

SUITABILITY ISSUES PART I



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Suitability Conduct

In the world of insurance, client's must decide when to insure, what to insure and how much to cover and pay. As an agent, it is your job to analyze these needs and be an advocate or problem solver to make sure the requested risk has been transferred. A client views policies in terms of obtaining reduced uncertainty. In most cases, your customers can only hope that the policy they purchase is appropriate. That is why agents are vital players in solving client needs.

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

Suitability Duties

It may not be your legal duty to secure complete insurance protection against every conceivable need an insured might have, but there is definite legal obligation to explain policy options that are widely available at a reasonable cost. Likewise, an agent has a legal duty to use reasonable skill in asking certain questions during the application process to determine types of coverage needed. Further, failing to determine the nature and extent of the coverage requested may subject you to a lawsuit.

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

An insurance agent owes the prospective insured a duty of unwavering loyalty similar to that owed by an attorney to a client. It is the special fiduciary nature of the relationship between a prospective insured and an insurer that lends the relationship a personal character similar in scope to the lawyer-client relationship. For this reason, alleged acts of negligence on the part of an insurance agent who has been consulted for the express purpose of meeting a client's unique needs create a personal tort.

For example, cases have looked to whether the insureds made express representations to the agent about the importance of arranging a set of policies that would prevent a gap in coverage. The insureds relied on these agents to obtain the appropriate coverage, and the agents failed to use reasonable care, skill and diligence

to procure suitable policies. The allegations in the complaints make clear that the insureds expected the agents to respond to the couple's unique, personal insurance needs. A \$600,000 claim proved that a gap in coverage existed and therefore it was not a suitable policy.

In another example, the agent had specialized in the sale of what is referred to as bank financed insurance or insurance under the bank loan plan. The plan was that premiums would be provided by borrowing the amounts thereof from a bank and securing the bank by assignment of old and new policies. The court discussed the issue that a bank finance plan could be useful for a person whose income and financial condition is such that his income tax puts him in high brackets and who has the means to liquidate the steadily increasing debt out of other sources.

Did this make the agent guilty of a breach of duty in a failure to make disclosure of certain facts? Was this product suitable? What about the rather large commissions, not ordinarily possible with a client in this income category?

The trial began by with a citation from another case, where the agent's license was suspended for making false and fraudulent representations in selling bank financed life insurance. There the court said, "the appellant was an experienced expert in the field; the insured a mere layman who was led to believe that the bank plan would meet certain expressed objectives. Certainly the relationship was a fiduciary one in which the plaintiffs were entitled to believe the agent's material statements."

In this case, the court determined that the insured did rely upon the agent's statements and that it would be unreasonable to argue that the insured should have found out for himself, because of some principle of caveat emptor, that the program was not at all what it was represented to be.

The insured testified, "I had my faith in him because he was recommended by a leading business man. I figured he knew what he was talking about. He had all the facts in my case. I figured he was giving me something that was designed for me."

It was also uncovered at trial that the insured inquired about reducing or dropping the program after starting it, in case he could not afford it. The agent assured the insured he could cancel. What the agent neglected to say was that cancellation would result in a substantial loss to the insured.

Insurance experts were brought in on both sides of the argument to prove or disprove suitability. Both experts, for the plaintiff and for the defendant, agreed what would constitute a suitable insurance plan for the insured and what factors to consider:

- the details of the existing insurance program;
- its values and benefits,
- the cost of continuing the old program,
- the additional cash outlay for the new program,

- loss of values and benefits, if any, under the old program and
- the additional values and benefits of the new program.

The court held that one who undertakes to make statements under circumstances such as this, is bound not only to state truly what he tells, but also not to suppress or conceal any facts within in his knowledge which materially qualify those statements. If he speaks at all he must make a full and fair disclosure. This is particularly true where one party to a deal, though in no sense a fiduciary, is possessed of superior knowledge as to facts material and important to the transaction which he fails to disclose to the other party.

Meaning of Suitability Conduct

Beyond being the most responsible agent you can be, you should size-up your client and anticipate his needs when he cannot. How can this be accomplished?

Aside from determining current and future risks that you know about, you need to expect those that have not happened. For instance, you should know that a 50-year-old baby boomer client is a far more complex individual than his parents before him. His insurance needs are also more complex: higher life limits to cover college and entrepreneurial pursuits; medical coverages, long-term care and more retirement needs for a longer life span; higher primary and umbrella coverages to protect against lawsuits.

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

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

In addition, you should do research about their needs as a group so you can better anticipate insurance needs. Every additional bit of information you learn about your client helps you get closer to knowing their goals, needs, and wants.

In some cases, your clients will not know the answers to your questions themselves – you may need to interpret for them. But, by all means never do this without involving them in the process. And, of course, once you have asked all the questions you must be sure that you implement or meet their needs to the best of your ability.

Risk

Before you can determine what is suitable or not, you need to discover the purpose behind your work. You are your client's unofficial risk manager. This means you help identify the everyday risks they are exposed to and recommend ways to transfer it, avoid it or reduce it.

Risk is a fact of life to be constantly analyzed and managed. There are many ways a client can suffer major financial setbacks in the face of an unexpected injury or natural disaster. Further, there are many more legal ways that others can get to your clients due to expanding liability theories in our courts and the trend to pursue "deep pockets".

Unfortunately, the time most people devote to managing their own risk is typically less than the time they spend planning a summer vacation. As important as it is to assess your client's risk issues, not everything can be covered and there are times you will not be able to provide any coverage at all. These are facts that all clients need to know before you can help them.

Identifying Client Risks

The process of identifying client risks is not as complicated as some make it to be. Clients fill out forms and insurance applications which help quantify and qualify the coverage is needed.

What a client does for a living, his age, where he lives and even his recreation determines the many risks that your clients are exposed to. Family relationships and responsibilities create additional risks as do what is owned and owed. A client's concern for family members he might leave behind is yet another risk determinant.

How are client risks discovered? Through insurance applications and/or forms you create. There are so many possibilities and options that it is impossible to present you with a single format. Adapting existing policy applications is probably a good start. When completely filled out, you will see areas of concern and potential exposure probably not mentioned in a verbal interview.

The Importance of Applications

Proper attention to the completion and submission of client applications cannot be stressed enough. Not only is there valuable risk information, but mistakes by you or a client can void, decline or reduce coverage. Be accurate, timely and explain to clients the serious nature of misrepresenting any information they provide.

Once you and your client have identified their risk exposures, you need to determine a strategy to handle it. Consider the following options: A client with an

identified risk can either control it or finance it. Controlling client risks involves avoiding or reducing them:

Avoiding Risks

The tools to accomplish this are in the decision not to own something, not to do something, not to say something or just to not do something that could create or represent risk exposure.

Reducing risk involves the issues of loss control with a focus on safety, procedures, pooling, segregation, and diversification. Financing risks involve transferring, sharing or retaining them:

Transferring or sharing risk can mean renting instead of owning, buying insurance, using credit instead of assets, or getting hold harmless agreements.

Retaining risk examples include insurance deductibles, co-insurance, self-insurance or simply ignoring the risk and absorbing the full cost if it occurs.

Needs-Based Analysis

Beyond the issue of risk, traditional industry thinking tells us that suitability should be based on needs. Needs analysis is a procedure to help prospective insurance clients plan for their future.

Needs-based analysis has been around since the early days but it was refined in the late 1960's by Thomas J. Wolff, a tenacious and studious insurance agent, who is today an industry legend. As a young agent, Wolff struggled to make it in the business.

While other agents and teachers dazzled their audiences with tales of sales wizardry and artful cherry picking among the rich and famous, Tom Wolff told a much different tale. Instead of trying to achieve his place by showing everyone how good he was, he taught his students how effective they could be as agents through capital needs analysis and financial needs analysis. Thus began the beginning of the suitability approach to selling insurance.

The purpose of a needs-driven sales system is to analyze a client's needs and determine how insurance can best meet those needs. It is not meant to generate the sale based upon the obvious points of the product or the need of the salesperson to produce. It uncovers a prospect's general financial problems or deficiencies so that the prospect begins to recognize the need.

The problem is personalized to arouse interest in a possible solution. Like any system, needs analysis works effectively only when it is used as it is designed. The system builds upon itself in terms of both content and data and is most effective when used from start to finish. Shortcuts undermine the effectiveness of the process. An

agent following this system from start to finish should never be accused of less than professional point-of sale practices.

Needs-based analysis goes into great detail in analyzing needs and creating recommendations that are based upon airtight logic and conclusions. Needs-based selling involves the client, allowing him or her to use his or her own ideas and assumptions. It is a process that allows the prospect to participate in creating his or her own solutions to needs based upon what he or she considers important. Analyses must represent and respect the client's opinions. The goals are those of the prospect, not the agent. If the goals are not the goals of the prospect, the prospect is not likely to go along with the agent's recommendations in the end.

Needs Based Selling?

The focus of needs based sales training is to teach techniques to uncover prospects' specific needs before features and benefits of the product or service are discussed. Needs analysis helps the agent sell the right amount of insurance to the client for the right reasons. This is much better than simply selling product and ethically more correct than convincing a prospect that the product you have is what they want.

The analysis is characterized by the recognition of accurately assessed needs, which are the result of careful and professional analysis. Through careful fact-finding, information is gathered about the prospect's desire to provide income to family members in the event of premature death or disability, plan for retirement needs and accumulation and/or cover unexpected loss of property. The analysis performed is based upon a myriad of things: interest rates, inflation assumptions, salvage value and the prospect's views about his or her objectives and timetables.

Needs analysis helps the agent sell the right amount of insurance to the client for the right reasons. In today's competitive environment, agents cannot afford the exposure of makeshift or piecemeal sales practices. They must provide a needs-based analysis for their clients and generate trustworthy recommendations based on this investigation. Learning how to effectively determine needs gives the opportunity to offer a full array of financial products and services.

A Complete System

Needs-based selling is a complete system for obtaining the appointment, opening the interview and gathering factual data for all types of prospects. At the end of the fact-finding process, a joint decision is made between the prospect and the agent as to which of three cornerstones of financial security is top priority:

- Accumulation (developing a sound plan to assist in paying for education and for other financial objectives),

- Retirement (planning to provide the additional income needed to supplement Social Security, pension plans, existing savings and investments) or
- Protection (planning to assure that obligations are met in the event of death, disability or loss of property).

Let's assume a life analysis was being conducted for a baby boomer client. Your fact finding will likely reveal that most boomers are underinsured and require more capital in the event of death than other segments because they have large loans, college-bound teens, business income replacement, partner buyouts, spouse retirement needs, etc. Seniors, on the hand, are "winding down" their lives with fewer protection needs. However, for those who have not planned as well, an in-force policy that can be sold as a life settlement to pay long term care costs or small burial plan can be a real comfort.

Performing Needs Analysis

The needs analysis system breaks the sales process down into carefully engineered parts:

The Pre-approach

This step is designed to get an appointment under favorable conditions for a face-to-face meeting.

The Approach

The objective of the approach is to obtain the appointment. During the approach, no detailed data-taking or selling takes place.

The Initial Interview

The agent's objective during this initial interview is to gather information and uncover the dominant needs of a prospect. Information such as name, birth date, spouse's and children's names and birth dates, address and telephone numbers, property owned and basic obligations are gathered at this time.

Other information to obtain at this time is occupation, spouse's occupation and whether or not the prospect is a smoker, works at home or engages in a high-risk occupation or hobby. A questionnaire is usually filled out at this point, rating his or her feelings, concerns and goals in a variety of areas.

Next, the prospect's financial situation must be assessed. This part of the questionnaire covers such areas as annual income, total life insurance, total assets and total liabilities, the value and the mortgage of the residence, and present investments (such as savings and CDs, money markets, mutual funds,

real estate other than the residence, stocks and bonds, U.S. government bonds, IRAs, 401(k)s or other salary savings plans, and pension or profit sharing plans).

The questionnaire then assesses the prospect's financial risk profile. For example, what kind of financial risk is he willing or able to take? Considerable risk? Almost none? Is he willing to take average risks in order to improve the rate of return? Is he or she willing to take substantial risks in order to maximize the rate of return?

In the next part of the questionnaire, the prospect is asked to make expectations and predictions about his future. For example, will he be changing jobs, starting a business, selling a business, receiving a promotion or retiring, buying a new home or car? Will he be buying a larger or smaller home, making improvements to a home, caring for a parent / spouse or changing marital status? Does he anticipate getting a raise, getting a bonus, inheriting assets, borrowing money, paying off a loan or purchasing property?

This initial interview begins the process of building trust. The initial interview and questionnaire allow the agent to screen the prospect and then determine whether to eliminate him or her based on the data gathered or to proceed with the selling process. The data gathering phase of needs analysis is designed to help understand people. It is often said that people don't buy because they are made to understand, rather they buy when they feel they are understood. The more time that is spent in the effective gathering of both facts and feelings, the less time that will be needed to be spent on the close. Being sincerely interested in people will permit them to be openly interested in the full presentation.

The Review

After the prospect completes the questionnaire, the agent reviews it quickly and looks for areas of importance. The agent may discover, for example, that the prospect is not satisfied with his current premiums, the percentage of income he or she is saving, that he or she does not have an understanding of trusts or that he or she does not participate in a pension or profit sharing plan.

The relationship should be terminated if the prospect is uncooperative, if his or her needs do not meet the agent's minimum requirements, area of knowledge or if insurability does not permit the agent to offer help.

The interview should be continued if the prospect agrees that this is an appropriate time to engage in further discussion, or another appointment should be scheduled. An appropriate prelude to further discussion might be advising the prospect that the 15 minutes are up, and that the agent is prepared to leave as promised. The agent may suggest that, based on the information shared, he or she can be of assistance to the prospect in the areas where the prospect's goals are not being met. The purpose of this interview is to screen the prospect and uncover his or her

needs. Naturally, some cases are more involved than others, and the agent may experience a situation where he or she feels overwhelmed and in over his or her head.

At this time, it is wise to make the decision to involve a manager, trainer or a fellow agent with expertise in the advanced market areas. Even if this means splitting a commission, the agent will benefit by learning more, earning more and developing a loyal client, not just a policyholder.

Matching Client Needs With Product

When you are comfortable that you know your client needs and have asked the client himself, it's time to match these needs with an appropriate product. Much has been written on the perils of matching the wrong product to a perceived client need. This is an area where agents need to exercise extra due care for the client's sake and their own financial well-being.

Questionable market conduct in the 1980's and 1990's created new demands for today's agent. Past agent abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts.

Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses. To compound the problem, the industry's image has been occasionally tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together - less support in marketing and support materials.

The bottom line in either case is that agents are forced to work harder and smarter. In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive.

Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell. The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag as you will see in this chapter.

Both regulators and clients will hold insurance professionals to ever higher standards. Agent due care and sales conduct will be more important than at anytime in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs. Following are some basic due care discussions which may help the agent get started. Of course, every situation will vary and require constant refinement:

Life Insurance Risk Analysis

Before determining the amount of life insurance needed by a client, due care would involve the agent and client in a discussion concerning the various types of life

insurance available: term, whole life, modified whole life, single premium whole life, universal life, variable life.

The attributes of these different policies are best left to a course on basic life insurance. However, it is critical, under due care, that agents recognize the pure risk need of clients and counsel them on the proper choice. For example, persuading a client to accept a high monthly premium whole life policy with a settlement payoff that leaves a significant financial gap at the death of a breadwinner, is not exercising due care.

This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations here a client's age and situation call for the agent to consider future estate settlement costs and liquidity as prime directives in making policy choices. There may even be conditions where due care by the agent might involve a recommendation for a client to carry little or no life insurance at all. Issues regarding life insurance needs for singles, non working spouses and children are often debated among financial planners and agents alike.

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

Capital needs for family income Most families will be able to maintain their standard of living with about 75% of the former breadwinner's income. Depending on the skills and resources of the surviving spouse, this fund may be large enough to provide lifetime income or for a specified period of transition.

Capital needs for debt repayment Typical debts to consider include home mortgages, charge cards, bank notes, business debt, etc. A decision can be made to totally liquidate the debt or to use life insurance proceeds to set up a "sinking fund" to make payments for the life of the loan or a specified period.

Other Capital Needs This might include emergency reserve funds, estimated to be between 50 percent and 100 percent of a client's annual after-tax income, and possible college education funds for surviving children.

Estate Settlement Costs Final expenses can be expensive. Uninsured medical costs and funeral expenses are one aspect. In addition, there are federal and state death taxes. Although the Economic Recovery Tax Act of 1981 eliminates the federal estate tax on property passed to a surviving spouse, the estate of the survivor may face a large death tax liability. Further, there have been recent attempts by Congress to lower the exemption levels. State death taxes vary considerably.

Current Assets Available for Income Production What current assets, such as savings accounts, investments, real estate, pension plans, etc, are currently available for income production or liquidity needs to offset the capital needs above?

Net Capital Needs By combining the above factors, the agent can arrive at the net capital needed to be replaced by life insurance.

Where capital needs analysis indicate that a \$500,000 gap will occur at the death of the breadwinner(s), the agent's due care life insurance recommendation should be for \$500,000 of life insurance. Anything less could leave the client underinsured.

Lesser amounts may be purchased where the client cannot afford the premiums or makes the choice to carry less. If there are additional concerns, such as a client's long-term health, the agent might be advised to disclose his recommendation even though a more expensive policy with less coverage is purchased.

Ongoing monitoring of capital needs is necessary to plan for new client objectives, repositioning of debt, inflation, estate settlement changes and potential health problems that may prohibit coverage in the future.

Another due care consideration concerning life insurance is ownership or title of the policy. Agents should recognize conditions where it would be beneficial to keep life insurance proceeds out of a client's estate by using a life insurance trust or alternative ownership. Due care may be sufficient where agent disclosure of estate tax consequences of life insurance owned by a client and a proper referral to a competent estate planning attorney is pursued.

Essential Life Insurance Due Care Questions

- What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- Who is insured? Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?
- Are there existing life policies that can be cash surrendered or tax exchanged to more efficient plans?
- Is waiver of premium available? Is this a desirable benefit for this client?
- Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
- Is coverage decreasing term? Is the balance sufficient?
- Is there a substandard rating that can be removed?

- Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
- What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc)
- Is there a plan for the "common disaster" involving both husband and wife?

Disability Insurance

Statistics have surfaced which indicate that the average person is three times more likely to suffer a lengthy disability than die. Providing a source of financial income in the event of a major disability is probably the most overlooked portion of client financial planning. By definition, a disability can be a temporary or permanent loss of earned income due to illness or accident.

Essential Disability Due Care Questions

- How much monthly protection is needed? Is an individual policy needed to supplement work plans?
- When does protection need to start? (30, 60, 90 days etc -- the elimination period) Can the client "self-insure" for a period of time?
- Does the client have discretionary income to buy needed protection?
- Is the coverage noncancellable or guaranteed renewable? Can a block of insureds, including your client, be canceled?
- If multiple policies are owned (employer, association, individual), will the benefits of one be reduced by the other? Is there a case for eliminating a policy?
- Is there an employer supported uninsured sick-pay plan available?
- What is the definition of a disability in the client's policy? How severe? How long?
- Does the policy include occupational and non-occupational coverage?
- Is there a substandard rating or waiver of condition? Will the company remove it? Will another company write without a waiver?
- Is there a waiver of premium benefit? Would this be necessary for the client?

Similar to life insurance, due care analysis by the agent involves "need analysis". Through inquiries and available financial papers the agent should determine the current after-tax income needs of the client. This amount could be reduced by expenses that might be eliminated due to the disability. For example, if the client is homebound, he will not need to cover transportation costs of commuting to work or other work related expenses.

Next, an adjustment for possible government benefits can be made using Maximum Benefit Amounts that might be available from Social Security. Minimum employment history and limitations on the term of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases. For just about

every client, the above process will establish that some form of disability protection is generally needed beyond the limits granted social security, and in some cases private, employer provided protection.

Once a disability need is established, it can be compared to the participation limits allowed by insurers and the ability of clients to afford it. Disability sales conduct would involve an agent/client discussion explaining how disability insurers may only offer certain maximum allowable coverage tied to income (a client who earned an after tax monthly income of \$7,500 might be eligible for a maximum of \$3,000 of monthly disability coverage).

There may also be limits of how long this protection is covered (24 months, five years, or to age 65). Further, there may be minimum waiting periods before coverage begins (90 days, 180 days).

Also, there may be reductions in the amount of disability protection paid based on the degree of the disability (a partial disability that allows a client to continue working may reduce benefits substantially). Finally, watch for renewability features. Some policies are truly noncancellable and guaranteed renewable. Others may appear to be renewable unless cancelled by "class".

Thus, if an insurer has a particularly bad block of business with a higher than normal claims experience, it can cancel that class of insureds. Clients need to be counseled that the gaps in coverage outlined by these events require them to seek alternative forms of protection, develop contingency plans or rely on available pension plans, family members and accumulated savings to make ends meet during times of disability.

Health Insurance

Health insurance is one of the most valuable segments of risk management and the most difficult to predict. This is further complicated by exploding medical care costs and the never ending efforts to create a national health care system. Hours of agent due care to develop a long term plan for clients may be broadsided by an entirely different style of health care brought on by federal directives or outrageous premiums.

For this reason, health care planning is one form of insurance that is in constant review. The most efficient form of health protection is by group coverage. Group insurance is the predominant way of providing health insurance today with a definite trend toward HMOs (health maintenance organizations).

Due care in health counseling would involve fact finding to determine sources of social insurance available to the client such as Medicare and occupational worker's compensation. Any gaps in coverage need to be filled through blanket health coverage or medical benefits under a liability policy if the health condition developed as a result of an accident.

In addition, an agent-to-client discussion should cover points concerning:

Basic Eligibility

- Exactly who is covered?
- Does "family" include the subscriber, spouse, one, two or more children?
- How old can the children be and still be covered?
- Does this change if the children are married?
- Will family members lose their eligibility when they turn 65 and Medicare takes over?
- How will a divorce affect a members coverage?
- Will a foreign or out of state residency longer than six months affect coverage?
- How long will a retarded or physically handicapped child or member be covered?

Total Maximum Coverage

A limit to coverage could be present in form of duration and/or a dollar cap.

- Is this a "lifetime cap"?
- Is this cap per family member or for the entire family?
- A lifetime cap of between \$2 and \$5 million, per family member would not be uncommon and might be considered a minimum considering the high cost of medical care.

Deductibles

- How much is the deductible, if any exists?
- Is it per family member? Per year?
- Is there a maximum deductible per family?
- Are there specific deductibles for medicines vs. health care?
- Are there deductible surcharges if the client does not pre-register with the insurer, say for non emergency care?

Stop Loss & Co-Payments

- After deductibles, is the client expected to share or copay any medical expenses?
- Is there an established time, usually after a specific amount of expenses have been incurred, that the co pay will stop and benefits will be 100% covered by the insurer?

Pre-Existing Conditions & Waivers

- Are certain known pre-existing health conditions prohibited or waived? If waived, for how long?
- Is there a waiting period for unknown pre-existing conditions? Some policies specify a 6 to 12 month waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins, nasal surgeries, foot and toe surgeries, breast reductions, otitis media (ear problems), pregnancy, etc.

Exclusions

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

Some "bare bones" plans may cover costs only at prescribed hospitals, although emergencies are typically covered no matter where. Some only pay for procedures incurred in the hospital by hospital employed physicians (regular doctor visits or follow-up sessions are not covered unless specified by the hospital doctor).

Further, many plans may cover certain hospital procedures but not the supplies (a blood transfusion procedure may be covered, but not the cost of blood).

One of the latest trends is the requirement that certain procedures, such as organ and tissue transplants, be pre-authorized. Additionally, some procedures are considered experimental and not covered under any conditions.

Mental health and home health care are usually very limited areas of care. Dollar limits per day with annual maximums are not uncommon, as are maximum visits per year.

Guaranteed Renewability & Rate Changes

- Can the insurer modify or change premium costs? Under what conditions?
- Can a class or "block" of subscribers be changed without changing rates for all subscribers?
- Can the subscriber be canceled? If so, how long will benefits last if client is in the middle of a health crisis?

Important Dates & Notification

While many of the above exclusions and limitations are typically spelled out in policy brochures or in bold print, issues of important dates and notifications can "fall through the cracks". Proper due care would involve a discussion or memo to the client concerning policy time lines. Examples include:

- "All claims must be filed within 15 days on approved claim forms";
- "the insurer must be notified within 60 days of any newborn or adopted children";
- "annual notice is required to sustain coverage for a retarded or handicapped child who is older than the specified age limits";
- "a family member must apply for his or her own plan within 31 days of the main subscriber's ineligibility"

Agents who handle multiple lines of insurance must consider the impact of health insurance on the client's financial planning. A medical catastrophe can permanently devastate a family. No one can argue the importance of life insurance, disability protection and certain property/casualty coverage, but health insurance is a clear priority. It would not be considered due care for an agent who handles different product lines to market a costly \$250 per month whole life insurance plan to a financially limited client when there was no health insurance in place.

A more prudent approach would combine a "basic hospital plan" for major medical emergencies at \$150 per month and a term life plan for \$100 per month. Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.

Essential Health Coverage Due Care Questions

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

Long Term Care Insurance

Long-term care is the kind of help your client needs if he is unable to care for himself because of a chronic illness or disability. Most long-term care policies and state regulations define a “chronically ill” individual as someone unable to perform at least two activities of daily living for a period of at least 90 days and/or someone who requires “substantial supervision” to protect themselves from threats to health and safety due to severe cognitive impairment.

Long term care services can range from help with daily activities of living, such as bathing, shopping or dressing, to skilled nursing care in a nursing home. Care can be provided by friends and family, local home care agencies, adult day care programs, nursing homes, and residential and retirement facilities.

The traditional long-term care policy is defined as any accident and health insurance policy or rider advertised, marketed offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid or other basis for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than acute care unit of a hospital.

The long term care continuum is the ever-expanding and multi-faceted range of services needed by the long term care market. Today’s continuum might consist of the following:

- Chore services: Volunteers buy groceries, mow lawns, vacuum, run errands, etc.
- Home visitors: Meals-on-Wheels, story reading, companionship, etc.
- Senior centers: Social activities, dances, bus tours, etc.
- Adult day care: Daytime activities, lunches, therapy, games, etc.
- Home health care: In-home services by nurses, physical therapists and dieticians, etc.
- Rehabilitation programs: Provide extensive physical therapy, occupational therapy and speech therapy.
- Respite care: Individuals provide relief to aid primary caregivers.
- Retirement housing communities: For the independent elderly, offering individual units, security, social activities, etc.
- Continuing care communities and centers: Designed to meet residents’ changing needs from retirement housing through skilled care.
- Assisted living centers: Offer medical attention, as well as assistance with eating, bathing and other activities of daily living.
- Nursing facilities / skilled nursing: Provide intensive nursing care around the clock.
- Subacute care: Provide post-acute or heavy skilled care that is expected to be of shorter duration than usual skilled care.
- Acute care: Surgical or hospital with lengths of stays limited by diagnosis-related insurance coverage.

The continuum is in a constant flux as it responds to new terms, new legislation, coverage limitations, medical breakthroughs and other market-driven demands.

Similarly, long term care policies, both old and new, must be placed in the context of continuum changes. Residential Care Facilities and Adult Day Care, for example, are increasingly covered in today's newer policies. Earlier policies restricted benefit payments to only those facilities that offered Adult Day Care, a much more restrictive definition.

Another example is policies that covered home care, but required that services were needed because the person would require institutional care without them. Agents need to understand how the policies they offer relate to Continuum of Care services in from the standpoint of policy triggers, ADLs, mental deterioration, etc. This can only be accomplished by evaluating individual policies and client needs.

Essential Long-Term Care Policy Questions

- Is the benefit amount enough to meet the cost of local nursing homes? Costs can range from \$90 in the mid-west to \$300 in New York City. Be sure to advise clients that costs may exceed benefits.
- Does the policy indemnify for a fixed daily amount or simply reimburse for actual costs? Most policies are indemnity plans which can cover incidental costs versus reimbursement contracts which cover actual costs. Reimbursement plans generally pay less, but cost less.
- What is the daily benefit for home care and assisted living? Typical policies cover these conditions at 50 percent of nursing home benefits. Unfortunately, the cost of either can meet or exceed nursing home expenses.
- Can benefits be used as a pool of money for both nursing and assisted living / home care? A pool of money may use the maximum benefits of the policy sooner but at least the cost of both assisted living and home care is covered for the meantime.
- Can the benefit amount be increased later? If so, will underwriting be required? This can be a valuable option for meeting unanticipated care down the road. However, added benefits are usually associated with higher premiums, especially if the new insurance is written at the insured's attained age.
- Can the benefits be decreased if the cost of the policy becomes too much to pay? Coverage will drop, but at least some benefits will be paid.
- Can benefits be purchased jointly for a married couple? The discount is typically 10 to 15 percent.
- Is a survivorship benefit available? Some insurance policies that cover both spouses have a "survivorship" benefit. Under a survivorship benefit, when one spouse dies, the other owes no further payments, as long as the policy has been in force for at least ten years.

- Will benefits be paid if the caregiver is a friend or family member? What about caregiver training? Some policies allow this under home care benefits. The daily benefit for informal care is typically one-half the home care benefit.
- How much does home care coverage add to the premium? Home care benefits are typically one-half the nursing home benefit but could raise premiums by 30 percent or more. Policies where home care benefits equal nursing benefits will probably increase rates about 50 percent.
- Is the premium for benefits more than 5 percent of the client's income? Some industry analysts believe that the cost of long term care should not exceed this threshold.
- Are premiums guaranteed to stay level? It's doubtful. Clients should know that rates can increase by state residency or by class of policyholder. Some say that clients should prepare for an average 50 percent increase over time. Remember, extremely low premiums today, might guarantee rate increases later.
- Is there a limited pay or "paid-up" feature? Nonforfeiture or paid-up features are an option that clients should know about. They can be expensive now but useful later, e.g., a working couple with strong income today can retire with a paid-up policy.
- Is there a restoration of benefits clause? If a policyholder receives care in a nursing home and recovers, the policy benefits may be restored to the original level.
- Does the insurer count days or years? Most benefits are expressed in years but insurers actually count days. In some cases insurers will count three or four days as a week. This is a completely unacceptable condition.
- Do benefits paid through an HMO count as a full day? Although it is rare, some policies count a day of care provided through an HMO as less than a full day. This could be a bonus for the insured.
- Do home health care and adult day care benefits pay for a full day? This can be important to the relief and effectiveness of the primary caregiver.
- Do nursing home / home health care benefits increase automatically? Nursing home costs have been increasing between 8 and 9 percent since 1985. A cost of \$110 per day today will run up to \$513 in 20 years at 8 percent inflation.
- Is the increase based on the Consumer Price Index, Medical Price Index or is it fixed? No one knows the future, but if benefits at least kept pace with inflation the policyholder should have some form of additional protection against rising costs.
- Is there a "cap" on the amount benefits can increase? Beware of companies that "cap" their inflation increases to two or three times the base benefits.
- Are future benefit increases available on demand? Some policies offer the option to increase benefits every so often at the client's attained age. Look for additional underwriting and be alert to any condition that eliminates this option if it has been offered and refused by the policyholder a specific number of times.
- What kind of inflation protection is offered? Protection can increase at 5% compounded or 5% simple. The corresponding increase in premium would be about 60% and 50%. A daily benefit of \$110 today will grow to \$292 in 20 years at 5% compounded vs \$220 under 5% simple.

- What is the cost of waiting to buy inflation protection later? Policies that allow the purchase of additional coverage later can be cheap today but expensive down the road. A 65-year old might pay only \$770 today for a policy with optional increases compared to \$1,598 for one with automatic protection. In 20 years, however, the policy with optional increases could cost over \$5,000 compared to the same \$1,598 for automatic benefit increase protection.
- If inflation protection is too expensive for a client today, is it cheaper to just increase benefit levels? Perhaps. A premium for higher benefits but no automatic inflation protection will most likely cost less today. The risk taken is that clients may be unable to afford the coverage needed in 10, 20 or 30 years or simply have to accept lower benefit levels than would have been provided with automatic protection. These are trade-offs that need to be discussed with clients.
- Are bathing and dressing on the list of daily activities? If a bathing or dressing disability is a trigger of coverage, policyholders will have a much easier qualification and will qualify sooner since these are two of the first daily activities that chronically ill people are likely to lose.
- Are activities explained in different ways than other policies? Some define an eating disability as the inability to feed oneself while another may define it as the need for someone to watch over the party eating. Look for clarification on all activities of daily living as well as terms like: assisted living, walking or wheeling, cognitive impairment, ambulating, transferring, etc.
- Does the policy assess physical activities on a “standby” or “hands-on” basis? IRS 97-31 rules clarify the difference: “Hands on” assistance means the physical assistance of another person without which the individual would be unable to perform the ADL. “Standby assistance” means the presence of another person within arm’s reach of the individual that is necessary to prevent, by physical intervention, injury to the individual while the individual is performing the ADL. Policies that cover only individuals requiring “hands-on” assistance would generally provide fewer benefits than one that included “standby assistance”.
- Will the policy pay on a “medical necessity”? Patients can be too frail to care for themselves from a medical condition like coronary disease, yet still able to perform daily activities. “Tax qualified” plans do not recognize medical necessity.
- Are there special underwriting definitions? One company uses the term “standard” to describe its worst class. For another, it means mid-grade.
- Is there “lifestyle” underwriting that will automatically cause an application denial? One company says that anyone who needs assistance with housekeeping, shopping and household finances is simply unacceptable.
- Does the policy require special equipment installation before benefits can begin? Some insurers may require the insured to install grab bars or a shower stall in place of a tub before they will pay benefits. These restrictions are not favorable to the policyholder.
- What are the measures of cognitive impairment? Look for methods that fairly measure cognitive impairment using terms like thinking, reasoning, remembering, memory, etc. HIPPA provisions measure cognitive ability based on whether the

individual needs “substantial supervision” to protect himself from threats to health and safety.

- Is cognitive impairment measured separately from physical measures of ability? A company that uses physical methods to determine cognitive assessment may overlook people who can pass the test or perform daily activities but forget how or why they did them. Worse yet, their mental impairment could become a threat to how they do them in the future.
- Does the policy pay for home care alterations? Some will pay for stair lifts, ramps, grab bars, etc; allowing an insured to receive care at home.
- Is there a return of premium or nonforfeiture option and how much does it cost? Clients are always concerned about paying insurance premiums and getting nothing in return. Offering them this option may increase premiums by 30 to 50 percent, but they will be certain to get something out of the policy.
- Is there a vesting schedule on any return of premium? Return of premium riders typically start or “vest” after five years. Some return more as the years go by. The return of premium is paid upon termination of the policy by lapse or death.
- Determine how the policy’s nonforfeiture options work. Nonforfeiture options will either return premiums or pay benefits. The benefit may be purchased as “full” (it accrues regardless of claims paid) or “limited” (claims are subtracted from any premiums or benefits paid).
- Nonforfeiture and return of premium options may be better suited to the policyholder who doubts he will use his coverage but still wants something out of the policy. He would have discretionary income and liquid assets to make the increased premiums. In essence, the cost of these additional options represent a potential loss in the time value of money.
- Is there a cognitive reinstatement option? Where mental impairment has set in, policyholders may forget to make premiums payments and risk cancellation. This clause allows reinstatement for up to five months so long as all back payments and proof of cognitive impairment is made.
- What about other useful policy features? Some examples of options to discuss with clients include bed reservation (If an insured goes home, bed space is reserved in case he returns within a specified period) for nursing homes, waiver of premium, respite care and survivorship benefit.

Annuity Analysis

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

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

time. Fixed rate annuities might be an alternative for CDs, GNMA's (Ginnie Maes), T-Bills or other similar obligations.

Variable annuities are better geared to individuals who seek tax deferral, yet are willing to ride with the ups and downs that accompany stock and mutual fund investments. Once an annuity can be established as an appropriate investment opportunity, agents must carefully weigh the following choices and discuss same with each client:

Immediate Annuity vs. Deferred Annuity

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

Single Premium vs. Flexible Premium

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

Fixed Rate vs. Variable Rate

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

Yield vs. Guarantees

It is logical that the stronger the guarantee the lower the yield. Agents must explain that a higher first year yield may include bonuses or special incentives to invest that later disappear. This type of contract should be compared to other contracts that may offer a slightly lower yield that is locked in for a specific period (determining overall predictable yield over time is important due diligence).

In the same vein, a disclosure would be appropriate as to the method used by the insurer to adjust yield. A contract with a guaranteed yield spread may be more appropriate for some clients than a yield that is adjusted by the insurer's board of directors.

Equally important is whether yield is banded (yields are adjusted separately for certain blocks of investors or are investors who entered five years ago given the same yield as new investors).

Yield vs. Liquidity

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

Maturity options

Annuity contracts may mature at specific ages. This can affect both a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85.

Further, agents must disclose the potential tax affect of a maturing annuity. Pre-1981 Annuities deliver principal first, then tax interest or appreciation. Post 1981 annuities tax interest or appreciation first then deliver principal.

Also to be considered is annuitization of the contract where a systematic withdrawal and payoff of the contract over time delivers some principal and taxes interest and appreciation with each payment.

Withdrawals & IRS Penalties

Where the client is withdrawing all or part of an annuity contract prior to age 59½, he should be apprised of the ten percent IRS penalty for early withdrawals. At present, this can only be avoided where the annuitant dies or becomes substantially disabled or, where annuitization is chosen within one year of investing in the annuity contract.

Guaranteed Death Benefits

Where agents assist in estate planning, due care would involve a disclosure concerning death benefits. Most fixed rate contracts guarantee the return of principal and any appreciation (interest left to grow). However, agents should uncover and review factors concerning potential surrender penalties or how they may be avoided, as well as the basis of the guarantee.

Is the death benefit guarantee, for example, the greater of all contributions of principal or simply the value of the contract on the date of the annuitant's death?

Settlement Options & Taxes

Clients should be made to understand that, at best, annuities represent tax deferral, not tax free income. Unless the beneficiary of the annuity is a surviving spouse, taxes on the accumulated growth will be due. There is no step-up in basis.

The tax liability is the difference between the amount invested subtracted from the value of the annuity contract, multiplied by the beneficiary's tax bracket.

Options to mitigate this include five year or lifetime annuitization of the contract. Other settlement options that should be discussed with the client include possible options such as life annuity, joint and last survivor, lifetime with period certain, etc.

State Guaranty Fund Coverage

Rules governing state guaranty coverage should be disclosed to the client. If the State does not permit advanced disclosure concerning guaranty fund protection, the agent should privately exercise diligence in planning annuity purchases. The primary concern? Is the full amount of the annuity covered against insurer failure. Perhaps due care is served by diversifying among several insurers and/or between fixed and variable contracts to take full advantage of guaranty protection.

Titling Options

If the agent is advertising tax and estate planning advice he should disclose the consequences of titling contracts. Where no tax or estate counseling is provided, the agent should still exercise due care by disclosing the fact that titling consequences may result and offer to refer a competent attorney or tax expert before any purchasing decisions.

As a general rule, the death of an owner or annuitant triggers a death benefit which carries tax liability. Unless the survivor beneficiary is the spouse, the beneficiary must take a lump sum and pay the tax or annuitize over a minimum five-year period.

An important area for agents to investigate is whether the annuity contract enforces or waives surrender charges where a death of the annuitant or owner has occurred. In some contracts, the surrender charge can be deferred where an owner dies and a contingent owner is allowed.

Essential Annuity Due Care Questions

- Is the client interested in growth or income?
- Is the client interested in current income or retirement income? How soon does he need to start receiving income?
- How much risk is the client ready to accept today and in the future? Could he stand the loss of his entire investment? How would an interruption in income affect him?
- What are the client's liquidity needs in the short-, intermediate- and long-term?
- What is the client's federal/state tax bracket? Does tax deferral through annuities make sense?

- Is the client under age 60, and is it likely that he will need to withdraw major portions of the annuity in the future? Will the ten percent penalty offset the benefits of tax deferral?
- Does the client demand full and complete protection of principal? Or, can the client afford to take risk in hopes of greater appreciation using variable contracts?
- Is the preservation of principal more important to the client than the effects inflation may have against a fixed yield?
- What are the survivor spouse/family needs in the event the client dies? How can these needs be accomplished?

Business Insurance

The risk managing agent recognizes that due care extends to businesses as well as individuals, since businesses are composed of the same people. The illness, disability or death of these people represent an exposure to businesses in terms of their survivability and commitments to principals, employees and their families.

Sales conduct in business analysis involves a determination of the reduced revenues and increased expenses that may result from the death or disability of a key person in the business, including the possible costs to replace or sell the business, if necessary. The degree of risk protection in business insurance varies by the person who is affected and the legal structure of the company.

Following are some due care considerations for three major forms of ownership – sole proprietors, partners and corporations:

Sole Proprietorships

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

Partnerships

The legal relationship between partners is personal: each is fully responsible for acts of the business and business debts of all others. If a partner withdraws or dies, the partnership must be terminated or reorganized. The disability of one partner can also create a significant financial strain on the entire business.

Due care planning here involves learning the wishes of the surviving family and surviving partners. Where a deceased or disabled partner's family wishes to exit the business, a buy-sell agreement can satisfy the purchase of his share, with the business passing to the surviving partner. Alternatively, the heirs of the deceased may become partners or sell the lost partner's interest, assuming this

is permitted in the partnership agreement. Again, preloss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

Corporations

Most agents will deal with the "close corporation" where the stock is closely held by a few individuals and not offered for public sale. Typically, the stockholders are also employees of the company. In this case, situations similar to the partnership can develop.

A key employee or stockholder can become disabled or die creating additional financial burdens on the company. Most corporation charters provide that remaining stockholders can purchase the share of the withdrawing or deceased shareholder. The risk manager needs to uncover the "formula" for purchase and plan available funds via buy-sell policies, disability protection, health care, etc.

Other significant due care factors concerning business insurance include planning for taxes and liability. For planning purposes, most transfers or sales of business interest become part of your client's gross taxable estate for purposes of death taxes. Income taxes become a factor in corporations where the challenge is to transfer assets out of the corporation without claims of dividend.

Essential Business Insurance Due Care Questions

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

Property Casualty

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

A binder can be written or oral. At the point when the client says "I want it" and the agent says "You're covered", a binder has occurred. Immediately upon creating any

oral binder, the agent should make note of the terms of coverage, when the binder was made and the parties involved. Further, to reduce the possibility of disputes, the agreement should be reduced to writing as soon as possible. Abuses occur where agents do not have binding authority, yet lead clients to believe they do. Likewise, clients may use binders as a means of obtaining free insurance for limited periods.

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

Elementary insurance defines a peril as the cause of a loss. Fire, lightning and collision are all examples of perils. A hazard is anything that increases the chance of loss. A loose gas connection to a main heater system is an example of a hazard.

Hazards, however, can also take shape in "morale" form. Reckless driving is one such example of a morale hazard. While there are, as yet, no formal rules on insurance redlining, there is pending legislation that would force insurers to comply with rules similar to Community Reinvestment requirements now imposed on banks. If passed, a majority of the burden would fall on underwriters. However, agents should be aware that clients living in inferior, low income or minority communities should not be denied application for coverage. The logic behind this is obvious. Without access to insurance, clients would not be able to buy housing.

Compared to life and health contracts, it can be said, that fewer property/casualty policies are read by clients. There is generally less understanding of liability or casualty matters, and therefore, a greater reliance is placed on agent advice and counsel. That is why proper sales conduct would encourage clients to read their policies and help them review the fine print to fully understand exact limits of coverage, define perils, clarify what constitutes a hazard and recognize policy owner duties. Having specimen policies available for this purpose should be standard procedure.

Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital. This should not occur, however, without also recognizing the value of other forms of insurance.

A deluxe homeowner's policy should be scaled back where high premiums might not allow clients to purchase basic health insurance. There may also be validity to the argument that insurance premiums should not be so excessive as to preclude clients from starting necessary retirement savings plans.

In addition to these points, there are many contributions that can be made by agents to promote greater client understanding of risk, loss control and proper valuation. By educating clients in these disciplines, a higher level of insurance efficiency will be

realized. The result can be stabilized or lower premiums through a lower claims experience. It is true, that this may not initially improve agent commissions, but in the long run client retention and income stability should be greater.

Essential Liability Due Care Questions

- What is the insured's "insurable interest"?
- Is the peril covered?
- Is the property covered?
- Is the type of loss covered?
- Is the person covered?
- Is the location covered?
- Is the time period covered?
- When does the policy take effect?
- Are there hazards that exclude or suspend coverage?
- What are policy owners duties after a loss?
- What are the insurer's options in settling a loss?
- What are the time limits for the policy owner to recover from the insurer?
- What are the time limits for the insurer to pay a claim?

Next, a due care discussion might include:

Risk

A client's perception of risk influences how insurance dollars are spent and, to some extent, how the industry is regulated. Unfortunately, much of society has set a low priority on reducing risk relying on the motto: "That's why I buy insurance". Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence. When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs?

Should accident victims who violate seatbelt laws receive full compensation? Should people who live in hurricane and earthquake country be responsible to better secure a structure with inexpensive metal ties? Some believe that people must realize what they can do for themselves before risk priorities can change. Agents can play a valuable role in helping clients accept a certain level of risk and strategies to reduce it.

Loss Control

In the insurance industry, the process of risk reduction is called loss control. Loss control procedures involve the steps necessary in eliminating exposures to

risk and reducing their frequency or severity. Today, loss control makes the workplace safer and reduces a broad range of liability exposures in homes as well. Offering loss control advice and services to clients has potential rewards as well as risks.

Reasons agents might consider advising clients on safety issues include: client credibility, client retention, new client generation, insurer qualification and attractability, favorable insurer status and additional profits where "advice fees" are permitted by law.

With competition stiff, some larger agencies are establishing entire subsidiaries to perform loss control-for-fee services. In these cases, loss control fees can represent from two percent to ten percent of total agency revenues. Smaller companies may contract to outside loss control consultants or simply rely on insurer provided services. Loss control services can run the gamut from standard, non-controversial safety recommendations to complicated compliance advice.

Whatever level of service provided to attract or retain clients, agents should realize that loss control advice exposes him to additional liability. There may also be statutory violations, particularly in the commercial area, for offering safety expertise without required licensing.

Code compliance is an extremely important area of loss control. It is a discipline usually reserved for underwriters and typically outside the venue of agents. This does not mean it should be ignored by the agent. Due care should involve the agent at least to the extent of a physical inspection of the property to determine that fire sprinklers are indeed in place or that a security fence has been installed around a construction site before delivery of materials.

The importance in doing so is underscored by a mitigation of exposure when an accident hits: particularly by third parties.

Valuation

A recent survey by a well known real estate statistics firm found that almost 70 percent of the homes in the U.S. are underinsured by an average of 35 percent. With an increased awareness of this problem, many insurers of large policies are sending appraisers to high value neighborhoods to determine if policy replacement values adequately reflect current values.

In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new

hurricane or earthquake standards; and illegal uses (a business run out of the home).

Bringing inadequately covered premises to full coverage levels increases underwriting income, which may allow a carrier to lower rates within a class of policy owners. Equally important is the liability protection afforded carriers and agents.

Homeowners Insurance

Agents should exercise due care in several important capacities:

Selection of Policy

The selection of policy type (HO-1, HO-2, HO-3, HO-4, HO-6 and HO-8) should be a function of client need. Obvious factors to consider include dwelling type, dwelling size, dwelling construction, dwelling replace ability, additional structures, type and extent of personal property, loss of use and basic liability.

Refinement of the process occurs where agent due diligence uncovers clients the true "limits of need" and special circumstances. This can only be accomplished by interview or systematized fact finding concerning key issues:

Value

The amount of dwelling insurance requested is typically a reflection of the mortgage amount. Does this reflect the true replacement value? Is an appraisal in order for larger policies or where a special construction has been used?

Remember, like kind and quality does not mean "exact" kind and quality. Clients must understand that replacement cost is limited to the style, quality and function of the destroyed or damaged property. Few or no allowances are made for increased costs of repair or reconstruction caused by ordinances or laws regulating construction or repair. An example is new construction school fees or special fees that are currently charged for construction that were not around when the client's house was built.

Concerning personal property:

- Does an inventory exceed policy limits?
- Is replacement value available?
- Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets?
- Are "sublimits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns?

- After primary values are established, the client's "insurable interest" must be determined since a policy owner will not recover for an amount greater than their insurable interest.

Eligibility

Due care discussions with clients should cover circumstances where their eligibility to recover a claim may be jeopardized.

- Is the policy owner the intended owner occupant or does he intend to rent the property?
- Will only one family occupy?
- Is a business being operated out of a home?
- Are there code violations like additions without permits, zoning violations, etc?
- Will the client be unable to perform his duties to mitigate losses (draining pipes to prevent freezing, maintaining heat if the structure is vacant, minimal repairs to protect the property from further damage, etc.)?
- Is a detailed inventory necessary to track descriptions, purchase dates, values, etc?
- Are clients aware that they should hold on to damaged property and make it available for adjuster inspection?
- Do clients need to produce books of account or fill out a proof of loss?
- Will the client be available to assist and cooperate with the adjuster?
- Are insureds aware that they should not make any voluntary admissions of guilt or make voluntary payments to someone they have injured?
- Many of these circumstances can be brought to surface in an initial meeting or physical inspection of the property.

Deductibles

Clients should be apprised of their deductible options. Although higher deductibles mean lower premiums and lower agent commissions, they represent a fair opportunity for clients accept part of the financial consequences of risk taking. This, in turn, can lead to fewer claims and a generally more stable client.

Policy Exclusions

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions. Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or

dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

Liability & Liability Exclusions

Primary to determining liability limits is the client's overall exposure.

- What is his or her personal net worth that could be at risk?
- Will the limits of the policy or an umbrella cover the exposure?
- Are there any liability exclusions in the policy that leave the client uncovered?

Some common areas of neglect include: Boats over 50 horsepower, aircraft, motor vehicles loaned or rented by the insured, certain professional services, most business pursuits, outside premises, cases where insured is liable for worker's compensation, for damage to property used by or rented by the insured.

Auto Insurance

Auto policies are typically divided into different segments covering liability: medical, uninsured motorists and damages (comprehensive, collision, towing, labor and transportation expenses). Insuring agreements traditionally offered "split limits" which apply to each person for each occurrence of liability, damage.

Today, the trend is more toward a single limit of liability, which can be expanded within the policy or through the addition of umbrella coverage, that applies to all covered liability losses arising out of an accident regardless of the number of persons injured or the amount of separate property damage. Minimum due care considerations in this area include:

Policy Limits

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

Policy Eligibility

Clients should be apprised of the specific vehicles eligible for coverage (private passenger autos owned or leased, longer than six months) and those which are not eligible (less than four wheel vehicles, autos used to carry persons or property for a fee) and those needing to be named as additional vehicles (trailers, off-road vehicles).

Clients should also be advised that new or replacement vehicles must be reported within 30 days of purchase to receive full coverage. Clients with poor driving records should be referred to assigned risk plans or "fair" plans organized through state programs.

Policy Conditions

Agents should direct clients to specific areas of the policy pertaining to "duties of the insured after an accident". Clients should be told that they should promptly notify the company of the accident, the time limits within which they should act and steps that they should take to reasonably protect the covered auto from further harm or damage.

Policy owners must provide sufficient evidence of loss, cooperate in any insurance investigation and notify the police if a hit-and-run driver is involved or if the covered auto is stolen.

Policy Endorsements

Clients should know the options they have to broaden their coverage to include coverage such as full replacement cost, towing and labor costs, rental reimbursements, specialized vehicle coverage, extended nonownership liability, additional damage coverage for special vehicles, named nonowner endorsements, coverage for special personal property coverage for items like tapes, CDs, CBs, portable phones.

Some attorneys might advise agents to prepare a written list of available endorsements and the applicable cost to present with the original quote. Clients who incurred claims but refused the option to buy these endorsements would have a difficult time pursuing agents for not making them available.

Policy Exclusions

Due care discussions should also disclose to clients items of coverage specifically excluded. Examples include: property being transported, bodily injury to an employee of a covered person, motorcycles, off-road vehicles, etc.

Also excluded is coverage in areas outside the United States, its territories or possessions and Canada. Clients should understand that an endorsement for extended coverage should be considered when traveling outside these domains.

Policy Effective Date

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

Named Insured

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

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

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

Commercial & Professional Lines

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

Policy Limits

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

Eligibility

Rules of eligibility in the commercial arena are very complex. Clients should be aware of all limitations that might exclude coverage, including: building size or height restrictions (buildings not exceeding 15,000 square feet and no more than four stories); business class restrictions (office uses permitted / manufacturing prohibited or retail permitted / restaurants prohibited).

Where liability is concerned, is the policy based on a "claims made" basis or a "claims occurred" basis? Clients should be well informed that coverage may exist only while they are in business and paying premiums. A claim made ten years after a client retires can be financially devastating.

Policy Endorsements

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

Scheduled Losses

The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises.

In the case of liability policies, premises and operations exposure is the heart of coverage. Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage.

Policy Exclusions

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

Named Insured

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

Beyond Insurance Needs

As solid as they seem, conventional methods of determining client suitability are today considered groundwork - a basic approach. A new level of sophistication is needed in response to a more complex world. Looking outside the box, suitability today must consider the following strategies and disciplines:

A Solutions Orientation

Clients who have needs, also need solutions. A responsible agent understands that this starts with matching specific needs of a client to dozens of policy features and benefit options. When all is said and done, however, a responsible, solutions-based agent must take the final step to assure himself and client that an insurance or planning suggestion is the most effective way to handle economic and health needs.

You must obtain client answers to the following questions:

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

These are essential questions because they help “clear the air” circulating around any doubts or concerns your client may have. And, they can also help limit your liability if something goes wrong down the road. A positive response to these questions is the feedback you need to know that you have “gotten through” to your client and are providing some real solutions to some very important needs. The point is, don't define the needs of your client without input from them. Don't go it alone.

Client Needs Research

The important of "digging deeper" to uncover a client's true need cannot be overstated. You need to spend more time on applications and interviews. However, we live in a "break-neck" world where time is at a real premium.

Your client may not be willing to wade through a lengthy interview process. So, you must get to know something about who they are and what they want from your products and services before you ever meet them. It's called suitability research or client needs research. It involves sophisticated-sounding processes like market segmentation, psychographics, or generational marketing; but it isn't difficult.

Why is this research helpful? Why should you determine insurance needs this way? Not all insurance consumers want the same level and type of service. Some clients require more "hand-holding" through frequent meetings, letters or constant phone contact. Others want to know they are being "taken care of" without the pampering.

When you conduct client needs research, you will be able to assess your client markets and best identify their needs either way. This same process also helps you recognize emerging trends to expand your service to new client groups. It's not just about sales, it's about satisfying customer needs and serving them right for long-term results. You benefit from a consistent income and clients are more likely to receive

better insurance coverage from someone they know and trust. What can you hope to learn by doing client needs research? Here is just a partial list:

- Strategic planning - in what direction are consumer trends driving your business? Where should you invest?
- New product/service development - what lifestyle need can your new product or service fulfill? What new products are opportunities?
- Product/service redesign - what changes in consumer lifestyles impact your product or service? How should you change your offerings?
- Positioning - what lifestyle do you need to satisfy that competitors do not? How do you communicate your superiority?
- Targeting - what lifestyle characteristics define the consumer groups you want to/should target? What new groups are the best opportunity and most need your product?
- Marketing communications - what marketing messages resonate strongest with your target consumers? How can you minimize disconnects?
- Channels - what is the best way to communicate with your consumers? What channels should you choose?
- Pricing - what are consumers' attitudes about price, value, quality? How do they feel about spending and saving their money?
- Brand loyalty - how do consumers perceive the role of brand in the shopping process? How can you encourage strong brand loyalty? What programs work?
- Market share - what do consumer trends suggest about the future of your business? How can this help you create a sustainable competitive advantage over your competitors? What actions can gain you more share?

A New World Means New Consumers

Before we explore this new world of research you should understand that insurance consumers today are much more complex than the relatively homogeneous buyer of the immediate post World War II era. Values back then were stable and centered around a shared vision of the American Dream.

Now, we see vastly different values, motivations, life experiences and insurance needs. By examining the various market groups that make up these modern-day clients and prospects, you will gain the confidence to understand their core needs and their motivation to insure in specific areas. The result should net a better client-agent relationship, better coverage and better client retention down the road.

Client Groups / Cohorts

Client needs research focuses on groups or clusters of clients. Members of a group or generation are usually linked by shared life experiences such as pop culture, music, world events, natural disasters, heroes, villains, politics, technology. These experiences create bonds that tie these groups together into what some researchers call cohorts. Because of their shared experiences, cohorts develop and retain similar

values and life skills. And, research has proven that these same skills and values are more powerful indicators of insurance needs.

In their book *Rocking the Ages*, 1998, J. Smith and Ann Clurman suggest that every cohort group passes through the same stages in life: getting a driver's license, buying a home, the joy and pain of parenting and the uncertainties of retirement. Similarly, each generation or group we belong to, must all deal with the same circumstances: economic downturns, wars, World Series. But, each group responds to these life changes and circumstances in different ways depending on generational differences. Therefore, it is likely that the insurance needs of one group are different than another.

To demonstrate this, let's look at the insurance history of today's seniors. In their younger years, virtually everyone bought whole life insurance to cover burial costs and/or to build a small pot of money down the road. You started with a small whole life policy and paid on it forever. Contrast this with boomers of today who more typically buy one or more term/universal/variable policies for \$1 million and up to cover huge mortgages, expensive college educations for their kids and / or staggering cost of living expectations if the breadwinner dies young.

Both generations bought homes and raised families, but the influences of their individual eras created a need for much different insurance products. The same is true for property/casualty and health coverages. Generations today buy substantially higher liability and lifetime medical limits in response to more lawsuits and escalating hospital bills. Generations past were more likely to self-insure all or a portion of these coverages because the legal consequences were not as grave.

Group Needs

Consumer research experts say that you would be making a mistake to assume that just because your customers behave in the same ways they will have the same insurance needs. For instance, an insurance agent who has successfully met the needs of a 50-year-old baby boomer with a specific product line might be fooled to believe that the generations behind them (yuppies, xers, etc) will find the same products satisfactory.

Boomers, for example, remain more free-spirited from habits formed early in life. They are not the savers their parents were. Now is more important to them, even though they are getting closer to retirement. Xers, on the other hand, are a more savvy generation willing to take on the challenges they face. For Xers, hard work is a pragmatic necessity and they tend to be more careful in planning for the future. In a few ways, they are embracing some of the values of Seniors who have seen more uncertain times. As an agent, you need to understand these trends and reposition yourself to better serve them. We can learn more about this using other industries.

In the late seventies, for example, publishers of a magazine called Apartment Life needed to change their image to respond to a wave of prosperous, independent Boomers. The country was emerging from a recession and urban-oriented Boomers no longer wanted to live in cheap "singles apartments", but they weren't quite ready to move to the suburbs like their predecessors (the Seniors).

To respond to this shift, the magazine successfully changed its name to Metropolitan Home and emphasized luxury and prestige apartment living. In a like manner, agents today need to find a common ground with every client group he serves. It would be a mistake to judge people by their appearance and selling on price alone may no longer be the path to keeping customers happy.

Know Your Clients

We have only lightly discussed a few of the significant client groups you will encounter in your business as an insurance agent: Seniors, Boomers, Generation Xers and Nexters. Each of these generations have unique work ethics, styles and views on issues like quality of product, service and their need for insurance. The agent of the new millennium strives to know as much as he can about these consumer groups because providing and servicing their insurance needs is no longer the homogeneous effort it was years ago.

Your ability to respond to their needs will determine your success in developing long-term business relationships where all parties involved are rewarded. In addition to knowing these clients, you must develop ways to work with them. If you are a young agent, for example, will you be able to convince a senior that you are capable of understanding his needs and meeting them. Older agents may have similar problems getting younger clients to listen or see value in their experience. Let's look at the profile of these clients and the interaction issues you face in serving them:

Seniors:

(Born between the turn of the Century and World War II. They number approximately 52 million). Seniors accomplished their goals through hard work. They are a very "team-oriented" generation having weathered a depression and major world wars.

Almost half of the men of this group served in the military which is probably why this generation is so well taken care of by the government. It also didn't hurt that they saw seven of their own in succession in the White House, beginning with John Kennedy and extending through Lyndon Johnson, Richard Nixon, Gerald Ford, Jimmy Carter, Ronald Regan and George Bush.

Research has shown that different generations tend to catalyze or define themselves in the shadow of a momentous event or members of their generation. Defining moments for seniors include the bombing of Pearl Harbor, "a date that

will live in infamy" said President Roosevelt. Heroes of this generation include MacArthur, Patton, Eisenhower, Winston Churchill, Audie Murphy, Babe Ruth, etc.

As Seniors came of age after World War II, they were armed and motivated by the ideology to rebuild society. They shouldered the burden of ensuring foundations of a better life which, indeed, is the reason that the generations behind them experienced stability and growth. Their self-sacrificing was very aptly summed up by John Kennedy in his inaugural speech when he said "ask not what your country can do for you, but what you can do for your country". Things weren't easy, but that was ok. Seniors understood that hard work was its own reward and sacrifice a virtue.

Duty before pleasure was their creed and their commitment to accomplish their goal was lifelong, not just a flash in the pan. In essence, unlike many other generations, Seniors had a clear sense of purpose to what they were doing: sacrificing for their children. Their individual struggles were shared by an entire nation which led to an unprecedented era of cooperation and mutual support. And, their efforts paid off.

Success seemed to follow anyone who worked hard. This only reinforced their core belief that anything worth having was worth working to get. Because they concentrated on their work and sacrifice, Seniors have always looked to the outside for direction and guidance. Authority figures like Dr. Spock were highly praised as was a general respect for government officials. Government programs flourished under the Seniors starting with the GI Bill of Rights which allowed virtually anyone to buy a house or go to school. The suburbs were filled with starter homes while the government provided all the infrastructure.

The prosperity of the Seniors, the respect they felt for institutions and their desire to conform all resulted into a true loyalty toward brand-name products. Seniors postponed a lot of material rewards, but when they finally let loose, they bought up a storm: mostly brand names they saw on TV or in ads. Anything that portrayed a glimpse of the American Dream was an immediate success. Financial services were not complicated and interest rates were low for most of the Senior generation. Seniors paid off homes, created large retirement savings accounts, secure jobs and retired earlier than the generation before them.

They are also richer, have more health benefits, better pension plans and live more comfortable lives. And, even in retirement they still want to conform as they flock to senior-oriented communities with names like Sun City and Leisure World. Smart marketers have also learned that you don't treat today's Seniors as decrepit or broken down. They see themselves as active, health, happy and vivacious. Even those who are not so healthy or energetic dislike advertising or products that remind them of their age or problems.

Seniors like consistency and uniformity in their business dealings, as well as brand name companies. They like to conform and believe in logical matters. Conversations should stay "on the topic" and not get "too personal". Seniors are disciplined but they get frustrated like everybody else with things like poor service or poor directions.

The history of your products and companies are very important to this group because to a great extent they base their decisions on what has happened in the past: What Worked? What didn't? Details are also important because seniors are very uncomfortable with conflicts that arise after the sale. Seniors believe very much in law and order so products that might "push the legal limits" may be viewed with suspicion. Technology devices like voice mail, computers or e-mail are not their favorite things. In essence, you are dealing with a very conservative group.

Boomers:

(Born between 1946 and 1964). There are over 80 million Boomers alive today making them one of the largest consumer groups ever. Boomers are bound together by their early expectations, skills and values shaped unbridled economic growth. For them, the bubble would never burst. They grew up in some of the most optimistic, positive times.

With few economic worries to distract them, they felt free to focus instead on themselves, on experimentation and on fulfillment. It did not help that Boomers grew up spoiled and pampered by permissive parents and authority figures who considered self-expression good for them. Boomers grew up thinking they were special and the media gave them the spotlight at every turn. They were and still are the "stars of the show". They believe themselves to be more interesting than Seniors or the Xers that follow. They also feel a sense of entitlement and expectation simply because of who they are. After all, they are the best educated and most sophisticated Americans in history. Personal freedom was a right not something to earn. They wanted no penalties for breaking the rules and complete impunity from criticism on the job.

For early Boomers, life was simple and orderly. However, this all changed with the Vietnam War, Watergate and the economic hard times of the later 1970's. For Boomers, all of these events represented "cracks" in their world. The system was in doubt and the Boomers saw themselves losing ground for the first time.

The post 1979 period was definitely a turning point in Boomer attitudes and expectations. A new desire for affluence emerged: "he who dies with the most toys wins" attitude. By the mid-1980's, economic and tax policies made this more pronounced by putting more money into the hands of Boomers who realized that they had to take care of themselves. It was an era of conspicuous consumption never seen before.

BMW's replaced VWs, designer jeans replaced tattered jeans and the Home Shopping Network came into our homes to make it all possible. Brands for the Boomers no longer dominated the marketplace. They wanted control. Discount and outlet stores thrived. This continued unabated until the shock of the '87 stock market. Suddenly, Boomers rejected the marketplace. Instead of "shop till you drop" the watchwords were "drop shopping".

By the end of the eighties, Boomers were actually losing for the first time. Even their kids were suffering because both parents were working. Debt was higher than ever and so was their weight. Boomers reasoned that they worked hard and played by the rules but still failed. Of course, they also believed that it was not their fault. They cast themselves as the victims – a resentment that lasted well into the 1990's.

Today, to a great extent, Boomers have regained their senses. They are realizing that they have created much of their own stress and they will pick their future battles more carefully. They are also realizing that they are in their peak earning years and they need to start saving for retirement.

It is important, say the experts, to remember that Boomers are rule breakers. Their individuality is more important than conformity. They have always done things different than the Seniors before them. If it takes some spending to accomplish this, so be it. Boomers are quite service oriented. They want to be liked, yet they are driven and willing to "go the extra mile" with a tremendous sense to "prove" themselves. Boomers have been described as "the most stressed generation in history", however, they are reaching an age when they want to simplify their lives as much as possible.

Generation Xers:

Americans born after 1964 are already a powerful force in the marketplace, yet they are a Generation that is much harder to label. In numbers, they are smaller than the boomers and seniors with approximately 44 million among their ranks.

There are many common themes that apply to all of them, but the way they express themselves and the way they are influenced is much more diverse than prior cohort groups. Perhaps, to some extent, this is because this group is the most demographically diverse segment of the population. There are fewer Caucasians, and in some states, it is predicted that certain ethnic groups within the Xers will represent the standard, not the minority.

What are the issues that bind the Xers? In his book *Generation X*, Douglas Coupland describes them as "fanatically independent individuals, pathologically ambivalent about the future, and brimming with unsatisfied longings for permanence, for love and their own home." This is not a flattering description of

today's youth and some believe it is simply the same old system at work: Each generation complaining about the other.

Statistics show, however, that GenXers have faced economic and social obstacles that did not exist for Boomers. Some believe, they have even more to overcome than Seniors. Older Xers witnessed splitting families, gas lines, stagflation, IRAN hostages, nuclear meltdowns and corporate meltdowns. Younger Xers saw more splitting families, homelessness, holes in the ozone layer and a lot of violence on TV. All of this instilled a certain air of survival.

While the Boomers inherited a world built-up by Seniors, Xers feel they are left with the aftermath and conflicts of the Boomers. For some, the feeling is that everything needs to be fixed, especially if a Boomer has something to do with it. For the meantime, these issues have left the Xers with a detached attitude.

Jobs are dead-end, life is one big conflict. But many feel this too will pass because Xers are tougher than Boomers. They are much more determined to be involved and in control. They will tire of being victims and unlike the generation before them, they will not focus on a "live for today" philosophy.

How will Xers shape their future? Instead of muscle and sweat, they will be more resourceful. Sure they can work hard when required, but they will more likely work smarter too. While Seniors and Boomers would "forge ahead", Xers will sidestep and wait for an opportunity to develop. They are far more entrepreneurial and less trusting than Boomers. Self-help is their best protection against failure. In the spirit of the best survivalist, they are protecting themselves against tomorrow.

One of the most important tools for Xers controlling their space is the computer. While every generation is known to be experts of the technologies commonplace at the time, the computer skills and cyberspace prowess of Generation X is well known. It defines their vocabulary and communications. So much so, that the PC and other techno tools are simply part of the background. Some feel, however, that the impact of all this technology will also contribute to their uncertainty. It has created the risk of distancing themselves from "real life" and forced them to have everything presented in short spurts of information, much like web pages. This is truly a visual generation. They are less likely to read, but more likely to network quickly.

What is in store for Generation X?. As Xers approach their thirties, they are taking their cautions and concerns with them, especially when it comes to families. Experts predict that they will not want to repeat the mistakes Boomers made in splitting households, nor do they want to inflict this on future generations. Stability in their household is a goal and success a dream with many barriers yet to overcome. Xers like informality and their approach to authority is casual. Basically, they are unimpressed with authority. Instead of

billing yourself as an insurance expert, for example, you might get farther with an Xer if you come to be known as their insurance "guru".

This group is also very skeptical. They have learned not to place their faith in others. Loyalty and commitment are secondary to getting "burned". With Xers, you need to tell them what it is. Tell them what it does. And don't make a big deal out of it. Of course, Generation X is technologically savvy. They take comfort in their knowledge of computers, e-mails and the Internet.

Nexters:

While this generation is now too young to be major insurance consumers, they represent a large base of the population (about 80 million strong) and they possess some unique characteristics that will make them noteworthy as future clients. This new wave is both optimistic about the future and realistic about the present. T

hey combine the can-do attitude of seniors with the technical savvy of Xers. Some call them the "ideal citizens". They are resilient because they take things that might annoy other groups for granted.

Goal setting and the 40-hour work week, for example, are expected to achieve dreams. They will be the best educated generation and their core beliefs are about government and the "establishment" is, in general, very much like seniors: conservative.

Serving Generational Needs

To be effective as an agent you need to know your clients and know how to meet their needs. You need to "empathize" with their current and past situation. Think of it as "walking a mile in their shoes"; imagine how they perceive you as their agent. Are you too young to gain the confidence of a senior? Are you too old to relate to a Gen Xer? Too stuffy? Are you going to fast? Too slow? Do you "speak" their language using words and mannerisms familiar to them. Is your demeanor so casual that a senior might think of you as rude or disrespectful?

This is not about "selling" something you have, it's about how to better communicate transactions so different clients can understand them better. For example, if you were approaching a Senior with a long term care policy proposal the insurance brand name would be important. But, in addition, be aware that Seniors have come to be somewhat distrustful of big business. You would need to do more to satisfy their need to know more about your insurer.

To be effective, you will also have to reach different client groups on different levels. Seniors and Boomers may not respond as well to websites as will Xers.

Boomers will want more detail, while Xers want it short and sweet. Seniors will want to know all the risks in plain English.

While all groups want the best price they can get, just selling price is not enough. Every generation has demonstrated they will be willing to pay a little more with a guarantee of better service.

As to efficiency, Boomers and Seniors are pre-occupied about what goes on during the sales process. They see the sales experience as unpleasant. Xers, on the other hand are more worried about what happens after the sale since they feel that if a problem occurs, nothing will be done anyway.

Serving Seniors

Serving seniors effectively means you must respect their experience. They might like hearing from you how valuable it is to hear how things worked in the past and that their perseverance is valued. They might also like to see that you are part of a team to meet their needs. Messages, literature and brochures should speak to issues of family, home, patriotism and traditional values. Use clear enunciation, good grammar and large type. Include "please" and "thank you" and avoid any kind of slang or near-profanity. Also, don't expect seniors to jump-in on a product you just presented.

They prefer to get to know you, what to expect from your policy and who's who with your companies. They will relate to the true story of your company from where it is to where it is going. Stress the long-haul using "months and years" rather than days and weeks. Seniors will respond to the personal touch such as a handwritten note instead of an e-mail or fax. Also, strive to be a respected "mentor" or "coach" to your senior clients. Don't avoid the difficult issues and try to get agreement on potential problems.

Never try to take them by surprise; they need time to prepare for their decisions. Agree on a course of action and set a follow-up date. Financial discipline is still the foundation of this generation. Few of them will betray a lifetime of saving to be big spenders. They might be more willing, however, to spend money on look at something that might benefit their children or grandchildren because they are still the generation that feel they need to make something better for someone else. When it comes to something new or experimental, you will have a much harder time convincing Seniors. They are less likely to want something new before someone else has tried it.

One of the best mediums to reach seniors are lectures or seminars given by an expert. However, this group does not like to be in learning situations (small or large) in which they might look foolish in front of someone because they don't know the right answer. If you ask a question, make sure they can answer it. Information should be organized, well researched and supported by facts, figures, details and examples. Seniors like their information in condensed form. Also, few, if any, Seniors would like to

be known as old. If you are appealing to them to contacting older clients, there is no need to point out that you are doing something a certain way because they are old.

Serving Boomers:

Serving boomers will be a challenge. Like seniors, they need to know that their experience is valued. Messages like, "you're important to our success", "we need your business" or "you will really make a difference" are important reinforcements. They need to know they are part of something dynamic and that in the final analysis "they" will be the winners.

Instead of historical significance, stress how your company and products are leading edge. Always focus on the future or near future, rather than the past. It is not specifically huge amounts of data that impress them, but the nature of the data being inside edge or "little known" to anyone else. Third party testimonials or articles from experts lends more credence to this group. If you need to coach or mentor a boomer, be tactful. Be warm and find opportunities for agreement and harmony. Ask lots of questions to get to their issues. Think of yourself as an equal but always ask permission.

Boomers want to win at most things, however, they are realizing that convenience can also be a good thing. You clearly need to be more detail oriented with Boomers. Technology is important but they are still suspicious. Boomers look for efficient organization of information. Pack it in, but make it easily available. Let them browse.

Brand names are not a "hot button" as long as they have choices. Value, on the other hand, is critical to their thought process. Because boomers see education as a means of climbing the ladder, they respond well to several learning mediums, especially when presented in a somewhat casual environment. To boomers, lots of information is considered a reward not a liability. Start with an overview and give them an option to get greater into the detail later.

Seminars and workshops work good although they, like seniors shy away from involved role-playing. They like books, videos, self-help guides and audio tapes. Money will likely still be a problem for Boomers. After years of spending and lack of retirement planning, they need help. And, they will increasingly delegate these matters to experts. Solid instruments deigned to help them save are needed most. Boomers will continue to reject traditional methods.

Serving Gen Xers:

Serving Xers will be a different experience. Doing something their way with the help for the newest technology is how you get through. The fewer rules the better. The more feedback the better. Your product or service must be helpful in them "making their

life easier" or "getting more out of life". Experience and traditional statistics are meaningless to this group: They will decide based on merit alone.

Make it easy for them to get information in snippets, rather than through a whole lot of reading and a good amount of "frequently asked questions" to ponder. Give them a lot of elbow room to make a decision, but be there (feedback) when they need to ask a question. People in the Gen X category will be diligent but uncertain that anything will last. They are the most likely group to hedge or insure against bad consequences. However, asking them to plan for a far away retirement is not high on their menu.

Xers are skeptical and do not like to be categorized. They don't want to be "preached" to about the benefits of a product. Tell them what it is, what it does and get out! Xers have little use for experts. They rely only on friends and self-help: Both are more trustworthy and less suspect than an "expert". The hard sell is not going to work because they have seen it all or they can access it for themselves right now. Lack of data doesn't bother them as much as lack of honesty. Get to the point and stick to the subject in an earnest way. Also, brand names mean less to this group than others.

Mediums to reach Xers vary widely. Statistically, however, they do not read as much as other groups. However, interactive CDs and internet solutions can be very effective. Gen Xers will judge you more so on your technical competence than on your people skills and you will not automatically earn their respect because you have a degree or professional designation. New and improved means little to a Gen Xer. His idea of new is something on the extreme edge of what's there already. However, you can score points if you stress that you do things very differently than other agents.

Anticipating Needs

Little in life remains the same. Your clients and their surroundings are changing and so will their insurance needs. You must plan, even when things seem very confused. The fact is, the future is a blur for everybody. No one expects you to predict what will happen to your clients. As a responsible agent, you should at least have a pretty good "sketch" of what is going to occur just around the corner and a "faint outline" of what is further down the road.

Anticipating client needs is especially important today, considering the speed at which the world is changing. To grow and progress in your career, however, you need to equip yourself with the skills and knowledge needed to be proactive to the threats and opportunities of the future. Your very survival and well-being could depend on your ability to anticipate and cope with future events and problems. What does the future have to do with understanding client needs? Simple: The future brings change and the need of your clients change as well.

To satisfy these new needs, agents must adapt. But when will the changes occur? What are some of the ways you will need to adapt? Interpreting future changes (at least from a "best guess" standpoint) should help you prepare better and get a jump

on the many new responsibilities that change will bring to the insurance industry and your business. For example, it is a widely accepted premise that a large economic gap is developing between the wealthy and the poor.

The middle class in America are losing their purchasing power on the heels of income losses, unemployment, antiquated skills. Knowing this, you might need to adjust methods of selling and servicing clients. Most will be less well-off than you are used to (looking for ways to stretch their insurance buying dollar with more term insurance or discounted casualty coverage) while others will be far better-off than the average guy on the street (looking for quality insurance products and ways to insure a highend lifestyle). Can you adequately serve both? Can you re-orient your products to better meet their needs?

It will also be important to be on the lookout for events expected to occur in the future that will run contrary to historical patterns. You will need to monitor things to determine if an emerging trend is actually developing. Healthier eating habits, for instance, are likely to improve as consumers age. The toll they will take, however, may cause a whole band of widely overweight, unhealthy clients needing special medical and life insurance alternatives. There will also be wild-card changes that are completely unpredictable.

The presence and attraction of the Internet, for example, has taken the entire world by storm. The methods and practices you need to serve clients in the future may depend on your knowledge and practical application of Internet-based programs and communications. Your clients may insist on it or shun it. Either way, a plan to handle it is needed. Following are some of the significant trends and predictions that agents need to analyze and monitor:

Demographic Trends and Possibilities

- People are living longer and older citizens will represent more of the mix. In most areas of the world, people over age 60, who equal about 18 percent of the total population, are expected to climb to over 30 percent by 2030. The influence of older citizens will grow not only because of sheer numbers, but also because older citizens are becoming more affluent. Many young adults will never be able to afford the lifestyle of their parents.
- Senior groups like AARP and others are growing in influence with huge numbers of boomers coming to the fold. These groups will influence Medicare, Social Security and other policies facing seniors. Agents need more senior products and ways to help them meet or supplement their coverage needs.
- The changing profile of women: More disposable income, more education, more jobs, more sophisticated needs. The agent's perspective of the "typical American family" must change. Two-wage earners and a growing element of "Mr. Moms" will require a reversal in traditional insurance needs analysis. Women will need more life and disability insurance in order to cover the economic hardship of their loss to the family.

- Some women will have problem saving for retirement because their child-bearing responsibilities mean they work fewer years. Many are single parents with even less opportunity to work. They will need help from very skilled financial advisors to make their money work harder.
- Minorities will soon become the majority in some areas on the heels of rampant immigration. Cities and regions will be more and more segregated by race, ethnicity and class. Schools and neighborhoods will be highly stratified: the wealthy and the minority underclass. A majority of whites, however, will tend to be less affluent and than before. Niche insurance needs will be amplified as various ethnic groups desire to be represented by someone who understands their core beliefs. Ethnic shopping centers and financial services centers will be developed. Services, products and information promoted in several different languages will be the norm (multilingual customer response centers, multilingual insurance agents).
- While traditions are a powerful force, a certain amount of attrition will occur where cultural consumers will fragment and diversify in their tastes and preferences and begin to explore other new and unique offerings or slowly adapt to American lifestyles.
- A large income gap is developing. Middle class Americans, even though better educated than the generation before them, will have fewer employment opportunities, less affluence and less wealth. Agents need to focus on the needs of a poorer middle class.
- The profile of entrepreneurs is changing. About 20 percent of all small business owners are under age 35 and women are forming businesses at twice the rate of men. The unfortunate side of this trend is that worker benefits are costs that few entrepreneurs can afford since they are already under the gun to keep up with payroll taxes, self employment tax and other forms of government fees.

Technology Trends and Possibilities

- PCs and the Internet will empower consumers. Armed with automated systems, they will be able to make buying decisions without leaving home. Everyone will need a website. A movement toward buying insurance online will happen for a certain segment of the population. However, wise consumers will always involve agents in the mix for advice and as a buffer between insurance companies.
- As consumers become more accustomed to quickly gaining access to information, they will start to incorporate their technology skills into everyday life. Product recommendations as well as complaints will spread at an accelerated pace. Consumers will be looking for more information to make knowledgeable decisions and ways to be more efficient and productive. This thirst to devour more and more knowledge will eventually lead to excess information and the need for someone to unravel all the input. Providing product comparisons, options, features and prices will be an important service.
- The rush to the Internet will make it difficult for services and manufacturers to differentiate themselves from the crowd. Also, the more impersonal the world

becomes with technology advances, the more people will need to be reconnected to other people.

- Relationship building will still prevail as the best method to serve clients.

Economic Trends and Possibilities

- The role of the private sector will become more important to consumers' financial wellbeing than the role of government. People will become more self-reliant as governments limit social spending. Self-health care will flourish as well the desire to control purchasing habits. Value in products and services will be high on consumer lists.
- Increased competition will keep a tight rein on prices. Product and service differentiation will become a critical factor to success. If your product does not stand out from the crowd, it may have to compete on price alone.
- The United States is gradually learning to survive without traditional smokestack industries. We are world's salespeople, shippers and financiers. While a manufacturing component will continue to exist for decades, it will become more technologically oriented; run by scientists and engineers rather than shop foremen. Manufacturing will be knowledge intensive rather than labor intensive.
- Networking, particularly among small firms, will increase along with greater customer supplier cooperation. Size will no longer be synonymous with success. Customers who only purchased from the large companies will shop around.
- Businesses and government agencies are buying more goods and services from outside sources rather than internally. Outsourcing will improve service quality as entrepreneurs obsess about winning and serving the customer. Home offices or small remote offices will allow employees to set up shop away from the main office.
- Continued downsizing will increase the pool of middle-class unemployed available to work as temporary employees. The trend toward smaller enterprises will also increase specialization of products and services.

Work Trends and Possibilities

- The number of full-time employed are falling as many white collar workers accept early departure packages and carve out new identities in skilled arena. Many of these people are boomers "getting out of the rat race" in a post affluent society mode. Some believe this is the start of the "American dream is over" movement leading to a society of "haves" and "have nots". As the simplicity movement grows, look for ways to serve basic needs.
- Because of emerging technology trends in the workplace, skills or professional knowledge will need to be upgraded constantly. Interpersonal and sales skills, in particular, must be sharpened as e-mails and teleconferencing accelerate and face-to-face meetings decline.

Life Event Trends and Possibilities

- A larger segment of aging adults means aging bodies, poorer vision, more cancer, more heart disease, osteoporosis, Alzheimer's and arthritis. People will become more focused on health and ways to protect it because the older we are, the greater chance we will have some personal experience with injury or disease.
- More aging consumers will demand services such as home maintenance, health care, home care and death care. Unfortunately, we will also see an overall increase of disease on the heels of drug-resistant strains of bacteria and the continued spread of other infectious illnesses such as AIDs, tuberculosis, and malaria worldwide.
- Consumers will look for natural or alternative remedies and/or doctors more and more. They will be less willing to take on the risks of surgery and drugs if there are alternatives. Gone are the days when people will simply accept the doctor's advice without question.
- Longer life expectancy will make having children later in life a more attractive option for couples who delayed having children because of their careers. Many women who delayed childbirth may seek fertility therapy, hormone treatments, etc, which may lead to more miscarriages, pregnancy complications and multiple births.
- As consumers become more educated, have better access to information and buying options and are feeling more empowered, they won't hesitate to let their feelings be known. Intolerance for company mistakes, complaint handling, price gouging and business practices generally will increase as consumers fight for what they believe. Increasing competition and technological advances will raise consumers' expectations even more. This will mean more for less, faster buying time, less complication, less effort before and after purchase, less risk, and fewer mistakes and handling of mistakes to their satisfaction.
- Grieving is on the rise. That's right, as the boomers head toward the final third of their lives, there will be more focus on grieving due to lost and ailing family and friends. Death and estate planning will be much in demand as well long term care and Medicare supplements.
- A resurgence in smoking is anticipated as Gen Xers find new and exotic reasons to smoke. Smoking is now a social grace among many and some feel that a cancer cure will be found so "why not enjoy". Consider new improved sales among flavored smokes, cigars and specialty cigarettes. Insurance costs will increase as tobacco users proliferate.
- Hospitals are becoming dangerous places to be as infected equipment and new bacteria strands kill more patients. It is estimated that more than 2 million people enter hospitals each year only to get sick with something other than their original problem. Health care costs will continue to be affected as will the need for home care and special procedures to assure sterile medical care.
- As governments and the medical profession grapple with escalating health care costs, one strategy will be a shift from hospital care to home care. People will be leaving hospitals "sicker and quicker". As the population ages more and heads home sooner, adult children will be taking on the role of caring for their parents more and more.

- The "casual" trend will continue as people value the quality of their life over traditional business methods. While this may translate into more comfortable clothes and the need for less formal offices, your clients will still want to know you are a professional. Your dress and surroundings are part of this equation.

Legal Trends and Possibilities

- Insurance companies and their agents will see increased activity in the area of civil rights claims, particularly those dealing with the American Disabilities Act (ADA).
- More cases will surface that challenge the AIDs/HIV policy exclusions and limitations. In one case, the limitation was outlined in the policy and listed in the data page entitled "Schedule of Benefits". The courts held that although the line pertaining to the limitation was clearly eligible, it was not highlighted, set apart, or emphasized in any way. Therefore, the limitation was not enforceable.
- Look for more of these "narrow definition" conflicts which may involve agents. An insurer denied a disability claim to a client radiologist (vascular interventional radiologist) where a spine and neck problem did not allow him to practice within his specialty but still permitted him to work as a radiologist. The courts disagreed because the insurance company initially listed his occupation as "radiologist" then later narrowed it to "vascular interventional radiologist". In essence, they could not deny benefits.
- There will undoubtedly be many cases defining what is experimental treatment under health policies in the years ahead. Recent cases have "tested" policy meaning regarding alleged experimental breast cancer treatment, AIDs-related liver transplants, bone marrow transplants. Clients have lost their claim for coverage on the basis of a legitimate denial based on policy terms. Insurance companies have lost their cases where an exclusion about experimental treatment was not highlighted in a conspicuous manner.
- There are new cases developing in the area of language misunderstandings where clients have pursued claims on the basis they did not fully comprehend the matters at hand. In one instance, a client prevailed in her action against a health insurer because she understood little English and could not read the application. She relied on the advice of the agent but failed to disclose a preexisting condition. The courts determined that the insurance company could only deny coverage where an intent to deceive was found. In this case, they said there was no intent to deceive.
- Policy language often limits coverage for "accidentally sustained" injuries. Thus, cases have and are developing where attempted suicides have left clients permanently or severely injured. Since the injuries were self-inflicted, insurance companies have refused to pay. In one case, the insurer lost to a client who attempted suicide because "accidental" was NOT defined in the plan documents. In another example, the client also prevailed because the courts decided her treatment for an attempted drug overdose suicide was really treatment for her underlying depression. Further, the insurer was found to have misled her by not informing that mental and nervous disorders would not be covered if followed by

an attempted suicide. Finally an insurer was prohibited from withholding a claim because the client had a "subjective expectation of survival", thus even though his injuries were self-inflicted it was still deemed an accident.

- The courts are leaning more and more to the proposition that tenant's are implied beneficiaries under a landlord's policy.
- Within the last 20 years the insurance industry introduced environmental impairment liability insurance (EIL) in an effort to provide pollution coverage for events the industry deemed not to be covered by the more well-known comprehensive general liability policy (CGL). A very important distinction between these coverages is that EIL policies are claims-made policies, while CGL policies are occurrence-based. The introduction of EIL insurance provided clients an alternative that was broader than CGL coverage in some respects, while narrower in others. For example, the insurance industry's position is that EIL insurance affords coverage for the gradual release of contaminants that, according to the carriers, would no be covered under typical CGL policies. On the other hand, as discussed above, claims under an EIL policy must be made during the policy period.
- One issue that continues to surface is the relationship of EIL coverage to other insurance purchased. For example, assume a company purchases both primary CGL insurance and EIL insurance. The question then arises whether the EIL insurance is primary coinsurance or excess to the CGL. The courts have ruled that the EIL was indeed excess coverage, however, there could be cases where EIL, if purchased alone, could be the primary insurer for environmental liabilities.
- Despite the fact that policies have been written as "All Risk," insurers continue to deny contamination claims based on policy exclusions.
- People have an unusual ability to acquire the problems and illnesses of others. Most "sick building" illnesses are found to be psychologically based rather than rooted in fact.
- The removal of asbestos continues to be a major source of conflict between clients and insurance companies.
- New standards require property owners who are selling or renting real estate built prior to 1977 to disclose any known lead-based paint or lead hazards. Experts believe that the next wave of lawsuits will result from these disclosures and potential client illnesses, real or not.
- On the heels of major hurricanes and earthquake, claims are surfacing concerning business interruption where clients have been forced to close stores and businesses incurring major damages. A major issue that occurs in these cases is the determination of income. Most policies include a clause similar to this: "In calculating your lost income we will consider your situation before the loss and what your situation would probably have been if the loss had not occurred".

Suitability Beyond Insurance

The most important advice that financial experts give their clients concerning insurance is to buy insurance that really insures. The meaning behind this advice is that

insurance can fail to insure for many reasons. Likewise, in some cases, insurance is simply not available. The purpose of this section is to explore how and why you need to help prepare your clients for these contingencies. This is a new area of planning that few agents practice. However, it can also be the most critical service you offer.

The Need to Look Beyond Insurance

Risk is a fact of life to be constantly analyzed and managed. Unfortunately, the time most people devote to this process is less than the time they spend planning a summer vacation. So, who assumes the role of unofficial “risk manager”; preserving worldly goods and family security? Insurance agents.

Like it or not, you are in the asset protection business. But, just how far can you expect your product (insurance policies) to go. Every agent knows that insurance has its limitations. There are times when clients are underinsured; there are clients who cannot be fully insured; and there are times when insurance simply fails to insure. Add to this a bevy of carriers, who withdraw or are unwillingly forced from the marketplace, a few insolvencies here and there, and you know why a growing band of attorneys and financial advisers are starting to look beyond insurance; supplementing insurance coverage with multiple legal strategies.

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

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

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

It Costs More

It costs a lot to live today and it will cost a lot more tomorrow. There are many rules of thumb you can use to gauge the amount of life or medical coverage needed to cover loss of life or a major health condition. Will the \$250,000 life policy you sold last month leave enough to cover an additional eight years of medical school for the surviving dependant who suddenly finds out he wants to be a doctor? Will the health policy you delivered this morning cover new treatment options that might be considered “experimental” today, but standard procedure years from now? If not, there will be a huge coverage shortfall. How about the long term care policy you sold to a middle-aged couple. Will the \$92 daily nursing home care coverage do any good when inflation has bumped the cost of nursing homes to \$250 per day in 20 years? All of these examples are possible outcomes that you or your clients cannot anticipate; or, perhaps you did but the cost to cover them is not currently affordable.

Expanding Liability

The idea of using and needing additional methods to replace or augment insurance coverage has more chance to grow today than ever before. There are many areas and ways by which your clients are exposed to liability.

Despite your best efforts to limit a client’s financial and legal exposure, you cannot insure that policy limits will be breached or, by exclusion or technicality, completely fail. Furthermore, our country’s expanding liability policy almost guarantees that along the way you will miss something. Just think about the thousands of legal decisions each year based on precedent.

Cost of Defense

Just as important as expanding liability is the high cost of defense. A single mistake or accident that exceeds policy coverage can bankrupt a client. And, in cases where punitive damages are involved, there may be no coverage at all.

Deep Pocket Pursuit

People work the first half of their life to build an estate. During the last half, they are constantly worrying about someone trying to take it away from them. It’s called “deep pockets” and it is the single greatest reason that people get sued. The question for your client is who’s pocket should it be: theirs or the insurance company.

Asset Protection Planning

Better Client Protection or Lost Insurance Sales

Some may think of asset protection as “doomsday planning”, but every agent who has spent time in the business has a file on cases where expected coverage was lost or reduced due to limits, exclusions, warranties, preexisting conditions or any one of the reasons presented above.

Attorneys who routinely sue agents and insurance companies also have a file. But their cases are different. They feature smart and financially secure people who dutifully purchased insurance yet lost everything over a technicality or unforeseen claim beyond the scope of the policy.

Seeing problems like this day after day, it is no wonder that some in the legal profession may have a hard time advising a client to “insure up”. Rather, they are encouraging their clients to supplement basic insurance coverage with legal entity planning or, more simply put, asset protection.

While it doesn't appear to be a watershed, a limited number of insurance sales will likely be lost to asset protection planning. Then again, there is cause to consider that both insurance and asset protection are closely linked in providing a higher level of client protection. Knowing this, it may serve the client's best interest for an agent to associate with a competent asset protection attorney and know when to refer.

Legal Protection Theories

There are as many legal techniques that form the basis of asset protection as there are forms of insurance. The nucleus of these strategies, however, is focused on specific principles of legal theory. Here are a few to consider:

Asset Protection and Suitability?

Insurance agents are in the risk business, but there is nothing that says you must be responsible to cover all your clients' risks. However, is the product you are providing truly suitable if it still leaves your client exposed?

The idea of agents understanding and informing clients about additional measures beyond the scope of insurance is more than you are required to do. From an ethical standpoint, though, it demonstrates your willingness to suggest possible solutions (carried out by professionals who can implement them) beyond the limits of traditional coverage.

Free Alienability of Property

Our common law system favors the free alienability of property. In essence, this theory concludes that one who is free from creditor concerns is absolutely free to dispose of his property as he sees fit. This may include gifts to children, a spouse or a transfer to a trust. Clearly, asset protection planning is not an excuse to defraud creditors or evade taxes. Furthermore, fraudulent conveyance laws generally protect present and subsequent creditors from transfers of assets made by a person who is or foreseeably will become their debtor.

In essence, asset protection should be viewed as a vaccine, not a cure. And, like a vaccine, it should be administered before a legal problem arises.

Whole vs Sum of the Parts

One of the basic premises of good asset protection is the legal assumption that "the whole is worth more than the sum of the parts". This issue takes on more meaning with the knowledge that most asset protection planning involves the intentional "breaking up" of large ownership blocks into much smaller blocks, each with its own title and life. The force and effect creates a smaller "target" for a plaintiff or large creditor to pursue.

It has long been a fundamental legal tenet that small, individual ownership can lead to better protection of assets because a third party interested in laying claim to a client's assets will consider a fractionalized interest to be worth far less than a whole.

The common sense of this issue prevails: A creditor or high ticket insurance claimant, will factor in the cost, time and effort needed to force the sale of a single block of assets, under one ownership, in contrast to the much higher cost, time, effort and delay to retrieve multiple, variously titled assets. Further, in the case of some fractionalized assets that have been planned properly, there is no hope of the third party actually acquiring the asset. Rather, he would have to settle for the right to any income or benefits that might accrue from the fractionalized interest.

For most, the thought of being in business with other fractionalized owners who are, for the most part, at "odds with the third party", will be a distressing issue to overcome. In such cases, third parties may be completely discouraged from pursuing such an action. This is an important element of asset protection to keep in mind when studying the forms of ownership that follow.

Choice of Governing Law

In the United States, individuals generally have the freedom to select the law that will govern a business transaction. Examples include the use of Delaware or Nevada corporate law. Choice of law principles likewise allows a grantor of a trust to set up a trust that is governed by the laws of his or her home state or any other state. Taken further, there is no reason to limit one's choice of law to a particular state, the fifty states or any one foreign country when a world of governing laws is available. Factors to consider when choosing a governing law include the tax laws of the jurisdiction, whether laws are more favorable and protective, the political and economic climate of the jurisdiction, language barriers, telecommunication facilities, etc.

Free & Clear vs Encumbering

The old school thinking of owning "free and clear" is not always the best way to protect assets. By owning property free and clear, one is exposed to the potential for a large loss. In the case of real estate, a large earthquake can demolish property. Similarly, a sizeable judgment from a lawsuit can take property away. Some asset protection attorneys suggest encumbering or highly leveraging property (loans) to such an extent that a creditor will lose interest in pursuing it.

Conventional Forms of Protection Are Losing Ground

The new school of thinking is that traditional methods are not working like they used to. The corporate veil is seemingly more pierceable than ever. Further, the concerns with insurance coverage exist on three fronts: insolvency of the carrier, the willingness to continue coverage and exclusions such as punitive damages and gross negligence of associates.

Problems With Legal Entity Protection

Most asset protection programs involve the use of "holding entities" designed to isolate liability and thus contain exposure. Of course, good attorneys and financial advisors will admit that these measures are not foolproof. And, critics also point to volumes of law known as fraudulent conveyance which can void a transfer of property if it is done without adequate consideration and with intent to avoid creditors.

Fraudulent Transfers

An example is a situation where a person hastily transfers title of a property to another family member to avoid creditors. This is not the ideal form of protecting assets. In fact it is called the "poor man's asset protection". Creditors are usually able to prove that a "fraudulent conveyance" occurred. Or, courts determine that the debtor failed to cut the strings by retaining benefits or control over the property. In either case, the creditor may proceed against the debtor and void the transfer of property.

For this method to have a chance, it must be used in the true context of "gifting" and be consistent with goals of the client (planning for college or an estate). The intent should be to have little control over the gifted asset. Broadly speaking, a fraudulent conveyance is defined as a transfer of property without adequate consideration and with the intent that the transferee will hold the property for the benefit of the transferor, returning it when requested, so as to defraud creditors who could otherwise seize the property in payment of their debts.

If a transfer is found to be fraudulent, it can be made "null and void" by a court of law. In essence, the law is not so naive that it will allow a person to avoid the payment of legal debts simply by making a "gift" of his property to another family

member or a friend. Fraudulent conveyance laws protect present and future creditors against transfers of property made with the intent to hinder, delay or defraud them.

Creditor Access

Besides suspicious transfers, creditors have many opportunities to seize or access property and/or income based on the client's existing holding entity. Following is a short list of their rights by the type of ownership entity:

Joint Tenancy: There are many ways that creditors can reach a joint tenancy. In the case of a dwelling, a creditor attempting to reach the interest of a joint tenant can cause only the interest of the debtor to be sold. This compares with community property in that the creditor can force the sale of the entire dwelling to satisfy payment. For most other property, the general rule is that the creditor can acquire the interest of the debtor.

However, if the debtor is a joint tenant, the creditor forces an end to the joint tenancy and he or she becomes tenants in common with the remaining joint owners. In essence, holding title as joint tenants carries little creditor protection since creditors can attach a jointly held interest and petition the court to "partition" or divide up the property. If it is property that cannot be divided, creditors can order it sold to receive the debtors share.

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

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

Community Property: The general rule is that community property is liable for debts of either spouse during the course of the marriage. Obligations incurred prior to the marriage or after a separation or divorce are consistently treated as the separate obligation of the spouse incurring the debt. Whether a spouse contracts for individual benefit or for the benefit of the community property is irrelevant. A creditor's ability to reach marital property is not effected by the purpose for which a spouse contracts.

If a debt that is a joint obligation of a husband and wife, the community property together with the separate property of each spouse will be liable for the debt. A spouse who pays a single payment on behalf of the other spouse is said to have granted apparent authority to the other spouse to contract joint debts. The

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

Partnerships: In general, the assets of a partnership are not available to a creditor of a partner on a personal debt of the partner. In practical terms, a creditor must only look to the debtor's share of partnership proceeds after the partnership has been dissolved and debts of the partnership paid. Alternatively, the creditor can look to attach the debtors profits and surplus from the partnership. This is called a charging order. It does not make the creditor a partner.

The charging order is intended to protect partners of a partnership that having nothing to do with the claims of creditors of another individual partner. A charging order is obtained by the creditor by making application to a court which then charges the interest of the debtor partner with payment of the unsatisfied amount of the judgment. The court may then or later appoint a receiver of the partner's share of the profits, and of any other money due or to be due him from the partnership.

If a charging order fails to be an available remedy, the courts have allowed the foreclosure sale of a partner's interest. At a foreclosure sale, only the partner's interest, not specific assets of the partnership, are sold. It is unlikely, however, that a partnership interest will bring a high price from third parties. If the creditor becomes the purchaser, and until the dissolution of the partnership occurs, the creditor will still be entitled to only receive the partner's profits.

Corporations: In general, creditors of the corporation can proceed only against the assets of the corporation and not ordinarily against the stockholders, officers, directors, agents or employees of the corporation. Exceptions to the above rule include where parties in the corporation have personally guaranteed some form of corporate obligation; where employees of the corporation have been negligent or have committed a wrongful act; where officers have not paid withholding taxes or similar taxes; where specific fiduciary violations can be determined.

Legal advisors are split on the issue of creditor rights against an incorporated sole practitioner. Some assess the "key person" rule in support of complete liability. Others argue that many lawsuits are derailed simply by the existence of a corporation. In many instances, the obstacles that must be hurdled to gain access to a debtors partnership interest help shield a partner from all but the most determined creditors.

Limited Liability Companies (LLC): In an LLC, no one has personal liability for the debts of the partnership. All members of the LLC are liable to creditors only to the extent of their investment in the company

Trusts: In general, unless there are restrictive provisions in the trust spendthrift verbiage, a beneficiary's interest may be attached by his creditors or the beneficiary may sell his interest.

Creditors have also gained access to trust assets when the following conditions exist:

- The trust was funded as a result of a fraudulent conveyance
- The settlor of the trust retained too much control over trust assets
- The settlor retained too much of an interest in the trust
- The trust is illusory (trust is non existent or a sham)

Exemption Planning

Exemption planning takes advantage of known "safety nets" already built into the law to help place certain kinds of assets beyond the reach of creditors. Most exemptions must be filed or claimed. If not, they are considered waived.

Civil Codes: Certain civil code sections offer exemption protection from creditors. They might include payments made for child support, spousal support and family support.

The Homestead: Homesteads are claimed on the principal dwelling of the debtor or the debtor's spouse. A declaration of homestead can only be made for a residence that is real property, not a houseboat or mobile home. This exemption may also be carried over where the proceeds from a formerly homesteaded dwelling are used to purchase a new dwelling within six months.

Personal Property: There are many articles of a personal and business nature that are exempt from creditors. A partial list includes:

- **Personal Possessions** Items such as health aids, jewelry, household furnishings (appliances, clothing and other items determined to be "ordinarily and reasonably necessary"), cemetery plots and motor vehicles may be excluded up to statutory limits.
- **Business Property** Tools, equipment and vehicles necessary to earn a living are exempt up to statutory amounts.

Life Insurance & Annuities: Both are exempt without filing. This means a creditor cannot force a policy holder to cash-in his policy. However, a debtor can be forced to borrow against the policy.

Health Insurance: Benefits from a disability or health insurance policy are exempt without filing (does not apply if the creditor is a health services provider).

Retirement Plans: In general, state laws protect most private or public retirement plans, IRAs and Keoghs from creditor claims unless they have exceeded their contribution limit or are needed for child or spousal support.

Personal Injury or Wrongful Death Damage Awards: Most are exempt to the extent they are needed to support the debtor and his family.

Bankruptcy: Filing bankruptcy is another method of exempting assets from creditors when necessary. It is important to note that there are federal and state bankruptcy codes. A federal filing alone may not exempt debtors from state creditors. Well known types of bankruptcy filings include: Chapter 13 allows an individual under court supervision and protection to develop and fulfill a plan to pay his or her debts in whole or in part over a three year period, but it can last another two years. Chapter 11 is a version of Chapter 13 for businesses. Chapter 7 is a complete discharge of debts. Assets are liquidated to satisfy creditor claims.

Miscellaneous Exemptions: Paid earnings, Veteran's benefits, unemployment benefits, workers' compensation payments and college financial aid are exempt.

Medicaid Planning: A huge portion of our senior population has been caught "off-guard". Their longevity combined with escalating costs of long term care has created a need to try and capture the benefits of Medicaid through exemption planning. If they don't, a reasonable stay in a nursing home could impoverish their entire estate. It is a small wonder, then, why these people have turned in record numbers to lawyers and financial advisers to find Medicaid loopholes: ways to divest themselves of income and assets in order to qualify for Medicaid.

The process by which medical and nursing home care reduces a person's assets is known as spend down. In the case of Medicaid, some have referred to it as the "path to poverty". In essence, a person can't get assistance from Medicaid until virtually all assets are depleted. Certain assets are considered noncountable or exempt. They include:

- A house used as a primary residence.
- A care for transportation to work or medical services
- A wedding ring
- A cemetery plot
- Household furniture
- Cash surrender value of life insurance under \$1,500

- Real property if it is essential for support (land to grow food) or it produces income for one's daily activities.

Assets that are countable vary from state to state. The general rule is, if the principal of the item can be accessed (even if it cost a penalty to get), it counts as an asset for Medicaid purposes. Here is a short list of what counts:

- Cash, CD's and money market accounts
- Stocks, bonds, mutual funds
- Treasury notes and treasury bills
- Vacation homes and second vehicles
- Cash value life insurance and deferred annuities
- Revocable living trusts

Medicaid rules do not also require the immediate impoverishment of a spouse. But, the limits of what can be kept may mean a lower quality of life than what he or she is accustomed to living. In addition to exempt assets like a house, car and burial plot, the amount a spouse can keep varies from state to state.

In addition to asset criteria, there are guidelines for income. Generally speaking, for a person to be eligible for Medicaid he must spend all his income -- Social Security, pensions, interest, dividends, and so on -- on nursing home care before Medicaid helps. In other states, the income restrictions are severe. Income is "capped," even if all assets are "spent down" and even if this income doesn't cover the cost of the nursing home. All of these guidelines and limits are a clear reminder that Medicaid benefits are supposed to be for low income individuals.

Offshore Protection

The most aggressive protection strategies involve the use of foreign trusts, offshore corporations and offshore banking. Certain foreign jurisdictions do not recognize the judgments of US Courts. To reach assets held offshore it may be necessary for the creditor to retry the claim in the foreign jurisdiction. This would require hiring local attorneys and have witnesses, exhibits and other evidence be presented in the foreign court.

The costs associated with such an action may deter a creditor from pursuing the debtor further. One method of obtaining this protection is through the use of a foreign trust. Typically, the trust is located in a jurisdiction with laws favorable to judgment debtors. This means that a very short statute of limitations for fraudulent conveyance and a very high burden of proof for creditors to overcome. A duress clause is added to the trust which makes the trust irrevocable in case of a lawsuit or threatened asset seizure. In the event that a creditor attempts to have the foreign court assert jurisdiction

over the trust, a clause in the trust agreement provides the power to move the trust to a new jurisdiction.

Additional protection can be obtained by creating an offshore corporation. This corporation would achieve greater confidentiality and protection through the use of nominee officers, nominee directors and bearer shares. The corporation would hold title to bank accounts, brokerage accounts and other investments. The bearer shares would be controlled by the offshore trust. The offshore corporation would typically be formed in a jurisdiction other than the location of the foreign trust.

Offshore bank accounts are another method of using offshore protection. Accounts are typically opened in a country with strict bank secrecy laws and with modern communications and financial facilities for quick transferability. Many of these accounts can be linked to time deposits, debit card services and even financially secure mutual funds and other securities.

Despite all the advantages that offshore protection appears to offer, it is not cheap. Only the most sophisticated and wealthy can justify these strategies. Properly implemented, however, an offshore structure can result in the most comprehensive and effective asset protection available.

Multi-Entity Protection

Asset protection professionals have discovered that, like insurance, there are many approaches to legally solving a client's exposure. Offshore trusts, the subject of the last section is one option that can represent an extremely strong defense. For most, however, more affordable and manageable stateside techniques, using a multi-entity approach, are gaining favor. The multi-entity planner's arsenal may consist of a combination of two, three or four of the entity methods to achieve added wealth protection in conjunction with and beyond insurance.

A coordinated approach can have, as a goal and outcome, many advantages:

- The preservation of assets from liability claims
- The lowering of the taxable value of an estate
- Reduction of current income tax liability
- Facilitate charitable gifting while keeping a legacy intact

Following are the entity structures involved:

The Limited Liability Company

The Limited Liability Company (LLC) is a hybrid business entity which has similar characteristics to both a Corporation and a Limited Partnership. The LLC is formed by at least two partners which can be any combination of one or more individuals and/or one or more legal entities. An LLC is structured much like a

Limited Partnership in that the Managing Member controls the financial organization of the company much like the General Partner of a Limited Partnership. The Members are the silent business partners who have no control over the management of financial affairs of the company but have a right to distributions (on an annual or other basis) of any income or loss of the business.

From an asset protection standpoint, the LLC is the recommended way to operate a business (Note: Businesses requiring professional licenses cannot use LLC's, but can use a related statute called a Limited Liability Partnership, (LLP). The reason for this is that you, as the business owner, will not be personally liable for any of the debts or obligations of your business. Therefore, a catastrophic lawsuit or IRS tax lien will not necessarily expose any of your personal assets to the liabilities of the business.

Corporations

The most traditional way to operate a business in America is to structure your business as a Corporation. Essentially, the Corporation is a business entity which is formed by filing Articles of Incorporation with the State in which your business is operating. The Corporation is formed by the Incorporator who files your Articles of Incorporation. Thereafter, an original Shareholder Meeting is held and a Board of Directors is selected. Thereafter, the Board of Directors selects the Officers who will actually operate the day-to-day operations of the company.

The downfall of the corporate format in some states is that the courts have indicated that if it is inequitable for the business creditor, they will not allow the corporate "veil" to protect your business or personal assets for your creditors. In essence, then, if your Corporation is sued or has an IRS problem, not only are all of your business assets completely exposed to the business liability, but your personal assets could also be completely exposed through the business liability.

The Family Limited Partnership

Asset protection planners say that the most preferred way to own personal after-tax assets is through a Family Limited Partnership (FLP). The FLP is a partnership format which requires at least two partners, like the LLC. The FLP generally will own all personal assets such as the family residence, stocks and bonds, mutual funds and other types of investments.

The general purpose of the FLP is to protect your personal assets from creditors. The FLP operates by virtue of the Uniform Limited Partnership Act which states that no creditor of yours can pierce your FLP and obtain assets held by your FLP. The only remedy that a creditor of the FLP has is to either receive an assignment or foreclose upon the individual/debtors Limited Partnership share utilizing a court procedure known as a "charging order". The charging order entitles the creditor to become an assignee of the Limited Partnership share held

by the debtor/partner. However, the great benefit of the Limited Partnership is that the General Partner (the client) does not have to make any distributions of income or other assets to any Limited Partner(s) through the course of the year.

In spite of the fact that the General Partner never has to make distributions, the Limited Partners are responsible for paying all the taxes of the partnership. Therefore, if a creditor obtains a charging order or forecloses upon a Limited Partnership interest, that creditor will have to pay their proportionate share of the taxes that they have foreclosed upon or have received via a charging order. In view of this unique capability, the FLP is the best asset protection tool that can be utilized to protect your assets.

An additional benefit of the FLP is that from an estate tax perspective, the IRS will allow discounts of between 15%-40% of the value of assets held in the FLP. This is the equivalent to reducing your estate tax exposure by that percentage upon your death. One of the most frequent questions about establishing family limited partnerships is how to unwind them. There are four basic ways to get assets out of the Family Limited Partnership:

- First, you may make pro-rata distributions from your Family Limited Partnership to the partners. Distributions will flow from the assets of the Family Limited Partnership to you or to your Revocable Living Trust, which would be recommended.
- Second, your Family Limited Partnership may pay a management fee to your Corporation. The amount of the management fee is determined by you and the terms of this fee can be very flexible. Income from that fee can be used to pay a variety of corporate expenses such as salaries, employee benefits, retirement plans, etc.
- Third, your Family Limited Partnership can loan money to you, your spouse, or other family members. Repayment of the loan is effectively repayment to yourself.
- Fourth, the Family Limited Partnership is totally revocable by you, your fellow shareholders and Limited Partners at any time. In the unlikely event that you would ever need to dismantle and revoke the Family Limited Partnership, the Corporation or the Trust, it simply takes unanimous vote by you and your spouse to do so. If this happens, title of your assets can be transferred back to your direct ownership without penalties or tax consequences.

The Revocable Living Trust

One of the most underrated legal documents which should be prepared for almost every family or individual is the Revocable Living Trust. Most people are not aware of the fact that if they have only a Will, or if they have no planning documents in place, that upon their death the probate court obtains jurisdiction of all their assets. Therefore, upon your death, your heirs would have to hire an

attorney and file a petition in probate court to transfer your assets if you do not have a trust. The major problem with the probate process is that it takes anywhere from twelve (12) months to twenty-four (24) months to probate even a \$200,000 estate. In addition, there are probate fees which can range anywhere from 3% - 10% of the gross value of your estate. Accordingly, your heirs may end up paying hundreds of thousands of dollars to acquire title to assets which are legally theirs to begin with. In view of the above, the implementation of a Revocable Living Trust is an essential to any estate protection plan.

Multiple Entity Structuring In Action

A possible structure for both business and personal affairs might utilize a Limited Liability Company to operate an existing or new business. The LLC is for the most part a marketing company. It enters into contracts, employs individuals, and generally absorbs all of the liability of the business. The LLC is operated as a "shell"; it owns no assets. The purpose for utilizing the LLC as a shell company is that if the LLC has creditor problems or is sued then it can file for bankruptcy protection and a new LLC can be put in its place very quickly and efficiently.

A corporation might be utilized in the business context to handle all of the advanced tax planning for the business. The Corporation is usually filed in Nevada to take advantage of the fact that Nevada does not have state income or corporate taxes. A Nevada corporation can be set up to be either one of the partners of the LLC or can be utilized to own the equipment of the business and lease the equipment back to the LLC. The advantage of owning the equipment through the Nevada Corporation and leasing it to the LLC is that if the LLC ever has creditor problems it can file bankruptcy and the Nevada Corporation can reclaim the equipment and re-lease it to a new LLC. With respect to personal assets, it might be recommended that they be held by a Family Limited Partnership or Limited Liability Company as represented in the illustration.

What Does Multi-Entity Structuring Accomplish Taxes: With respect to the Limited Liability Company from which the business is operated, a possible illustration might be a \$60,000 per-year net income being paid to the LLC from the operation of the business. From the \$60,000 net income, \$25,000 per year would be paid to the client in the form of a salary. The remaining \$35,000 would be payable to the client through a beneficial distribution of income from operations on either a monthly, quarterly or annual basis. Without a Limited Liability Company, you would pay approximately \$9,180 in self-employment taxes based upon a \$60,000 per year business income at the current 15.3% self-employment tax rate as seen in the Figure. With the implementation of the LLC and a beneficial distribution of \$35,000 per year, you would save \$5,355.00.

Utilizing a Corporation in the business plan allows the business owner to receive a variety of benefits through the Corporation. The expenses involved in providing such benefits may be deductible to the Corporation and not includable in the taxable income of the client. These benefits include health, accident insurance, payment of unreimbursed medical and dental expenses, disability insurance and group term life

insurance. In addition, automobile expenses can be reimbursed and/or paid through the Corporation. The Corporation can also reimburse and/or pay the entertainment expenses made on behalf of the client or the clients family.

Pension Planning

Utilizing the corporate format, business owners can set up their own corporate pension plan which they can control as both the administrator and trustee. Therefore, the business owner or individual can contribute up to 15% of their net taxable income in said plan in any given year. Once the money is contributed to the plan, it grows tax-deferred but is completely taxable upon retirement.

The significant advantage of the Corporate Pension Plan is that the Internal Revenue Code allows for business owners to borrow from their own corporate pension plan of up to 50% of the pension plan assets not to exceed \$50,000. This benefit allows business owners to contribute 15% of their gross salary every year to a corporate pension plan and still allows said business owner to obtain a certain amount of liquidity with respect to pension plan contributions.

Alternative Pension Planning

Because of the problems above, Multi-Entity Planners offer alternative methods to better facilitate retirement planning. A highly recommended method utilizes various sections of the Internal Revenue Code (specifically Sections 79,162, 419A(f)(6), 501(c)(9) and ERISA) a specific insurance product and trust to overcome the problem areas indicated above. Alternative pension planning utilizes the concept of an Irrevocable Trust which receives all of the client's contributions. An employer's contributions are made to the Irrevocable Trust which is managed by a multi-billion dollar financial institution.

The client's business has no control over the Trust nor does the owner have any control over assets until such time as the business owner decides to terminate his plan contributions and obtain it back on a tax-free withdrawal basis! These pension plan alternatives allow business owners or other professionals to deduct 100% of their contribution as a business fringe benefit (expense) and receive 100% tax free withdrawals (income).

Estate Planning

Advanced Multi-Entity Structuring can provide the following estate planning advantages:

- The market value of your estate is lowered due to well-established principles granting discounts for lack of marketability and fractional ownership of an asset. You save up to fifty-five percent (55%) in estate taxes for every dollar your taxable estate is lowered through the implementation of a Family Limited Partnership. The Internal Revenue Service allows a minimum of a twenty-five to

forty percent (25%-40%) discount on all the assets placed in a Family Limited Partnership. In a typical illustration, a \$2,000,000 estate could receive a 40% discount thereby excluding \$800,000 of assets from estate valuation. This \$800,000 exclusion would represent an approximate \$400,000 in estate tax savings to the heirs of the client.

- The estate plan allows for lifetime gifts of Limited Partnership interests to your children, grandchildren, other loved ones or charities while you maintain control over the assets. You can begin to reduce your estate by making gifts of fractional interests in your Family Limited Partnership which will further reduce the estate taxes due upon your death.
- This estate plan creates a way for you to manage your family assets. This is accomplished by setting up your Corporation as the General Partner of your Family Limited Partnership which will continue to manage your Family Limited Partnership despite the death or disability of any of the shareholders.
- This estate plan eliminates the need for probating your estate since a trust will transfer all assets to your children or grandchildren without court intervention even beyond the death of you or your spouse.
- This estate plan will clarify, prioritize and systemize your entire estate by (1) compiling all the essential information regarding your estate into one complete source; (2) reorganizing your financial paperwork into a single comprehensive file; and (3) transferring your diversified investment portfolio into a single, easier-to-manage asset - your Family Limited Partnership.

Asset Protection Plans

What happens today if a third party gets a judgment against you, your spouse or our business? Without implementing an asset protection plan, the majority of your assets are subject to seizure by third party creditors. Your creditors can pick and choose whatever they please in order to execute upon a judgment taken against either you or your business. Without an asset protection plan, almost all of your personal and business assets will be exposed to execution by a potential creditor. After implementing an asset protection plan, the majority of your assets are owned by a Family Limited Partnership and are safe from seizure by creditors.

Once your assets are transferred to a Limited Partnership format or a series of Limited Partnerships, the third party creditor cannot seize or obtain any portion of your estate. The creditor's only recourse is to obtain a "charging order" against your interest in your Family Limited Partnership or Business Limited Partnership. A charging order is similar to a garnishment of wages and requires that all distributions from your Family Limited Partnership which would have gone to you must now be paid to the third party creditor.

If you or your Corporation, as General Partner, decides not to distribute any income to the limited partners, then the creditor does not receive any money. At the same time, the creditor is responsible for all of the income tax responsibility or liability from the Limited Partnership. Assuming your Limited Partnership has taxable income

and no pro rata distributions are made to the partners, the creditor becomes liable for “phantom income”. In other words, the creditor must pay income tax on money earned by the Partnership but for which it did not receive any distribution. This unfavorable result dramatically improves your negotiating position against any creditors and helps to level the playing field. An asset protection plan developed by a professional provides the following asset protection advantages for your business and family:

- It shields your assets from the ever-expanding damage awards for personal injury and professional liability and it protects your assets from unfair or outrageous financial claims of judgment creditors.
- It insulates your assets from the effects of death or bankruptcy of your co-guarantors, co-makers of debts and fellow General Partners. With the asset protection plan, the problems of your partners do not become your problems.
- It provides an entity you control to be the beneficiary of the estate from which you anticipate an inheritance. Parents redraw their Wills or Trusts to leave their estate not to their children directly, but to their children’s Family Limited Partnership so that the children’s inheritance is protected from creditors.
- It provides protection for your legacy. If a son or daughter is in a high-risk occupation, you can implement an asset protection plan and thereby leave your children a Limited Partnership interest as their inheritance. This protects the assets of the parents while they are alive and passes on the same protection to their children.

Charitable Remainder Trust Planning

Although most people do not think of gifting assets to charities, the gifting of assets to a Charitable Remainder Trust is oftentimes an effective tax avoidance and asset protection. An advanced protection program designed by a multi-entity planner provides the following charitable advantages for your family:

- By transferring the family business, ranch, farm or other family asset into a Family Limited Partnership, a gift of a Limited Partnership interest to a charitable organization can be made while the family business, ranch, farm or other family asset remains intact to produce income for the benefits of all partners.
- As a Limited Partner, a Charitable Remainder Trust or organization has no control over the daily management of the Family Limited Partnership so that the family business, ranch, farm or other family asset may be operated essentially the same as before the transfer of Limited Partnership interest.
- The value of the Limited Partnership interest that is given to the Charitable Remainder Trust or organization can be taken as an immediate tax deduction on your current year’s income taxes. In some cases, this may provide you liquidity that you previously did not have.
- By requiring the vote of all Limited Partners of the Family Limited Partnership and all the shareholders of the corporate General Partners, including the charitable organization, to liquidate the entities, you have optimized your potential to obtain a reduction in the valuation of your taxable estate.

Implementing a Multi-Entity Asset Protection Plan

Implementation of an Advanced Tax Planning and Asset Protection Program involves the transferring of title of your assets to various entities which include: Family Limited Partnerships, Business Limited Partnerships, Corporations and certain types of Trusts as well as Limited Liability Companies. The only limitations to the asset protection plan espoused by asset protection professionals is that the person implementing the plan must be financially solvent in accordance with general accepted accounting principles both before and after implementation, and the purpose of the transfer must not be to hinder, delay or defraud creditors.

Your net worth after implementing this program will remain substantially the same. The percentage of ownership in the Limited Partnership will not change the total amount of your net worth despite the fact that you now do not own any assets directly in your own name. However, you still control them through the connection of your Family Limited Partnership and your Revocable Living Trust.

Maintaining Control of a Multi-Entity Program

To maintain effective lifetime control over the any multi-entity program, you, your family members and other shareholders enter into carefully drafted agreements. These agreements include a Family Limited Partnership as well as various other contracts which bind all members and entities to vote for you as the person in charge. With respect to the Limited Partnership Agreement, since you act as General Partner, you control each and every movement of cash and other assets in and out of the Limited Partnership. You have total lifetime control over all of your assets utilizing these entities which cannot be disrupted even by death. As a result, the plan works much more favorably than the implementation of just one Trust Agreement or just one Corporation.

Is A Multi-Entity Asset Protection Plan Right For Your Client?

- Do they want to reduce the amount of income taxes they are paying?
- Do they want to leave the majority of taxable estate to your family rather than to the IRS?
- Do they want your assets to be preserved from expanding liability judgments?
- Do they want to make a charitable gift while keeping assets intact?

If they answered "yes" to any of these questions you should consult with a multi-entity planner.

A Final Word On Suitability

Getting to your client's true need and matching appropriate product is the heart of suitability conduct. However, the issues we presented in this section underscore the fact that finding a single need for a client is not enough. Surely, a serious conversation with a prospect about current challenges, unrealized opportunities, hassles and trends

would uncover multiple needs. Therefore, you need to dig deeper with your questions and resist the urge to jump at the very first need your client revealed. In addition, you should always ask your client for clarification of their needs. Never assume without their input.

Product suitability is dynamic, not static. One "size" will not fit everybody and even for the same client it will shrink and expand over time. Therefore, the product you recommended 10 years ago may need to be replaced by another meeting new suitability requirements and the transformation in world events. Traditional methods of determining suitability will always play a role, but your ability to solve client problems and anticipate their needs is where you will earn your client's respect and business in the future.

Solvency Conduct

Like it or not, you are in the solvency business. Your job is to make sure that in your particular area of licensing you have done all that you can to prevent gaps in coverage and place your client's insurance with a reliable and secure company. Both are important to your client keeping his liquidity and assets. But, just how far can you expect your product (insurance policies) to go.

Every agent knows that insurance has its limitations. There are times when clients are underinsured; there are times when insurance fails to insure; and there are clients who, for a variety of reasons, cannot be fully insured. Insurance shortfalls or failures may surface in many ways. The source can be an agent's negligence in providing coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to pay (insolvency of the insurer).

In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent. Preferred solvency conduct would find you going to the lengths to recognize areas of client exposure you are unable to cover and referring out to professionals who can assist. This may involve supplemental coverage, readjustment of existing coverage, or even looking beyond insurance protection.

Coverage Shortfalls

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

the agent may find himself in the position of breaking the bad news or worse, liable for the shortfall.

Sometimes, insurance shortfalls cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference. Then too, there are times when the coverage purchased or sold to a client exceeded what was needed in one type of insurance at the expense of another insurance coverage being under funded and under covered: a high premium whole life policy leaves no monthly budget for health insurance, or an auto policy with low deductibles is chosen or sold instead of a higher deductible policy permitting the additional purchase of umbrella coverage. Where clients depend on an agent for multiple lines of insurance or simply because it's right to do so, agents need to consider the balancing of coverage to avoid critical shortfalls.

Coverage Disputes

In the midst of the litigation explosion, the stakes are high. Insurers are offering increasingly high policy limits, and insureds, who cannot secure coverage or who fail to be awarded coverage, risk losing a lifetime of assets. Given this scenario, conflicts between insureds and insurers and agents can easily gather steam. To further confuse the issue, the courts are constantly bending statutes while public attitudes produce more and larger plaintiff verdicts, this despite the fact that the industry operates under fairly standard contracts. In essence, there has never been a time for greater disputes in coverage.

One form of coverage dispute results when the agent fails to secure the promised coverage. The courts have found that when an insurance agent agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with reasonable care, skill and diligence. As seen earlier, agents have been sued for neglecting to secure the requested coverage, failure to notify the client that the insurance is not available, failure to forward premiums on policies which then lapsed, unintentionally omitting a specific type of coverage, providing unsuitable coverage, failure to properly bind the client and much more!

A more common form of dispute occurs when the insured and the insurance company simply do not agree on the interpretation of coverage provided. In practice, insurance coverage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large. Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be

litigating coverage for the same underlying claims or addressing the same coverage issues.

In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

Legal Maneuvers

Attorneys at Work

Where coverage disagreements persist beyond an initial settlement, policy holders or their attorneys must begin the tedious task of processing documents and information relating to the insurance companies' interpretations and meanings of their policies. This often leads to a drafting history. The drafting history contains detailed records of the insurance industry's deliberations regarding policies and seeks the original meaning of policy terms and the manner in which they were intended to apply.

Courts have found such histories to be relevant and material, as well as filings made by insurance industry organizations on behalf of their members to state insurance departments and insurance regulatory agencies. Policy holders and their attorneys also seek underwriting and claims handling manuals written by insurance company experts that are used to provide guidance to insurance company employees. These manuals may demonstrate how the insurance company interpreted their policies. In addition, they may contain the company's official position on coverage, claims and loss control.

Many courts have ordered the production of such manuals and guidelines in the early stages of coverage cases. Another valuable source used by attorneys is reinsurance documents. Communications between an insurance company and its reinsurer can provide information on whether and how policies may apply to underlying claims and may offer assessment of the insurance company's coverage obligations. Access to reinsurance documents is a hotly contested issue in insurance litigation discovery, and some courts have refused access to such documents.

Disputes also lead to discovery of insurance company marketing policies by documenting company advertising and agent/broker representations, as well as how the insurer has handled other policy holders with similar coverage claims. Also investigated is the possible cause and effect of the insurance company's involvement in other coverage litigation.

Agent Records

A dispute between you and a client or you and an insurance company may require that you produce certain records and evidence. In your own defense, you can typically produce any file, note or electronic record (fax, e-mail, computer record) as long as it is something generated in the ordinary course of business. In other words, if

you use as operations manual or stick “post-it” notes in you client files as standard operating procedure they are generally admissible. The test will be: Do you use these methods for every client?

An example might be a standard checklist of coverages that you review with each client. If you can show that the client was offered, but refused a particular coverage on your checklist, it will be harder for clients to say they were unaware this coverage was available. Keep in mind that most parties to a claim will eventually gain equal access to your records. So, you want to keep all legally required records and be consistent from file to file. Also, never write derogatory comments about clients or the company in files. This could work against you in a trial or settlement.

Agent Cooperation

In a nutshell, most suits settle before going to trial so cooperation on all sides is generally desired. However, you should proceed with caution in any dispute or potential claim. Check with your errors and omissions carrier before discussing matters with clients or your represented companies. Do not try to settle the case, it could void your E&O policy. Do not make any promises to clients about resolving the matter or give them legal advice of any kind. Do not ever try to cover-up mistakes.

If your errors and omissions carrier wants to settle it is usually best to agree. If you do not, you could be liable for court judgments that exceed the settlement already proposed by your E&O carrier.

Insurance Litigation

Although most insurance conflicts settle prior to trial, some disintegrate into protracted and unnecessary litigation. Some areas of specific conflict include the following:

Triggers of Coverage: The term trigger is merely a label for the event or events that, under the terms of an insurance policy, determine whether a policy must respond to a claim in a given set of circumstances. While this definition seems clear, “trigger of coverage” disputes have been raging for decades and have been the source of much confusion.

In a life policy, the trigger seems clear: death. However, issues of whether the death was an accident or suicide within the incontestable period is often up for debate.

Disability and health policies, however, have a higher propensity for dispute: What is a permanent disability? Are there waivers and if so, how long? What is a major illness? Has the deductible been met? Are there additional policy exclusions? In long term care policies, trigger of coverage is even more acute where a written declaration by a physician may be required to solidify a patient’s inability to care for himself: the prerequisite for insurance benefits.

Policy language in most casualty policies center around three primary triggers of coverage issues. First, the carrier agrees to provide coverage for all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence. Second, an occurrence is defined in the policies as "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured..." Third, bodily injury is defined as "bodily injury, sickness or disease sustained by any person which occurs during the policy period", and "property damage" is defined as "injury to property which occurs during the policy period..."

The trigger is plain under these three policy provisions when property damage or bodily injury occurs during the policy period. But, the trigger question becomes somewhat complicated when a long period of time has elapsed between the act giving rise to liability. Examples include a leak or spill involving hazardous waste or exposure to asbestos or lead which may result in problems years later.

Most of the litigation concerning coverage for latent injuries have raised at least four different explanations of when damage occurs and thus triggers coverage. 1) The date of exposure to the toxic substance (the "exposure" theory); 2) the years in which the claimant incurred tangible injury ("injury in fact" theory); 3) the date of manifestation of injury (the "manifestation" theory) and 4) the year in which damage "occurs" or "could have occurred" (the "continuous trigger" theory). The continuous trigger theory has received considerable attention during the past twenty years surrounding property damage or bodily injury due to hazardous waste/environmental contamination.

In essence, the courts have generally ruled that casualty insurance policies can be triggered continuously from the initial exposure to the contamination to the manifestation of any injury, disease or damage of property. By far, most policy holder attorneys adopt a continuous trigger approach to litigation. Insurance companies continue to argue, sometimes to no avail, that insurance policies cover an "occurrence" and not a "reoccurrence".

Definitions: The following are terms that often become the focus of coverage disputes:

- **Bodily Injury** - bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time.
- **Property Damage** - physical injury to or destruction of tangible property which occurs during the policy period. Loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period.
- **Occurrence** - an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.

Conditions: In addition to standard provisions and definitions, coverage is further defined in a conditions section where the duties and legal requirements of the insured and insurer are established. Typical conditions are the insurer's right to inspect, and the insured's duty to cooperate with the insurer and the notice provision. The notice provision is the most frequently litigated condition.

A sample notice provision might include the following language: "In the event of an occurrence, written notice containing particulars sufficient to identify the insured, the time, the place and circumstances thereof, and the names and addresses of the injured and of available witnesses, shall be given by or for the insured to the company".

Some courts have relieved the insured of its notice of obligation unless the insured was in some way prejudiced or harmed by the insured's delay in providing notice. The insurance company usually has the burden to prove that it was harmed by the insured's failure to comply with the notice requirement.

Exclusions: There are many standard policy exclusions as well as those relating to high risk issues such as partial disability, pollution, nuclear attack, "owned property", aircraft and liquor liability. The purpose of these types of exclusions is to limit the policy coverage to contemplated risks only. The burden of proving that an exclusion applies generally falls on the insurer in coverage disputes.

Named Insured: The definition of a "named insured" varies from policy to policy. Some define it in broad terms, while others insist on a more narrow description. Often, standard policy formats will provide a "listing" which has resulted in legal conflicts where coverage was denied a party on the listing who is no longer associated with the primary insured. The burden to prove continued association is with the insured.

Assignments: Conditions of most standard policies prohibit assignments without written consent of the insurer. Such provisions are enforceable because they ensure that the risk the insurance company agreed to insure remains the same. In fact, the majority of courts have refused to hold an insurer liable for an occurrence derived from a risk not contemplated by the insurer at the time the policy was issued. It is important to note, however, that prohibiting assignments does not bar the assignment of insurance proceeds.

Rules of Construction: The rules governing the construction of insurance contracts are usually the same as those for other contracts: the policy language is to be interpreted given its plain and ordinary meaning. If a court determines that an ambiguity exists in an insurance policy, it will look to any outside factors or evidence that may help determine the parties' intentions. Where an ambiguity is not capable of resolution, most courts have construed the ambiguity in favor of the insured.

Other courts have applied a "reasonable expectations" test and construed ambiguous policy language based on what a reasonable person in the position of the insured would understand the language to mean.

Duty to Defend: The prevalent view by the courts is that an insurer has the duty to defend an insured where the policy language gives the insured a reasonable expectation that the insurer will provide a defense. Standard policies employ language reading: "the company shall have the right and duty to defend any suit against the insured seeking damages on the account of bodily injury or property damage even if the allegations of the suit are groundless, false, or fraudulent".

Insurers maintain the position that they may be contractually bound to defend, but may not be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage.

Coverage disputes are likely to develop and do, when an insurance company attempts to shield itself from any defense of an insured whatsoever, or when it withdraws from an action after it determines there is no basis for recovery. Other conflicts center around whether an insurer must defend only against an action that is a actual lawsuit seeking damages or be required to defend against all claims which may result in liability. In general, courts assume a connection between the filing of a complaint and the triggering of a duty to defend by an insurer.

A PRP letter (Potentially Responsible Party), received by a client although not an actual claim, has also been interpreted by the courts to be a serious event that could, in fact, represent a new legal action against the insured. The duty to defend is typically established here, but not in the case of a simple demand letter which only exposes one to a potential threat of future litigation. If there is any doubt as to whether the facts give rise to a duty to defend, it is usually resolved in favor of the insured, but it is the insured's burden to show that the claims come within the coverage.

Claims related to acts of an insured in the area of crime, sexual misconduct, wrongful termination, contractual obligation, loss of profits or goodwill, have been ruled unacceptable ways to force an insurer's duty to defend.

Breach of Contract / Refusal of Coverage: Breach of contract claims typically allege that an insurance company failed to defend or indemnify the policy holder under terms of the insurance contract. To a great extent, public policy supports the policy holder in most breach of contract allegations in an effort to solidify the "strict enforcement of insurance contracts". This is why state insurance regulators will typically be involved or called upon to rule on an insurer's potential or actual violation of codes.

Many times, an insured is denied protection because the insurer knows facts which would defeat coverage. A majority of different courts have ruled that under such conditions, an insurance company is not bound to "defend" such claims simply because

it cannot be bound to indemnify: the duty to defend can be disputed. Here, the insurer has the burden to prove that the facts of the insured's claim fall squarely within a policy exclusion.

Bad Faith: There is increasing judicial recognition that the relationship between an insurer and its policy holder is fiduciary in nature. Courts have compared the relationship of an insurance company to its policy holder to that of a "trustee for the benefit of its insured". Where an insurance company allegedly has violated its fiduciary duties owed its policy holders a bad faith claim could be appropriate in addition to any breach of contract action.

Choice of Law / Venue: Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are state law questions even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as 1) the place where policies were contracted; 2) the location of the damage and/or 3) the principal place of business/residence of the policy holder.

Lost Policies: Some claims between insureds and insurance companies have developed over the inability of the policy holder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policy holder must satisfy two requirements to prove coverage.

- First, the policy holder must prove that the policy was, in fact, lost or otherwise unavailable by showing that he made a diligent search for the policy in all places where it can likely be found.
- Second, the policy holder must prove the existence and the contents of the policy by identifying the parties to the contract, the policy period and the subject matter of the policy. Secondary evidence includes any correspondence, certificates of insurance, claim files, management reports, corporate records, ledger entries, receipts, licenses and agent files and agent testimony. Coverage disputes also evolve around the nature of damages or hidden exposures such as:

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

Agents were instructed to sell the new policy on the basis of its broadened coverage in the area of pollution which was then only a growing, but minor exposure.

Since the 1960s, the Environmental Protection Agency (EPA) has contended with almost 300 million tons of hazardous industrial chemical waste leading to passage of the Superfund legislation which has obtained almost \$4 billion in settlements from waste generators, disposers and transporters of hazardous materials.

Similar pending litigation involves other forms of mass tort liability, including asbestos, DES and other substances. The generators, disposers and transporters of hazardous waste and product manufacturers, installers and sellers faced with mass tort claims all turned to their insurance companies for coverage, and insurance coverage litigation often followed.

In response to a flood of litigation, the insurance industry began making adjustments. In 1973, certain terms in the C.G.L. policy were revised. For example, the 1973 C.G.L. policy defines "occurrence" as "an accident,, including continuous and repeated exposure to conditions, which results in bodily injury or property damage neither expected or intended from the standpoint of the insured." Obviously, an occurrence under the 1973 definition required exposure to conditions over a period of time. "Property damage" was also changed to read "physical injury to or destruction of tangible property which occurs during the policy period . . . or, the loss of use of tangible property which has not been physically injured or destroyed, provided such loss of use is caused by an occurrence during the policy period." Thus, compared to the pre-1973 contracts, "property damage" now requires physical injury to tangible property. This distinction may be critical in certain hazardous waste cases and in asbestos property damage cases. In fact, courts have held that some insurers are not required to provide a defense in suits where there was no covered "occurrence" or "property damage" as defined in the C.G.L..

In the late 1970s and early 1980s, a number of carriers made even more dramatic moves by changing the "pollution exclusion" clause in their policies from the "sudden and accidental" variety to what is called the "absolute pollution exclusion". Although there are several versions of this exclusion, the basic thrust of each is to exclude coverage if the omission or discharge was accidental or sudden. Since most hazardous waste problems are sudden and accidental, the absolute exclusion appears to exclude most pollution incidents.

A growing number of courts are siding with insurers where the absolute exclusion is in place. In these cases, most environmental exposure falls back to the insured and his own ability to cure the problem. The results can be devastating to a company, its owners and their respective estates. In more recent years, new court cases are again changing interpretations of CGL. Past court cases held that CGLs covered only those liabilities arising from torts. The new precedents now say that CGLs cover BOTH tort and contractual liability. Experts say that this decision has far-reaching negative effects on insurers across the country.

Excess Insurance Claims: With the increase in mass tort litigation, environmental litigation and substantial jury awards, excess insurance policies and the

role of excess insurance carriers have received increased scrutiny. In general, the fact that a primary carrier owes duty to its insured is well known. With respect to an excess insurer, the courts continue to struggle with the origin of duty. In coverage disputes where the insured is bringing action against both a primary and excess insurer, the excess carriers sometimes moves to dismiss the lawsuit on the basis that the actual exhaustion of the underlying primary liability limits is a prerequisite to a claim under the excess policy.

Policy holders, on the other hand, argue that the mere potential that the underlying insurance will be exhausted is enough to justify a coverage dispute against the excess carrier. The courts have sided with each. Another area of dispute is the drop down: where an excess insurer "drops down" to provide insurance when the primary insurer has become insolvent. Courts are split on this issue, although a majority currently feel that an excess insurer is not obligated to drop down and provide coverage to an insured.

The court's determination is usually based upon the language of both the primary and excess insurance policies. In yet another decision, the courts have determined that the "trigger" of excess coverage is the amount "indemnified", not the additional costs involved in defense nor punitive damages.

Business Insurance Disputes: In recent years, the number and variety of claims brought against business has increased significantly. In spite of this fact, many businesses have not given adequate consideration to the potential insurance coverage for these claims. As an example, businesses which face claims only against their directors and officers, might tend to ignore the possibility of comprehensive general liability (C.G.L.) insurance coverage.

Likewise, when companies face claims of unfair business practices or statutory violations, they consider the bodily injury and property damage portions of their C.G.L. policies only, failing to consider the advertising injury and personal injury provisions, which may provide broader coverage. In one advertising coverage dispute, the court held that the insured was NOT covered by its C.G.L. policy because the insured failed to establish that its advertising activity *caused* the alleged injuries.

The insured was selling a product that "infringed" on a competitor suggesting that the relationship of selling and advertising were the same thing. Another court's rejection of coverage involved copyright infringement. Here, an insured distributed brochures that merely advertised copyrighted material for sale.

Directors and officers liability coverage typically insures the directors and officers directly and provides that the insurer will pay on behalf of or reimburse the directors and officers for "loss" arising from claims alleging "wrongful acts". Coverage is not afforded under this insuring agreement if the corporation is required or permitted to indemnify the directors and officers.

Coverage has also been denied for claims involving dishonest conduct, claims in connection with the Employee Retirement Income Security Act (ERISA), claims involving bodily injury, personal injury and property damage as well as claims involving seepage, pollution and hazardous waste.

Defenses of the Insurer

Much attention is devoted to the rights of policy holders. Insurance companies, however, have their own safeguards, which help protect their interests, but add to the growing list of things that can go wrong with insurance. Depending on the issue at hand, the result of having these built-in protections can completely void a policy or greatly limit its scope of coverage.

Defenses consist of legal tools and techniques that help an insurer initially determine pertinent aspects of the insurance risk for purposes of deciding whether to issue the policy and at what premium. After a policy is committed, additional policy conditions help the insurer "contain" the risk within the intended bounds of the contract. Over the years, a series of standard defense devices have evolved. These can be categorized as concealment, representations of the insured, conditions, warranties and limitations to coverage.

Concealment

The insured has the duty to disclose to the insurer all material facts that might influence a decision to issue a policy of insurance at all, or issue it at a particular level of premium. The holding back of information can, in some cases, constitute fraud by the insured and can render a policy void. In general, the rule on determining when a policy is voided lies in the issue of "bad faith".

If the insured withholds information that he knows would be necessary to the insurer in evaluating risk, the insurer has grounds to void the contract. Examples might include a life insurance policy where an insured has agreed to an examination by the insurer's physician but still fails to disclose a medical condition that is critical to the insurer's risk decision. The burden of proof as to fraud in concealment falls on the insurance company.

In some cases, courts have sided with the insurer in establishing fraud by "inference". An example might be discovered evidence that the insured had made a previous attempt to destroy the covered building. On occasion, the insured has won based on the argument that facts uncovered by the insurer were not material because it was not made a subject by the questions asked on the application even though most applications include a provision requiring the insured to represent that he or she has disclosed all material information.

Only when the insured conceals a fact in bad faith, knowing the fact to be material, will the policy be voidable. An example is a life insurance application which

contains a question as to how many times the insured has been hospitalized and for various causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered material and grounds for avoidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be obvious and not grounds for avoidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to facts, and not to mere fears or concerns of the insured about his health or the subject matter of the policy. There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires.

Misrepresentations

A representation by the insured that is untrue or misleading, material to the risk, and is relied upon by the insurer in issuing the policy at a specific premium is considered a misrepresentation and grounds for avoidance of the policy, unless the policy is beyond the incontestable period. This is true even if the misrepresentation was made by the insured innocently, with no intent to defraud. A minority of courts, however, take a somewhat less severe position limiting or prohibiting avoidance where the insured's misrepresentation was not an intent to deceive the insurer.

Representations by an insured to an agent bind a contract because they are considered to be made to the insurer itself. However, a policy refusal or avoidance could occur when the insured has reason to believe that the agent will not pass information on to the insurance company. The insurer cannot void a policy based on a representation by an insured regarding an intention or future conduct unless it is made a condition of the contract.

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

Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium. The point where representations by an insured cause coverage problems is where such representations are made with the intent to deceive and defraud.

The burden of proving a representation to be material falls on the insurance company. If a material representation is found to be substantially correct, or believed to be correct by the insured, the courts have not permitted a voidance or limitation of coverage. An example might be an insured indicating he has not seen a physician within the past five years when he has been to a doctor for treatment of minor and passing ailments.

Warranties & Conditions

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

In recent years, the effectiveness of warranties and conditions have come under fire. In fact, many statutes now place stiff definitions and limitations on warranties. One statute, for example, provides that all statements made by the insured will be considered to be a representation rather than a warranty unless fraudulently made. As previously discussed, it is much harder to void a policy for misrepresentation than for a violation of a warranty or condition.

Another statute requires that the breach of warranty is a defense for the insurer only if it actually contributed to causing the loss, as opposed to simply increasing the risk. This is the most severe type of statute for the insurer, since even in cases in which the breach caused the loss, it is frequently impossible to prove the cause, e.g., a fire completely destroys a portion of a building.

Limitations on Coverage

Insurers over the years have attempted to control their exposure by tightening terms of the insurance contract. Adding personalized warranties and conditions is cumbersome and not always useful as a defense for insurers (see warranties and conditions above). Some courts, however, believe that insurers side-step warranties and conditions by creating numerous clauses that serve, instead, to limit coverage.

The reason insurers have do this is because many of the statutes which commonly limit warranty defenses, such as incontestability, contribute to loss statutes and increase the risk statutes, do not apply to limitations to coverage. There are several types of limitations that insurance companies can and do employ:

- **Limitations of Policy Subject Matter** -- A homeowner's policy may cover most household possessions in general, but specifically exclude from coverage

particular items like cash or coin collections. Likewise a health policy may exclude or waiver certain illnesses.

- **Limitations by Type of Peril** -- A fire policy may except from coverage any loss caused by a fire resulting from lightening or earthquake.
- **Limitations on Proceeds Paid** -- Casualty insurance policies frequently specify an upper limit of proceeds payable for any loss, as well as limiting the payment to the value of the insured's interest in the property damaged. Automobile policies generally fix the upper limit of coverage both in terms of maximum proceeds per person and maximum proceeds per accident.
- **Limitations on Period Covered** -- Every policy will be specific as to the date of expiration, and in some cases, as with life insurance, will also specify a grace period beyond the date of expiration that insureds may make a premium payment. Also, the date of inception of a policy can be specified on the policy or can be subject to the occurrence of some event such as the payment of the first premium or delivery of the policy to the insured. A limitation on coverage can cause considerable conflict between insurer and insured.

One reason is the fact that in some instances, it is nearly impossible to determine from the wording of a clause whether it is a warranty or limitation. In response, the courts have developed two tests to distinguish the two. In one test, if the circumstance which is the subject of the clause is discoverable by the insurer at the time of inception of the policy, the clause will be classified as a warranty rather than a limitation.

Another test deals with risk. If a clause refers to a fact which potentially affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit while the insured is flying in a private plane. The insured can bring action to force payment of such a claim, even if the insured died of a heart attack while in a private plane. The flying merely increased the risk, but need not be the actual cause of death. Such a clause is considered a warranty. On the other hand, if flying in the plane was the cause of death, it could be interpreted to be a limitation that is better defended by the insurance company.

Settlement Disputes

Some forms of insurance, like life insurance, are generally settled with ease since the amount paid in the event of loss is fixed by the contract. Similarly, in the case of accident insurance, the proceeds are measured by a specific amount agreed to be paid for loss of a particular limb or faculty, or, as in the case of health insurance, by the medical expenses actually incurred.

By far, most settlement disputes occur over property/casualty policies where the payment in the event of loss is determined by an amount up to the "actual cash value" of the property at the time of loss. There are two basic approaches which insurance

companies use in an attempt to arrive at a mutually agreeable value: reproduction costs less depreciation and market value.

Reproduction Cost Less Depreciation

This measure is aimed at determining the cost of replacing the exact depreciated property that was lost. If this were the only option for insureds, it would represent an extreme hardship where, for example, the owner of a fifty-year old home that is destroyed would have great difficulty replacing it with a new building on the depreciated settlement, for this reason, replacement cost insurance is offered. Here, depending on the wording of the contract, the insured may be required to actually repair or replace the building in order to collect full payment.

The most pressing problem for insureds is to keep policy limits above the 80% of market value requirement. Insurance companies require policy limits above this level to assure adequate coverage and keep premium levels high. Insureds may lose, however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

Market Value

Items of commerce that are readily replaceable in kind (a warehouse full of books, shipments of grain) have a market value that is relatively easy to establish. In the case of income producing property such as office buildings, apartments or commercial buildings, market value is determined by a more detailed method using the capitalization of earnings. Disputes in this area usually require testimony of an expert witness who determines the rate of return on investment that a reasonable investor would require in investing in this type of property.

Failing Insurers

Today potential trouble spots and ideas for constructing new regulations to protect consumers are being unveiled at a fast and furious pace. The suggestions come from consumer coalitions, industry groups, auditors, state regulators and some members of Congress who continue to press for some form of uniform federal supervision of the entire insurance industry. At the center of attention are the issues of safety, solvency and agent due care: how to regulate, who will regulate, what the consumer will be promised and whose going to pay if something goes wrong.

Clearly, the insurance professional is at risk to know as much about his product and company than ever before. Recent and past problems are complex and visible and not limited to insurance companies. Most financial markets and many industries have changed dramatically especially in the last 20 years. Changes in financial institutions have resulted from events like information and communication technologies to substantial financial disasters among independents and insurance conglomerates alike.

Geographic and product boundaries for financial markets, traditionally, not a factor for insurance companies, have faded, and new products and services have blurred the distinctions between bank or thrift institutions, security brokers and insurance agents. A place once reserved to buy groceries, for example, may now be a convenient spot to deposit or cash a pay check.

Further, with the Internet beaming financial and educational services to anyone who owns a computer, there is no indication that this era of change is over. On the contrary, financial markets and institutions will continue to evolve. The need to adapt to the increasingly competitive environment, new products, financial "heart attacks" and more has presented problems for many types of financial institutions: commercial banks, savings and loans, securities firms, and insurance companies.

As always, when things change or require restructuring, there is a period of adjustment accompanied by trial and error, financial stress and an increased likelihood of less than top performance or the threat of complete collapse. It happens to many kinds of companies (including property/casualty and life/health insurers). It is a fact of doing business and part of any free-market system. Multiple and prolonged insolvencies, however, take their toll.

The insurance industry becomes tarnished, and new consumer/political pressures expound. This, in turn, expands the burden on regulators, industry groups and the insurance professionals to correct the potential effects a major insurance failure may have against the public and the economy. In some cases, over-regulation and speculation result in panic or perhaps a "light trigger" that could catapult a seemingly secure company into the solvency spot light. During the 1980s, solvency paranoia was focused on the banking industry.

The insurance industry has had its bout with solvency wars. In fact, just the cast or suspicion of problems or a drop in bond ratings has put companies at bay or, in some cases, out of business. With rare exception, the insurance industry has enjoyed the comfort of consumer and regulator confidence throughout its history. Conservative marketing and investment practices in the industry scored high marks with a remarkably low rate of failure. Performance has periodically fallen below adequate levels, but generally not to a point that would jeopardize solvency.

In the few episodes that varied this trend, insurance regulators, insurance companies and industry groups like the National Association of Insurance Commissioners have appeared to provide appropriate regulatory responses. Recent episodes are no exception. Most of the major insurers that went insolvent are in the process of being rehabilitated by state regulators or private investors. It is doubtful that policy owners will incur material losses.

The Failure Rate

It is true that the decade of the 1980s and the early 1990s subjected the industry to higher levels of financial and market trauma than ever before. This period was marked by new records in sales and innovations. Fierce competition and increasing cost pressures became new problems in addition to outside influences like federal deregulation of financial services, higher interest rates, new financial instruments, expansion of tort liability, soaring medical costs, catastrophic claims, the entry of some inexperienced, small insurers and relatively poor investment results.

In a rather short time frame, the industry evolved from a conservative, mature business with stable elements and generous profit margins, to a business marked by higher risks and narrowing profit margins. A combination of these factors has also brought media and political attention and a definite erosion in consumer confidence. As this confidence declined, redemptions increased dramatically. At the same time, a major recession created financial havoc via junk bonds and plummeting commercial real estate values. The result: insurer failures.

The additional toll of many years of rate wars and dramatic natural disasters created even greater pressures on the property/casualty side of the industry. The federal government has published volumes on insurance industry abuses and made scathing comparisons of insurer problems and the huge banking debacle of the late 1980s. Actual statistics, however, tell a somewhat different story. For example, in 1989, the peak of the bank and thrift controversy, failures in that industry numbered over 500 institutions involving some \$130 billion in assisted mergers or closures. In the same year, which coincidentally seems to be the peak year for insurance company problems, the number of failed companies numbered about 40 property-casualty insurers and about 40 life companies with a combined total bailout of less than \$1 billion.

A 2001 Standard & Poors study uncovered fewer failures where only 56 companies failed (31 P&C, 17 health insurers, 5 life companies and three title groups). And, a recent Weiss Research found even more improvement with only 23 failures (20 P&C and 3 Life) in 2002. While no one should be happy with company closings, it is clear that insurance industry failures have and will not likely become another savings and loan fiasco; especially, since recent information seems to indicate a cycle of declining failures.

What Do the Problems Mean

Many of the pressures described above have already "vented" in the form of a rise, in the latter half of the 1980s, in a number of insurance companies failing, at least by certain regulatory standards, and those requiring formal action. Most of the underperforming activity, until only recently, was confined to companies writing between \$6 million and \$12 million in premiums per year and assets of between \$20 and \$40 million: small companies in the world of insurance.

According to many industry professionals, however, the typical American insurance company is in no way facing the kinds of risks faced by major company breakdowns like Executive Life, Mutual Benefit Life and others. In their opinion, the bulk of the industry has pulled through a tough economic environment and remains financially responsible. Most insurers are generally well capitalized, relative to other financial institutions, and are restructuring assets to meet new solvency standards, merging with stronger insurance and non-insurance companies and still conservative.

Whether these measures are enough to weather the economic storms, natural disasters and terrorist activities remains to be seen. The industry is typically optimistic. The independent agent, however, continues to walk a tightrope between clients who demand a "close to perfect" recommendation, an industry that is reeling from some major restructuring, aggressive competition and regulators who seem to have their own agenda. Through it all, no one has decided on a uniform system to determine safety and solvency and what role the agent will play. Any practicing agent should obviously stay close to this developing arena since you could be held responsible for recommending an insurer who later fails.

What Can We Expect In The Years Ahead

During the last half of the 1980s industry failures filled the spotlight. During the 90's, poor profitability due to severe price competition and continued underwriting losses became the problem. For the new millennium, other problems in the industry have been brought to surface like deceptive sales practices, misleading illustrations, national health care, asset risks, the adequacy of the state guaranty system, private rating service deficiencies and certain industry tactics used to "shore up" balance sheets.

This negative exposure accelerated political investigations which have and will continue to result in new regulatory pressures. In addition, new troubles from major growth in class-action filings are disturbing. For the meantime, most insurers have been fairly successful in stabilizing their financials (particularly capital surplus) through aggressive cost containments and the "bulk sale" of selected assets.

Some experts believe that company managers are overcompensating, building surplus beyond reasonable levels in response to new or proposed risk based capital rules. While this will help companies meet new regulatory quotas, future earnings will decline, as potentially profitable acquisitions are by passed and the development of new product lines is placed on the back burner.

Some believe, in the long run, insurers will be legislated out of their ability to make any investment risks. Since investment profits play a major role in surplus, this could leave the industry at a major disadvantage to cover future liquidity problems. A major turn of events or more catastrophic hurricanes or floods could again push many insurers over the brink.

Further, the insurance industry position as a major source of capital for real estate and bond markets will be diminished or lost. The convergence of financial markets and the enactment of the Graham-Leach-Bliley Act (GLBA) in 1999 ushered in another phase in the evolution of insurance markets and their regulation.

GLBA significantly eased Depression-era financial regulations (the Glass-Steagall Act of 1933) that hampered the ability of banks and other financial institutions to provide a full range of financial services that crossed artificial organizational barriers. The new law permits financial services companies to merge and engage in new business activities and the cross selling of financial services and products, while attempting to address the regulatory issues raised by such combinations. Insurance and non-insurance financial entities are developing and implementing various strategies in reallocating capital and serving consumers in an environment where an array of financial products compete as substitutes or are marketed as complements.

Future Operational Changes

The biggest challenge facing insurance companies is how to balance profits and solvency. The industry is entering a period of higher regulatory action and reaction. But what standards will they have to meet and who will regulate them? Further, will complying with new surplus and investment standards jeopardize an insurer's ability to satisfy shareholders and meet its own financial goals? These questions will probably not be answered for many years. In the meantime, insurance companies will likely be taking a double books approach of testing for regulatory reporting on one side, while the other side is testing for investment strategies and new products. Blending the two together will not be easy. While insurers have improved their monitoring of cash flows and asset/liability matching, the danger of interest rate fluctuations is now a substantial risk. If rates edge upward, carriers risk disintermediation, or a major outflow of funds, if they are unable to keep pace with consumer demands for higher rates.

A concern shared by industry groups is that this condition, or additional casualty catastrophes (hurricanes, floods, earthquakes, terrorist activities) might strain carriers beyond their resources. And, even though their liquidity level may be higher, under risk based capital rules where future investment returns might be less, there will not be large "profit pools" to draw on for contingencies and as emergency claim funds. As a result, insurers may be forced to raise mortality and/or premium rates at a time when the forces of competition, regulatory pressures and consumer demand can least tolerate it.

Aside from slim profit margins, other factors which could influence future solvency include changing demographics which have reduced the demand for life insurance; increased competition for savings dollars / insurance products from the banking and mutual fund industry and the ever present threat of potential loss of insurance tax advantaged status. On the casualty side, the industry is still suffering from past baggage in the form of liability suits and environmental claims (asbestos, toxic, etc). And, of course, no one knows what mother nature is likely to dish out.

Convergence

Another concern for the industry is the ever-advancing insurance conglomerate. For a variety of reasons, there is still an "urge to converge" in the insurance industry that can effect the ultimate solvency of the company you choose for your clients. Why do insurers merge with banks, security dealers? Insurance companies buy or merge to expand their financial base, take advantage of cross-selling opportunities and better serve customers. For many, the ability to gain access to a broader customer base is now crucial to their survival. A recent stimulus for the trend to re-appear is the passage of the Gramm-Leach-Bliley Act.

The new law enables financial service companies to establish holding companies that provide banking, brokerage and insurance services to their customers. There are several ways for this to happen:

- Insurers can acquire a bank or securities firms through a merger or acquisition.
- Insurers can establish partnerships and technology links with banks.
- Insurers can seek federal charters to offer their own banking products.

What could go wrong with a merged company? Nothing or a lot. However, it is well known that intragroup activities have become something of a concern within the US insurance industry, mainly because of the risk of exposure. This can occur even though off balance sheet transactions and guarantees have to be disclosed in an annual statement files with state insurance departments.

What can agents do about this? There is nothing you can do about a merger. However, since it is your duty to place business with reliable, safe companies, you should do everything possible to assess the solvency of insurance carriers prior to contracting for your client.

Safety Analysis Tools

As an insurance agent, it may unreasonable to expect you to analyze with high accuracy the true financial status of your carriers. Studies prove that in virtually all cases of failed companies, a direct correlation existed between the failure and financial strength ratings and / or certain benchmarks. Agents and regulators should have seen it coming and reacted sooner.

The regulators and rating companies who "missed the mark" simply backtracked. They re-invented their procedures and went on with their lives. Agents accused of the same mistake, however, might face a different scenario: loss of major clients and potential litigation. For some agents, this is a devastating prospect; for others, it is just another day.

If you are not concerned with the ethical reasons to practice solvency conduct for your client, consider that you have a legal obligation to "exercise reasonable care, skill and judgment in procuring insurance".

What is reasonable care? "If for some reason, the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss". This language is only a steps away from you being responsible for spotting troubled insurers.

Follow the preferred practice of assessing the solvency of potential carriers. Above all, if you discover or confirm something is wrong, the last thing you would want to do is continue promoting the company to clients. If it sounds like we are stating the obvious, take note: during the substantial failure rate of the 1980's, word on the street commonly fingered several prominent insurers as potential problem carriers. However, with higher commission structures and client bonus incentives, these companies had no problem attracting premium business in the hundreds of millions. Agents truly backed the failure and opened themselves and their clients to potential solvency exposures.

Ratings and Agents

Agents can easily be lulled into believing that placing business with an A-rated or better company is sufficient to stay out of trouble. Unfortunately, some in the industry are of the opinion that even well-rated companies are at risk of failing. If so, your clients and their attorneys may attempt to hold you responsible.

You might be asking what you are supposed to do: After all, if regulators and rating agencies with all their resources can't predict a solvency how can an independent agent or producer be expected to know? Isn't reliance on an authoritative third-party rating agency sufficient due diligence?

History has proven that a high rating is not a guarantee of anything other than the fact that at the time the ratings occurred, a particular company is more solid than another. And, this fact can change rapidly as it did in the late 1980's when even A+ company balance sheets deteriorated within a matter of months. The decline was not just a drop in ratings; for some companies it was a drop to liquidation. Also, rating agencies, as you will soon see, have created complicated systems of classification with many qualitative and quantitative measurements. This makes a complete explanation of their criteria almost impossible and it is why virtually all rating companies include disclaimers in their analysis.

In general, a higher rating can mean a lower probability of failure compared to insurers that are not rated as well. Again, however, there are no guarantees. You can advise your clients that the company is licensed in the state to conduct business and that the company and industry-accepted rating services suggest it is in good financial standing; however, you are not a guarantor of its future financial condition.

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

Another misconception by agents is that the use of one rating service is sufficient to determine an insurers financial condition. In fact, you would be encouraged to consult the ratings of at least three services. If the rating of your company by all three is consistent, there is some agreement among the raters on the financial condition of your company. However, if the ratings vary widely, this might be a signal that there are factors for concern.

Company Ratings

The activities of insurance company rating agencies have become increasingly prominent with the industry's financial difficulties and any well-publicized failures of several large insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policy holders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business. Even the rumor of a downgrade may precipitate a run on the bank, as in the case of Mutual Benefit years ago, and seriously exacerbate an insurer's financial problems.

There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s.

Questions have been raised about the motivations and methods of the raters in light of the sensitivity surrounding an insurers' financial conditions and what some perceive to be a rash of arbitrary downgrades. On the one hand, insurer ratings historically have been criticized for being inflated or overly positive. On the other side, there are concerns that raters, in an effort to regain credibility, have lowered their ratings arbitrarily in reaction to declines in the bond and real estate markets and the resulting insurer failures and diminished consumer confidence.

Of particular concern to some regulators and the industry are the practices of Weiss Research and Standard & Poor's (S&P) publications of qualified solvency ratings. Both the Weiss "safety" ratings and the S&P "qualified solvency" ratings are based on a strictly quantitative analysis of financial data. While there has been a concern about inflated ratings historically, Weiss has been criticized for marketing bad news to consumers, i.e. ratings that are skewed to the negative.

S&P's qualified solvency ratings also have been criticized for utilizing a scale that appears to be lower than their claims paying ability ratings. Some have accused S&P of using the qualified solvency ratings to "extort" insurers to pay a \$22,000 - \$28,000 fee to obtain a higher claims paying ability rating. S&P strongly denies these allegations and believes that consumers and agents properly understand the meaning of the qualified solvency ratings.

Both S&P and Weiss contend that their quantitative ratings provide valuable, unbiased information to consumers. The influence of the rating agencies and the practices of Weiss and S&P have prompted some regulators and insurers to suggest that the states and others should limit access to their database, which is utilized by these raters. There also have been calls for regulators and the NAIC to evaluate and certify rating agencies to ensure that their methods and practices meet certain established standards. However, other regulators have questioned whether it is appropriate and practical for regulators to withhold data or regulate rating agencies.

The regulators suggest that a more appropriate regulatory role is to improve consumers' understanding of the rating process and allow them to decide how to use the information raters provide. This discussion of the rating agencies presents certain factual information relating to the structure and activities of the five most prominent rating agencies: A.M. Best, Standard & Poor's, Moody's, Duff and Phelps and Weiss Research.

The philosophy, scope, fees, resources, process, methodology and classification scheme of each of these agencies is described below. While issues relating to certain practices of the raters are discussed, this is not an attempt to evaluate the validity of the raters' methods or practices.

Remember, an insurer failure may render you liable for losses or at least a target for expensive litigation. Therefore, it is reasonable that you should take steps to avoid this by becoming a student of insurance company ratings, regulations and benchmarks.