

Ethical Practices

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LESSON 1

INTRODUCTION TO INSURANCE ETHICS

What is Ethics?

According to Merriam-Webster, ethics (plural but singular or plural in construction) comprises:

"the principles of conduct governing an individual or a group....a guiding philosophy."

The Ethics Resource Center (ERC), a nonprofit, nonpartisan, educational organization whose vision is "a world where individuals and organizations act with integrity," defines ethics as:

"standards of conduct that guide decisions and actions, based on duties derived from core values."

Ethics may also be viewed as a combination of moral principles, which, when applied to acceptable standards of behavior within a business context, might include the following:

- probity;
- rectitude;
- uprightness;
- virtue;
- integrity;
- fairness;
- responsibility;
- honesty;
- honor;
- sincerity;
- goodness;
- decency;
- trust; and
- accountability.

What Is the Difference Between Ethics and Values?

Frank Navran, ERC's Principal Consultant, says,

"Values are our fundamental beliefs or principles. They define what we think is right, good, fair, and just. Ethics are behaviors and tell people how to act in ways that meet the standard our values set for us."

Author Jennifer J. Salopek, in an article entitled, "Do the Right Thing," (T+D Magazine, July, 2001,) states,

"It's not the company's place to tell you what your values ought to be; they come with you when you enter the workplace. But it is the company's responsibility to set behavioral standards and its obligation to train employees in what those standards are."

Intrinsic moral values cannot be legislated; however, ethical behavior can be required of licensed professions. This takes the form of consumer protection laws. Because consumer protection is such an important area of discussion, an entire chapter, Lesson 5, "Consumer Protection," will be devoted to this subject.

The Role of Ethics

Mutual Trust

Insurance transactions require a condition of mutual trust between agent and customer. Such trust is only possible when founded upon the highest ethical standards. Therefore, insurance producers have a social responsibility to adhere to accepted standards of ethical behavior when conducting their business.

Ethical standards in the insurance industry are governed by regulations at both the state and federal level. It is essential that insurers adhere to the highest standards of ethical behavior and that they require ethical behavior of their licensed agents. This is especially important in that the agent is the company's principal point of contact with the public.

Customers have a right to expect ethical conduct by insurers and their agents. Consumer confidence in the insurance industry and its professionals is dependent upon the ability of the industry as a whole to meet the public's expectation of ethical behavior. It is the responsibility of every insurance professional to contribute to the establishment of this condition of public trust through the practice of ethical fitness.

Codes of Ethics

Though many professional societies such as the American Society of Chartered Life Underwriters (CLU) and the Society of Chartered Property and Casualty Underwriters (CPCU) have adopted codes of ethics, there is still no single code of ethics governing the insurance industry as a whole. Therefore, many individual organizations have developed such codes for ethical practices of their members. While there is much in common among such standards, there will also be found many variations in labeling, categorizing, and characteristics of code provisions, depending on regulations, requirements, and goals for the code.

A professional society's code of ethics generally includes principles such as:

- using the member's full ability to perform duties and functions toward clients and principals;
- placing clients' interests above their own;
- honoring confidential relationships;
- applying due diligence to determine client needs;
- undertaking only those assignments that can be performed properly and professionally;
- accurately representing material facts and risks;
- upholding laws and regulations;
- abiding by any society or organizational ethical standards; and
- accurately representing the nature of the organization.

Other common provisions among codes of ethics covering financial transactions of all types, including the purchase of insurance, might include:

- **Legitimacy of Client and Transaction** – for example, not knowingly submitting to an insurer information on an application for insurance that is inaccurate or misleading;
- **Professionalism of Agent** - possessing an appropriate level of knowledge relating to the business, improving knowledge with continuing education, meeting high standards of professional ethics, meeting financial obligations, properly maintaining financial records, following sound business practices, and meeting all regulatory requirements;
- **Disclosure of Agent Information** - accurately representing agent education, qualifications or experience, and revealing to the client the names of the business licenses and registrations held by the agent;
- **Disclosure of Financial Products Information** - disclosing to the client all relevant facts, considerations, costs, and risks necessary for an informed decision; and delivering all policies, amendments, and other documents in a timely manner;
- **Conflicts of Interest** - disclosing to a prospective buyer of life insurance all conflicts of interest associated with any recommendations and transactions and affording the client an opportunity to halt or reverse the transaction based on the information divulged; and
- **Behavior** - acting in good faith at all times and meeting high standards of professional ethics, handling complaints and disputes in a timely manner, and not engaging in behavior which might detract from the public professional image of insurance agents.

Learning Objectives

The learning objectives for students in this course are as follows:

- becoming familiar with the provisions of the Kentucky Insurance Code;
- understanding legal obligations to the Kentucky Department of Insurance, to consumers, and to insurance companies;
- understanding the character of agency with particular emphasis on the principal/agent relationship;
- demonstrating a knowledge of federal and state insurance legislation;
- knowledgeably describing unfair or deceptive trade practices;
- knowing the similarities and differences between acting legally and acting ethically;
- enhancing awareness of consumer protection issues facing insurance professionals; and
- observing fair claims practices and settlement regulations.

LESSON 2

REGULATION OF THE INSURANCE INDUSTRY

A Brief History of the Insurance Industry

Insurance can be traced to ancient Babylonia. Caravan trade was insured through loans that were repaid with interest once the goods had arrived safely. This practice was a form of bottomry.

Bottomry is a contract under which the owner of a ship, or the master as his agent, hypothecates or pledges the ship, and sometimes the accruing freight, as security for the repayment of money advanced or loaned for the use of the ship. If the ship was lost by perils of the sea, the lender loses the money, but if the ship arrived safely, the premium was returned with interest to the owner.

Later, the guilds of medieval Europe protected their members from loss by fire and shipwreck and provided funds to mitigate against poverty and illness and even ransomed members from captivity by pirates. In the 14th century, marine insurance was nearly universal among the maritime nations of Europe. In London in 1688, merchants, ship owners, and underwriters met in Lloyd's Coffee House to transact business. By the end of the 18th century, Lloyd's had become one of the first modern insurance companies.

With respect to life insurance, the first mortality table was introduced, based on the statistical laws of mortality and compound interest, by the astronomer Edmond Halley in 1693. This table was updated in 1756 by Joseph Dodson, who introduced the practice of correlating premium rate with age, rather than the previous method of applying the same rate regardless of age.

The growth of British commerce in the 17th and 18th centuries resulted in the rapid growth of the insurance industry. Before the existence of insurance companies, policies were written by individuals, each of whom signed his name and indicated the amount of risk he was assuming under his proposal, thereby giving rise to the term "underwriter".

Milestones in Insurance History

Other significant milestones in early insurance history include:

- **1720** – the first insurance company was founded in England;
- **1735** – the first insurance company in the American colonies was founded in Charleston, South Carolina;
- **1787** – fire insurance corporations were formed in New York City;
- **1794** - the Presbyterian Synod of Philadelphia sponsored the first life insurance corporation in America for the benefit of Presbyterian ministers and their families;
- **1840s** – the business of life insurance began a continued decline because of a religious influence against the practice;
- **1830s** - the practice of classifying risks was introduced;
- **1837** - Massachusetts was the first state to require companies to maintain reserves;
- **1871** – the Great Chicago Fire called attention to the human and financial costs associated with fires in densely populated areas, and reinsurance, a method of insurance by which losses are distributed among many companies, was developed;
- **1880s** - public liability insurance was launched; and

- **1897** - the Workmen's Compensation Act of 1897 was introduced to require employers to insure their employees against industrial accidents.

Benefit societies were founded to insure the life and health of their members in the 19th century. Later fraternal orders were begun to provide low cost insurance coverage to their members, and these organizations continue to maintain coverage.

Today the individual states primarily regulate the business of insurance. The federal government regulates a few areas of insurance such as anti-trust activities and securities practices.

Insurance Regulation Today

Before 1944, the regulation of insurance companies in the United States was the exclusive responsibility of the individual states, based primarily on the fact that insurance was not a tangible good and therefore did not meet the formal definition of commerce. In 1945, however, the business of insurance was deemed to fall under the jurisdiction of the federal government as interstate commerce.

Until the 1950s, insurance companies in this country were generally permitted to provide only one type of insurance. That began to change with the introduction of legislation to allow fire and casualty companies to underwrite multiple lines of insurance.

Federal Regulation

The McCarran-Ferguson Act

In 1943, the Department of Justice brought an action against the Southeastern Underwriters Association (SEUA) for anti-trust violations. The suit alleged SEUA was involved in price fixing, a violation of federal law. The association's defense contended that insurance was not commerce, so it was not subject to federal law. In June of 1944, the U.S. Supreme Court ruled that insurance was indeed commerce and, therefore, subject to federal regulation.

The McCarran-Ferguson Act, cited as 15 U.S.C. 1011, et seq., was adopted in 1945 after the extended controversy over the jurisdiction of state and federal governments in regulating the business of insurance. The Act declares that the continued regulation and taxation of the business of insurance by states are in the public's best interest and further clarifies the power of individual states to regulate insurance, limiting the application of many federal statutes to that industry. The Act states that the Federal Trade Commission Act, which regulates commerce, is only "applicable to the business of insurance to the extent that such business is not regulated by state law."

Through this law, Congress reaffirmed the power of individual states by permitting the states to continue to regulate insurance. However, in order to maintain regulatory control after July 1, 1948, each state had to enact the same type of anti-trust laws used at the federal level. All of the states eventually passed their own anti-trust laws, maintaining insurance regulation at the state level.

The Gramm-Leach-Bliley Act

In late 1999, Congress passed the Gramm-Leach-Bliley Financial Services Modernization Act. This federal law removed long-standing distinctions among various types of financial institutions, including insurance companies, banks, and investment services firms. The Act was a response to marketplace and technological developments that obscured the traditional roles of financial service providers.

The law's primary goal is to allow financial services firms to offer more comprehensive services to consumers. However, the Act has also introduced privacy concerns and addresses the obligations of institutions regarding the use of information gathered about consumers.

The Act requires that all financial institutions notify customers about the types of information they collect and with whom and under what circumstances the information is shared. The rules that govern insurers are found in state laws and regulations enacted to implement Gramm-Leach-Bliley, as the Federal Trade Commission (FTC) has ruled that the Act "explicitly commits the enforcement jurisdiction of 'persons engaged in providing insurance' to state insurance authorities...".

Gramm-Leach-Bliley restricts the disclosure of nonpublic personal information. The Act imposes on insurers an affirmative and continuing obligation to respect the privacy of customers and consumers. It is designed to protect the security and confidentiality of nonpublic personal information.

Generally, nonpublic personal information can be shared without consent among "affiliated" companies, those within the corporate family. Privacy standards apply to "nonaffiliated" companies.

Gramm-Leach-Bliley requires companies to provide a privacy notice to its customers and consumers. The privacy notice must contain the following:

- types of nonpublic personal information collected;
- types of affiliates and nonaffiliated third parties with whom information may be shared;
- types of information about former customers which may be shared;
- an explanation of the consumer's right to opt out of the disclosure of nonpublic personal information to nonaffiliated third parties, including the method for exercising that right; and
- a description of policies and practices with respect to protecting the confidentiality and security of nonpublic personal information.

Information which can be shared includes:

- confirmation of customer status;
- information found on an application;
- account information;
- payment history;
- information collected through an Internet cookie; and
- information from a consumer credit report.

The Act generally provides that any information may be shared among affiliated companies, and information with nonaffiliated companies may be shared only following notice of a company's information sharing practices. This provides an opportunity for customers to opt out of certain types of disclosures.

State Regulation

As previously discussed, the impact of McCarran-Ferguson Act was to ensure that individual states would continue to be the primary regulatory authority for the insurance industry.

Consumer Protection

Deceptive Trade Practices. Consumers are protected from unfair methods of competition by both federal and state legislation. At the federal level, Congress addressed the issue by passing the Federal Trade Commission Act (FTCA), a comprehensive law prohibiting deceptive or unfair acts affecting commerce. The Act encompasses a wide range of business practices, offering protection not only for organizations, but for the individual consumer as well, against such things as fraud, misrepresentation, misleading packaging, and a host of other prohibited practices.

Many individual states have also enacted their own versions of deceptive trade practice acts or consumer protection legislation to protect their citizens from such activities within their borders, as the FTCA applies primarily to interstate and foreign commerce. All consumers within the state, including insurance consumers, are protected by these deceptive trade practice laws.

Kentucky's Consumer Protection Act. Kentucky protects its citizens against unfair or deceptive trade and business practices by enforcing the state's Consumer Protection Act. Under this act, "trade" and "commerce" mean the advertising, offering for sale, or distribution of any services and any property, tangible or intangible, real, personal or mixed, and any other article, commodity, or thing of value. It includes any trade or commerce directly or indirectly affecting the people of the Commonwealth.

Kentucky's Consumer Protection Act, and identifying prohibited trade practices deemed misleading or deceptive, will be discussed in greater detail in Lesson 5, "Consumer Protection," the final chapter of this course.

The Kentucky Insurance Code. Just as all consumers, including insurance consumers are protected by the Commonwealth's Consumer Protection Act from deceptive and unfair trade practices for business conducted within its borders, insurance consumers are further protected by the provisions of Kentucky's Insurance Code. The Code takes consumer protection one step further by regulating trade practices and acts particular to the business of insurance.

Thus, to supplement the protections already afforded all citizens of the Commonwealth under its Consumer Protection Act, Kentucky's Insurance Code addresses certain prohibited practices unique to the insurance industry. It also sets forth the responsibilities and obligations of insurers and producers and defines the regulatory process for the industry, defining the powers, duties, and obligations of those whose duty it is to enforce the Code.

Kentucky's Insurance Code governs all matters related to the business of insurance in the Commonwealth, some of which include:

- authorizing the establishment of insurance companies;
- classifications of insurance;
- permissible insurance products and services;
- establishing reserve requirements;
- licensing of insurance producers;
- defining the legal and ethical obligations of insurance agents; and
- defining powers, duties, and obligations those who administer and enforce the Code.

The Kentucky Insurance Code, will also be discussed in greater detail in Lesson 5, "Consumer Protection.

The material which follows in the sections entitled, "Kentucky Department of Insurance" and "Executive Director of KYDOI/Insurance Commissioner" was extracted primarily from the Kentucky Insurance Code, which sets forth the nature of the Department of Insurance and the powers, duties, and obligations of the insurance commissioner (executive director).

Kentucky Department of Insurance

Clarification of Nomenclature. In the Commonwealth of Kentucky, the business of insurance is governed by the Kentucky Department of Insurance (KYDOI). An executive and administrative reorganization has resulted in the establishment of the Department of Public Protection under Environmental and Public Protection at the cabinet level. The Kentucky Department of Insurance now resides under the Department of Public Protection. Despite these administrative changes, the original organizational designations remain in the language of the statutes.

Mission Statement of the KYDOI. The Kentucky Department of Insurance has advanced the following as its mission statement:

"We promote sound, competitive insurance markets; protect the public through effective enforcement and regulation; and empower the public through outreach and education"

Some of the functions of the KYDOI include:

- working with the state legislature on consumer protection laws;
- regulating insurance companies;
- monitoring insurance companies and their financial stability and business practice;
- approving insurance rates;
- distributing free insurance shopping guides to consumers;
- licensing of insurance producers;
- conducting public forums and seminars;
- assisting consumers with insurance-related complaints;
- investigating insurance fraud; and
- overseeing Kentucky Access, a program for people with high-cost conditions who must purchase their own health insurance.

KYDOI/Insurance Commissioner

The insurance commissioner is appointed by the Governor with the consent of the Senate for a term not to exceed four years, is the head of the Kentucky Department of Insurance.

Powers, Duties, and Responsibilities. The responsibility of the insurance commissioner is to protect the public through regulation of Kentucky's insurance market by reviewing actions of all licensees for compliance with the state's insurance laws and regulations, monitoring insurers' financial solvency, promoting viable insurance markets, and ensuring the fair and equitable treatment of insurance consumers.

The commissioner is vested with the following general powers and duties:

- personal supervision of the operations of the Department;
- examination and inquiry into violations of the Insurance Code;
- impartial enforcement of the provisions of the Code;
- execution of the duties imposed upon him or her by the Code;
- examinations and investigations of insurance matters as he or she may deem proper upon reasonable and probable cause in order to determine possible Code violations and to lawfully administer any provisions of the Code;
- establishment of branch offices for efficient administration of the Code;
- powers and authority expressly conferred or reasonably implied from the provisions of the Code; and
- additional powers and duties as may be provided by other laws of the state.

Regulatory Authority. The commissioner has the authority to create any reasonable rules and regulations necessary for administering any provision of the Code, as long as no rule modifies or conflicts with any state law. The commissioner also has the authority to extend, by administrative regulation, in-state insurance activity to match that of federally regulated financial institutions, which confers upon a licensed agent, producer, broker, or insurer the power to engage in any insurance activity that federally regulated financial institutions are authorized to engage in by federal law.

Enforcement Authority. The insurance commissioner enjoys fairly wide latitude in enforcing possible violation of the Insurance Code, including invoking the aid of the courts to prohibit any existing or threatened Code violation or to enforce any of his or her proper orders or actions.

If there is reason to believe that criminal prosecution is warranted, any information gathered by the commissioner will be given to the appropriate Commonwealth attorney or to the Attorney General for appropriate legal action. The Attorney General is even authorized, upon request of the commissioner, to proceed in the courts of any other state or in any federal court or agency to enforce any order, court decision, or administrative decision resulting from proceedings before the commissioner.

Any person who willfully violates any rule, regulation, subpoena, or order of the commissioner or any provision of the Insurance Code will be subject to suspension or revocation of certificate of authority or license, an administrative fine, or both.

Conflicts of Interest. The commissioner is prohibited from being directly or indirectly connected with the management of or having a financial interest in any insurer, insurance agency or broker, or insurance transaction

except as policyholder or claimant under a policy. The commissioner may, however, employ or retain from time to time insurance actuaries, examiners, accountants, attorneys, etc., who may be similarly employed or retained by insurers or others, as long as the employment does not represent a conflict of interest.

Neither the commissioner nor any person employed or retained by the Department of the commissioner may receive, directly or indirectly, any form of pay, loan, gift, or other compensation for any service rendered in connection with his or her official duties associated with the work of the commissioner.

Conclusion

This lesson has dealt with regulation of the insurance industry at both the federal and state levels, at the heart of which is the obligation to protect all consumers and potential consumers of insurance products and services, by ensuring that the business of insurance will be undertaken fairly, honestly, and ethically by its professional practitioners and that a healthy competition will continue to exist in the industry.

The issue of consumer protection, specifically as it relates to the conduct of Kentucky insurance producers and the necessity of maintaining a high degree of ethical fitness in the industry, is critical to our study. Consumer protection mechanisms will be given significant emphasis in Lesson 5.

LESSON 3

OBLIGATIONS OF INSURANCE PRODUCERS

Insurance producers operate within a framework of statutory and common law, under which they are expected and required to perform their duties according to the highest legal and ethical standards. This expectation has always existed; however, today more than at any other time, insurance agents and brokers are being held legally accountable for their acts of omission and commission as they practice their profession.

Distinction Between “Agent” and “Broker”

The distinction between “agent” and “broker,” both of whom are insurance “producers,” is based upon which party to the insurance transaction that each represents. Agents, under the common law of agency, represent and act on behalf of the insurer, called the “principal,” and have the power to bind the insurer to contracts.

Brokers act on behalf of prospective insureds and attempt to arrange insurance contracts with one or more insurers. In fact, it might be said that brokers initially represents themselves while they are seeking prospects and then represent the prospect, once found. If a broker collects a premium to be forwarded to the insurer with an application for insurance, some states actually consider the broker to be an agent of the insurer with regard to that portion of the transaction.

In carrying out his or her professional duties to the highest ethical standards, the agent is bound by four sets of legal and ethical obligations. These are:

- obligations to the public in general;
- obligations to customers or clients;
- obligations to insurers; and
- obligations to regulators.

These obligations will be discussed in greater detail in several of the sections to follow.

The Law of Agency

Common Law vs. Statutory Law

The law of agency has its roots in common law. Common law was originally developed in England and arose from court decisions that were grounded in tradition, custom, and precedent under the English adversarial system. Before the invasion of England by William the Conqueror in 1066, unwritten local customs, varying from community to community, governed the lives of English citizens. Enforcement was often arbitrary, as courts were generally informal public assemblies that mediated conflicting claims in cases brought before them. If they were unable to reach a decision, they might have required defendants to “prove” their innocence by successfully carrying out some sort of painful or dangerous task in a “trial by ordeal.”

Originally, under the common law, a distinction was made between civil and criminal cases. Civil cases were formulated as a means of compensating someone for the wrongful acts of another, which were known as “torts”

and which included both intentional acts and those caused by negligence. Cases of this kind underpin the body of law which recognizes and regulates contracts.

In the U.S. during the late 19th and early 20th centuries, the great jurist Oliver Wendell Holmes was almost single handedly responsible for explaining, organizing, and justifying the English common law as the foundation for our system of jurisprudence and for the legislative enactment of our written laws, or statutes, which are referred to collectively as "statutory law." Together the common law and statutory law form the basis for our legal system today.

Roles of the Agent

The general concept of "agency" refers to any relationship in which one person has legal authority to act for another. This relationship may be created by an explicit appointment or by implication. In the business of insurance, an agent is designated by an insurer, the principal, to act on its behalf receiving and transmitting information. The agent introduces and offers insurance for sale and must provide complete and accurate information to those purchasing insurance and to the principal whom he or she represents when implementing insurance contracts, operating within the scope of authority conferred by the governing contracts of the agency relationship.

The roles of the insurance agent include:

- describing the insurer's policies to potential consumers and providing clear and complete explanations regarding the conditions under which the policies may be acquired and coverage granted;
- solicitation of applications for insurance policies from prospective customers;
- collecting premiums for those policies (in some cases); and
- providing services to prospective consumers as well as to existing customers.

A "contract of agency," sometimes called an "agency agreement," between agent and insurer clearly defines the agent's authority to carry out these functions, and within the authority granted, the agent is considered one and the same with the insurer. This relationship between agent and principal is governed by the law of agency.

Authority of the Agent

The authority created by the relationship between agent and principal may be conferred by an explicit appointment or by implication. Sometimes the interpretation of authority can be inexact. However, an insurer is responsible for its own acts, as well as the acts of its agents, and since an agent's actions can legally bind the insurer to the agent's representations, misunderstandings regarding the authority granted to the agent can result in costly mistakes. Therefore, it is imperative that agents understand the authority they have been granted and that they not exceed it.

The determination of the rights of an insured, when disputed, frequently depends on the extent of the agent's authority to represent the insurer. Courts and arbitrators have traditionally tended to settle cases in favor of the insured.

Under the common law of agency, three types of authority are recognized. These are:

- **Express (“Actual”) Authority** - explicitly bestowed power to act for another based on written or verbal directives of the principal;
- **Apparent (“Ostensible”) Authority** – from a consumer’s perspective, the powers, actual or not, that an agent could be reasonably believed by a third party to possess, based on acts or conduct of the principal; and
- **Implied Authority** – authority which, though not necessarily expressly granted, can be logically assumed from the nature of the business and the agent who represents it.

Principles of the Law of Agency

An agent is legally defined as a person who acts for another person or entity, the principal, regarding contractual arrangements with third parties. In carrying out their professional duties and within the scope of the agency agreements under which they are operating, agents have the power to bind principals to contracts and to the duties and obligations inherent in those contracts. The primary principles of the law of agency are:

- that the acts of the agent are the acts of the principal when the agent is acting within the scope of his or her authority;
- that any contract completed by an agent on behalf of the principal constitutes a contract with the principal;
- that any payments made to an agent on behalf of the principal are considered to be payments made to the principal; and
- that the knowledge of the agent regarding the business of the principal is presumed to be the principal’s knowledge.

Remember that brokers, although treated under the law for all practical purposes as agents, actually represent the insureds, while agents represent the insurer.

Agents as Fiduciaries

The term “fiduciary,” derived from Roman law, refers to persons having certain duties to act primarily for another’s benefit in matters regarding a particular task. By virtue of the common law of agency, agents are considered to be legal representatives of the insurers they act for. As such they are fiduciaries of their principals.

This status entails specific responsibilities and obligations to the insurer on the part of the agent, chief among them to remain loyal to the best interests of the insurer, to remain faithful to the insurer’s objectives, and to carefully and diligently protect the insurer’s interests.

Some of the important fiduciary duties owed the principal by the agent include:

- **The Duty of Good Faith** – to maintain total truthfulness, absolute integrity, and total fidelity to the principal’s interest;
- **The Duty of Care** – to exercise a reasonable degree of care while transacting the business entrusted to the agent by the principal;
- **Honesty and Integrity** – to act with fidelity and truthfulness, grounded in sound moral principle and character;
- **Obedience or Faithful Performance** – to obey all legal instructions given by the principal and to apply best efforts and diligence to carry out the objectives which conform to the purpose of the agency relationship;

- **Disclosure** - to disclose all material facts which could influence in any way the principal's decisions, actions, or willingness to enter into a transaction;
- **Loyalty** – to refrain from acquiring any interest adverse to that of a principal, unless providing full and complete disclosure of all material facts and obtaining the principal's informed consent;
- **Confidentiality** - to safeguard the principal's lawful confidences; and
- **Accounting** - to safeguard any money, documents, or other items entrusted to the agent by the principal.

Liability. Agents are liable to their principals for violations of their duties under the agency relationship and may sometimes even be liable to certain third parties. Therefore, agents frequently purchase errors and omissions insurance in order to provide coverage for defense and indemnification against injury or loss sustained by third parties due to their mistakes, negligence, or failure to take appropriate action in the rendering of professional services. Errors and omissions policies do not offer protection against an agent's intentional misconduct.

The following sections will discuss in detail some of the specific obligations and responsibilities of agents to the public in general, their customers, their principals and to regulators.

Obligations to the Public in General

Insurance agents have an obligation to the public in general, and to the communities within which they undertake their business, to abide by the spirit and the letter of the law governing their professional activities and the products and services they provide.

The ethical agent will never, in the conduct of his or her professional practice, knowingly violate the law nor engage in any fraudulent practice or act, such as deception, bribes, collusion, misrepresentation, or any other conduct which would affect the public trust or infringe upon the rights of others. Nor will the ethical agent discriminate in his or her professional activity on the basis of race, religion, gender, age, national origin, or sexual orientation.

Furthermore, whenever any agent becomes aware of fraudulent, illegal, or unsafe activity by another agent of his or her principal or by a client, the agent should promptly remedy the situation or report the improper activity to the appropriate authority. The ethical agent will never assist any client in conduct that the agent knows or believes to be fraudulent or illegal.

Obligations to Customers or Clients

In addition to the public in general, agents also have certain responsibilities and obligations to their individual clients. Some of the more important of these duties are discussed in the following paragraphs.

Accurate Proposal Information

The agent must make accurate contract and proposal recommendations and avoid any misstatements or false or misleading estimates and illustrations when representing the benefits of a recommended product.

Suitability of Product Recommendations

The agent should accurately and appropriately assess the correlation between the recommended product and the client's needs, based on meticulous fact finding discussions and the continual education of the client, as well

as on a realistic understanding of the client's capabilities, financial and otherwise, in order to establish a "reasonable basis" for placement of the product.

Full and Accurate Disclosure

The agent should inform the client fully and accurately about all aspects of the product or products being recommended, including all limitations as well as benefits, with no attempt to hide or disguise the nature of the products or the insurer being represented.

Prompt Delivery of Promised Services

The agent should make sure that the insurer delivers all services promptly and as promised.

Maintaining High Ethical Standards at All Times

The agent must maintain ethical fitness while carrying out his or her professional activities, upholding the highest ethical standards and scrupulously avoiding the use of any prohibited or unlawful practice or act.

Obligations to Insurers

The agent's general fiduciary duties to the insurer have already been mentioned. Insurance agents have in addition several other important responsibilities to the insurers they represent.

Careful, Accurate, and Complete Field Underwriting

The agent should use legitimate underwriting guidelines (rules, standards, marketing decisions, or practices, which an agent uses to examine, bind, accept, reject, renew, cancel, or limit coverage available to various classes of consumer) to screen out applicants who are potentially bad insurance risks.

Not Exceeding Authority

The agent must understand and correctly and judiciously apply the express, apparent, or implied authority allowed in his or her capacity to represent the insurer.

Disclosure of All Material Facts

The agent must provide to the insurer all material facts regarding the condition of the prospective insured concerning information in a policy contract, representations on an insurance application, and other known and material details about the customer and the transaction.

Protecting Insurer Interests

The agent must act at all times in a manner consistent with his or her status as a direct legal representative of the insurance company.

Obligations to Regulators

Insurance agents operate under both federal and state regulation. They are bound by sets of laws that govern consumer protection, the confidentiality and privacy of consumers and customers, and the conducting of the business of insurance within state jurisdictions. Agents are required to comprehend and follow complex sets of rules and guidelines issued by the state which regulate and enforce the insurance industry.

The ethical agent will become educated regarding his or her duties and responsibilities as well as regarding any prohibited practices and will conscientiously follow the spirit and the letter of the law.

State Insurance Code

The statutes regulating how the business of insurance is to be undertaken in the state are collectively referred to as a state's "insurance code." The code lays out and defines the relationships of insurers, producers, and regulators and specifies the way in which the code will be enforced.

Previous sections in this course of study have discussed the Kentucky Department of Insurance (Department of Insurance) and the role of the insurance commissioner (executive director) as policymaker and enforcer of the laws of the state, all of which are specified in the Kentucky Insurance Code. Agents are responsible for understanding and meeting the requirements of the Insurance Code as well as all other applicable laws and regulations.

Licensing. Each state is responsible for the licensing of its insurance agents and brokers. The state requires those who sell insurance to obtain a license from the state. However, before a license is issued, the candidate must pass a licensing exam administered by the state. Licensing in the Commonwealth of Kentucky will be discussed in greater detail in Lesson 5, "Consumer Protection."

Continuing Education. The purpose of a continuing education requirement is to ensure that agents and brokers are well informed about insurance matters. Individual resident agents licensed in the Commonwealth of Kentucky are required to complete 24 hours of coursework every two years, with at least six hours directly related to one or more of the agent's active lines of authority and, as of the date of this writing, three hours in ethics.

Continuing education requirements for Kentucky agents and brokers will be discussed in greater detail in Lesson 5, "Consumer Protection."

Prohibited Practices. State insurance codes in virtually all jurisdictions prohibit certain deceptive or misleading act or practices unique to the insurance industry. The ethical agent will avoid engaging in any prohibited activity, including twisting, misrepresentation, misuse of premiums, and the offering of rebates. These terms will be defined and discussed further in Lesson 5, as they are set forth in the Kentucky Insurance Code.

State Consumer Protection Laws

As previously discussed in Lesson 2, all consumers in the Commonwealth Kentucky are protected against unfair or deceptive trade and business practices by the state's Consumer Protection Act, which defines and regulates the conduct of all trade and commerce within the state. Lesson 5 will discuss the subject of consumer protection in greater detail as it relates to the business of insurance.

State Regulation of Fair Claims Practices

Many states have adopted legislation to oversee and regulate the handling of claims payments by insurers. In most cases this legislation has been patterned after model legislation promulgated by the National Association of Insurance Commissioners (NAIC). Kentucky's version of the law is called the Kentucky Unfair Claims Settlement Practices Act. Among other things, it describes the obligations and duties of insurers with regard to the proper handling of claims and the conditions under which claims may legitimately be denied. The law also spells out the rights and obligations of insureds with regard to establishing an allegation of bad faith on the part of an insurer.

All insurers and their agents and brokers are required to engage in fair claims practices.

Good Faith/Bad Faith

Implied Covenant Of Good Faith and Fair Dealing. The theory in the law of contracts is that people will act in good faith and deal fairly without acting against their word, utilizing dubious means to evade obligations, or contradicting what the other party reasonably understood. Typically, when one party resorts to technicalities to explain the breaching of a contract or refers to the fine print in order to refuse to perform, an action for breaching the implied covenant of good faith and fair dealing may be brought by the aggrieved party.

Bad Faith. The essential and most generally recognized element of bad faith is *intent*. In order to establish bad faith, a claimant must prove that the insurer's conduct was unreasonable and that the insurer intentionally engaged in bad faith.

Some examples of bad faith include:

- unreasonable denial of a claim;
- unreasonable delay in payment of a claim;
- suggesting a claimant not retain legal counsel; and
- forcing a claimant to initiate litigation in order to recover benefits.

Negligence

The doctrine of negligence, the failure to use such care as a reasonably prudent and careful person would use under similar circumstances, is based on the idea that every person has a duty to exercise due care in his or her conduct toward others where injury may result. The law of negligence is founded on the concept of "reasonable conduct" or "reasonable care." The breach of the duty of good faith and fair dealing is often construed as negligence.

An agent's conduct may violate the standard of care and support a tort action based on negligence if he or she holds one or more of the following duties and fails to perform:

- securing coverage;
- selecting the correct coverage; or
- arranging for coverage which is to go into effect at a time designated by the applicant.

Breach of Contract

Breach of contract is the violation of or failure to perform any terms or conditions in a contract without legal excuse and includes any act that illustrates that the terms will not be fulfilled or completed by a party. Breach of contract is one of the most common causes for lawsuits and is the basis of most insurance disputes. Breach of contract may be found when:

- the policy provides coverage which is not awarded;
- the insurer fails to pay benefits or claims as contracted; or
- the insurer fails, in any way, to abide by the terms of the policy contract.

Interpretation Favors the Insured. When considering breach of contract, the courts generally favor the insured over the insurer. The following are the principles for interpreting a policy contract in favor of the insured:

- ambiguous or unclear clauses are usually construed in favor of the insured;
- ambiguous or unclear policies are usually construed against the insurance company;
- ambiguous policies are usually interpreted to provide coverage, rather than to deny coverage;
- when a policy has more than one reasonable construction, the construction favoring coverage is assumed; and
- no limitations or exclusions are implied into any policy contract.

LESSON 4

ETHICS AND POLICY REPLACEMENT

Overview

Policy replacement entails inducing a policyowner to cancel, or allow to lapse, an existing policy in order to replace it with another. Policy replacement is not illegal nor necessarily improper and, in fact, in some cases may be entirely appropriate. However, this practice constitutes one of the areas of greatest abuse in the insurance industry.

Prior to the product revolution of the 1980s, before interest rates were at an all time high, producers who replaced life insurance policies were generally assumed to operate for their own pecuniary benefit, and replacement was rarely to the benefit of the insured. In the 1980s, new products were introduced, which, due to higher interest rates and new money rates, significantly outperformed earlier vehicles. New policy illustrations demonstrated a distinct economic benefit for the policyowners who opted for replacement.

The ensuing years saw substantial drops in interest rates and fundamental changes in money markets, which rendered the new products much less attractive than when they were introduced. Many insureds experienced unexpected changes in their policy status in the form of reduced death benefits or an increase in premiums, as insurers found it increasingly difficult to guarantee premiums, death benefits, and loan values.

Despite these alarming trends, the practice of policy replacement has persisted at record levels, even when it became increasingly unfeasible for agents to demonstrate an economic advantage to the policyowner, as they had been able to do earlier. The situation became a monumental ethical dilemma for the industry. While policy replacement has not been banned, additional regulations and guidelines have been introduced in most jurisdictions in order to control the conditions under which policy replacement may be considered ethical and appropriate.

Twisting

“Twisting” is the abusive replacement of an existing policy to the detriment of the policyowner. The practice was rampant in the 1800s, eventually leading to severe prohibitions on policy replacement. In fact, in the minds of many, the term became synonymous with “replacement”, though replacement per se is not – nor was it ever – illegal, when done appropriately. It is only the abuses of replacement that have been prohibited.

This lesson sets forth arguments for and against replacement, describes methods of measuring the financial effect of replacement, examines some replacement myths, and explores pertinent ethical considerations.

Pros and Cons

Arguments for Replacement

The majority of the arguments for replacement listed below are subject to cost justification to ensure that any advantages of replacement are not offset by additional costs. The following conditions may present justification for policy replacement:

- though the Insured's health or insurability may have improved, the current insurer refuses to re-underwrite the existing policy or reclassify the insured;
- though the current policy may be heavily loaned, with the interest nondeductible under current tax law the current insurer refuses to issue an exchange policy;
- there are legitimate concerns over the insurer's financial condition;
- it is difficult for the producer to obtain accurate data about a client's policies with another carrier due to a reluctance to supply information to competitors;
- the client's current policy provides insufficient coverage, and the amount payable at the client's death may be too small to be practical;
- the client may be co-owner of the policy with someone with whom an adverse relationship has developed, such as an ex-spouse or ex-business associate;
- the old policy may not suit the client's current needs, for example, in terms of premium or death benefit;
- the policy may be an old nonparticipating policy that has not been updated by the carrier; and
- the client may insist that the producer replace an in force policy, perhaps because of a prior problem with the company or one of its representatives, in which case the producer should state in a written document any disadvantages of replacement and have the client initial it.

Arguments Against Replacement

Below are some of the situations that would tend render policy replacement a disadvantage to the policyowner:

- the client will once again have to pay first-year expense charges for compensation, issue, and underwriting;
- on replacement, certain limitations, such as the suicide and incontestable provisions start anew, unless waived by the replacing insurer;
- the insured's health has deteriorated since the issue of the original policy and the new policy would be rated substandard;
- the existing policy includes some favorable policy provisions, such as guaranteed settlement options, for example, which the replacement policy is unable to duplicate or exceed; and
- the new product triggers a taxable event.

Replacement Ploys

The ethical agent will adhere not only to the letter but also the spirit of the law regarding full disclosure of all material facts, especially when policy replacement is under consideration, since an inappropriately replaced policy can result in serious financial detriment to the policyowner.

In their zeal to reap the financial windfall from replacing existing policies, unethical agents sometimes resort to various ploys in order to alarm the policyowner. These often take the form of factually correct statements as reasons for policy replacement which don't tell the entire story or convey implications that are inaccurate. The fact that such reasons are sometimes valid under certain circumstances only serves to further cloud the issue. Confusion can, of course, be avoided by providing full disclosure of all relevant facts.

The following are examples of the types of partial information sometimes used by unethical agents in an attempt to induce policyowners to replace their existing coverage:

The Policy Is Out of Date

The implication here is that older policies should be replaced as a matter of course, regardless of other conditions that might exist. The age of the policy is not an issue as long as current mortality and interest rates are being credited. In fact, there may be a number of compelling reasons not to replace. The point is that the age of the policy alone cannot provide enough information to make an informed decision regarding whether to replace.

The Contestable Period Has Expired

Many policyowners are unclear as to exactly what contestability means and will mistakenly conclude that the right to contest is something they rather than the insurer have lost, which of course it rarely is. The unethical agent will neglect to correct this misconception.

Advice: Buy Term and Invest the Difference

The implication here is that the insurer is paying substandard interest rates on the accumulating cash value of the policy and that the policyowner could invest at more favorable rates the difference between the cost of term insurance and the existing product.

The Policy Uses an Old Mortality Table

This is another of those statements that supplies too little data for an informed decision, while implying some sort of victimization by the insurer. In many cases only the non-forfeiture values and reserves are derived from the old table, while dividends and interest rates reflect the current mortality experience.

Misuse of Official State Replacement Forms

In this case, simple governmental forms are portrayed as some sort of official state sanction or endorsement of policy replacement, rather than as simply documents for recording this type of transaction, should it be warranted.

The Old Company Is Out of Business or Has Been Taken Over

The insurance industry, like many others, sees its share of mergers and acquisitions. Many of these result in companies that are even healthier or stronger than the merging or purchased entities. The mere fact of having been involved in such a corporate rearrangement says nothing about the reliability of the company that now holds the consumer's policy. However, the unethical agent will sometimes allow a policyowner to infer that such events would inevitably serve to undermine the soundness of the existing policy.

The Kentucky Insurance Code on Replacement

With respect to replacement practices in the Commonwealth, Kentucky's Insurance Code states,

“Any person who solicits an application for new life insurance on the life of another and who knows, or with the exercise of reasonable inquiry should know, that such insurance will be purchased or otherwise acquired in a replacement transaction shall not issue new life insurance to the applicant

until thirty (30) days after notice of such proposed replacement together with a copy of all soliciting material shown or delivered to the proposed insured has been delivered by the replacing insurer to the existing insurer."

Note that this provision does not apply when the same insurer issued the existing policy or to an insurer belonging to the same group of affiliates.

The law further stipulates that no insurer, including the insurer that issued the original policy, is permitted to issue any life insurance replacement policy without agreeing in writing to the following:

- the new policy will not, in the event of the death of the insured, be contestable by the replacing insurer to any greater degree than it would have under the existing policy; and
- the insured has the right to surrender the new policy for a full refund at any time within 30 days after delivery of the policy by the replacing insurer.

With regard to replacement, no one is permitted to make any written or oral statement of a material fact which is untrue or to omit any material facts upon which statements or representations are made, in order to induce a policyowner to "lapse, forfeit, borrow against, surrender, retain, exchange, modify, convert, or otherwise affect or dispose of any insurance policy."

Conclusion

In order for a professional agent to fully assess a prospect's insurance needs, he or she must embark on a thorough evaluation of those needs and of the prospect's existing assets, including reviewing existing policies and considering all reasonable means of improvement. If, of all the alternatives, replacement is clearly the best for the client, it is the obligation of the ethical agent to recommend it. This view is supported by court decisions that have held that agents have an obligation to put the client's interests above those of the agent and above even the directives of insurers to their captive agents, maintaining that the client's interests are superior to the agent's relationship to the company.

There are a number of situations in which policy replacement may be justified, some measurable financially and some involving intangibles. However, the burden is on the producer to accurately assess the needs of the client and provide appropriate disclosure to the client of all pertinent facts regarding the proposed replacement.

Most state laws require life insurance and annuity transactions to include questions regarding replacement. If a replacement is involved, the agent must state the reasons and justifications for that action. The agent also should also provide:

- a full and fair disclosure to the policyowner of all relevant facts about the new and existing policies;
- a signed document in which the policyowner indicates a full understanding of all of the implications of the policy replacement; and
- a notice to the current carrier that its policy is about to be replaced.

LESSON 5

CONSUMER PROTECTION

Deceptive Trade Practices

All consumers, including insurance consumers, are protected by states' deceptive trade practice laws. Our subject matter concerning state insurance regulation begins with the Federal Trade Commission Act (FTCA), which prohibits unfair or deceptive practices with respect to interstate commerce and the individual states' regulation of deceptive trade practices and acts within their own borders.

The Federal Trade Commission Act, 15 U.S.C. sec.45, is the model "deceptive trade practice law." Under the Act, the Federal Trade Commission (FTC) is authorized to ban "unfair methods of competition in or affecting commerce and unfair or deceptive acts or practices in or affecting commerce."

Protection of consumers from unfair methods of competition was addressed by Congress with the passage of the Federal Trade Commission Act, which prevents deceptive or unfair acts that could possibly affect commerce. In prosecuting violations of the Act, it is necessary only to demonstrate the likelihood of consumer deception, even if no actual deception has occurred. Such cases are usually won by showing bad faith, fraud, or a violation of public policy. A business might also be liable for the unfair and deceptive acts of its employees, agents, or representatives.

The Federal Trade Commission Act encompasses a wide range of business practices, not only those aimed at competing businesses, but also those acts that target the average consumer. For example, if a business were to advertise by stating half-truths or employing bait and switch techniques, it would be engaging in deceptive acts. The same would be true for product packagers using misleading labels, tags, or product names or misstating ingredients or product origin.

Although the Federal Trade Commission Act can only be enforced by the Federal Trade Commission, Kentucky and other states have enacted their own deceptive trade practice acts or consumer protection laws to supplement the FTC regulations and to protect consumers from unfair competition or deceptive acts taking place within state boundaries. The federal law applies to interstate and foreign commerce activities, while a state's law covers these activities within state borders.

Kentucky's Consumer Protection Act

All consumers in Kentucky, including insurance consumers, are protected against unfair or deceptive trade and business practices by the state's Consumer Protection Act, KRS 367.110 to 367.300, found in Title XXIX of the Commerce and Trade Code.

Within the context of Kentucky's Consumer Protection Act, "trade" and "commerce" mean the advertising, offering for sale, or distribution of any services and any property, tangible or intangible, real, personal or mixed, and any other article, commodity, or thing of value. It includes any trade or commerce directly or indirectly affecting the people of the Commonwealth. This of course, includes the business of insurance.

The public health, welfare, and interest require a strong and effective consumer protection program to protect the public interest and the well being of both the consumer public and the ethical sellers of goods and services.

Therefore, a Consumers' Advisory Council and a Division of Consumer Protection of the Department of Law have been created for the purpose of aiding in the development of preventive and remedial consumer protection programs and enforcing consumer protection statutes.

Consumer Protection Functions

Some of the functions of the Department of Law include the following:

- to promote the coordination of consumer protection activities between departments and agencies concerned with activities involving consumer interests;
- to assist, advise, and cooperate with federal, state, and local agencies and officials to protect and promote the interests of the consumer public;
- to conduct investigations, research, and analysis of matters affecting health, safety, the human environment, the marketplace, and all other consumer affairs, taking appropriate action where necessary;
- to study the operation of all laws, rules, regulations, orders, and state policies affecting consumers and to recommend to the Governor and to the Legislature new legislation, rules, regulations, orders, and policies in the consumers' interest;
- to hold conferences on problems affecting consumers;
- to undertake activities encouraging business, industry, the professions, and others offering goods or services to maintain high standards of honesty, fair business practices, and public responsibility in the production, promotion and sale of consumer goods and services;
- to provide a central clearing house of information for all citizens of the Commonwealth by collecting and compiling consumer complaints and inquiries and forwarding them to the proper governmental agencies;
- to organize, promote, and conduct consumer education programs within the Commonwealth; and
- to cooperate with and establish necessary liaison with consumer organizations.

The issue of consumer protection is an important one not only to consumers, but to legislators and regulators as well.

Prohibited Practices

The following are examples of unfair trade practices prohibited by Kentucky's Consumer Protection Act:

- unfair, false, misleading, or deceptive acts or practices in the conduct of any trade or commerce ;
- contracts or conspiracy in restraint of trade or commerce in the Commonwealth;
- monopolization, or the attempt to monopolize or conspire with any other person to monopolize, any part of the trade or commerce in the Commonwealth.
- the sale, delivery, holding, or offering for sale of any self-testing kits designed to tell persons their status concerning human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS) or related disorders and any advertising of such kits;
- secret payments rebates, refunds, commissions, unearned discounts, or special services or privileges extended to certain purchasers but not extended to all purchasers purchasing upon like terms and conditions, where such payment or allowance tends to destroy competition;
- the use of a product marketing document mailed to members of the general public, purporting to inform the recipient that he or she has won a prize, without clearly, prominently and conspicuously displaying the exclusions or conditions to receiving the prize;

- the use a false brand on anything sold, or to be sold or offered for sale, with intent to deceive the purchaser; and
- the unauthorized use of manufacturer's brand or name on the label of any parcel or package.

Remember, Kentucky's Consumer Protection Act protects all consumers, and some of the acts and practices listed here, while they may not apply to the business of insurance, are relevant to our broad discussion of deceptive trade practices.

Remedies. Whenever the Attorney General of the Commonwealth has reason to believe that any person is engaged in or likely to be engaged in any of the practices prohibited by Kentucky's consumer protection statutes, he or she may immediately move for a restraining order or injunction in the name of the Commonwealth in a Circuit Court.

Whenever it reasonably appears that any person will suffer immediate harm, loss, or injury from a prohibited method, act or practice, the Circuit Court will grant the restraining order. If the defendant moves for dissolution of the order, the court must hold a hearing on the matter within five business days of the date of the defendant's motion, or the restraining order will automatically be dissolved.

Restoration of Property, Appointment of Receiver. The court may make additional orders or judgments as may be necessary to make whole the victims of unfair practices by restoring property of money lost or paid out as a result of unlawful practices. The court may also appoint a receiver to oversee the restoration process and may revoke the license of the offender.

The Kentucky Insurance Code

Kentucky's Insurance Code prohibits certain practices particular to the business of insurance and spells out the responsibilities of agents and others for providing information to consumers and safeguarding the confidentiality of consumer information.

The state regulation section of this course began with a general discussion of unfair and deceptive business and trade practices. It was pointed out that issues are regulated at the federal level for interstate and foreign commerce by the Federal Trade Commission Act and at the state level by the statutes of the individual states, which are patterned after the FTCA or other model legislation. The states, including the Commonwealth of Kentucky, have both general consumer protection laws and insurance codes covering unfair or deceptive acts specific to that industry.

As already stated, Kentucky's Consumer Protection Act protects all consumers, including insurance consumers. Insurance consumers are further protected by the provisions of the Kentucky Insurance Code, which takes consumer protection one step further by regulating insurance trade practices and acts. To supplement the protections already afforded all citizens of the Commonwealth under its Consumer Protection Act, Kentucky's Insurance Code addresses certain prohibited practices unique to the insurance industry, lays out the duties and responsibilities of persons and organizations engaged in the business of insurance, and defines the powers and duties of the industry's regulatory authorities.

Provisions of the Kentucky Insurance Code

The material presented in Lesson 2, "Regulation of the Insurance Industry," in the sections entitled, "Kentucky Department of Insurance and Insurance Commissioner" was extracted primarily from the Insurance Code, which sets forth the nature of the Department of Insurance and the powers, duties, and obligations of the insurance commissioner.

The Code also governs other matters related to the business of insurance in the Commonwealth, including the authorization of insurance companies, classifications of insurance, reserve requirements, producer licensing, and the obligations of insurance agents with respect to carrying out their duties in an ethical and legal manner. It should be noted that agents are responsible for complying with not only the regulations promulgated by the KYDOI and insurance commissioner, but also the statutory provisions of the Insurance Code and Consumer Protection Act, as well as any applicable federal laws, such as the FTCA or Gramm-Leach-Bliley.

The Code specifies all of the requirements for becoming a licensed insurance agent and for maintaining that status by such means as continuing education and acting ethically and in accordance with all applicable laws and regulations when conducting the business of insurance.

Licensing of Insurance Agents. Under the Insurance Code the term "insurance producer" includes agent, managing general agent, surplus lines broker, reinsurance intermediary broker and manager, rental vehicle agent and managing employee, specialty credit producer and managing employee, and consultant.

The Code defines "agent" as "an individual or business entity appointed by an insurer to sell or to solicit applications for insurance or annuity contracts or to negotiate insurance or annuity contracts on its behalf." A license is issued by the commissioner to anyone other than insurers and grants authority to engage in the business of or operation of insurance in Kentucky. Insurers are issued certificates of authority, rather than a license.

Available Insurance Agent Licenses. An insurance agent may receive qualification for a license in one or more of the following applicable lines of authority:

- **Life** - insurance coverage on human lives including benefits of endowment and annuities, and may include benefits in the event of death or dismemberment by accident and benefits for disability income;
- **Health** - insurance coverage for sickness, bodily injury, or accidental death and may include benefits for disability income;
- **Property** - insurance coverage for the direct or consequential loss or damage to property of every kind;
- **Casualty** - insurance coverage against legal liability, including that for death, injury, or disability, or damage to real or personal property;
- **Variable life and variable annuity products** - insurance coverage provided under variable life insurance contracts and variable annuities;
- **Limited line insurance** – credit, crop-hail, mechanical breakdown, motor vehicle physical damage, surety, and travel;
- **Personal lines** - property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes; and

- **Any other line of insurance authorized** by Kentucky law and deemed by the commissioner appropriate to be issued as a separate line of authority.

The Code states that any insurer will be liable for the acts of its agents, to the extent that the agents are acting in their capacity as representatives of the insurer and within the scope of their authority. When a business entity that is licensed as an agent of an insurer and designates a licensed agent to exercise that business entity's license, the agent so designated is considered to be an agent of the insurer.

License Requirements. No individual or business entity is permitted to solicit or sell insurance unless licensed by the state for that line of authority. Nor are insurers permitted to accept the placement of insurance from anyone not possessing an agent's license.

The purpose of such a license is to allow the producer, acting in good faith, to engage in the business of insurance with respect to the general public and not for writing predominantly "controlled business," which is insurance written on those with whom the agent is closely associated, such as family members or an employer. If the commissioner finds that the license is being sought primarily for this purpose, the license will not be granted or renewed.

Anyone seeking an agent's license is required to:

- submit an application for a license to the commissioner, using the forms prescribed by the commissioner's office;
- be at least 18 years old;
- be a resident of the state or an eligible non-resident;
- be "trustworthy, reliable, and of good reputation;
- have no record of any act that would be grounds for denial or revocation;
- be a high school graduate or to have attained an equivalent educational level;
- complete (except for limited lines licenses) 20 hours of pre-licensing classroom study for the lines of authority applied for;
- demonstrate financial responsibility by filing with the commissioner either a policy certificate for errors and omissions insurance or a cash surety bond in the amount of \$20,000.00.
- pay a license fee; and
- pass (except for limited lines licenses) an examination for the lines of authority applied for.

The Examination. The exam of licensure tests the knowledge skills and abilities of the individual regarding the lines of authority being applied for, as well as the duties and responsibilities of the licensee and the relevant Kentucky insurance laws and regulations.

Appointment. In order to transact insurance, an agent must be appointed to an insurer or insurers and the appointment confirmed by the commissioner. The agent's license does not specify the name of any insurer since he or she may represent as many insurers as may confer appointment.

Continuing Education for Insurance Agents Licensed Kentucky

Kentucky resident agents are subject to a continuing education requirement of 24 hours every two years.

The lines of authority requiring continuing education are as follows:

- life;
- health;
- property;
- casualty;
- variable life and variable annuity; and
- personal lines.

The following limited lines of authority are exempt from the continuing education requirement:

- credit;
- crop-hail;
- mechanical breakdown;
- motor vehicle physical damage;
- surety; and
- travel.

***EFFECTIVE February 6, 2009**, for Licensees with a Continuing Education compliance date beginning February 2009, the Twelve (12) hour **CLASSROOM REQUIREMENT has been removed**; therefore, you may now meet your twenty-four (24) hours of continuing education without the classroom restrictions.*

Twenty-four (24) hours of approved continuing education must be completed during each continuing education biennium. At least **six (6) hours** must be directly related to any **line of authority** for which the agent is licensed. At least three **(3) hours** must be **ethics each biennium**.

Automatic termination of an agent's lines of authority requiring continuing education will ensue as a result of failure to:

- complete continuing education by the agent's due date
- renew your license through **eServices** on the Department's web site.
- verify with the Department of Insurance that the courses have been recorded correctly.

If the agent has no remaining lines of authority, the license will terminate, and the agent must return the license certificate to the Department of Insurance without demand.

If the agent has one or more limited lines of authority, the license will not terminate. However, the agent must return the license certificate to the Department of Insurance so that the Department can reprint the license with the lines of authority that are still active.

Deceptive Insurance Practices

The Kentucky Insurance Code addresses deceptive and discriminatory practices and unfair methods of competition by insurers, their agents, and others with regard to conducting the business of insurance within the Commonwealth. The Code describes and specifically prohibits the activities discussed in the following paragraphs. If, after a hearing, the commissioner finds that any person in this state has engaged in, or is engaging in, any act or practice defined in or prohibited, he or she will order the person to desist from the act or practice

Prohibited Unfair or Deceptive Practices in the Writing of Insurance. The Kentucky Insurance Code prohibits unfair or deceptive practices in the transaction of life and health insurance with respect to the human immunodeficiency virus (HIV) infection and related matters.

Advertisements in General. No person may produce or disseminate in any form or manner any material or information, written or oral, which:

- misrepresents the terms, benefits, advantages, dividends, or share of surplus to be received on any policy or uses false or misleading information or estimates as to dividends or share of surplus previously paid on similar policies;
- uses a name or title for any insurance policy or class of policies, which misrepresents the true nature of the coverage;
- makes any misleading statement or misrepresentation as to the financial condition of an insurer or as to the legal reserve system upon which any life insurer operates; or
- contains any untrue, deceptive, or misleading representation regarding the business of insurance or way any individual is conducting his or her insurance business.

False Financial Statements. Making, disseminating, or filing with any public official any false statement regarding the financial condition of any insurer with intent to deceive is prohibited.

No one may make any false entry in any record, report, or statement of any insurer, with intent to deceive the commissioner or any examiner lawfully appointed to examine the insurer's records. Nor is anyone permitted, with intent to deceive, to willfully omit to make a true entry of any material fact pertaining to an insurer's business.

Advertisement of Assets, Liabilities. Anyone who advertises or in any other manner disseminates information by or on behalf of an insurer stating the insurer's assets is required to state the insurer's liabilities computed on the same basis. Any statement purporting to show the insurer's capital may state only the amount of actual paid-in capital.

Defamation. No person is permitted to promulgate in any manner whatsoever any oral or written statement of any kind, which is false, or maliciously critical of or derogatory to the financial condition of an insurer, or of an organization proposing to become an insurer, and which is calculated to injure any person engaged or proposing to engage in the business of insurance. The direct or indirect aiding or abetting of such activities is also prohibited.

Boycott, Coercion, and Intimidation. Involvement in any effort to undertake an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of the business of insurance is prohibited.

Unfair Discrimination Prohibited. No insurer, other than a life insurer or health insurer, may discriminate between insureds or subjects of insurance having substantially the same insuring risk in the terms or rates for any insurance contract.

No life insurer may discriminate unfairly between individuals of the same class and equal expectation of life with regard to the rates, dividends, other benefits, or the terms and conditions for any life or annuity contract. However, in determining the class, consideration may be given to such things as the nature of the risk, plan of insurance, or other relevant factors.

Similarly, no health insurer is permitted to unfairly discriminate between individuals of the same class involving essentially the same hazards with regard to premiums, fees, benefits, rates, or terms and conditions for any health insurance contract, except that in determining the class, an insurer may give due consideration to the nature of the risk, plan of insurance, the actual or expected expense of conducting business, and other relevant factors.

Denial of Insurance Because of Race, Color, Religion, National Origin, or Sex Prohibited -- Genetic Tests. No one is permitted to refuse to issue or renew insurance to any person because of race, color, religion, national origin, or sex, except that rates determined through valid actuarial tables are allowed.

Insurers may not deny coverage or alter the plan or premiums for any insured or beneficiary on the basis of a genetic test for which symptoms have not manifested or because the participant or beneficiary has requested or received genetic services. A group health or disability income insurer may neither require a participant, beneficiary, or applicant to disclose his or her genetic test nor disclose a genetic test about a participant or beneficiary without prior written authorization for each disclosure.

Rebates Prohibited. No insurer, or anyone connected with the insurer, is permitted, except in accordance with the applicable terms of the policy, to knowingly offer to any insured, directly or indirectly, any rebate, discount, abatement, or reduction of premium, any special favor or advantage, or valuable consideration whatever as inducement to insurance either before or after the effective date of the insurance. Nor is any insured named in a policy permitted to receive or accept such consideration.

No life or health insurer may offer any life, health, or annuity contract upon any terms other than those plainly expressed in the contract or may offer as an inducement to the insurance any valuable consideration of any kind.

Exceptions to Discrimination and Rebate Prohibition. The following are exceptions to the preceding paragraphs on unlawful rebates:

- payment of lawfully earned commission or other lawful compensation to duly licensed insurance producers;
- distribution by a participating insurer to its participating policyholders of dividends, savings, or the unused or unabsorbed portion of premiums and premium deposits;
- furnishing information, advice, or services for the purpose of reducing the loss or liability to loss under a policy;
- payment of bonuses to policyholders or the abatement of premiums by life insurers out of surplus accumulated from nonparticipating insurance, if such bonus or abatement is fair and equitable to all policyholders and for the best interests of the insurer and its policyholders;
- in the case of debit plans, making allowance to policyholders who have continuously for a specified period made premium payments directly to an office of the insurer in an amount which fairly represents the savings in collection expense or making allowance to policyholders who make premium payments at less frequent intervals than required; or
- readjustment of the rate of premium for a group insurance policy based on loss or expense experience at the end of any policy year, which may be made retroactive only for the policy year.

Illegal inducements prohibited. No insurer, insurance producer, or any other person is permitted to offer in any manner any of the following as an inducement to insurance:

- employment;
- shares of stock or other securities issued, or at any time to be issued, including interest in or rights to stock or securities;
- any advisory board contract, or any similar contract, agreement or understanding, offering, providing for, or promising any profits or special returns or special dividends; or
- any prizes, goods, wares, merchandise, or property of an total value in excess of \$25.

Coercion in Requiring Insurance. No person engaged in the business of financing the purchase of real or personal property or of lending money on the security of real or personal property may, as a condition of doing business, require any borrower to utilize a particular insurer, agent, or type of insurer to obtain or renew insurance on the property or the life or health of the borrower, except that the lender is permitted the reasonable exercise of its right to approve or disapprove the insurer selected to underwrite the insurance and to determine the adequacy of the insurance offered.

Notice of Free Choice of Agent or Insurer. A lender must provide notice to a debtor, borrower, or purchaser of property with respect to the kind of insurance required in connection with a debt or loan on the property and of his or her right of free choice in the selection of the agent and insurer through the insurance is to be placed. The lender may not interfere in any way with the borrower's free choice of agent and insurer, refuse an adequate policy tendered by the borrower, or collect a separate charge for the handling of insurance required in connection with a loan or extension of credit based on the consumer's choice.

Certain Fees for Handling Insurance Transactions in Connection With Loans Prohibited. No person who makes a loan on real or personal property may, in connection with such a transaction, require an extra fee of any kind for handling the substitution by a borrower of one insurance policy on the property for an existing policy on the property, when the existing or substituted policy is provided through an insurer or insurance agent licensed to do business in the state.

Interlocking Ownership, Management. Except where in violation of the Code, any insurer may invest in or acquire insurers, or have a common management with any other insurer or insurers, unless doing so substantially lessens competition generally in the insurance business or creates a monopoly. Similar restrictions apply to any qualified person seeking to be a director of two or more insurers which are competitors.

Illegal Dealing in Premiums. With regard to handling insurance premiums, no one is permitted to willfully:

- collect insurance premiums without providing the insurance either immediately or in due course subject to acceptance of the risk by the insurer;
- collect premiums or charges in excess of the amount actually expended or expected to be expended in connection with the insurance; or
- fail to return within a reasonable time any sum collected as premium or charge for insurance in excess of the amount actually expended for insurance, or for medical examination, in the case of life insurance.

Insurer Name -- Deceptive Use Prohibited. No person who is not an insurer may assume or use any name which deceptively infers or suggests that it is an insurer.

Domestic Violence and Abuse as Reason for Insurer's Limitation or Denial of Coverage. No insurer may use the fact that an applicant or insured incurred bodily injury as a result of domestic violence and abuse

committed against him or her as the sole reason for rating or underwriting decisions, refusing to insure, refusing to continue to insure, or limiting the amount, extent, or kind of coverage available.

If a property or casualty policy excludes property coverage for intentional acts, the insurer may not deny payment to an innocent co-insured if the loss arises out of a pattern of domestic violence and abuse and the perpetrator of the loss is criminally prosecuted for the act causing the loss. Payment to the innocent co-insured may be limited to his or her ownership interests in the property as reduced by any payments to a mortgage or other secured interest.

Discrimination on Basis of Blindness Prohibited -- Application. Unfair discrimination against individuals on the basis of blindness or partial blindness is prohibited.

Time Payment of Claims. All claims must be paid to the named insured or health care provider not more than 30 days from the date notice and proof of claim, in the substance and form required by the terms of the policy, are furnished the insurer. If an insurer fails to make a good faith attempt to settle a claim within this time, the value of the final settlement will bear interest at the rate of 12% per year from the expiration of the 30-day period.

If an insurer fails to settle a claim within the time prescribed above and delay is without reasonable foundation, the insured or health care provider is entitled to be reimbursed for reasonable attorney's fees incurred.

Unfair Claims Settlement Practices

The proper and fair handling of insurance claims is a subject that is vital to all concerned – insureds, insurers, the regulators, and the general public. Policyowners have a right to expect that they will be paid promptly and fully when they incur a loss. When an insurer resorts to unreasonable or dishonest means in order to deny or delay payment on a legitimate claim, the claimant may be subjected to additional hardships and damages.

On the other hand, insurers must have the ability to conduct legitimate investigations and employ appropriate processes to avoid making payments on fraudulent claims, which also ultimately affect the general public in the form of higher insurance premiums. Balancing these opposing requirements is an ongoing concern for regulatory agencies and state governments.

Under the Kentucky Insurance Code, it is an unfair claims settlement practice to engage in the following acts or omissions:

- misrepresenting pertinent facts or insurance policy provisions relating to coverage at issue;
- failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- refusing to pay claims without conducting a reasonable investigation based upon all available information;
- failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed;
- not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear;

- compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by insureds;
- attempting to settle a claim for less than the amount to which a reasonable person would have believed he or she was entitled by reference to written or printed advertising material accompanying or made part of an application;
- attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured;
- making claims payments to insureds or beneficiaries not accompanied by statement setting forth the coverage under which the payments are being made;
- making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration;
- delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring the
- requiring subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information;
- failing to promptly settle claims, where liability has become reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage; failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or
- failing to comply with the decision of an independent review entity to provide coverage for a covered person as a result of an external review.

In order to prevail on a bad faith claim under the Kentucky Unfair Claims Settlement Practices Act, an insured must establish the following:

- that the insurer was obligated to provide coverage under the terms of the policy;
- that the insurer had no reasonable basis for denying coverage for the claim; and
- that the insurer knew there was no reasonable basis to deny the claim or the insurer acted with reckless disregard for whether a basis to deny the claim existed.

Kentucky Administrative Regulations

Claims settlement practices in Kentucky are also regulated by the Kentucky Administrative Regulations (KAR). Under these directives, life and health insurers are governed by standards different from property and casualty insurers.

Life and Health Claims Handling Schedule. Life and health insurance claims settlement practices are governed by 806 KAR 12:092. This administrative regulation sets forth minimum standards for the investigation and disposition of life and health insurance claims arising under policies, certificates, and contracts. It is intended to define procedures and practices which constitute unfair claims settlement practices. This part of the KAR does not cover claims involving workers' compensation insurance.

The National Association of Insurance Commissioners created the model regulation on which this administrative regulation is based. The sole purpose of this regulation is to provide guidance in the investigation and examination of claims practices.

The following are obligations of the insurer with regard to the handling of life and health insurance claims:

- **Providing Claim Forms** – Every insurer, after receiving notification of a claim, must within 15 days of the notification, provide the necessary claim forms, instructions, and reasonable assistance so the insured can properly comply with the insurer's requirements for the filing of a claim.
- **Timely Investigations** – Upon receipt of proof of loss from a claimant, the insurer must begin any necessary investigation of the claim within 15 days.
- **One Set of Forms Filed for All Similar Policies** – If the insured has more than one similar policy from an insurer and identifies that fact to the insurer, the filing of notice of claim and proof of loss under one of the policies will fulfill the insured's obligation for such filing under all such similar policies held. If, under one or more of the policies held, additional information is required to fulfill the insured's obligation, the insurer may request the additional information.
- **Acknowledgement of Additional Liability** – When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer must communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.
- **Timely Payment or Denial of Claim** – The insurer must affirm or deny any liability on claims within a reasonable time and must offer payment within 30 days of receipt of proof of loss. If the insurer fails to pay the claim within 30 days and the delay or denial is due to lack of a good faith attempt to settle the claim, the insurer must pay 12% interest on the amount of settlement from the expiration of the 30 days. Furthermore, if the delay or denial is without reasonable foundation, the insurer will be required to reimburse the insured for reasonable attorney's fees incurred in collecting the claim.
- **Payment of Undisputed Portions of a Claim** – If a portion of the claim is in dispute, the insurer must pay any portion of the claim which is not in dispute within 30 days of receipt of due proof of loss.
- **Explanation of Benefits** – With each claim payment, the insurer must provide to the insured an explanation of benefits that includes the name of the provider of health care services covered, dates of service, and a reasonable explanation of how the benefits were calculated.
- **No Pre-Certification Penalties If Not in the Policy** – The insurer is not permitted to impose a penalty on any insured for noncompliance with insurer requirements for pre-certification unless the penalties are specifically and clearly set forth in writing in the policy.
- **Written Explanations for Delays** – If a claim remains unresolved for 30 days from the receipt of due proof of loss, the insurer must provide the claimant with a reasonable written explanation of the delay. This must be repeated if the investigation remains incomplete 45 days from the date of initial notification and every 45 days thereafter, upon which occasions the insurer's letter to the claimant must set forth the reasons additional time is needed for the investigation and also describe to the claimant the availability of insurer-paid interest and attorney's fees.
- **Response to Communications** – The insurer must acknowledge and respond within 15 days to any written communications relating to a claim.
- **Notice of Denial** – When a claim is denied, the insurer must send to the claimant a written notice of denial 15 days of the determination. The notice must refer to the policy provision, condition, or exclusion upon which the denial is based.
- **Documentation of Sources** – Insurers may not deny a claim based on information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file.

- **Refusal to Settle** – An insurer may not refuse to settle a claim on the basis that responsibility for payment should be assumed by others, except as provided by policy, certificate, or contract provisions.
- **Calculation of Future Disability Benefits** – Except in cases where there is a legitimate dispute as to coverage or amounts due, all insurers that offer cash settlements for long-term disability income claims must develop a present value calculation of future benefits, based on facts appropriate to the risk, which must be given to the insured and signed by the insured at the time a settlement is entered into.
- **No Final Payment Notification** – An insurer is not permitted to indicate to the insured on a payment draft, check, or in any accompanying letter that the payment is final or represents a release of any claim unless:
 1. the policy limit has been paid; or
 2. there has been a compromise settlement agreed to between insured and insurer as to coverage and amount payable under the contract.
- **No Withholding of Benefits to Adjust for Prior Claims** - Insurers may not withhold any portion of any benefit payable as a result of a claim on the basis that the settlement held is an adjustment or correction for an overpayment made on a prior claim arising under the same policy unless the insurer has within its files clear, documented evidence of an overpayment and written authorization from the insured permitting the withholding procedure, or has within its files clear, documented evidence that:
 1. the overpayment was clearly erroneous under the provisions of the policy (unless the subject of a reasonable dispute as to facts);
 2. the error which resulted in the payment is not a mistake of the law;
 3. the insurer notified the insured within six months of the date of the error, except where the error resulted from representations or nondisclosures by claimants or third parties, in which case the insurer must notify the insured within 15 days after discovery of the error is included in its file; and
 4. the notice stated clearly the nature of the error and states the amount of the overpayment.
- **Notices of Time Limitations for Claims** - Insurers may not continue negotiations with a claimant who has no legal representation until the statute of limitations or a time limitation in a policy, certificate, or contract expires, without giving the claimant written notice of the impending expiration at least 30 days prior to the date on which the time limit may expire.
- **Documentation and Record Keeping** - Each insurer is required to maintain adequate file and record documentation, as each insurer's claim files are subject to examination by the commissioner. To aid in an examination:
 1. the insurer must maintain claim data that is accessible and retrievable for examination for all open and closed files for the current year and the five preceding years to include claim number, line of coverage, date of loss, date of payment of the claim, and date of denial or date closed without payment;
 2. the documentation must be contained in each claim file to permit reconstruction of the insurer's activities relative to each claim;
 3. each document within the claim file must be noted as to date received, date processed, or date mailed; and
 4. for those insurers which do not maintain hard copy files, claim files must be accessible from a computer terminal available to examiners or on micrographics and be capable of duplication to hard copy.

Property and Casualty Claims Handling Schedule. Property and Casualty insurance claims settlement practices are governed by 806 KAR 12:095. This regulation does not cover claims involving fidelity, suretyship, boiler and machinery insurance, or workers' compensation, except for claims for unearned premium refunds. It establishes procedures which constitute fair claims settlement practices for property and casualty insurers.

Documentation and record keeping requirements are the same as set forth in the previous section for life and health insurers.

The following are prohibitions and obligations of property and casualty insurers with regard to the handling of claims:

- **Misrepresentation of Policy Provisions** - Insurers and their agents may not misrepresent or conceal from claimants any pertinent benefits, coverage, or other provisions of any insurance policy or insurance contract if the benefits, coverage, or other provisions are pertinent to a claim.
- **Denial Based on Failure to Exhibit Property** - Insurers may not deny a claim on the basis of failure to exhibit property unless there is documentation in the claim file of breach of the policy provisions.
- **Denial Based on Failure to Give Written Notice** - Insurers may not deny a claim based upon the failure of a claimant to give written notice of loss within a specified time limit unless it is a written condition in the policy and the claimant's failure to provide written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.
- **No Final Payment Notification** – An insurer is not permitted to indicate to the insured on a payment draft, check, or in any accompanying letter that the payment is final or represents a release of any claim unless:
 1. the policy limit has been paid; or
 2. there has been a compromise settlement agreed to between insured and insurer as to coverage and amount payable under the contract.
- **No Release from Liability upon Partial Settlement** - Insurers may not issue checks or drafts in partial settlement of a loss or claim under a specific coverage which contain language that releases the insurer or its insured from total liability.
- **Acknowledging Notification of a Claim** - Insurers, upon receiving notification of a claim must acknowledge the receipt of the notice within 15 days, unless payment is made within that period of time. Notification given to an agent of an insurer is considered to be notification to the insurer.
- **Inquiries from the Department of Insurance** - If an insurer receives an inquiry from the Department of Insurance respecting a claim, the insurer must furnish an adequate response to the inquiry, in duplicate, within 15 days.
- **Replying to Pertinent Claimant Communications** - The insurer must make an appropriate reply within 15 days on all pertinent communications from a claimant which reasonably suggest that a response is expected.
- **Claim Forms and Instructions** - Every insurer, upon receiving notification of claim, must provide to claimants within 15 days all necessary claim forms, instructions, and reasonable assistance so that they can comply with the policy conditions and the insurer's reasonable requirements.
- **Standards for Prompt, Fair, and Equitable Settlements** – Insurers must affirm or deny any liability on claims within a reasonable time and must offer any payment due within 30 calendar days of receipt of due proof of loss for claims which are not in dispute. If there is a reasonable basis for believing the claim may be fraudulent, the insurer must notify the claimant of the acceptance or denial of the claim within a reasonable time to allow for a full investigation.
- **Notifications of Additional Time Needed for Investigation** - If the insurer needs more time to determine whether claim should be accepted or denied, it must notify the claimant within 30 days from the receipt of due proof of loss, giving the reasons that more time is needed. This must be repeated if the investigation remains incomplete 45 days from the date of initial notification and every 45 days thereafter, upon which occasions the insurer's letter to the claimant must set forth the reasons additional time is needed for the investigation and also describe to the claimant the availability of insurer-paid interest and attorney's fees.

- **Refusal to Settle** – An Insurer must not fail to settle a claim on the basis that responsibility for payment should be assumed by others, except as provided by policy provisions.
- **Notices of Time Limitations for Claims** - Insurers may not continue negotiations with a claimant who has no legal representation until the statute of limitations or a time limitation in a policy, certificate, or contract expires, without giving the claimant written notice of the impending expiration at least 30 days prior to the date on which the time limit may expire.
- **Representations Regarding Release Forms** - Insurers are prohibited from making statements which indicate that the rights of a third-party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is to notify the claimant of the provision of a statute of limitations.
- **Polygraph Examinations** - Insurers may not request or require any insured to submit to a polygraph examination unless authorized under the applicable policy, certificate, contract, or applicable law.

Conclusion

This lesson has covered many of the ways in which the insurance industry must be regulated in order to maintain a high degree of professionalism and accountability as well as high ethical standards on the part of those who are engaged in the business of insurance. Regulation serves to protect the consumer of insurance products and the public in general from a wide range of unfair acts and abuses that may be perpetrated by a few unscrupulous individuals.

The lists of prohibited practices and discussions of legal remedies which have been presented here are by no means exhaustive, and ethical agents will continually seek to gain knowledge in these areas in order to advance the level of expertise and competence with which they undertake their professional duties.