout this course were being retained. So, this checkpoint question is – How many operational branches exist in the California Department of Insurance?



And the answer is . . . 11. Remember, there are 11 branches, with the Enforcement Branch being the largest.

CDI ENFORCEMENT

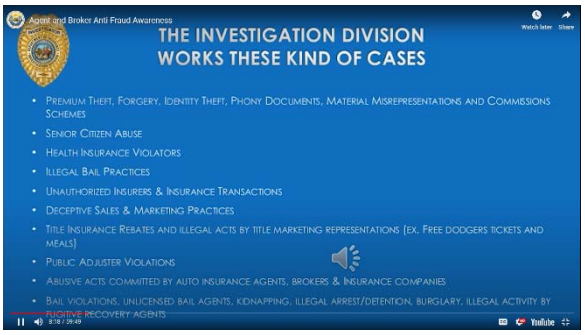
Before we get into numbers, figures and the particulars of what the Enforcement Branch does, please allow me to first outline our structure.

The Enforcement Branch has two divisions and an administrative support section.

Today, you will hear from both the Fraud Division and Investigation Division. But as a quick summary, the Fraud Division handles fraud committed against the insurance industry, such as claimant fraud, while the Investigation Division handles fraud and misconduct committed by agents, licensed and unlicensed, brokers and insurers.

Our divisions and the administrative support personnel occupy nine regional offices within California.

As mentioned earlier, we account for about 30 percent of CDI employees, equaling 424 positions. The rest of our resources are broken out here. You can see we operate with a significant budget as well as handle the administration of tens of millions to County District Attorney offices to assist in our fight against insurance fraud.



Insurance fraud in California impacts all of us and we are pleased to have these resources available to work toward helping California consumers.

For the next several minutes you are going to hear from one of our Investigator Supervisors and a seasoned Fraud Division Detective. They will provide some insight on recent cases and how the resources provided to our Department are used.

The mission of the investigation division is to protect California consumers by investigating suspected violations of laws and regulations pertaining to the business of insurance and seeking appropriate enforcement actions against violators.

Effective enforcement of the insurance laws help to safeguard consumers and insurers from economic loss and eliminate unethical conduct and criminal abuse in the insurance industry.

The investigation division is charged with enforcing applicable provisions of the California Insurance Code under authority granted by Section 12921. The Division pursues prosecution of offenders through both regulatory and criminal justice systems. The Investigation Division employs over approximately 90 investigative and support staff that are assigned to seven regional offices statewide to handle the large volume of complaints that are filed.

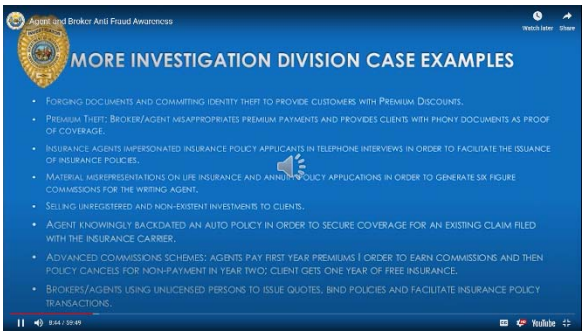
When appropriate, the Division will partner with a number of other state and federal agencies. Which include local law enforcement agencies, the Franchise Tax Board, the U. S. Postal Service and the FBI.

The Insurance Commissioners priorities emphasize investigation and prosecution and in the following areas that concern the Investigation Division.

They include premium theft, senior citizen abuse, health insurance violators, illegal bail practices, unauthorized insurers and insurance transactions, deceptive sales and marketing practices, title insurance rebates, public adjuster violations, abusive acts committed by auto insurance agents and companies.

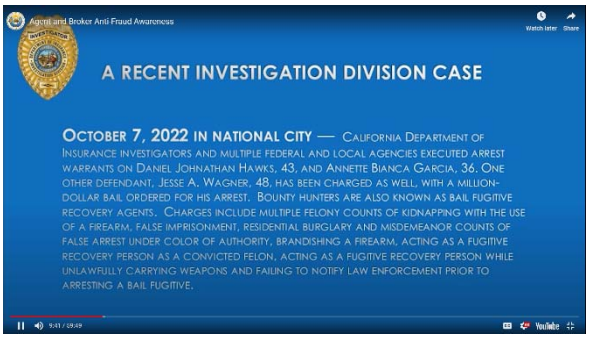
In the last Fiscal Year, the Investigation Division opened 472 new cases, and working with the Departments Legal Division, obtained 236 administrative actions. The Investigation Division also made 20 criminal arrests while also carrying out the mission of protecting California consumers.

Examples of case work done by the Investigation Division include agents forging documents and committing identity theft, premium theft, a broker or agent misappropriates premium payments and provides clients with phony documents as proof of coverage.

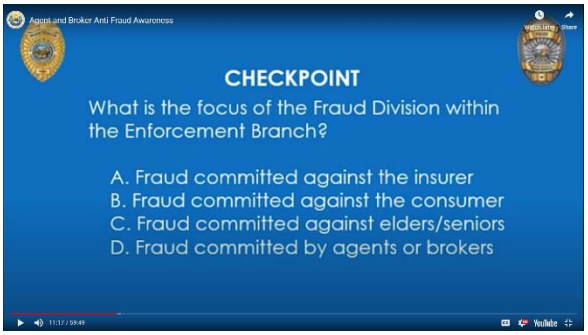


Material misrepresentations on life insurance and annuity policy applications in order to generate six figure commissions for the writing agent. Selling unregistered and non-existent investments to clients. Agents knowingly backdating an auto policy. Advance commission schemes and brokers and agents using unlicensed persons to issue quotes, bind policies and facilitate insurance policy transactions.

Here is an example of an investigations case. Here we have a case that is joint between the California Department of Insurance and multiple federal and local law enforcement agencies against bail bondsman acting in bad faith and outside the law. These three defendants are charged with multiple felony counts of kidnapping with the use of a firearm, false imprisonment, residential burglary and misdemeanor counts of false arrest under color of authority, brandishing a firearm, acting as a fugitive recovery person as a convicted felon, acting as a fugitive recovery person while unlawfully carrying weapons and failing to notify law enforcement prior to arresting a bail fugitive.



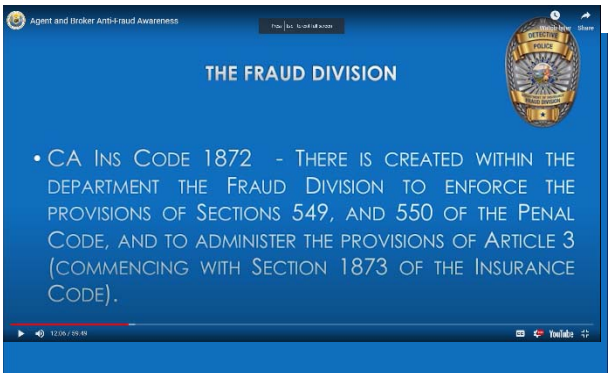
Here is another recent example of investigative casework. In this case, a previously licensed agent stole identities of multiple individuals in a scheme to open a fraudulent insurance agency. His actions didn't stop there, he also used those stolen identities to attempt to open small business loans to fund his fraudulent insurance agency under the name of Cyber Access Insurance Agency.



It's time for another checkpoint question.

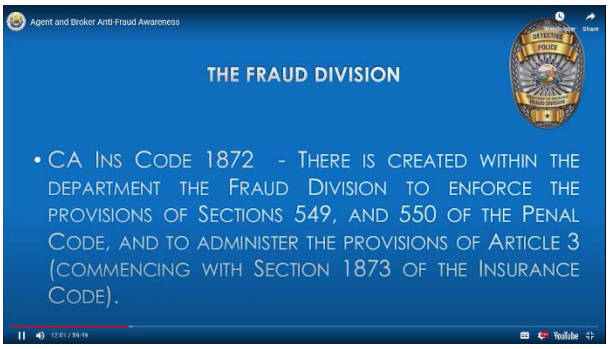
This one asks, what is the focus of the Fraud Division within the Enforcement Branch?

Your options are fraud committed against the insurer, fraud committed against the consumer, fraud committed against elders/seniors, fraud committed by agents or brokers.



And the answer is . . . A. Fraud committed against the insurer.

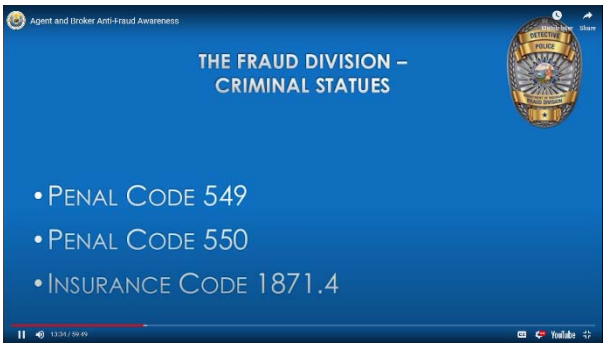
In looking at your other options here, fraud committed against the consumer do not meet the definition of insurance fraud. Fraud committed against elders or seniors also won't meet the definition unless the fraud includes an element of misrepresentation on an insurance policy where the insurance company is the victim. The final option, fraud committed by agents or brokers is not the responsibility of the Fraud Division, but rather the responsibility of the Investigative Division that you just heard about.



The Fraud Division is staffed by sworn personnel who conduct criminal investigations into various types of insurance fraud related violations. The Fraud Division is composed of four separate insurance fraud programs: Automobile Insurance Fraud, Workers' Compensation Fraud, Property/Life/Casualty Fraud, and Disability and Healthcare Fraud. Fraud Division detectives also provide assistance, as well as training for consumers, the insurance industry, and allied law enforcement agencies. The Fraud Division hosts several task forces with the mission to combat specific areas of insurance fraud, such as the Organized Automobile Fraud Activity Interdiction Program and regional worker's compensation anti-fraud consortiums. Fraud Division detectives may be assigned to various local law enforcement task forces such as auto theft, computer forensics, underground economy, pharmaceutical fraud, and disaster fraud. This pooling of resources and expertise has identified strategies to aggressively investigate and deter fraudulent behavior. Fraud Division detectives are also tasked with identifying emerging trends in insurance fraud in order to protect California consumers.

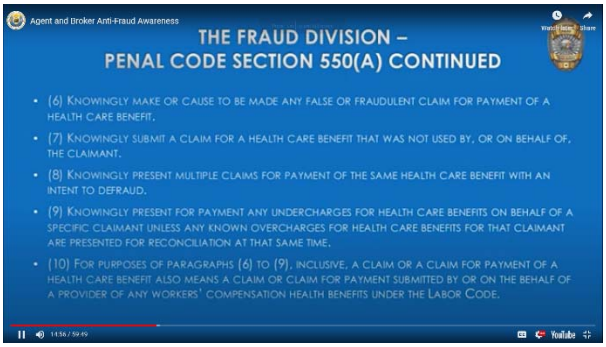
Within the four Fraud Division programs, detectives investigate crimes related to sections 549 and 550 of the Penal Code, and 1871.4 of the Insurance Code.

Additionally, there are many other criminal violations associated with insurance fraud found in the Penal Code, Insurance Code, Labor Code, and Business and Professions Code.



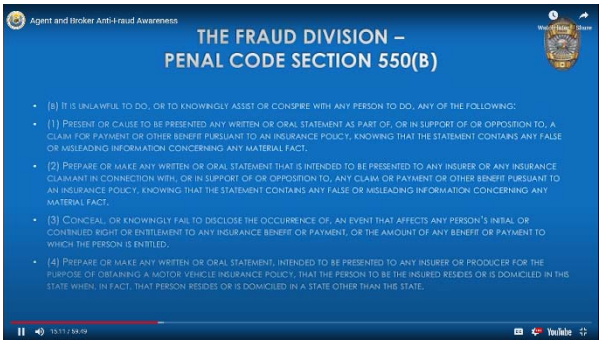
Oftentimes, detectives uncover related crimes during their investigations, such as conspiracy, human trafficking, grand theft, automobile theft, arson, forgery, and embezzlement.

Penal Code 549 addresses illegal referrals and solicitation in connection with insurance fraud. This code is often associated with illegal activities concerning automobile insurance, however, the code applies to any type of fraud that falls within Penal Code 550 and Insurance Code 1871.4.

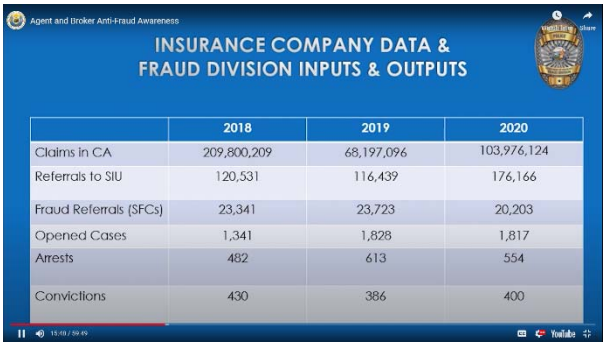


Penal Code 550 (A) delineates the various unlawful acts regarding any false or fraudulent claim. Subsections 3 and 4 specifically mentions claims associated with vehicles, however subsections 1, 2, and 5 apply to any false or fraudulent claim.

Subsections 6 through 10 cover unlawful acts connected specifically with health care benefits.

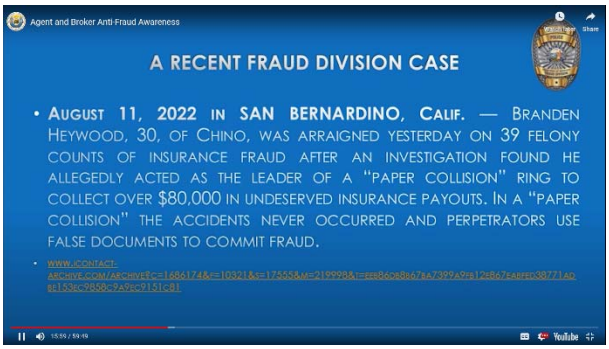


Penal Code Section 550(B) covers unlawful acts in connection with a claim or payment or other benefit pursuant to an insurance policy. This section can apply to an unlawful act committed in connection with a legitimate claim for a loss.

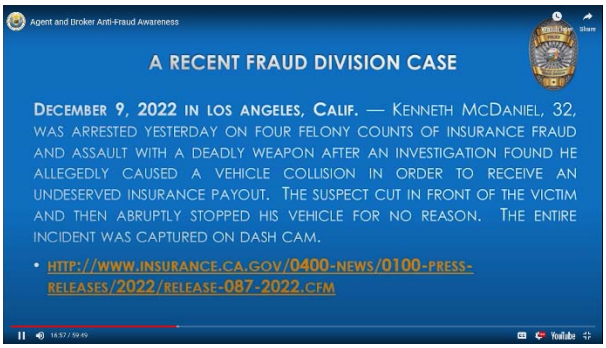


	2018	2019	2020
Claims in CA	209,800,209	68,197,096	103,976,124
Referrals to SIU	120,531	116,439	176,166
Fraud Referrals (SFCs)	23,341	23,723	20,203
Opened Cases	1,341	1,828	1,817
Arrests	482	613	554
Convictions	430	386	400

This chart shows a three year comparison of the total amount of insurance claims filed in California, the amount of claims referred to insurance carriers' Specialized Investigative Units, the amount of Suspected Fraudulent Claim referrals made to the Fraud Division, the amount of arrests made by the Fraud Division, and the amount of criminal convictions obtained by the various district attorney's throughout the state.

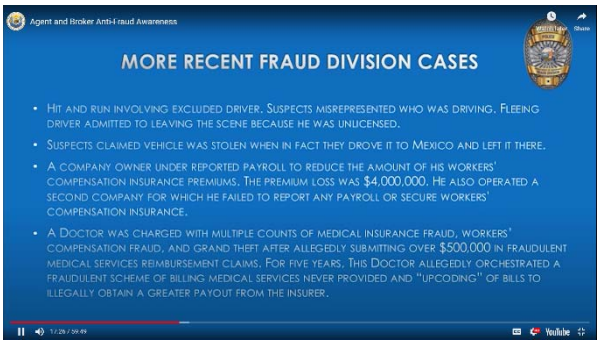


This recent case involved an individual that functioned as a ringleader for a staged collision ring. The investigation revealed that the suspect was using his identity and others', including the identities of his minor children, to stage fake collisions by submitting fictitious medical records and altered California Highway Patrol collision reports to insurance companies in order to collect insurance payouts. The suspect recruited people on social media to say they had been passengers in the fake collisions. As a result, five additional suspects have been charged with felony insurance fraud.



The type of alleged scheme in this case is called a swoop and squat and is used to force a victim to remain in their lane so a collision cannot be avoided. These types of intentional collisions are extremely dangerous, not only for those involved, but for anyone on the road. The Fraud Division not only investigates these types of collisions, they also conduct training with local and state law enforcement agencies on how to identify and investigate these types of violent crimes.

This slide (next page) details several more recent investigations conducted by the Fraud Division. These examples demonstrate how insurance fraud can take a variety of forms, from concealing hit and run collisions to doctors submitting fraudulent bills pursuant to workers' compensation claims.

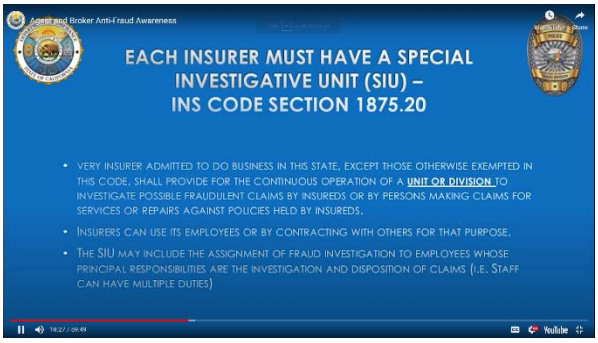


I hope you enjoyed hearing a little bit about what we do here at the Enforcement Branch.

COMPLIANCE

Next, I am going to cover compliance requirements.

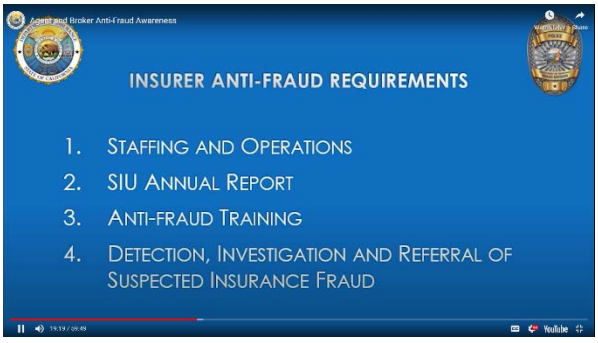
We will start with insurance company requirements and then get into the specifics of what you, as an agent or broker, are required to comply with.



Please keep in mind, the requirements we are reviewing today only pertain to anti-fraud operations. Other units within the California Department of Insurance may have additional requirements for the groups listed here. If you have questions about statutes and regulations that are outside of scope of anti-fraud operations, I encourage you to review our public website to determine the best resources for your questions.

Insurance companies admitted to do business in the state of California are required to comply with the Insurance Frauds Prevention Act and the California SIU Regulations.

One of the initial requirements is to establish what is called a Special Investigative unit, or SIU for short. This unit is required to be available to investigative suspected insurance fraud on behalf of the insurance company. The unit can be comprised of internal or external employees. If an insurance company decides to go external for this function, they are subject to additional requirements, which we will go over shortly.



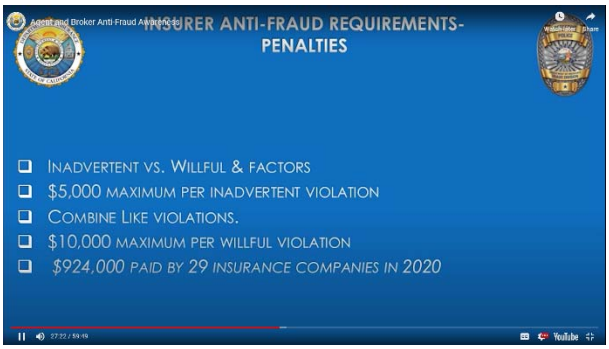
The requirements within the IFPA and California SIU Regulations can be subdivided into these four sections.

Staffing and Operations. This begins with the existence of the SIU itself. The unit must also be comprised of staff that is knowledgeable in claims practices, investigative techniques and detecting fraud. As mentioned previously, if this unit is contracted to an external company, then contractual obligations also fall in this category. An external company must have a contract in place with the insurance company that contains very specific verbiage. The external SIU must also comply with all provisions of the IFPA and the California SIU regulations. If they fail to be compliant, the insurer they contract with could be assessed penalties. Operations also covers response requirements if a law enforcement agency, such as ours, reaches out to get documents or conduct an interview.

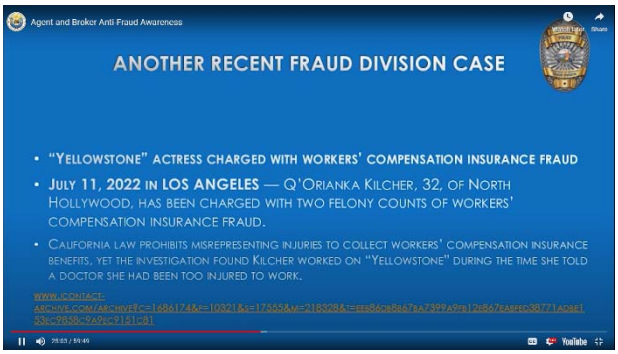
SIU Annual Report. The SIU Annual Report is a report filed each fall by approximately 1,200 insurance companies operating in California. This report contains statistical data, structural outlines and names and contact information for insurance company SIU personnel. This is a confidential report and the data is not released outside the Department. It is an insurers responsibility to know this filing is required. Notifications are mailed on the last business day each June; however, even if a notification does not reach its intended target, the filing obligation still stands. Since the filing does contain several levels of data, you may get a request for information from an insurer you contract with seeking information. If this occurs, be sure you confirm who you are releasing information to and be certain you provide them with exactly what they ask for. Errors in data could result in penalties for them so it is important they be accurate.

Anti-Fraud Training. Training requirements for anti-fraud personnel comes in three levels. The first is training required to be given to newly hired personnel within 90 days of commencing their assigned duties. The training must cover specific criteria, some of which are the detection of fraud red flags or indicators and how to refer something to the SIU. The second level of training is an annual training for the integral anti-fraud personnel. This would be underwriters, claims adjusters, possibly premium auditors – basically anybody in a position to detect insurance fraud red flags. This training has similar topics to the new-hire training and is required to be given minimally once per calendar year. The third level of training is specific to the SIU personnel. SIU personnel are required to have five hours of continuing anti-fraud training annually and it must cover at least one of the topics of investigative techniques, communication with Fraud Division, legal and related issues, red flags or insurance fraud trends. Even though these training requirements do not apply to you as agents or brokers, be aware that some of this information is still needed for you to comply with reporting requirements. For example, in certain circumstances, you will need to know what the referral process to an insurance companies SIU is. So, even if you don't need the training, be sure you have the knowledge needed to effectively operate.

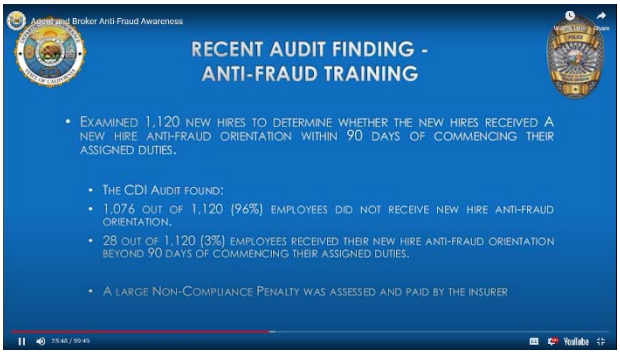
And finally, the detection, investigation and referral of suspected insurance fraud. This area covers a lot of requirements for both the integral anti-fraud personnel and the SIU personnel. It encompasses everything from how to detect red flags, how to refer those red flag files to the SIU, what investigative steps the SIU is minimally required to take, how to determine if and when a referral to the CDI Fraud Division is warranted and how to make that referral when it is required. Later in this training, we will talk more about when a referral is warranted to the CDI Fraud Division if you are an insurance company employee and if you are an agent or broker. While similar, there are key differences you'll need to know.



Within the area of staffing and operations, a common violation is failing to communicate with the CDI Fraud Division, California District Attorneys or other authorized governmental agencies within the timeframes specified by statute. Statute requires that insurers respond within 30 days to all lines other than workers' compensation and for workers' compensation insurers are allotted 60 days. Shown here is a recent violation that was written up by our SIU Compliance Unit. As you can see in column three, this company was significantly late on several communications. Violations such as this one hinders our ability to investigate and prosecute insurance fraud. As an agent or broker, you are also required to respond to file requests within these timeframes.



We put in this example of a recent case to highlight that nobody is exempt from having to be honest about workplace injuries or other types of insurance claims. This actress thought she could get away with working while collecting workers' compensation benefits. California law prohibits this and her status in Hollywood did not exempt her from being charged with insurance fraud. We feel examples like this one are important to highlight. Too often people get into a mindset that they are either entitled to something or exempt from having to follow rules or laws. When it comes to insurance fraud, we don't care who you are, what your title is, or who you know. If you commit insurance fraud, we will be there to set you straight.

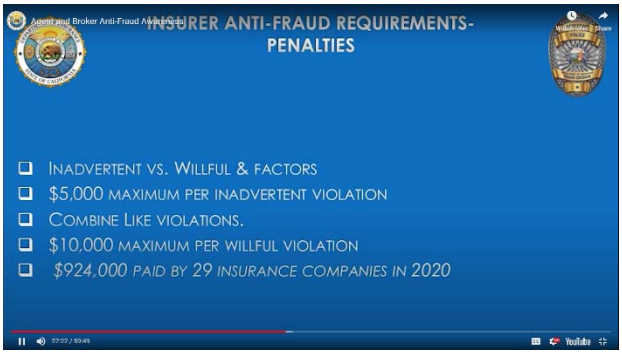


Another recent violation written up by our SIU Compliance Unit. This one is in the area of training, specifically the new-hire training. As you can see here, our SIU compliance unit reviewed training records for a total of 1,120 new hires for this company. In that review, which reflected both the hire dates as well as the training dates, the compliance unit found that this company failed to train 3 percent of their new hires within the 90 day timeframe and failed to train 96 percent of the new hires at all. That amounts to a 99 percent noncompliance rate overall. The penalty assessed on this violation alone was well over six figures and the company also earned a fairly quick follow-up audit to make sure they implemented proper steps to rectify this issue going forward.

PENALTIES

Speaking of penalties, California has two types of penalties for anti-fraud violations.

Violations are either considered to be willful or inadvertent.



Inadvertent penalties has a $5,000 maximum. If something is considered inadvertent, we also combine like violations that are similar.

Willful violations carry a $10,000 maximum. In cases of willful noncompliance, the Department does not combine like violations and so that $10,000 figure can be assessed for each act of noncompliance.

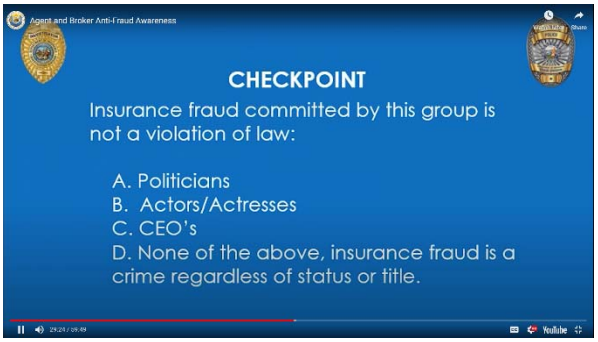
For example: in the previous slide, I showed you a finding that included over 1,000 people that were either trained late or not trained at all. If this were an inadvertent penalty, we would assess up to $5,000 for the entire violation. As a willful penalty, the company can be assessed a separate $10,000 for each individual that was not trained or trained late. Using that math, you can see how we got to a six figure penalty very quickly.

It is important to note, that to be considered willful, all the company needs to do is be aware the statute or regulation existing. It is very rare to have a violation be considered inadvertent for this reason.

This is not to say that for every violation we go after the maximum penalty allowed by law. Since we do consider fighting insurance fraud to be a partnership with the industry, we take into consideration several factors when determining what exactly a penalty will look like.

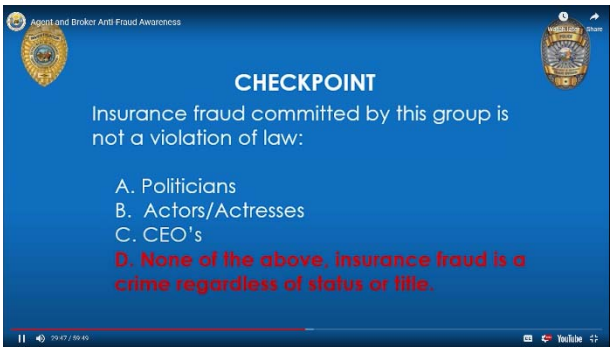
Some of those factors are, how quickly did an insurer come into compliance, what does their prior compliance record look like if we've examined them before and what kind of corrective action are they putting in place to avoid it in the future.

Some years are better than others when it comes to how much we assess in penalties. We noted our 2020 figure of $924,000 on this slide. We did that to illustrate that penalties are significant and insurance companies should not consider violations and penalties to be simply a cost of doing business.



checkpoint. Insurance fraud committed by this group is not a violation of law.

Politicians, actors/actresses, CEO's, none of the above, insurance fraud is a crime regardless of status or title.



And the answer is . . . D. Remember the Yellowstone actress we talked about? Nobody is above the law.

RED FLAGS

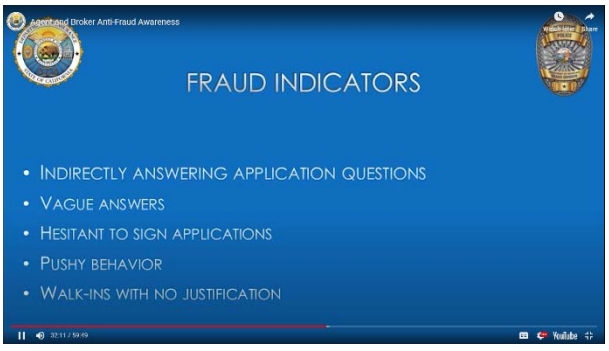
Some of the most common red flags you may encounter are listed here.

They may include asking questions about specific types of losses that may be covered, asking about taking out a life insurance policy on a person they don't appear to have a direct connection to or attempting to purchase coverage on collateral they don't appear to have a connection to.

Any one of these, or combination, should be enough for you to pause and consider what your next steps should be.

Alright, picture this, a new customer calls and they want to insure a 1970 Pinto Station Wagon, and they want full coverage, meaning comprehensive and collision both included, they don't care what the policy is going to cost and they want to make sure the policy will be effective today. Sounds odd, right? I certainly hope so. While the scenario sounds somewhat entertaining, and perhaps you are even picturing this Pinto now, we would hope you stop, ask some additional questions and then decide if something is just isn't right.

That, of course, is an extreme example. What you will more likely encounter will just be someone who wants to take out a policy, doesn't want to have the collateral inspected or just seems to really want the policy to be effective immediately without really caring about cost.

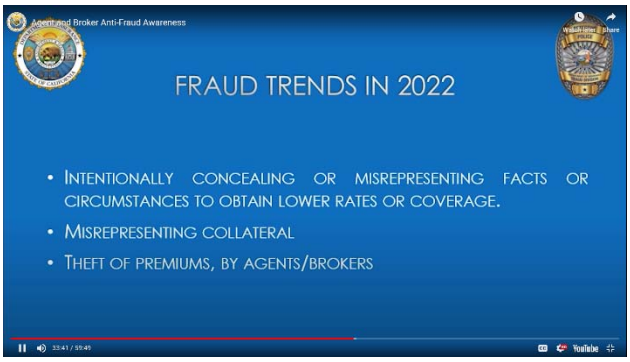


Here are some of the more general indicators. Red flags tend to be specific, whereas indicators are not. If someone answers a question with hesitation, it could be a sign of potential insurance fraud, or it may just truly be a fuzzy memory.

For example: if I ask a potential client if they had a specific type of cancer in the last 20 years and they hesitate or respond in a non-committal way, it may not be someone trying to commit fraud, it might legitimately be someone

who did have cancer but truly can't remember if they were considered cancer-free 19 years ago or 21 years ago.

Walk-ins with no justification we get asked about quite a bit. Cold calling an insurance company for quotes does happen, but usually it is spurred by something specific. A person might be shopping for lower rates or they may be unhappy with their current agent, broker or company. Perhaps they were referred to you by someone that you made extremely happy. Asking the question, how'd you here about us? Or, what caused you to reach out to us today? can be simple, valuable and effective ways to determine if a person has a reason to be calling you, or if they are simply calling every broker or agent in the area to see who they can trick. Again, not saying cold calls don't happen, but we'd recommend taking a closer look to see if additional flags or indicators are present if you do get a call with no reasons behind it.



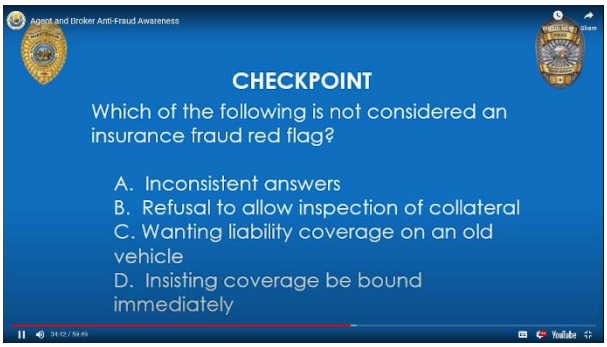
FRAUD TRENDS

Over the last few years we've seen some new trends come about in the industry, much of which is centered around claims and telehealth in a virtual reality. For underwriting and agency fraud, not much has changed. We do see an increasingly higher volume of policies purchased online or through phone apps, but we were seeing that before the pandemic as well. So, for 2022, we settled on these three trends to bring to your attention.

The intentional concealing of information, this could be something such as not listing all the drivers in the household.

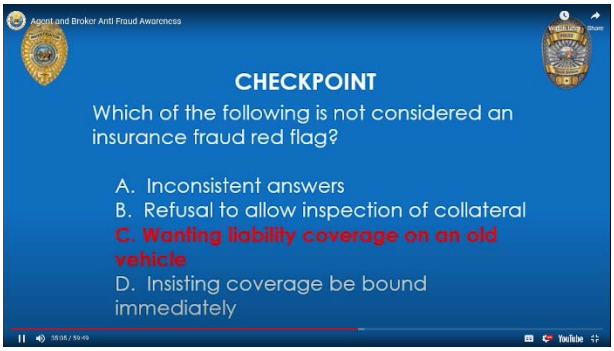
The misrepresenting of collateral. This could be the number of something that is owned, such as how many pieces of artwork does somebody have or it could be the condition of something that is owned.

We also included an item that our Investigative Supervisor mentioned earlier in this training, and that is theft of premiums by agents or brokers. This can be the use of money provided to purchase a policy that is ultimately pocketed by an agent or broker and the poor policyholder has no idea until they have a loss and there is no coverage.

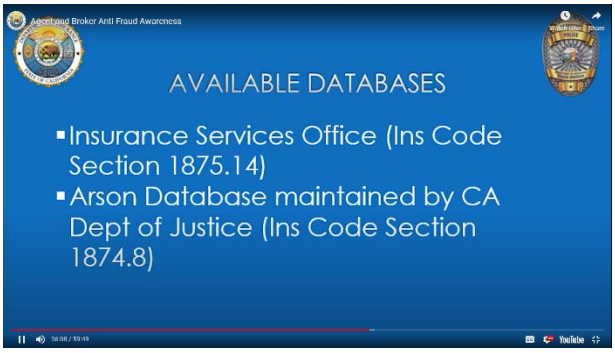


Next checkpoint. This question is, which of the following is not considered an insurance fraud red flag?

Inconsistent answers, refusal to allow inspection of collateral, wanting liability coverage on an old vehicle, insisting coverage be bound immediately.



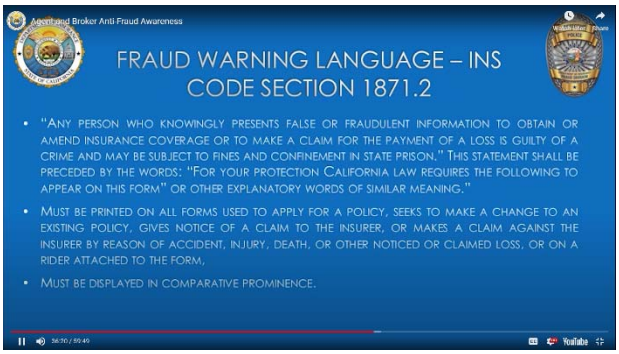
And the answer is . . C. Wanting liability coverage on an old vehicle. California law requires all vehicles have liability coverage if they are registered and so this is not an unusual request. Now, if the person is seeking to add comprehensive and collision coverage to an older vehicle, that should cause you to want to ask questions and have a deeper conversation.



Here are a couple of databases that exist to help you identify red flags as well.

Insurance Services Office, better known to the industry as ISO. If you have access to ISO, you will be able to see past claim history, potential fraud indicators that other companies may have noted. There's really, truly, a lot of great information available through ISO. If you don't have access, consider asking the companies you are working with if they can provide you access.

We also have the Arson database, this database is maintained by the Department of Justice is also a good resource if you are doing property policies. If someone has been convicted of arson, they should show up here, and that would be a pretty big indicator that perhaps you should stop, and consider whether or not you want to write a policy for them.



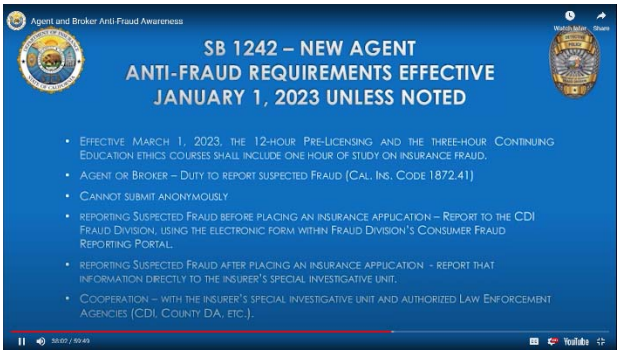
AGENT REQUIREMENTS

Alright, let's talk about the California fraud warning language.

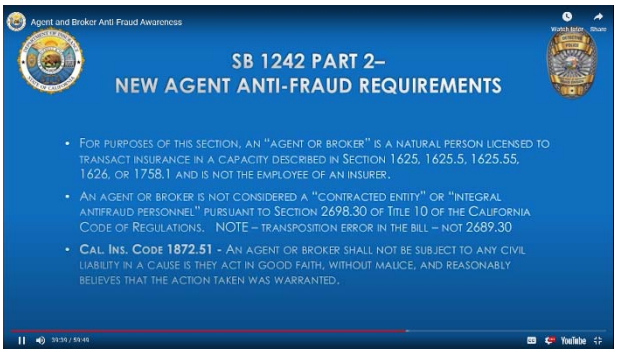
This statement, "Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison," must be provided to insureds.

As an agent or broker in California, you are going to see this wording a lot. Or at least, you should. This wording is required to be on forms used to apply for a policy, make a change to an existing policy or within the claims process. So, you may see it on applications, endorsement pages, basically on anything used to apply for or change a policy.

This requirement is actually amended as of 2023. Prior to January 1, 2023, you would find this wording only during the claim process. It was expanded because the Department saw a need to ensure consumers seeking to get coverage or change coverage were aware that honesty matters at all points of an insurance transaction.



Senate Bill, or SB 1242 is the reason you are all listening to this. In this bill, a few things happened, but those pertinent to you at this moment are: the creation of this 1 hour anti-fraud training that as I mentioned at the opening you are either getting now because you are seeking to obtain a license or you have one renewing. The bill also creates specific reporting requirements for agent and brokers. There are two reporting requirements depending on the status of the policy. If the policy is in the application stage and has NOT been placed with a specific carrier then the agent or broker is required to report the red flag directly to the Fraud Division Consumer Portal. If the policy has already been placed, the agent or broker will report the red flag to the insurer's special investigative unit. Also on this slide, please note that an agent or broker is required to cooperate with the insurer's SIU or law enforcement. This is not actually new, but something that we wanted to point out as your interaction with us may increase with the implementation of these requirements.

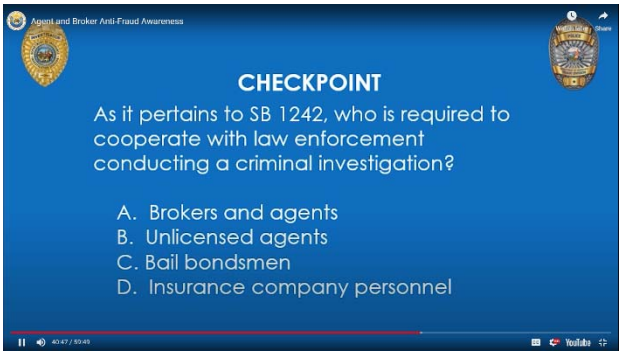


It is important to know if you fall under these requirements.

An agent or broker is a natural person licensed to transact insurance in a capacity described in Section 1625, 1625.5 1625.55, 1626 or 1758. 1. They are also not an employee of the insured.

For the purposes of the remainder of the of the California SIU Regulations, it is also important to know that the Enforcement Branch does not consider an agent or broker, as defined by these codes, as a contracted entity.

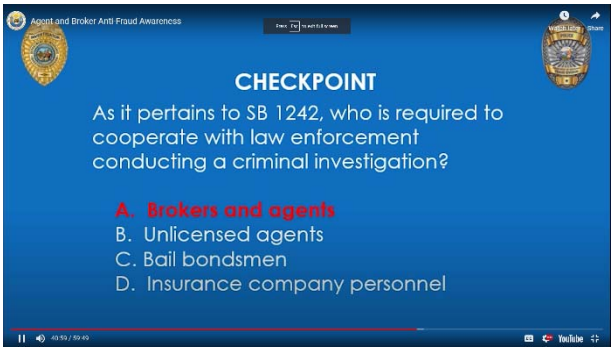
Lastly, but no less important, agents and brokers who refer to either a carrier or directly to the Fraud Division do have protections against civil liability as long as they were acting in good faith, without malice and reasonably believed that the action taken was warranted.



And here is our next checkpoint. As it pertains to SB 1242, who is required to cooperate with law enforcement conducting a criminal investigation?

Brokers and agents, unlicensed agents, bail bondsmen, insurance company personnel.

And the answer is

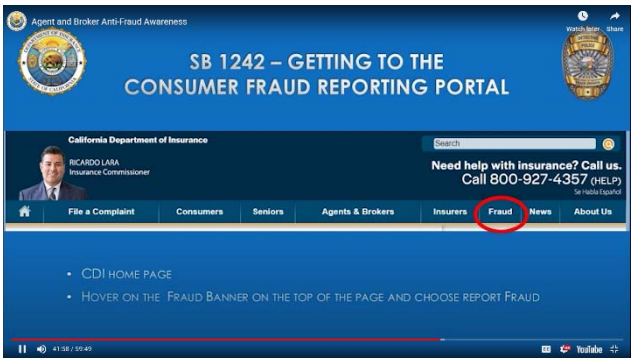


A . . . Brokers and agents. The other listed individuals or groups here may have a duty to cooperate, but this question is specific to SB 1242, which applies to brokers and agents.

REPORTING FRAUD

Over the next several minutes, I will walk you through how to access the consumer portal and what needs to be entered.

Keep in mind as we go through that this form is in the event of an unplaced policy. If you have placed the policy, refer the file to the insurance company SIU using whatever internal referral method they have created.

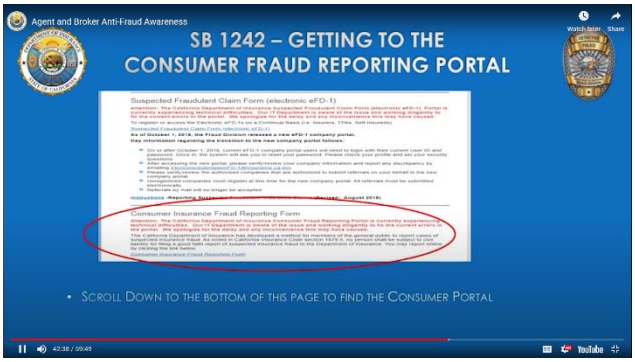


We begin with the California Department of Insurance public website, which is located at www.insurance.ca.gov.

From the home page, you will find the word Fraud on the banner, this is located third from the right and we have it circled here in red.

When you hover over the word Fraud, it will produce a drop-down with several options.

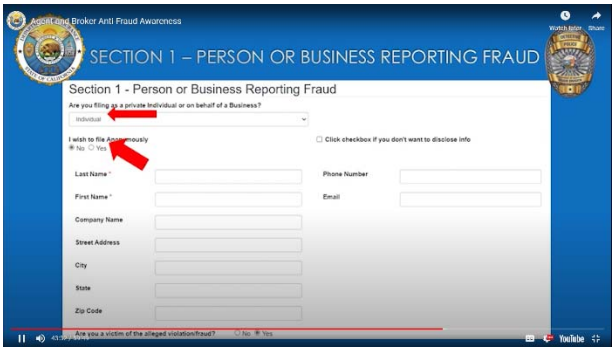
Toward the bottom you will find an option that says "Report Fraud" and that is where you will click.



Clicking on Report Fraud will take you to this screen here, which has two options. The top option is for insurance company SIU personnel to report. As agents or brokers, you want to select the second option, which says Consumer Insurance Fraud Reporting Form.

Clicking the link to open the Consumer Insurance Reporting Form will take you here and you will fill out the boxes as presented.

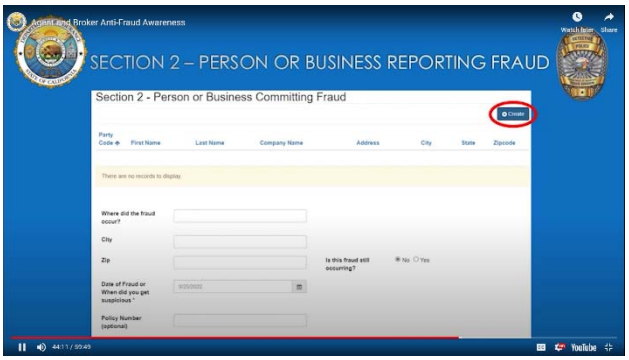
At the top, you will have a drop down giving you the options of individual, business or agent/broker. You will select agent/broker.



The next line down asks you if you wish to file anonymously. As agents or brokers you may not file anonymously. Statute does not allow for that. And the reason is, if the Fraud Division wants to open a case on this referral, we need to be able to reach out to you to get information or for the files.

The remainder of the form is fairly self-explanatory, please enter your name and contact information.

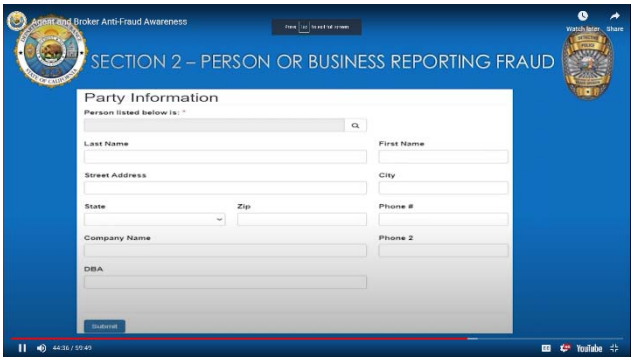
At the very bottom, you will indicate "yes" for being a victim of the alleged fraud. Even if you did not end up writing a policy because you detected the red flags and declined the business, you were still the victim of that fraudster trying to take advantage of you.



The next section of the form is where you will enter the information of the person, or business, committing the fraud. More than likely in your case, it will be person.

To the right of the screen, circled in red here, you will find a button to create a suspect.

Clicking the create button will bring up a pop-up screen, so make sure pop-ups are enabled, and on that pop-up you will enter any data you have on the suspect.

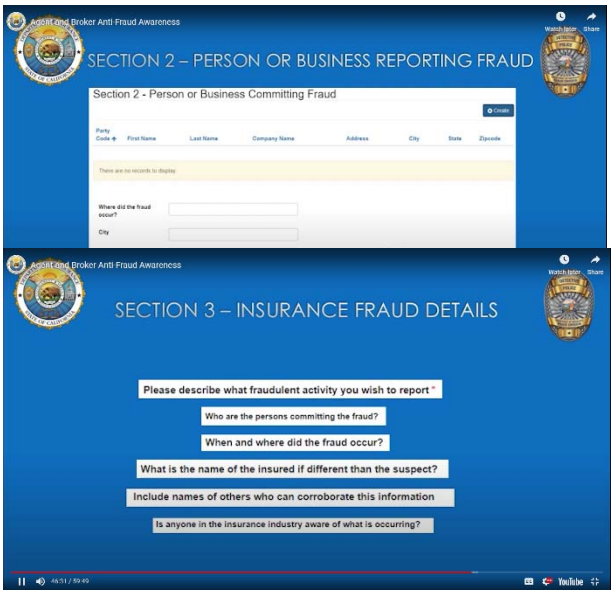


Here is what that popup looks like.

At the top, it asks you who the person listed is. Your options here are going to be insured, claimant or other. Most likely, you will be selecting insured since you are not dealing with claimants under most circumstances and other would be reporting fraud perpetrated by providers, attorneys, medical personnel or similar individuals.

We do recognize that the term insured implies they are an insured of yours. In your case, this may not be wholly accurate. Reporting red flags through the consumer portal is for applicants who you have not placed business for and so they are not your insured at this point. That is ok, please select insured anyway. We will see that you are an agent or broker submitting and know that insured is potentially not a client of yours.

The remainder of the form, as you can see, will ask you for name, company name if applicable and address information.



When you save the information on that popup, you will see it populate under the line at the top of the screen shot where it now says "there are no records to display. "

After entering the information, you will complete the rest of the section. For the location of the fraud, please be as specific as possible. This will help us ensure we get the referral to the right Regional Office for handling.

The next screen in the portal asks you write out what the suspected fraud details are. What you see here are the questions that

appear on the form. Please do your best to answer these as thoroughly and accurately as possible.

The first question. Who are the persons committing the fraud?

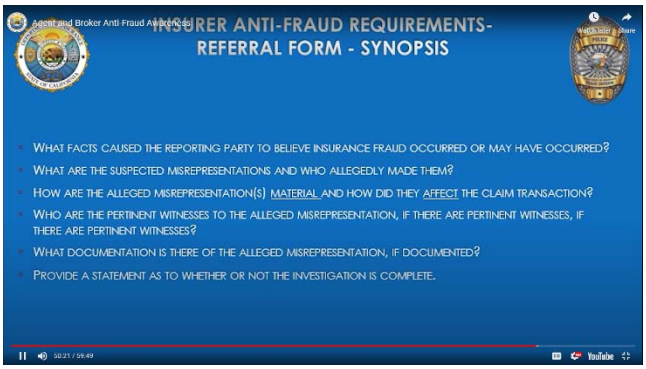
When you answer this, be as specific as possible. What is their name? Full name preferably. Not just Sally. Also, not nicknames, provide the legal name. If someone goes by Bob, but their actual name is Robert, please enter Robert. If there is more than one person involved, enter them all. Don't hold back, we need to know everyone who is part of the potential fraud.

The second question. When and where did the fraud occur? This one may be difficult to pinpoint. If someone called, you may not know exactly where they are calling from. If someone submitted something online, again, you won't know from where. The easiest way to handle this question if you don't have an exact location would be to use your office location. If a criminal case gets opened, our Detectives or Investigators will take on the task of confirming location for jurisdiction purposes.

The third question. What is the name of the insured, if different than the suspect? Now that is an interesting question, right? We do see a fair amount of fraud committed by someone other than the policyholder. Common examples include children taking out policies for parents. This could be property casualty policies and the parents don't speak English, and so the children are there facilitating. This could be medical or life insurance where the children are intentionally misrepresenting medical history of elderly parents in order to take advantage of something. There are other examples as well, could be significant others, could be other relatives that are not children. Unfortunately, the opportunity to commit insurance fraud when you are not the policyholder is just as prevalent as if the fraudster were the policyholder themselves.

Next question, include names of others who can corroborate this information. Ok, let's be honest, we could have written this easier. Simply put, what witnesses exist? The others that can be a potential witness range from family, friends, coworkers of the insured all the way to other employees within your agency. Did this person talk to more than one person in your office? If they did, list it here.

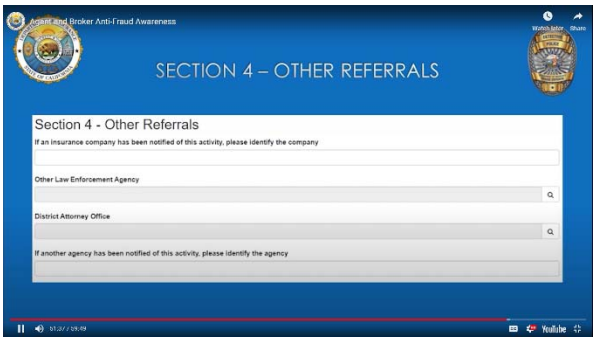
Last question. Is anyone in the insurance industry aware of what is occurring? When this is answered by a member of the general public, they provide us names of people from insurance companies, such as adjusters or agents and brokers. When you are answering this from the perspective of an agent or broker, you will not need to list yourself. We know you are aware, that is why you are reporting it. What you may want to add here is whether or not anyone with a company you contract with is aware? Perhaps you called an underwriter for advice, ultimately ended up not writing the business, and still need to report it. That underwriter should be listed here. Or, are you a member of an agent or broker association and the suspect has been the topic of discussion? Let us know that. It helps us determine the scope of the fraudulent activity if we know that this suspect is known to an entire agent or broker group.



Alternatively, you can answer these questions. So, what you are seeing here are the questions that an insurer is required to answer when they submit referrals in our portal. As agents or brokers, you are not required to answer these questions; however, we have found that following these questions gives you greater success at conveying to our Detectives what the misrepresentation was and what information you have to support the allegation.

Please note: choosing to answer the questions on the preceding slide versus this slide is not a matter of compliance. It is a pure choice. What we ask is that either direction you go, you provide us with as much information as possible.

You also will not see these questions populate automatically when you are in the form because they are not your compliance requirement. If you are considering answering these questions, you will need to know what these are. You are welcome to take a screen shot of this, or you can reach out to the SIU Compliance Unit and they can email it to you. Their contact information is on the Departments public website.

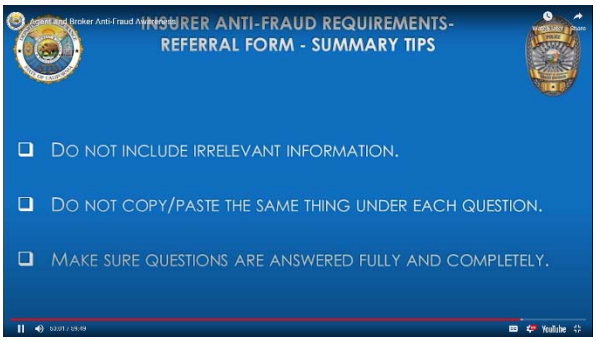


Section 4 of the form is next and the final section you will encounter when you complete the referral.

Remember, if you have already placed a policy, your reporting requirement is to the insurance company where that policy is placed. If, for some reason, you wish to also notify us directly, you are welcome to do that. In those cases, you will enter which insurance company you reported to in the top box.

If your case involves workers' compensation, we also strongly recommend you notify the applicable district attorneys office for the county of where the fraud took place. If you do this, please note on line three, what District Attorneys office you sent it to.

The purpose of this section is simply you notifying us if you have also reported the suspected fraud to anyone else. This allows us to know who else might be working the case or other companies or agencies we can seek information from.

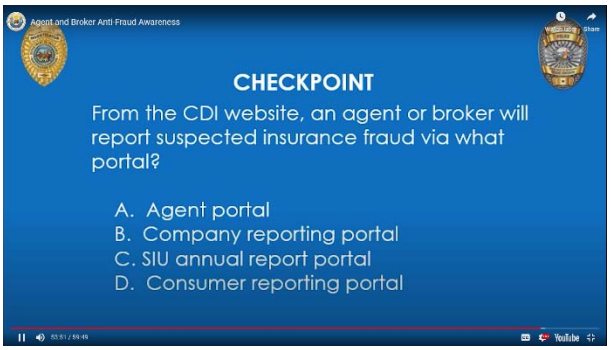


Here are some tips for writing summaries.

First, do not include irrelevant information. If the sky that day was grey instead of blue, unless it matters to the suspected fraudulent activity, we really don't need to know.

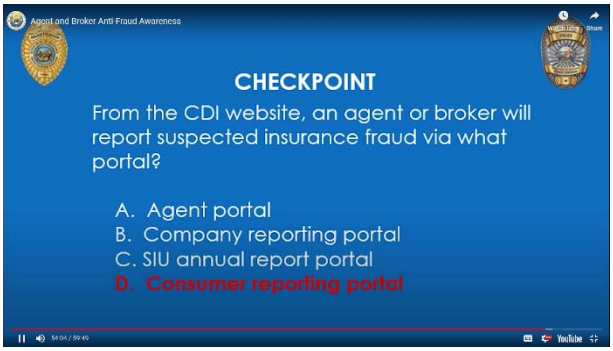
Secondly, please do not copy and paste the same information under each question. We do read each and every referral and when you do that, we spend a lot of time re-reading the same information over and over just looking to see if something is different between them.

Last, when you answer the questions, and this is whether you are answering the ones prompted on the form or choosing to enter the questions as insurers, please make sure you are complete, thorough and accurate.

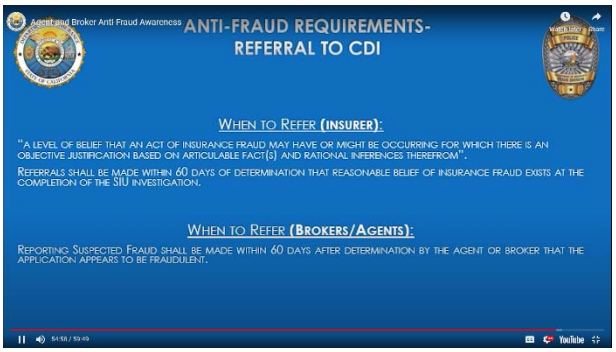


And it's checkpoint time. From the CDI website, an agent or broker will report suspected insurance fraud via what portal?

Agent portal, company reporting portal, SIU annual report portal, consumer reporting portal.



And the answer is . . . D. Consumer Reporting portal. At this time, a specific agent or broker portal does not exist. Statute specifies that an agent or broker will use the consumer reporting portal. The other options listed are the company reporting portal, which would be where insurance company personnel report and the SIU Annual Report portal, which if you recall much earlier in this training is an annual obligation of an insurance company operating in California.

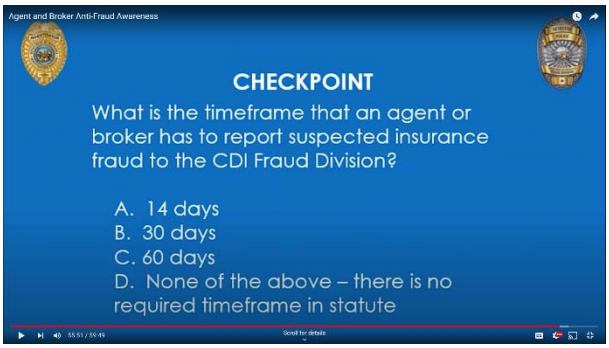


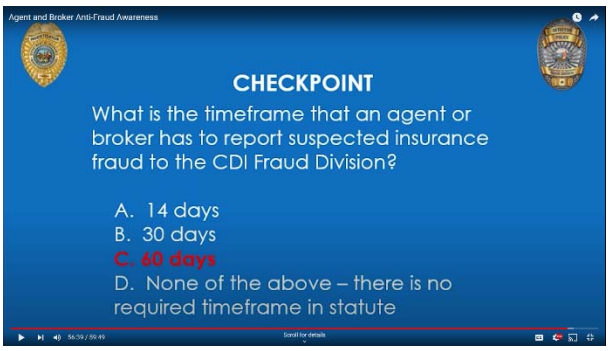
So now that you know your two referral options and how to refer through our consumer portal, you may be wondering if the requirement comes with a timeframe in which you must refer. The answer is yes, you are required to refer within 60 days.

Insurers referring also have a 60 day requirement as noted here. But you will notice that the level of belief of the insurance fraud to refer is different. An insurance company has to establish what is called reasonable belief of insurance fraud, which means they've done some additional investigation to the red flags that you've notified them of.

Your referral obligations is at the point of detection of the red flag itself. And again, you're either going to refer that to an insurance company if the policy is placed or, you are going to refer it directly to us here at the Fraud Division for policies that are not placed. That is calendar days.

The sooner the better, just to ensure you are never outside that window.





We have another checkpoint.

What is the timeframe that an agent or broker has to report suspected insurance fraud to the CDI Fraud Division?

14 days, 30 days, 60 days, or none of the above because there is no required timeframe in statute

And the answer is . . . B. 60 days. Please be mindful of this. It is 60 calendar days and so that does include weekends and holidays. As a best practice, it is suggested that you refer as soon as possible. Waiting 60 days not only delays our ability to review the referral and make a determination on how to handle it, but it also allows you to potentially forget specific details that may be necessary for us to know.

Earlier in this training, I noted that you also have a duty to cooperate with an insurance company SIU and law enforcement agent.

So, what exactly does that mean?

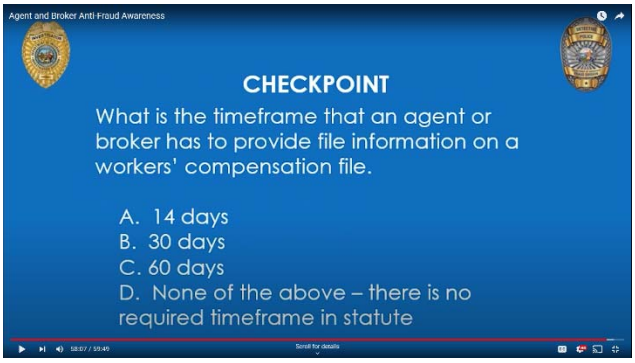
If you receive a call or email from a law enforcement officer, whether that is one of our Fraud Division Detectives or perhaps a District Attorney Investigator does not matter, just please remember you have a duty to cooperate.

You are required to provide files and documents upon request. You are bound by the same time standards as insurance companies, as a reminder that is 30 days for all lines of business other than workers' compensation and 60 days for workers' compensation.

Please be sure to respond to all calls and emails asking for clarifications or additional information.

Also, please know that statute provides law enforcement the authority to interview you. You may not decline an interview. If you are asked to be present for an interview, either on the phone or in-person, work with the law enforcement officer to establish a time and place and be sure to be available and present.

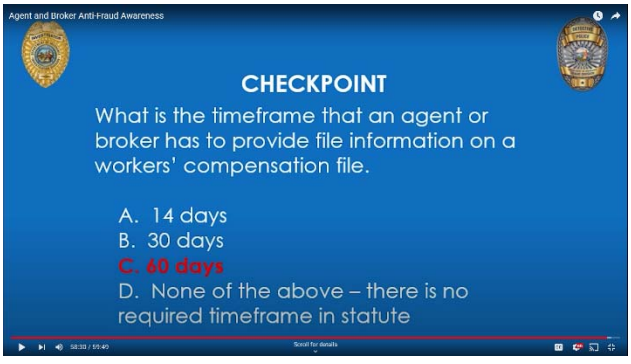
Checkpoint question.

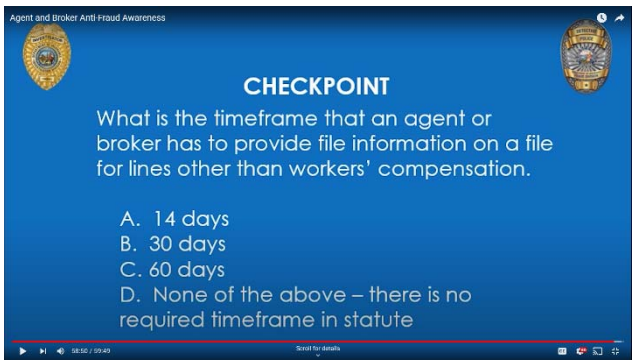


What is the timeframe that an agent or broker has to provide file information on a workers' compensation file.

14 days, 30 days, 60 days or none of the above

And the answer is . . . C . . . 60 days. Requests for workers' compensation allow 60 days to respond to authorized governmental agencies asking for the release or documents.

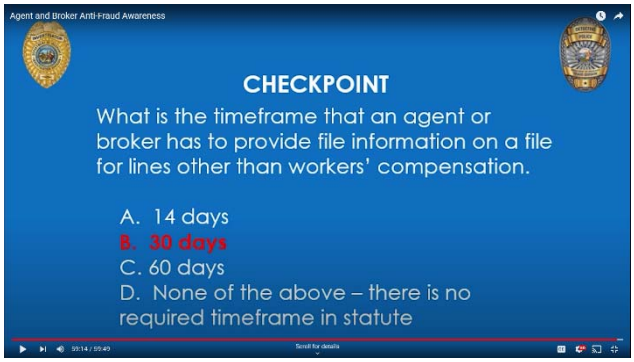




And, one final checkpoint.

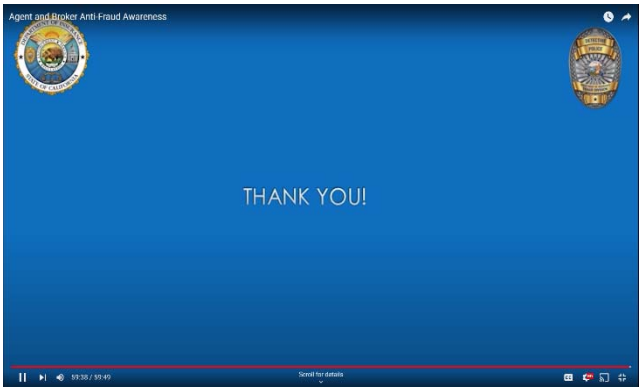
What is the timeframe that an agent or broker has to provide file information on a file for lines ***other than workers' compensation***.

14 days, 30 days, 60 days, none of the above



And the answer is B . . .

30 days. You only have 30 days in which to respond to requests for file information for all lines of business other than workers' compensation.



Thank you for joining us for the last hour as we took you through several aspects of the anti-fraud requirements for agents and brokers in the State of California. We look forward to working with you. Should you ever need information from the California Department of Insurance, please visit our public website at www.insurance.ca.gov to locate contact information for our various units.

--END REQUIRED ANTI-FRAUD TRAINING-