Agent Survival Handbook

What Every Agent Must Know to Survive in Today's Marketplace

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INTRODUCTION

The line between legal responsibility and agent misconduct is often thin. Few agents can say they have never “crossed the line”, went out on a limb for a client, looked the other way or fudged just a little when selling or serving a client.

These indiscretions, hopefully tiny and few in number, usually lead to nothing. But when something goes wrong an agent’s biggest fear comes true – *a malpractice lawsuit.*

Anyone involved in a lawsuit will tell you it’s a living nightmare. Beyond the financial liability, victims are dragged, kicked and punched through the legal maze known as our “justice system”. It is the domain of judges, attorneys and plaintiffs, a place no one no one cares to revisit.

If you think this cannot happen to you, you should know that almost 15% of the agent population is sued each year, with nearly three-fourths of these claims being “frivolous.” The longer you stay in the business and the more expertise you develop, the bigger the target you become. The threat to your practice becomes greater over time.

The reason this threat is greater now than ever before is a matter of public record. Insurance companies are fighting back, standing firm, and taking plaintiffs to trial. As a result, attorneys are looking for suits with less resistance.

In the case of insurance conflicts, can you think of anyone these attorneys might pursue who might be easier to get at than a major insurance company? Someone who does not have staff attorneys, with little time to spare and without a deep pocket.

Are there individuals who might settle (much easier than a big insurer) to avoid a long and protracted trial? If you haven’t guessed by now, it’s you. You could be the next victim of a clever attorney looking to cash-in on a quick settlement when something goes slightly astray with your client’s coverage.

You can protect yourself through education. This text will show you that the root of most agent conflicts lies in the inability to understand statutory and fiduciary duties.

When you know what is expected of you, proper legal and sales conduct legal and sales conduct can be followed and conflicts minimized. The end result is less liability risk to you and your practice.

AGENT/BROKER LIABILITY

Today’s agent deals with stiff competition, fast-paced decisions and some very unpredictable insurance markets. To aggravate this condition, we live in an era where courts are very sympathetic to consumers. People feel entitled to seek complete and generous compensation for the smallest problems, even when they are contributors or the discovered source.

Furthermore, the consumer of our time has lost all respect for the status of the professional, any professional. This includes doctors, lawyers, teachers, clergy, real estate brokers, stockbrokers and

insurance agents. Few would think twice about suing any one of these professionals to receive satisfaction for an honest mistake, let alone one leading to a financial loss or injury.

Understanding this, it is easy to see that the selling of insurance can lead to conflicts and legal disputes. When an insurance agent and his client cannot resolve differences, agent liability can result, even when the agent is right. In fact, about 75 percent of all insurance malpractice claims are frivolous, and while an agent may never pay any damages from these claims the process of responding is very costly, both in money and lost production.

Claims against you may surface as a result of events that occur before or after before or after a policy is issued, and they may involve you and a client, your insurer or a third party who is an intended beneficiary. Cases can be built around issues of legal conduct as well as sales conduct.

Throughout this text you will learn the “triggers” that launch insurance related lawsuits. They can be as basic as failure to secure the type or amount of coverage requested by the client to more complex and seemingly "blue sky" claims where clients demand to recoup losses and damages simply because of a relationship that existed between agent and client.

Other claims span the gamut from client losses due to an insurance company failure to refusal to pay a claim. Sometimes, an agent’s liability is the result of simply being too busy to witness a signature or too rushed when entering a policy premium payment – small mistakes.

Of course, a single incorrect digit or a blank you forgot to complete can mean the difference between a policy being “in force” and a policy being cancelled or a claim being denied.

Agents who have never been sued are sometimes lulled into believing that the way they do business must be working. Unfortunately, this ignores the real possibility that the same events of the past, that weren’t a problem, can now become a problem. It is a world of legal rights and little trust. The long-term client whom you trusted, can change. Also, regulations change, industries change, economies change and no one can really keep up or control every aspect of their present business, let alone the future.

- Can you imagine, for example, the changes that will occur over the life span of a whole life policy between today and when it matures in fifty or sixty years (or worse yet collapses)?
- Will a state or federal regulation change the way automobile or health policy benefits are triggered?
- Will the IRS retroactively disallow tax benefits for a an annuity contract or single premium policy you sold three years ago?

No one knows the answers to all these questions, but it should be clear by now that as an insurance agent you are prone to errors, some beyond your control. As a business person, you need to accept the fact that your business carries risk. Then, you need to find ways to manage and plan for these risks to minimize the fallout when a claim occurs.

You can try to avoid conflicts, make friends with your clients, buy errors and omissions insurance, incorporate and practice other means of asset protection, but you will always be at risk for the one problem that seems to “fall through the cracks” and rear its ugly head at your doorstep. You have to plan for that day now.

AGENT LIABILITY – DUTIES &STATUS

The most critical questions in determining agent liability is the extent to which accepted legal standards, state licensing and agency status obligates the agent. This process involves the investigation of many areas, including:

- basic agent duties,
- the law of agency,
- producer's status (relationship to the client/insurer) and
- the classification of the producer as agent/broker or agent/professional.

Basic Agent Duties

The agent/broker generally assumes duties normally found in any agency relationship.

The primary obligation here is to select a company and coverage and bind the coverage (if the agent has binding authority, e.g. property/casualty agents). However, since clients typically request coverage, the basic duty may expand to include the agent deciding whether the requested coverage is available and whether the insured qualifies for it.

The mere existence of an agency relationship, or the simple selling of insurance, imposes no duty on the agent/broker to advise the insured on specific insurance matters.

Duty also does not require the broker/agent to secure complete insurance protection against any conceivable loss the insured might incur, but there may be a duty to explain policy options that are widely available at a reasonable cost.

An agent’s duty to provide correct coverage is not triggered by a client’s request for “full coverage” because that request is not a specific inquiry about a specific type of coverage. In other words, just because a client asks for full coverage an agent may not be liable to provide it. However, if a client requests a specific type of coverage, the agent is responsible to see if it is available and determine if the client qualifies.

An insured is also entitled to rely on an agent/broker’s advice on the meaning of policy provisions. However, a client’s reliance may be unjustified when the advice given by the agent “is in patent conflict with the terms of the policy”.

It is a clear legal responsibility of agents to understand the difference between two products that he is attempting to sell. Whether an agent has an affirmative duty to inform a client of possible gaps in coverage depends on the relationship of the parties, specific requests of the client and the professional judgment of the agent.

Once a policy is issued, traditionally theories of legal conduct provide that an agent does not have the duty to ferret out, at regular intervals, information which brings the policyholder within provisions of a policy. In essence, it seems the courts have been more concerned about general agent duties to inform clients of appropriate coverage at the time of sale.

Recent departures from this theory includes a case where an agent was found liable for failing to determine that the insurance policy was no longer needed by the client. In another example, an agent assured his client that the limits of the policy continued to meet his needs when they actually fell short (i.e., agent duties may also include informing clients their coverage is appropriate after the sale).

Although each case stands on its own, the underlying determinant of "after sale" duty may be the "special relationship" that exists between client and agent (e.g. an agent handling the client's business for an extended period of time may assume a higher standard of care).

These are the basic agent responsibilities. Agents are not precluded from assuming additional responsibility, which they normally do in most client transactions. When a lawsuit arises, however, it is the client's burden to show that greater duty is the result of an express or implied agreement between agent and client where the agent has taken more responsibility. In most instances, the facts of the particular case determine whether the court finds a greater duty has been assumed.

THE LAW OF AGENCY

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

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

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

General Agents

The general agent assumes many responsibilities, greater liability and usually incurs higher business expenses. As a result, they are typically paid the highest commissions.

In the property/casualty field, many sales agents with general agent contracts do not serve all the functions of a general agent but are important enough to their insurers to receive general agent commissions.
In all lines of insurance, general agency contracts, or similar classifications, are frequently awarded as a competitive device to obtain or retain a particularly outstanding agent or firm.

Local Agents

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

The local agent is principally a sales representative of the insurer who acquires business and counsels clients.

Brokers

Theoretically, brokers are agents of insurance buyers and not of insurers. Their job is to seek the best possible coverage for clients. This is can be accomplished in a direct manner with the broker acting as salesperson or through a network of agent contacts. Premiums paid by clients include the cost of commission paid to the broker by the insurance company, so the client indirectly pays the commissions of both the broker and agent.

In the liability/casualty area, some brokers maintain a loss-control staff to help counsel clients on safety and prevention matters thereby aiding clients to secure a lower premium. In a sense, these brokerage firms act as insurance and risk managers.

Surplus Brokers / Agents

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

Solicitors

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

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

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

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

Insurance Producer Status

When marketing insurance, the agent may assume the character of a mere sales representative or the specified agent of the client. As mentioned earlier, agents generally start out representing the client who requests coverage and then become the agent for the company when business is placed. Other than brokers, agents rarely retain principal status throughout a transaction.

When a dispute occurs and a producer's status cannot easily be determined the courts usually rule in the direction of agency relationship. This bias is commonplace for two reasons:

1. It is easy to establish that an agent is representing his insurance company since there is typically a pre-existing, written agency contract between the parties (the agent and the insurer). This relationship is distinguished from a principal- agent relationship where the client requests that the agent accomplish a specific result (such as "Buy $150,000 of coverage from XYZ Company").
2. Holding a producer to be a true principal could block many claims a client might have against the "deep pockets" of the insurance company. If the insurance company was not made part of the claim, the client's only recourse would be the resources of the agent which are likely to be a lot less than the insurer.

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

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

Of course, a written disclosure agreement indicating that the agent was a representative of the insurance company, acting as principal or not disclosing the principal for a specific reason would go a long way to clarify that the status between the agent and client, or agent and company. In commercial insurance transactions, agents go to great lengths to "clear the air" concerning agent status by using

a broker of record letter. These letters authorize or terminate agency and stand as proof of evidence that an agent is representing the client/principal or “out of the loop”.

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

Producer status problems also occur when unlicensed employees of the agent are found to be doing the work of a licensee. A small mistake here can become a big deal. You can be held responsible for any claim or shortfall and it will likely void your errors and omission coverage. Insurance department sanctions, fines and possible revocation of license could also follow.

Agent vs. Broker

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

- An agent is legally defined as "a person authorized by and on behalf of an insurer, to transact insurance". Agents must be licensed by the state and typically require a notice of appointment be executed. This document appoints the licensed applicant as an agent of that insurer in that state. Thus, an insurance agent is the agent of the insurer, not the insured (client). Of course, an insurance agent may be the appointed agent of more than one insurer.
- An insurance broker is "a person who, for compensation on behalf of another person, transacts insurance, other than life with, but not on behalf of, an insurer". Brokers must be licensed through most states and are not prohibited from holding an insurance agents license as well. A broker who is also a licensed agent is deemed to be acting as the insurer's agent in the transaction of insurance placed with any insurer who has a valid notice of appointment on file.

Basically, an insurance broker is an independent business or business person that procures insurance coverage for clients. Brokers generally receive commissions from the insurer once coverage is actually placed, and except when collecting premiums or delivering the policy, is the agent of the insured for all matters connected with obtaining insurance coverage, including negotiation and placement of the insurance. Typically, brokers are insurance professionals who maintain relationships with several insurers but are not appointed agents of any of them.

The purpose of determining whether the insurance producer was acting as a broker or as the insurer’s agent when an insurance contract was placed helps establish the theories of liability that the client may plead and what defenses the agent or his insurer may raise. In many court cases, it is not clear whether the producer was acting as a broker or an agent. So, attorneys typically plead their

case under the banner of each status thereby plucking the feathers of the agent and the “deep pockets” of the insurance company at the same time.

Agents should be prepared to prove or disprove legal status at any given time. Under basic liability theory, a client and his attorney may find it quite difficult to seek recovery from a producer acting only as an agent. Traditional agency law in most states concludes that the insurance agent, acting as agent of the insurer, owes duties primarily to the insurer. Of course, this assumes that the agent performed in the ordinary course of his or her duties as agreed between the agent and insurer per terms of the agency contract.

Where an agent is acting properly, a person wronged by an agent's negligence has a cause of action against the principal or insurance company, although this does not preclude clients from naming the producing agent also. Another general rule of agency law states that if an insurance agent acts as the agent of a disclosed principal, the principal (not the agent) is liable to the client.

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

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

Agent vs. Professional

Despite rules which seem to offer reasonable protection of the agent producer, it should be made clear that agent wrongdoing outside the agency contract and other torts, will subject the agent to additional liability exposure.

Consider the dual agency and the liability it creates. Dual agency also occurs when an agent assumes non-agency duties by agreement or simply by professing to have special expertise. A slogan on a business card, letterhead or company brochure may have sufficient information to establish you as an agent and an expert in the eyes of the law.

When dual agencies such as these exist, the agent may be held liable for a breach of fiduciary duties owed directly to clients and, perhaps, contract and statute duties to the insurer.

It is clear that activities beyond the scope of an agency contract can be dangerous to your financial health. If you go there you need to proceed cautiously. This is not an indictment of any agent who seeks to improve his practice by becoming a true insurance professional, complete with degrees and designations. The existence of these honors, by themselves, are not the problem nor a target. Rather, it is the agent who, regardless of his degrees or credentials, professes to be an expert but fails to deliver.

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

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

CONFLICTS THROUGH CONTRACT DISPUTES

Regardless of producer status, agent or broker, disputes develop where terms of an insurance contract are violated or promises are not kept. Producers can be liable under two principles:

1. The existence of an insurance contract or principal-agent agreement or an implied agreement
2. The breach of contract or non-fulfillment. A violation of contract terms is fairly clear-cut. Primary breach of contract, however, can surface under any of the following headings:

Failure to Act/Procure Coverage

This is one of the most important areas of agent/broker liability because an estimated 60 percent of all claims result from agent malpractice in failing to procure coverage. In a typical transaction, a broker or agent agrees to procure a certain type of coverage for an insured. It is well established that the broker has a duty to exercise reasonable care in procuring that coverage.

In general, when an agent negligently fails obtain coverage for a client, he steps in the shoes of the insurance company and becomes liable for loss or damage the limits of the policy until insurance is found. Liability may also be held to result from an agreement to procure a desired coverage at the lowest obtainable premium rate.

Failure to Notify Lack of Coverage

Agents/brokers can also be liable for silence or inaction, as in an agent’s failure to reasonably notify the applicant that the he is unable to obtain insurance. The key here is “how long” a delay is normal before informing the client. The courts have not established any parameters other than what is reasonable. In one case, this meant 2 days, in another four weeks. The best advice is to keep clients fully and continually informed.

Failure to Place Coverage At Best Available Terms

As part of the duty to exercise good faith, reasonable skill, and ordinary due diligence in procuring insurance, a broker has a higher duty than agents to be informed of the different insurers and policy terms and to place coverage at the best available terms. If other brokers working in the same market knew that better terms were readily available, the broker who failed to obtain these terms for the client could be liable for the client's loss. In one case, the broker failed to obtain "coinsurance" clauses that

were commonly available and carried a lower premium. This must be distinguished from cases proving that the broker does not have an absolute duty to obtain the lowest possible rate.

Failure to Renew

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

Policy Promises & Provisions

Agents should always review client policies and retain "specimen policies" on file to answer prospect/client questions and compare with policies received. In most states, agents are legally bound to accurately describe the provisions of policies they procure for their clients and point out the difference between different products he is selling.

Many lawsuits have been pursued on misunderstood policy time limits that restricted the client’s ability to perform or file a claim. Agents can easily become a focus of these disputes. Another misinterpretation might be in defining policy terms (e.g. what is an "accident" defined to be?).

Some agents might be taught not to volunteer information on an issue such as this. But, insurers and agents have a fiduciary duty to their insured clients to disclose full and complete information. Failure to do so may result in a claim of fraud.

Agent Promises

From time to time, agents make promises that exceed what the actual policy promises. Obvious violations would be intentional or unintentional misquoting of policy limits, specified coverage and exclusions. Agent liability also existed in a case where a producer promised to arrange "complete insurance protection" for a business or where an agent promised (but failed) to evaluate an appraisal of an individual's property to determine its "insurable value".

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

Advertising Promises

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

By contract, agents are required to secure company approval of all advertising. Few agents, however, would think twice about scrutinizing company provided ads. However, it is suggested that agents

carefully review advertising provided by the insurer to make sure it honestly reflects the promises of the policy.

Violations that result in claims would probably not be actionable against the agent, but may name the agent nonetheless or may establish some form of "alleged" agreement that binds the agent / insurer.

What Policies Say versus What They Mean

No matter how clear the language, all policies will contain areas of ambiguity. The universal rule of policy ambiguity, generally upheld by most state courts, goes something like this:

"If the policy could imply to a reasonable or average policy holder that coverage is in force, yet that exact language does not exist in the policy, then coverage does extend to the policy holder."

Agents may easily be involved in claims resulting from contract ambiguity.

Client Understanding and Reading of Policies

In days gone by, courts required people to be accountable for their actions. Clients were required to live up to the terms and conditions of a policy even though they did not read them or fully understand what they read. Agents have been cleared in many policy conflicts simply by pointing out the applicable clause or meaning.

Consumer groups kicked and screamed and pushed for simplified wording. Today, policies are indeed more user friendly and the courts are still sympathetic to consumer confusion about their policies. Now, policy conflicts are determined by whether it was reasonable for a certain client to have read his policy and/or understand its meaning. The decision can be based on how simple or complex the policy is written or the client's level of sophistication.

Minimum Standards

Courts have upheld that even though a policy does not promise to expressly act in good faith and fair dealings, it is the minimum that policy holders can expect. Agents owe a duty of good faith and fair dealings to their clients and their insurer.

CONFLICTS CREATED BY AGENT TORTS

In an action against an agent or broker, the plaintiff's (client's) attorney rarely distinguishes between contract and tort wrongdoings. Both are routinely pleaded. In the case of tort action, agents can be pursued on two fronts:

1. Applicable professional standards
2. The broker/agent's acts or omissions that do not meet these standards

Who decides what these standards are? In most court cases, the plaintiff's attorney will arrange for "expert testimony" by an agent or broker working in the same field. The fundamental issue is whether the accused broker's professional judgment and methods were appropriately exercised in line with acceptable standards.

Following are some important areas of agent wrongdoing (torts) considered to be outside acceptable standards:

Negligence & Misrepresentation

Agents and brokers can be liable for failure to procure the requested coverage. Examples include:

- An agent promises to procure "complete" business premises liability coverage and represents that a policy he procured afforded the desired protection when, in fact, it omitted coverage for a freight elevator occasionally used to transport.
- An agent was negligent in failing to advise fire insurance coverage on a leasehold made known him by the client in advance.
- An agent negligently obtained non-owner motor vehicle liability coverage for a client knowing it would not provide the coverage desired.
- An agent negligently obtained a policy with smaller limits of coverage than had been agreed upon.
- An agent notified the client that the original insurer was insolvent and that a replacement policy would be needed. The broker replaced this policy with a new policy having less coverage. The broker was held personally liable for $150,000 because of the gap between the insured's primary and excess coverage.
- A lending institution that was licensed to sell credit life insurance failed to offer it to a client who later died.
- An agent represented that $150,000 of life insurance, where premiums were so high that they had to be bank financed, was a suitable plan for an individual earning less than $10,000 per year knowing that it was not suitable.
- Another case of misrepresentation involved an application of life insurance with critical blanks (missing information). The deceased’s widow held that the agent told her husband that the missing information did not need to be disclosed on the application.

Bad Faith

The insurance agent runs a great risk of personal liability in the event that he is less than fair or reasonable when dealing with either a client or claimant. Bad faith actions and violations of various statutes, such as the Unfair Claims Practice Act, are considered a breach of the implied duty agents have to deal with clients in complete good faith.

Agent liability may accrue due to unfair conduct by agents or allegations of fraud, deceit, misrepresentation or the statutes dealing with unfair settlement practices (where the agent is acting as a claims representative for the insurance company or in his individual capacity, independent of the agency).
Agents must remember that the number one reason that people purchase insurance policies through agents is for service. When an insured makes a request to procure coverage or turns in a claim, he is not bargaining for promises, but rather action.

Additionally, the insured is under the assumption that, due to his prudence in securing insurance in the first place, he will have peace of mind in knowing that he is being protected by the insurance company.

Any breaches of this reasonable expectation will usually subject the insurance company and the agent to the exposure of insurance bad faith practices and a breach of the fiduciary duties owed to the insured. Licenses have been revoked for misrepresenting benefits of policies and entering false medical information on an application or in the making of false and fraudulent representations about the total cash that would be available from a policy.

In the property/casualty arena, many bad faith issues surface under the title of "claim avoidance". Some agents play judge and jury with client claims by advising them to not submit a claim since it would be cheaper to repair the vehicle or property or pay his own medical bills rather than incur potential insurance rate increases or even cancellation. Such conduct will expose agents to a breach of his fiduciary duty to the insured as well as a breach of the implied in- law covenant of good faith and fair dealings. It may also be a breach of the unfair claims practices act in some states. This kind of agent deception even justifies potential punitive damages.

CONFLICTS CREATED BY CLIENT/AGENT RELATIONSHIPS

The insurance agent/broker is increasingly regarded as a professional whom clients turn to for advice and guidance in insurance matters. In some states, the insured's pattern of reliance on the broker's advice has been the basis for a higher standard of duty. Relationship liability generally occurs on two fronts:

1. Contributory and
2. Agents as Fiduciary

Contributory Liability

When an agent holds himself out to be an "expert", a "specialist" or a "professional", he is creating contributory liability and may be held to higher than normal standards or standards beyond the disciplines of insurance. The earning of credentials or designations further compounds the agent's exposure, since he is considered, in the eyes of the law, to be subject to a higher standard of knowledge and responsibility.

Yet, faced with stiffer competition, agents are somewhat compelled to upgrade their image by creating marketing "niche" expertise with titles, credentials and job descriptions like: financial planner, estate planner, retirement planner, "one-stop" insurance agency, loss control consultant, etc.

Contributory liability relationships have also been cast simply because an agent has always handled a client’s business over the years, so much so, that clients have blindly depended on their advice. The result of these "titles" and "agent trust" is a higher level of culpability. In fact, plaintiff attorneys have and continue to develop legal strategies that establish contributory liability of agents by multiple approaches, including:

Lack of Client Knowledge

The insurance purchaser usually is not versed in the intricacies of the insurance business. Prospective insured’s seek the assistance of the insurance "specialist" and come to rely on his knowledge. In some cases, the reliance on the agent is total and complete.

When the agent procures coverage that turns out to be defective in some way or fails to make arrangements, the applicant should have a cause of action against the agent. This takes on more meaning today as agents and brokers have increasingly promoted their “professional expertise” in serving the public's insurance needs.

Improper Advertising

Advertising has clearly affected the importance and desirability of acquiring insurance, especially where the agent claims to have substantial or special expertise that can be used to guide the consumer. Advertising has lead clients to have reasonable expectations, true or not, that these agents are independent business entrepreneurs and, in some instances, are capable of expertise in a wide variety of business areas (e.g. financial planners, health specialists, catastrophe experts, business continuation consultants, etc.).

Dual Agency

In many insurance transactions, the agent can generally be shown to have acted as a "dual agent" – representing both the insurer and client. As such, he owes a duty to exercise due care and reasonable diligence in the pursuit of the client's insurance business regardless of the insurer chosen or represented by the agent.

Errors & Omissions Insurance

The availability and wide subscription of errors and omissions insurance for agents creates an argument that agents can be liability targets in any insurance disputes. In some cases, the absence of errors and omissions coverage has practically absolved the agent of liability where attorneys assume there is nothing to go after. But, who wants to risk going bare in this market?

Client / Agent Interaction

There is a lot of discussion about building solid relationships with clients. Considerable study has been done on customer satisfaction and the close association that develops with agents who are responsive to customer questions, explain policies well and are able “get it right” the first time.

Agents as Fiduciaries

New legal theories are continually attempting to establish an agent selling an insurance contract as a principal fiduciary and therefore a probable "deep pocket". A fiduciary is defined as someone who is held in trust or complete confidence. Compared to an agent’s contractual duty, which requires negligence or tort action, fiduciary duty is intrinsic to his business. In other words, an agent’s liability as a fiduciary simply comes with the territory.
In recent years, cases of fiduciary duty are more prevalent. The most obvious fiduciary responsibility of agents is to protect and safeguard client monies. Other fiduciary related liabilities relate to an agent’s duty of care. These cases even rear-up in a one-time business transaction (e.g. you do not have to be a longstanding advisor to be liable).

More often than not, the issue of fiduciary exposure surfaces where an agent proposes a “full coverage” policy but failed to describe a certain provision or exclusion that existed in the written

policy. In addition, fiduciary problems are launched by special agent relationships where the insurance contract is established as a collateral issue of some greater purpose such as an insurance agent claim to have special “expertise” where the client is unsophisticated, or when an agent promises to provide "complete coverage."

The exposure also seems to exist where the agent is the "exclusive" insurance provider for clients or in cases where the client, over time has come to be totally dependent on insurance decisions made by the producer.

Employment Retirement Income Security Act (ERISA)

Many life agents help clients establish and fund retirement plans using insurance products. Under ERISA, a plan must designate a fiduciary to administer its operation. An ERISA fiduciary has been interpreted to be any person exercising managerial control over the plan or any person exercising managerial control over the plan or its assets, regardless of their formal titles.

In recent years, the U.S. Labor Department, the federal agency that administers ERISA, has become more aggressive in reviewing insurance funded plans and the link to agents as fiduciaries. It is even proposed that agents and brokers be labeled ERISA fiduciaries simply by how they advertise and market their retirement plan services.

In the past, it was typically the owner of the business, the board of directors or a specifically assigned fund manager that was considered the principal fiduciary. ERISA imposes a variety of duties on fiduciaries of life, health and retirement benefit plans, including a duty to act for the exclusive benefit of plan participants and beneficiaries.

The act also establishes prohibited transaction rules governing plan fiduciaries that would disallow, for example, a fiduciary receiving personal benefit from a third party dealing with the plan. Does this mean that a commissioned agent who helps establish a retirement plan and recommends products to fund the plan violates these rules? The answer lies in whether the agent is actually deemed a fiduciary.

If the agent arranges to receive a fee for consulting on the pension plan, he is clearly a fiduciary. If the agent has an ongoing relationship with trustees of a plan who regularly accept the agent's proposals without advice from other consultants, he can be classed as a fiduciary of the plan. On the other hand, where the agent is only acting in the capacity of an agent, offering a choice of products from which choose, and as a member of a team of plan consultants, he is less likely to be classed as a fiduciary.

To summarize, ERISA fiduciary status may be established where the trustees of a retirement plan "relied" heavily on the agent's advice in the purchase of insurance contracts. Examples include:

- An agent was found liable for unsound insurance purchases because the plan trustees relied on his advice.
- An agent was found liable as a fiduciary when insurance transactions absorbed the majority of the fund's assets. In addition, the agent failed to disclose his compensation or relationship with the insurer. Since the fund trustees were inexperienced in insurance matters and accepted every recommendation offered by the agent he was considered a fiduciary.

- An agent, as a courtesy, notified employees that their group term life coverage had lapsed shortly before their employer's death. But, he failed to forward the insurance company's routine offer to reinstate coverage and was found responsible.
- An agent was found to be a fiduciary of a profit sharing plan, even though he only sold a whole life policy in the plan's name. The policies later proved unsatisfactory from an investment and tax perspective. In support of their decision, the court stated that the primary purpose of a qualified retirement plan is provide retirement benefits. Here the court found that the plan had purchased life insurance on a plan participant in excess of the 50% (incidental benefit rule). Since the ERISA rule on incidental benefits had been violated and the life insurance agent had violated the rule, he was declared a fiduciary and seemingly responsible for the taxes, penalties and possible disqualification of the plan. In further implicating the agent, the court pointed to Boswell's (the agent's) strong relationship with the custodian bank, management of the company, its employees and the plan administrator, deciding that he was *"...clearly more than a mere salesman"*. (Reversed on appeal)

Medicaid Planning

Agents who routinely counsel clients on methods of transferring assets so as qualify for Medicaid benefits may be subject to fines and penalties under H.R. 3101 The Health Insurance Portability & Accountability Act of 1996 (Kassenbaum-Kennedy). Under this bill, if the transfer of assets results in a "period of ineligibility" both clients and agents could be subject to misdemeanor fines of between $10,000 and $25,000 per violation and/or one to five years in prison. (NOTE: This law was amended in 1997 to eliminate the client liability).

Many agents recommend that clients purchase annuities, previously "exempt" in calculating assets qualify for Medicaid. Under these new rules, if the payout of the annuity contract does not match the payout schedules established by the Department of Health (most don't) a disqualification of asset transfer and ineligibility period can be established. Look for future court cases here.

INSURER CLAIMS AGAINST AGENTS

When most agents ponder professional liability, they think client lawsuits. But agents and brokers also face exposure from the insurers they represent. When agents are sued by their insurer, it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty.

Between agent and principal, (the insurer), fiduciary duty of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions. Fiduciary responsibility is especially pronounced when the agent writes insurance for himself.

Beyond fiduciary matters, agents are bound to his insurer by other statutory duties.
They include:

- Duty of Care and Skill, using standard care and skill
- Duty of Good Conduct
- Duty To Give Information by communicating with the principle and clients
- Duty To Keep Accounts by keeping track of money
- Duty To Act as Authorized
- Duty To Be Practical not attempt the impossible

- Duty To Obey or comply with the principal's directions.

A violation of these duties can be considered grounds for termination and represent legal exposure for the agent. Following are some examples:

Basic Agency Violations

When an agency agreement exists between agent and insurer, the agent/broker has a duty to exercise reasonable care. The agent is considered a fiduciary of the insurer. He or she must exercise skill and diligence and is liable for negligence that induces the insurer to assume coverage on which it suffers a loss.

Brokers who have agency agreements with insurers have been found liable to the insurer for clerical mistakes – incorrect policy dates, erroneous limits of liability and omissions of endorsements.

Misappropriating Premiums

As representatives of the insurer, agents and brokers owe a fiduciary responsibility to the insurer to remit premiums collected from clients promptly or hold them in a trust account. In one case, the agent converted premiums for his own use, facing liability to the insurer and possible criminal charges for embezzlement.

Failure to Disclose Risk Factors

An agent has a duty of good faith and loyalty to his insurer and may be liable for negligently inducing the insurer to issue coverage on which it suffers a loss.

In one case, it was successfully argued that an insurer may obtain indemnity from a broker, if:

- The broker knows or should know that insurer is relying on the broker to supply information about the client
- The information furnished is incomplete or incorrect
- The incomplete or incorrect information is material to the decision to accept or decline the risk
- The insurer is forced to pay a loss under a policy that the insurer would not have issued if complete and accurate information had been provided by the broker.

In a similar case, the insurer sued its agent, alleging negligence for failing to notify the insurer of the exact nature of the insured's business when applying for business interruption coverage. The jury attributed 70 percent of the loss to the insurer and 30 percent to the agent's negligence.

Failure to Cancel or Notify of Cancellation

Agents do not normally have an obligation to the insurer with respect to canceling an insured's coverage. For example, if the policy is billed directly, the insurer usually notifies the insured directly of the insurer's intent to cancel and, thereafter, of the actual cancellation. The broker/agent is typically "out of the loop".

However, a broker who has undertaken responsibilities in canceling through agreement with the insured, owes the insurer a duty to follow the insurer's instructions promptly and correctly. For

example, an agent was accepted as the insurer's general agent for purposes of signing policies, issuing endorsements, etc. As the insurer's agent, the broker was instructed by the insurer obtain a flood and landslide endorsement from an insured. If the insured refused to accept such an endorsement, the agent was to notify the insurer who would cancel the policy. The broker failed to do either and was held liable to the insurer for the insured's flood damage. (For life or health insurance, think about the changed health status at time of policy delivery.)

Authority to Bind

An agent may be a general agent with general powers, or his powers may be limited by the insurer. Some agents are authorized to issue insurance contracts that bind the insurer, they have binding authority (typically casualty agents). Some agents may have binding authority only as to certain classes or lines of coverage.

Legally, the agent possesses the powers that have been conferred by the company or those powers that a third party has a right to assume he possesses under the circumstances of the case. In one instance, the agent exceeded his binding authority yet his acts and representations were relied upon by the insured. The agent was held liable for the insurers' losses.

Premium Financing Activities

Frequently, brokers play a role in helping clients finance their insurance premiums by bringing the insured and the financing entity together. There have been cases where the financing company has been the victim of fraudulent schemes misleading them into issuing loans to nonexistent insureds. In an effort to recover its losses, the financing entity may look to the insurer on grounds that the broker was acting on the insurer's behalf in arranging the financing, even though the insurer may not have given the agent explicit authority engage in premium financing activities.

In one case, an insurer was held liable for its agents actions in such a financing scheme because it was "implied" that the agent had been authorized to conduct premium financing. In a similar case, the court held that the insurer had not authorized its agent to engage in premium financing activities because nothing in the agency agreement referred to such activity. The agent was held liable.

Unfair Practices

Insurers may also lash out against agents under the National Association of Insurance Commissioners "Unfair Trade Practices Law" which many states have enacted. The thrust of this code is contained below:

"Persons (defined to include insurance companies and insurance agents) are prohibited in engaging in "unfair methods" of competition and deceptive acts and practices." Including, "making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance."

Under this act, it is conceivable that an insurer could commence litigation naming an agent where the company's insolvency was related agent "derogatory" actions.

Consider a case where agents were actively involved in the disintermediation or withdrawal of "blocks" of client policies after rating drops occurred. Ultimately, this "run on the bank" was deemed the single greatest issue (Mutual Benefit Life) contributing to the companies liquidation. Were agents exercising "due care" for clients or breaching their legal and "unfair practice" duties to their contracting company?

LIABILITY CREATED BY INSURER FAILURES

To date, few courts have held that insurance brokers or agents are liable for the losses that policy owners might suffer from an insurer insolvency. Be assured, however, agents continue to be sued and pursued for malpractice in this area, and there are countless legal theories being proposed to force accountability.

The basis for most tort actions where an insolvent insurance company is involved lie in certain cases and written code sections. At first glance, these regulations imply that agents are not responsible for involving a client with an insolvent company or a carrier that eventually is state liquidated. Here is how the law of liability is interpreted in most states:

"The general rule in the United States is that an insurance agent or broker is not a guarantor of the financial condition or solvency of the insurer from which he obtains coverage for a client."

In an actual case against a California agent, similar results accrued:

"An insurance broker has no duty to investigate the condition of an insurer that transacts business in California pursuant to a certificate of authority because the scheme of licensing and regulation of insurers administered by the Insurance Commissioner was sufficient for this purpose and could be relied upon by the broker when placing insurance."

Before an agent rejoices in knowing that laws of this nature are on the books, he must realize that regardless of this implied protection, court cases continue to be tried and a trend is developing that places greater legal responsibility on agents concerning insurer insolvency.

Note: If agent liability laws and codes represent a "safe harbor" and if agents are "untouchable", why do professional liability policies refuse to defend and refuse to indemnify agents where an insurer insolvency arises?

The legal caveat that "muddies the waters", relevant to agents and insurer failures, is the results of a 1971 lawsuit. It proclaimed the following:

"The agent or broker is required to exercise reasonable care, skill and judgment in procuring insurance, and a failure in this regard may render him or her liable for losses covered by the policy but not paid due to the insolvency of the insurer."

The questions is, what is "reasonable care"? In one case, the fact that the carrier was an admitted company proved to be adequate care. However, the courts have further clarified:

> *"If, for some reason, it is shown that the agent or broker knew, or should have known, that the insurer was insolvent at the time of placement, he or she may be liable for the loss caused by insolvency."*

In all these cases, the agents won, or prevailed on appeal. The reader should be aware, however, that in addition to the expense of lengthy trial a pattern is established.

To summarize, the burden of agent liability involving financially distressed insurance companies is greater today for two reasons:

1. Because more liquidations are in process
2. Because the courts want agents to be more responsible for their actions.

In addition to these known precedents and cases, agents are continually subjected to harassment suits from disgruntled clients and others that are settled out of court. Because these settlements are not published, it is impossible to know the depth and breadth of the problem.

Most agents, however, know someone or has had some personal experience realize they occur frequently. One such case involved an Oregon couple who invested their $26,000 retirement fund in an annuity with Pacific Standard Life in 1987. About three years later, they attended a financial planning seminar where they learned that their insurance company had been taken over by the California State Insurance Department due to losses in "junk bond" holdings. The couple immediately demanded a surrender of their policy. Of course, they were blocked from withdrawing their money by the conservators and the six-month payment delay provision in their policy. Seven months later they received a check for about 70 percent of their annuity value. The agent was threatened with legal recourse to pay the deficiency. After weighing the possibility of a lengthy court case and to keep an action from going public, the agent agreed to pay.

From the above court recitals, this agent clearly had no exposure. The least path of resistance, however, was to pay the client and move on. Fortunately, the dollars involved were controllable. But what of the situation where multiple clients are seeking reimbursement or the numbers are significant? The answer is not easy to predict, but the solution involves a multi-faceted approach to managing exposure while still providing service.

Misrepresentation & Insurer Failures

Insurer insolvency cases against agents may be based on misrepresentations by agents. Where agents have made expressed warranties or specifically agreed to supply a solvent carrier or one with stated or minimum amounts of capital are the most obvious areas where liability abounds.

An even worse situation occurs where an agent knowingly distorts actual capital or asset statistics of an insurer to make it more appealing. A similar violation occurs where an agent represents that he made a detailed investigation of the insurer when, in fact, he did not.

Examples where agent liability is not so clear, however, include cases where an agent convinces a client to surrender or cancel a policy from one company for a policy of another company and it is determined that the second insurer is weaker and maybe even be liquidated at some later date. In this instance, the law might interpret the agent actions to be more than just a "usual transaction", where a policy product is simply "sold". Here, the agent acted more as an advisor. His actions might appear to be assurances that the new company is better than the old company when, in fact it was not, for purposes of generating a commission.

In yet another legal strategy, agents may be culpable by his statements of confidence. Saying things like, “trust me" or “I guarantee it” could be construed as a warranty by the agent. Since most agents find it impractical to "clear" every representation with compliance departments, many oral declarations are made in the course of a sale or counseling clients. Technically, a guarantee should be in writing, but this would not stop an attorney from pursuing a talkative agent who made similar representations to more than one client.

A common example is in the area of "safety" regulations. The following are terms probably used every day by agents and though they stop short of creating an absolute financial guarantee for policy owners, they infer financial stability and give the purchaser a measure of confidence that the company behind the product is financially secure. An agent who cites these utterances is likely to be responsible for their truth:

Claims of Regulation by the State Insurance Department

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

Claims of Minimum Capital and Surplus Requirements

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

Claims of Minimum Reserve Requirements

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

Claims of Annual Statements

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

Claims of Periodic Examinations

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

Claims of Statutory Accounting

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

Claims of Investment Restrictions

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

Guaranty Fund Claims

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

Virtually every state has enacted what are commonly known as "guaranty fund" laws for the added protection of the policy owners of insolvent insurers. These laws generally provide that other insurers doing business in that state will contribute funds to alleviate any deficiency of assets in the insolvent insurer. The provisions of the laws generally cover all policy owners, wherever located, of insurers domiciled in such states and all residents of such states who are policy owners of insurers who are not domiciled in such states, but who are authorized to do business there.

The law in some states, however, limits protection on several fronts. There are coverage limits or caps ranging from $50,000 to $1 million per claim. Some completely eliminate claims or place severe restrictions on certain policies including life, variable life blends, disability, mortgage guaranty, ocean marine, surplus lines, HMOs, PPOs and other nontraditional markets.

Many states disallow advertising or use of any statements regarding state fund insurance prior to the sale. The premise is that guaranty fund warranties made to fortify the financial security of a weaker insurer could lull the public into overlooking the need to deal with sound companies. Further, violations of sales tactics using guaranty funds may cost an agent more than a liability suit. It may result in additional monetary fines and license suspension.

Agent Relationships & Insurer Failures

Often, agents develop special relationships with clients that can result in additional liability exposure. This can occur when an agent has handled all the insured's business or when a client has come to completely depend on the agent for all his insurance decisions and the agent knows it. In these cases, there may be legal authority to proceed against the agent where losses are due to an insolvency.

Even when faced with limited success, policy holders and their attorneys have pursued agents asserting a "personal" claim - that is, the culpable conduct of a third party (the agent) was personal to the policy holders, who relied upon that wrongful conduct.

One justification for placing tort responsibility on the agent is the conclusion that:

"The risk of loss in an insolvency setting should not rest with the insured or the claimant."

In essence, the courts are sympathetic concerning an insured's need for complete protection. This stems from the special circumstances that surround an insurance contract. Also, the insured cannot bargain or require a provision of the policy to protect or indemnify for a potential insolvency. The insured can only seek other insurance with a more stable company. And, even when an insured is informed about the financial condition of an insurer, the courts feel that they would lack the knowledge and experience necessary to evaluate financial statements, reports and terms like surplus, reserves, etc.

Finally, an insured cannot mitigate or control his damages since insurance cannot be purchased after a loss (i.e. the insured could have already paid for a benefit he cannot receive if an insolvency occurs).

Recent legal research, which will be cited in claims against agents, presents a clear and loud indictment of agent and broker responsibility:

> *"When one considers all of the factors of tort recognition, including the social policy aspects, the argument for the establishment of a tort duty on the part of the collateral parties (agents, broker brokers, reinsurers, etc.) to the insurance relationship is compelling. Placing a duty on the collateral parties to investigate and monitor reasonably the solvency of insurers with which they deal yields a much more socially advantageous result. This duty logically extends the duty already existing for brokers to exercise care in the placement of insurance with solvent insurers.*
>
> *The proposed duty, however, requires affirmative investigation and monitoring. This investigation and monitoring should, at least, include an evaluation of National Association of Insurance Commissioners' data, Insurance Regulatory Information System data, ratings service data, and any other public information and general information circulating within the industry. Thus, the duty requires a more thorough investigation than present law apparently requires brokers to make. In addition, the duty continues past the placement of the insurance or the commencement of the insurance relationship."*

Congress has also chimed in by suggesting that:

> *"Brokers should be required to check the integrity of the people and records which determine ultimate premiums and losses charged on policies".*

AGENT SALES CONDUCT

Sales conduct is responsibility you choose to uphold in order to do a better job for your clients. If you need more reasons as of why you should practice proper sales conduct here's a short list:

- It might keep you from being sued by a client or your insurer.
- The cleaner your record, the less involved underwriters will be in the sales process (i.e. you have more control over the sales process and less compliance).
- Sales conduct violations drive up the cost of doing business which could effect your commissions, or, completely replace the current system of incentive pay with a salary or other form of measured compensation.
- Sales conduct problems erode the public trust and that can cut into your sales.
- Sales conduct lawsuits are now part of how companies are rated. More suits mean a lower rating and a harder sale for you.

There are many industry groups and agent associations who feel that the movement toward sales ethics is way behind schedule. Too much emphasis and money has been spent on grooming sophisticated "salesmen", they say, when there is a greater need for agent diligence and fair dealing.

The cornerstone of this agent diligence movement is now called agent due care or sales conduct sales conduct. Roughly translated, the meaning of sales conduct is an agent's professional and ethical handling and choice of company, product and sales presentation to best serve a client's financial planning.

Others have embellished on this definition where the practice of sales diligence might read like this:

"Conduct business according to high standards of honesty and fairness and to render that service to its customers which, in the same circumstances, it would demand for itself. Provide competent and customer-focused sales and service. Engage in active and fair competition. Provide advertising and sales materials that are clear as to purpose and honest and fair as to content. Provide fair and expeditious handling of customer complaints and disputes."

If you went a step further and combined legal conduct and sales conduct you might run your business by the following credo:

- I will know everything possible about my client's financial and insurance needs.
- I will have a complete understanding of all products I sell and present them fairly.
- I will find the most suitable product for my client and make sure I place him with financially capable companies without "bashing" the competition.
- I will document any lack of knowledge with a full disclosure agreement.
- I will request each client to sign a binding arbitration agreement for any potential misunderstanding or dispute.

While it would be wonderful if every agent lived by these rules "real world" situations often get in the way. Taking the time to follow each and every rule would probably add to your work load. On the other hand, a little less free time today might save you considerable time and money by avoiding a major legal confrontation later. Likewise, the loss of a policy sale or two today might make it a whole lot easier to sell one later.

Fundamental to sales conduct is the understanding that all insurance is constructed of the same elements: expenses; experience (claims risk or mortality); and return or profit. Therefore, a policy that appears to be significantly better than others in the marketplace should be suspect.

Once a suitable product can be found, the decision to buy should be based on the assumptions in the policy and the financial stability of the company. Policy illustrations and quotes are one method to make this assessment. Unfortunately, agents and clients rely too much on these presentations to the extent that policies are rarely read.

As a result, agents should be sure that any projection or estimate disclose the assumptions that went into the projection and the fact that variations in these assumptions can significantly change insurance results. Recent laws have even made it mandatory to bold or highlight any "guaranteed" portions, as compared to simple projections. It is further suggested that illustrations be run again, without forecasting better times or improved rates into the future, to see if they still meet client expectations.

With reference to agents choosing safe companies to insure their clients, it will be demonstrated that sales conduct involves many disciplines including: disclosure, diversification among multiple carriers, product variation diversification, regulatory knowledge, multiple rating verification, key ratio comparisons, periodic monitoring and more.

A recent business magazine survey is a painful reminder to the industry that the road to agent diligence may still be cluttered with potholes and a fair share of detours. Money Magazine tested 20 insurance agents on their accuracy and clarity in explaining their insurance products and the role they played in a client's financial planning. Most of the agents failed simple standards of due care, including the ability to demonstrate simple financial assumptions concerning the solvency of a chosen insurer - either at time of purchase or later.

Agents must realize, that doing "too little" concerning how and where they place client business can be hazardous to their financial health and moral responsibility to the people they serve. This takes on special meaning to agents when they discover that lawyers want to prove that a pocket rating card and other company supplied financial condition brochures may not be enough to demonstrate that an agent did his best in selecting a carrier who, after purchase, declined to unsafe or liquidated status.

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

SALES CONDUCT IN CHOOSING ACOMPANY

Agent legal conduct in choosing a company centers on the ability to direct a client to an insurer that is solvent at the time of purchase and able to meet its contractual obligations.

Sales conduct considers diversification (spreading risks among carriers) and ongoing monitoring by private rating services.

Policy owners must depend on agents for choosing insurers because they are generally unsophisticated in analyzing the financial complexities of solvency. Agents help businesses and individuals purchase property and liability insurance to minimize current financial losses. Life, health

and annuity policies cover losses of future economic potential. In both cases, the purpose is to shift the financial consequences of loss.

Sometimes, however, policy owners find that the "safety net" they purchased is not always as safe as it started out to be. The recent increase in frequency of insurance company failures and inability to pay claims is proof. It is further substantiated by the substantial increase in claims submitted to state guaranty funds which are forced to step forward and make good on failed promises of defunct or faltering companies.

An agent is engaged by a client because he is an insurance professional. Clients should expect to be placed with financially reliable insurers. Too often, it is believed that state regulators are monitoring solvency closely and will advise agents and brokers by some mysterious "hot line." However, it just doesn't happen that way.

Regulators of insurance companies, like regulators of financial institutions such as banks and thrifts, do not make public announcements of pending problems. This could cause a "run on the bank" or a "run on the insurance company". Severe disintermediation, withdrawal of policyholder funds or policy cancellations, could initiate a complete collapse similar to what happened with Mutual Benefit Life.

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

There are no set rules on solvency due care techniques since the actual process must consider the risk capacity of a client, the current economy and the specific financial result or exposure needing coverage. However, there are some steps that agents might take to help mitigate bad choices.

It is hoped that at least a few of the following sources and considerations will have application and will involve the agent in an area of due care that has been largely ignored. If this is considered too time consuming, an agent would be advised to concentrate only on those companies where this information can be acquired. In some cases, due care is not simply a matter of collecting a financial ratio. The story behind the numbers is often as important.

Using the Rating Services

An agent choosing a company for his or her client would be advised to consult the major rating services. The activities of insurance company rating agencies have become increasingly prominent with the industry's recent financial difficulties and the well-publicized failures of several large life insurers. The ratings issued by these agencies represent their opinions of the insurers' financial conditions and their ability to meet their obligations to policyholders. Rating downgrades are watched closely and can significantly affect an insurer's ability to attract and retain business.

Even the rumor of a downgrade may precipitate a "run on the bank", as in the case of Mutual Benefit, and seriously exacerbate an insurer's financial problems. There is little doubt that rating organizations play a significant role in the insurance marketplace. Some have expressed concerns about the potential adverse effect of ratings on particular insurers and consumer confidence in the insurance

industry in general. Once the province of only one organization, A.M. Best, a number of new raters emerged during the 1980s.

One consultant suggests a way to determine if an insurer is running into difficulty is to monitor several ratings. If the ratings vary widely, this should send a signal that there are other factors of concern regarding the insurer. A recent example is United Pacific Life. In 1992 it was rated (A-) Plus by Duff and Phelps, BBB by Standard & Poors and Ba-1 by Moody's.

On Going Monitoring & Policy Replacement

In the past, there has been no legal premise to hold agents responsible for monitoring solvency of a company after the initial sale. However, recent cases have suggested that agents need to keep clients informed about significant changes in the financial condition of the company on an ongoing basis.

Sales conduct goes much further by emphasizing on-going due diligence, and when replacement is considered, documentation of files and published and third party testimonials as justification, especially for any recommendation to move a client's coverage from a company rated "A" or better to a lesser rated carrier. Even if the intent was to provide superior coverage, the client's security position has technically downgraded.

Company Deals

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

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

Company Diversification, Business Lines & Parent Affiliation

In the quest to exercise proper sales conduct, a strategy of multiple company coverage may be the answer. For a client's life insurance needs, some combination of term, whole life, variable life or universal life may be employed to spread the risks among many different insurers and product lines. The variable life component could be diversified even more by using multiple asset purchases.

On the casualty side, similar diversification might be employed between business and home owners policies, workers' compensation, professional liability, etc.

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

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

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

Who or what kind of company owns the insurer is another consideration.

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

Name recognition can go a long way in giving a client a high level of comfort. Other abuses have occurred with a slightly different twist. For example, Senate investigations have revealed that the failure of many insurers can be directly tied to the "milking" of these companies by a "non-insurance" parent. Further, not all abuses have been on the side of the parent. Insurance companies themselves have been known to tap huge sums of capital from their parents, commingle assets and devise elaborate schemes, including sale and leaseback arrangements and the securitization of future revenues.

Conflicts of Interest

Agents receive a commission for their expertise in selecting a suitable product and company. The fact that the agent receives this commission from the same company represents a definite conflict of interest. An ethical agent should disclose this fact in reference to the choice of the company selected. Where the commission is higher than normal, one might question the specific policy elements that will be affected, higher surrender or cancellation charges, etc. or considerations about the financial qualifications of the insurer and include these facts in any disclosure. A number of recent liquidated insurers were noted for paying higher than prevailing commissions.

Reinsurance

Reinsurance is an effective tool for spreading risk and expanding capacity in the insurance marketplace. The strength of the guarantees backing the primary company, however, are only as strong as the financial strength of the reinsurer.

Abuses have occurred where the levels of reinsurance have been too high, the quality poor and the controls nonexistent. Industry analysts suggest that the total amount of reinsurance should not exceed 0.5 to 1.3 times a company's surplus. Agents should also be concerned about foreign reinsurance since U.S. regulator control and jurisdiction is difficult.

- See how much of the foreign reinsurer's assets are held in the United States.
- Ask if the reinsurer has directly guaranteed the ceding company or used bank letters of credit for this purpose. These credit letters have not been effective guarantees in the past.
- Under terms of the ceding contracts, can the reinsurance be "retroceded" or assumed by another reinsurance company?
- Does the ceding contract have a "cut-through" clause which allows the reinsurer to pay deficient policy owners or ins ureds directly, rather than to the liquidator?
- Is the insurer writing a significant amount of new business that may require costly amounts of first- year reinsurance?

Reinsurance insurance surplus relief is another area of concern to investigate. The first year that an insurance policy goes on the "books", the insurance company suffers a loss. This is attributed to laws related to the accounting valuation of the policy and the high costs or expenses paid in the first year, such as commissions.

A loss to an insurer also reduces a company's surplus. A strain on surplus can create all kinds of problems with regulators and lenders, so insurance companies go to great lengths to shore up their surplus from the losses of first year policies. This may be accomplished by raising additional capital or through some form of financing.

More often than not, however, an insurance company will simply call up the local reinsurance company and obtain surplus relief reinsurance. Once in place, surplus reinsurance provides the ceding company, the insurer who uses the reinsurance funds, with assets or reserve credits which improve the insurers earnings and surplus position.

The major difference between using reinsurance to cover first-year losses and a loan is how the transaction is reported. When an insurer obtains a loan, the accountant must record a liability. Reinsurance for surplus relief, however, is not considered a liability under statutory accounting because the repayment is tied to future profits of the policy or policies being reinsured.

Collateral for the reinsurance, in essence, is future profits. Thus, reinsurers run substantial risks when the ceding company cannot pay. The fee or interest for providing the reinsurance is typically from 1 percent to 5 percent of the amount provided.

Regulators are well aware of reinsurance surplus relief practices. Over the years, they have introduced rules which attempted to minimize abuses. The 1992 Life and Health Reinsurance Agreements Model Regulation was adopted by the National Association of Insurance Commissioners

for implementation starting in 1994. The National Association of Insurance Commissioners also adopted a 1988 regulation which reads as follows:

> *"...If the reinsurance agreement is entered into for the principal purpose of providing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the unexpected potential liability to the ceding insurer remains basically unchanged".*

Size of Company & Loan Portfolio

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

Statistically, fewer failures have hit companies with assets greater than $50 million. It is thought that larger companies have more diverse product lines, bigger sales forces, better management talent (they are better equipped to ride out financial cycles).

In recent wide scale downgrading of insurers, A.M. Best seems to have favored significantly larger companies in the over $600 million category. However, another advisor feels that a small, well capitalized companies can deliver as much or more solvency protection as a large one suffering from capital anemia.

State Admission

Checking that an insurer is licensed or admitted to do business in the state at least assures that the company has met solvency and financial reporting standards. Most states offer toll free numbers for these inquiries.

Some states will also divulge the rank of an insurer by the number of complaints per premium volume. Agents should realize, however, that to date no court has allowed an insured who has suffered a loss as a result of an insurer insolvency to recover from a state run department of insurance for failure to regulate the solvency of the insurer.

Risked Based Capital

Risked Based Capital guidelines could prove to be one of the most useful tools for quantitative analysis. In a nutshell, it is a capital sufficiency test that compares actual capital, surplus, to a required level of capital determined by the insurer's unique mix of investment and underwriting risks. Guidelines for this new regulation took effect in 1994 for life and health companies and 1995 for property/casualty insurers. Risk Based Capital Risk Based Capital is the brainchild of the National Association of Insurance Commissioners.

Since its inception, the National Association of Insurance Commissioners has strived to create a national regulatory system by the passage of model acts or policies designed to standardize accounting and solvency methods from state to state. Risk Based Capital is one of many "model acts" recently adopted by the National Association of Insurance Commissioners.

The Risk Based Capital Model Act defines acceptable levels of risk that insurance companies may incur with regards to their assets, insurance products, investments and other business operations. Insurers will be required, at the request of each state insurance department, to annually report and fill out Risk Based Capital forms created by the National Association of Insurance Commissioners.

Formulas, under risk based capital, will test capitalization thresholds that insurers must maintain to avoid regulatory action; recalculate how reserves are used; reduce capitalization required for ownership of affiliated alien insurers and noninsurance assets; and allow single-state insurers to qualify for exemption from reinsurance capitalization if their reinsurance doesn't exceed 5 percent of total business written.

The risked based capital system will set minimum surplus capital amounts that companies must meet to support underwriting and other business activities. Because the standards will be different for each company, the guidelines run counter to existing state-by-state regulations that require one minimum capitalization requirement for all insurers regardless of their individual styles of business or levels of risk.

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

It is clear that Risked Based Capital encourages certain classes of investment over others. For example, an asset-default test under Risked Based Capital, called C-1, establishes varying reserve accounts be established for various classes of investments based on their default risk. These amounts could be as much as 30 percent for stocks and low quality bonds and 15 percent for real estate owned as a result of foreclosed mortgages.

Industry critics say that the C-1 surplus requirements alone could be far greater than all other categories of Risked Based Capital like mortality risk assumptions, interest rate risks and other unexpected business risks.

Since the 1994 Risked Based Capital reports are based on 1993 financial conditions, many insurers have already started to restructure their portfolios to avoid as many C-1 assignments as possible. This has included the wide scale disposition of real estate and real estate mortgages, the repackaging of real estate products into securities and large reductions in "junk bond" holdings.

Despite these efforts, C-1-rated classes of assets continue to represent a sizeable share of insurer portfolios.

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

Some in the industry also feel that the Risk Based Capital rules are simply too restrictive, subjecting many of the best known insurers to immediate regulatory action and "bad press". This, in turn leads to

a "run on the bank" that could tip these insurers into worse condition. The concern of these parties is that the risk based capital system doesn't falsely identify adequate capitalized insurance companies and undercapitalized ones as being adequately capitalized.

Too much is concerned with the type of investment, rather than its quality. Just how companies react to these guidelines remains to be seen. As mentioned, many life and health insurers have already changed their investment strategies to more favorably align with risked based capital guidelines by selling their large-scale real estate investments and junk bonds.

SALES CONDUCT IN CHOOSING PRODUCT

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

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

Regardless of the sequence of policy decisions, agents must recognize that the choice of a policy is viewed differently between agent and client. An agent seeks coverage as a means of transferring pure risk.

A client views policies in terms of obtaining reduced uncertainty (e.g. in most cases, your customers can only hope that the policy they purchase is appropriate). That is why agents are vital players in any insurance purchase.
The greater agent due care exercised, the more valuable the service. It is also why, when viewed from an agent's liability, all options should be disclosed.

Policy Choices & Risk Management

The process by which agents help clients select the most suitable policy is known as risk management. The two basic rules concerning risk management are:

1. The size of potential losses must have a reasonable relationship to the resources of the client, and
2. Benefits of risk reduction must be related to its cost

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

The agent must also consider a client's pure risk vs. speculative risk. Both pure risk and speculative risk involve uncertainty, but in pure risk, the uncertainty relates only to the occurrence of the loss. In other words, there is no chance for a profit to be made.

Speculative risk offers the opportunity for both gain and loss. An example of a speculative risk is when a dilapidated apartment burns and is replaced with new housing. Society can gain from speculative risk. However, the agent would do better to concern himself with the pure risk losses of the client. In the above case, for example, does the apartment policy provide pure risk provisions, such as a "lost rent clause" to provide the client and his family sufficient cash flow while the new apartment is being built?

The process of risk management requires setting and achieving goals in at least four areas:

- Pure risk discovery
- Options to deal with the risk
- implementation
- Ongoing risk monitoring

Pure risk discovery requires knowledge about a client's assets, income and activities of his family or business. Several sources can be valuable, including: financial records (balance sheet and income statement), specific information on each asset (location, title replacement cost, perils, hazards they are exposed to).

Questions about sources of income and expenses help determine the client's ability to self-insure all or a portion of any potential loss. Physical inspections of the client's home and business might also pinpoint additional liability loss hazards. This can even include a study of all existing contracts such as leases, employment contracts, sales and loan agreements.

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

Options deal with risk can be evaluated after specific risks have been identified. The risk manager's goal is to reduce the "post loss" resources needed by the client using the most efficient method. In essence, this is the age old battle of balancing costs and benefits. That is why risk management is maximized when using more than one insurance company to carry the burden.

In this decision, however, there is temptation to resist paying for excess coverage of any type which can rob the client of cash flow that could otherwise be used to build assets more quickly and less expensively -- specifically, assets that are needed to provide for the present or to create a "living" for the future. As part of this consideration, it may just be that the client pays premiums for many years, is never disabled or does not die earlier that his life expectancy. Or, he may never sustain a loss of property. The responsible agent should advise the client that this too, is a possible outcome.

Factors to consider include personal and business resources the client may wish to devote to covering losses (cash, assets, bonds, etc.), available credit resources, the use of higher than average deductibles and any possible claims for reimbursement the client may make against outside parties who may be legally responsible to help pay all or part of the loss. Of course, it is likely that the major transference of risk, or the final source of loss coverage, is the insurance contract.

Implementation of the insurance contract is made after the agent has developed specifications for coverage, established criteria or standards for insurers; compared rates and terms for the most

efficient contracts and arranged for all contractual requirements, like the application, rating history, specimen tests, inspections, etc.

Probably the most important contribution the agent can make at this phase is in aiding client indecision. Clients and agents alike can be frequently confused by the continuing arguments favoring term versus whole life or the value of an inflation rider to protect future property values. The result of these conflicting considerations and advice can be that too much time is spent wallowing in indecision about levels and type of protection for what reasons.

The fallout may be over insurance or under insurance or no insurance at all. The professional agent who practices due care will also provide counseling to bring these decisions to settlement.

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

While the process of risk management is conceptually similar across most product lines, the analysis of exposure is quite different. Following is a discussion of possible due care precautions an agent might explore when working in each product line. In cases where the agent does not handle multiple lines of insurance, a simple disclosure and referral may be advised to meet minimum due care.

SALES CONDUCT – LIFE/HEALTH

Questionable market conduct in the 1980's and early 1990's created new demands for today’s agent. For life and health agents, past abuses have centered around twisting, wholesale replacement, deceptive advertising, misleading illustrations and other unethical acts. Regulators have responded with replacement policy forms, insurer fines, agent reprimands, and in some cases, revocation of licenses.

To compound the problem, the industry's image has been further tarnished by solvency problems. Further, stiffer competition, declining interest rates and thinner profit margins have impacted how insurers and agents work together (less support in marketing and support materials). The bottom line in either case is that agents are forced to work harder and smarter.

In lieu of sitting back and waiting for the market to improve, industry forecasters say that agents must accept new roles to survive. Repeat business, referrals and long-term rewards must center more around client needs, rather than the products agents wish to sell.

The trend toward "agent as counselor" is the most obvious path. Putting oneself out to be knowledgeable in many financial matters, however, will come with a price tag. Both regulators and clients will hold insurance professionals to ever-higher standards. Agent due care and sales conduct will be more important than at any time in our industry's history. This will involve a commitment by agents to polish skills and acquire a systematic approach to filling client needs.

LIFE INSURANCE

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 (e.g. annual renewable term, deposit term, decreasing term, level term, whole life, modified whole life, single premium whole life, universal life, variable life, etc.).

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

This is not to imply that whole life forms of insurance are inappropriate. Rather, there are situations where 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.

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 make 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 ownership or title of the policy. Agents should recognize conditions where it would be beneficial to keep life insurance proceeds out of a client's estate by using a life insurance trust or alternative ownership.

Due care may be sufficient where agent disclosure of estate tax consequences of life insurance owned by a client and a proper referral to a competent estate planning attorney is pursued.

Essential Life Insurance Due Care Questions

- What existing death benefit sources does the client have? Group life, survivor's income, individual plans, association group life plans, pension plan death benefits.
- Who is insured?
- Is someone contributing economically who must be added?
- Do all death benefits, along with available assets, meet client objectives?
- Are there other needs to consider such as dependents with special problems? Business debts? Personal debts?
- Are there existing life policies that can be cash surrendered or tax exchanged to more efficient plans?
- Is waiver of premium available? Is this a desirable benefit for this client?

- Is there accidental death benefit or double indemnity? If so, is this desirable or can it be dropped in favor a lower premium?
- Is coverage guaranteed renewable? To what age? Is the client's health stable enough to change policies?
- Is coverage decreasing term? Is the balance sufficient?
- Is there a substandard rating that can be removed?
- Are there policy dividends? Is the client making the best use of these dividends? Or, would reduced premiums be recommended?
- What are the settlement options available at death? (Lump sum, payment options, insurance trust, etc.)
- Is there a plan for the "common disaster" involving both husband and wife?

DISABILITY INSURANCE

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

Essential Disability due Care Questions

- How much monthly protection is needed? Is an individual policy needed to supplement work plans?
- When does protection need to start? (30, 60, 90 days etc -- the elimination period), i.e., can the client "self-insure" for a period of time?
- Does the client have discretionary income to buy needed protection?
- Is the coverage non-cancellable 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 amounts that might be available from Social Security. Minimum employment history and limitations on the term of protection covered should also be considered. Other adjustments that an agent should investigate include earned income continuing from other family members, investment income that might be derived from current assets and inflation to keep pace with cost of living increases.

For just about every client, the above process will establish that some form of disability protection is generally needed beyond the limits granted social security, and in some cases private, employer provided protection. Once a disability need is established, it can be compared to the participation limits allowed by insurers and the ability of clients to afford it.

Disability sales conduct would involve an agent/client discussion explaining how disability insurers may only offer certain maximum allowable coverage tied to income, e.g. a client who earned an after tax monthly income of $7,500 might be eligible for a maximum of $3,000 of monthly disability coverage.

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

Also, there may be reductions in the amount of disability protection paid based on the degree of the disability, e.g., a partial disability that allows a client to continue working may reduce benefits substantially. Finally, watch for renewability features.

Some policies are truly non-cancellable and guaranteed renewable. Others may appear to be renewable unless cancelled by "class". Thus, if an insurer has a particularly bad block of business with a higher than normal claims experience, it can cancel that class of insureds.

Clients need to be counseled that the "gaps" in coverage outlined by these events require them to seek alternative forms of protection, develop contingency plans or rely on available pension plans, family members and accumulated savings to make ends meet during times of disability.

HEALTH INSURANCE

Health insurance is one of the most valuable segments of risk management and the most difficult to predict. This is further complicated by recent efforts to create a national health care system. Hours of agent due care to develop a long term plan for clients may be broad-sided by an entirely different style of health care brought on by federal directives.

The most efficient form of health protection is by group coverage. Group insurance is the predominant way of providing health insurance today with a definite trend toward HMOs (health maintenance organizations).

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

Basic Eligibility

- Exactly who is covered?
- Does "family" include the subscriber, spouse, one, two or more children?
- How old can the children be and still be covered?
- Does this change if the children are married?

- Will family members lose their eligibility when they turn 65 and Medicare takes over?
- How will a divorce affect a members coverage?
- Will a foreign or out of state residency longer than six months affect coverage?
- How long will a retarded or physically handicapped child or member be covered?

Total Maximum Coverage

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

- Is this a "lifetime cap"?
- Is this cap per family member or for the entire family?

A lifetime cap of between $2 and $5 million, per family member would not be uncommon and might be considered a minimum considering the high cost of medical care.

Deductibles

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

Stop Loss & Co-Payments

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

Pre-Existing Conditions & Waivers

- Are certain known pre-existing health conditions prohibited or waivered?
- If waivered, for how long?
- Is there a waiting period for unknown pre-existing conditions?

Some policies specify a 6 to 12 month waiting period for listed conditions such as: hernia, tonsils, adenoids, hemorrhoids, varicose veins, nasal surgeries, foot and toe surgeries, breast reductions, ear problems, etc.

Exclusions

Possible policy exclusions or highly limited protection might include conditions and services as follows: medical costs exceeding limits, unlisted services, service covered by occupational insurance (worker's compensation, etc.), health problems due to acts of war, government provided services, Medicare benefits, services from relatives, private nursing fees, custodial care, long-term care, inpatient diagnostics (x-rays not related to specific surgery), dental and hearing aids, vision care,

speech therapy, cosmetic sex changes, infertility, weight reduction, orthopedic devices, maternity care, outpatient drugs, acupuncture, nutritional counseling, physical or occupational therapy outside the hospital.

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

Further, many plans may cover certain hospital procedures but not the supplies, e.g., a blood transfusion procedure may be covered, but not the cost of blood. One of the latest trends is the requirement that certain procedures, such as organ and tissue transplants, be pre-authorized. Additionally, some procedures, like bone marrow transplants, are considered experimental and not covered under any conditions.

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

Guaranteed Renewability & Rate Changes

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

Important Dates & Notification

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

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

Agents who handle multiple lines of insurance must consider the impact of health insurance on the client's financial planning. A medical catastrophe can permanently devastate a family. Despite the importance of life insurance, disability protection and certain property/casualty coverage, health insurance is a clear priority.

It would not be considered due care for an agent who handles different product lines to market a $250 per month whole life insurance plan to a financially limited client when there was no health insurance in place. A more prudent approach would combine a "basic hospital plan" for major medical emergencies at $150 per month and a term life plan for $100 per month.

Even the agent who specializes in a specific product line should exercise due care to inquire that clients have health coverage in place or at least budget for same before selling other forms of insurance.

Essential Health Coverage due Care Questions

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

ANNUITY ANALYSIS

Sales conduct concerning annuity investing first involves fact finding to determine what portion, if any, annuities should play in a client's overall financial plan. Next, a needs analysis should be conducted to uncover growth vs. income requirements, risk tolerance, liquidity specifications, now and in the future, and whether tax deferral benefits are worthwhile to pursue.
Who should invest in annuities? One rule of thumb follows that a client looking for a long-term investment with a tax bracket greater than 15 percent might consider annuities. Other likely candidates include moderate or high tax bracket individuals looking for a conservative way to shelter current income or growth over a long period of time, i.e., retirement monies.

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

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

Immediate Annuity vs. Deferred Annuity

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

Single Premium vs. Flexible Premium

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

Fixed Rate vs. Variable Rate

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

Yield vs. Guarantees

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

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

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

Yield vs. Liquidity

Clients demanding easy access to their money should be prepared to settle for lower overall yields. Agents need to go farther to determine special needs such as the potential for large sums of money to pay for a potential illness or nursing home. Certain contracts allow penalty free withdrawals for special circumstances.

Due care dictates that agents carefully and clearly explain all surrender charges associated with the contract and when they occur.

Maturity options

Annuity contracts may mature at specific ages. This can affect both a client's long-term investment planning as well as tax planning. A client wishing to plan for long term deferral to age 95, for example, might be disappointed to learn that the contract must annuitize at age 85. Further, agents must disclose the potential tax effect 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 10% IRS penalty for early withdrawals. At present, this can only be avoided where the

annuitant dies, becomes substantially disabled, or where annuitization is chosen over a minimum five year period.

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 (e.g. 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?).

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 whether the full amount of the annuity is 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 that 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 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 owner’s 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 re-organized. 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, pre-loss arrangements covering the possibility of reduced revenues and higher expenses during this transition must be considered.

Corporations

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

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

Essential Business Insurance Due Care Questions

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

SALES CONDUCT – PROPERTY/CASUALTY

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

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

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

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

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

Having specimen policies available for this purpose should be standard procedure. Areas where agents should exercise additional due care involve the "agent as counselor". Insurance is the first line of defense in asset protection. The role of the property/casualty agent in preserving what clients have already accumulated is vital.

This should not occur, however, without also recognizing the value of other forms of insurance, i.e., A deluxe homeowner's policy should be scaled back where high premiums might not allow clients to purchase basic health insurance. There may also be validity to the argument that insurance premiums should not be so excessive as to preclude clients from starting necessary retirement savings plans. In addition to these points, there are many contributions that can be made by agents to promote greater client understanding of risk, loss control and proper valuation.

By educating clients in these disciplines, a higher level of insurance efficiency will be realized. The result can be stabilized or lower premiums through a lower claims experience. It is true, that this may not initially improve agent commissions, but in the long run client retention and income stability will be greater.

Essential Liability Due Care Questions

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

Risk

A client's perception of risk influences how insurance dollars are spent and, to some extent, how the industry is regulated. Unfortunately, much of society has set a low priority on reducing risk, i.e., "That's why I buy insurance".

Many in the industry, however, feel it is extremely important to reassess societal views on risk by assuming more responsibility for risk consequences. An example would be clients who continue to build in flood plains or high-risk fire areas, despite knowledge of their existence.

- When disaster strikes, should these individuals receive subsidies through taxpayer financed state and federal disaster aid, government flood control projects and mandatory shared-market insurance programs?
- Should accident victims who violate seatbelt laws receive full compensation?
- Should people who live in hurricane and earthquake country be responsible to better secure a structure with inexpensive metal ties?
- Some believe that people must realize what they can do for themselves before risk priorities can change. Agents can play a valuable role in helping clients accept a certain level of risk and strategies to reduce it.

Loss Control

In the insurance industry, the process of risk reduction is called loss control. Loss control procedures involve the steps necessary in eliminating exposures to risk and reducing their frequency or severity. Today, loss control makes the workplace safer and reduces a broad range of liability exposures in homes as well. Offering loss control advice and services to clients has potential rewards as well as risks.

Reasons agents might consider advising clients on safety issues include: client credibility, client retention, new client generation, insurer qualification, favorable insurer status and additional profits (where "advice fees" are permitted by law). With competition stiff, some larger agencies are establishing entire subsidiaries to perform loss control-for-fee services. In these cases, loss control fees can represent from two percent to ten percent of total agency revenues.

Smaller companies may contract to outside loss control consultants or simply rely on insurer provided services. Loss control services can run the gamut from standard, non-controversial safety recommendations to complicated compliance advice. Whatever level of service provided to attract or retain clients, agents should realize that loss control advice exposes him to additional liability. There may also be statutory violations, particularly in the commercial area, for offering safety expertise without required licensing.

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

Valuation

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

In addition, companies are directing it encouraging agents to re-evaluate coverage levels. In many cases, this involves inspections of properties to account for recent improvements, such as finished basements, patio covers, garage conversions; deterioration; code compliance to rebuild; i.e., new hurricane or earthquake standards; and illegal uses, e.g., a business run out of the home.

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

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 replacement, additional structures, type and extent of personal property, loss of use and basic liability.

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

Value

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

Remember, like kind and quality does not mean "exact" kind and quality. Clients must understand that replacement cost is limited to the style, quality and function of the destroyed or damaged property. Few or no allowances are made for increased costs of repair or reconstruction caused by ordinances or laws regulating construction or repair.

An example is new construction school fees or special fees that are currently charged for construction that were not around when the client's house was built. Concerning personal property, does an inventory exceed policy limits? Is replacement value available? Should items be "scheduled" like paintings, historical documents, original manuscripts, exotic pets, etc.?

Are "sub-limits" of the policy meeting client needs, cash, gold, coins, stamps, securities, deeds, trailers, jewelry, watches, furs, precious stones, silverware, guns, etc.?

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

Eligibility

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

Deductibles

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

Policy Exclusions

If the policy is in "readable form" it should be easier for the client to pinpoint policy exclusions.

Some obvious disclosures, however, should include exclusions related to damages caused by earthquakes, flooding, sewer flooding, flooding driven by wind, power interruption, owner neglect, war, freezing of appliances or pipes (especially if vacant over 30 days), theft of a dwelling under construction, breakage of glass if vacant over 30 days, continuous or repeated seepage from plumbing or heat & air system, normal wear & tear, latent defects, mechanical breakdowns, rust, mold, wet or dry rot, contamination, smog, settling, cracking, expansion of pavements, patios, foundations, walks, walls, floors, roofs or ceilings, rodent or pest infestations.

Liability & Liability Exclusions

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

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

AUTO INSURANCE

Auto policies are typically divided into different segments covering liability, medical, uninsured motorists and damages (comprehensive, collision, towing, labor and transportation expenses).

Insuring agreements traditionally offered "split limits" which apply to each person for each occurrence of liability, damage, etc.

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

Minimum due care considerations in this area include:

Policy Limits

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

Policy Eligibility

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

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

Policy Conditions

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

Policy Endorsements

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

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

Policy Exclusions

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

Also excluded is coverage in areas outside the United States, its territories or possessions and Canada.

Clients should understand that an endorsement for extended coverage should be considered when traveling outside these domains.

Policy Effective Date

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

Named Insured

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

Auto User

Is everyone who uses the auto a named insured?

Associated Named Entities

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

COMMERCIAL & PROFESSIONAL LINES

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

Policy Limits

As with most other forms of insurance, a client needs analysis should determine the extent of assets to protect, including any personal exposures. Policy endorsements and/or commercial umbrella protection may be considered as options. Special occurrences may have individual limits that must be evaluated for each client.

For example, a "products-completed" limit may be small for a bakery but should be expanded for a lawnmower repair service.

Eligibility

Rules of eligibility in the commercial arena are very complex. Suffice to day, clients should be aware of all limitations that might exclude coverage, including: building size or height restrictions, business class restrictions, etc.

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

Policy Endorsements

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

Scheduled Losses

The exact property or premises covered should be disclosed, buildings, insured's business personal property and the personal property of others located at the business premises. In the case of liability policies, premises and operations exposure is the heart of coverage.

Options should also be disclosed concerning upgrades to broader forms of coverage perils like extended reporting periods or extending coverage beyond termination of the policy, earthquake damage, crop insurance, livestock, loading/unloading accidents, window glass breakage, falling objects, weight of snow, water damage, etc.

Policy Exclusions

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

SALES CONDUCT – ILLUSTRATIONS/QUOTES

In the past few years, media "sound bites" and state regulator attention concerning the financial stability of insurers and sales misrepresentations have been the primary focus of sales conduct. Not far behind are the issues and supporters demanding agent due care in choosing the right policy - after all, an industry cannot rise to responsible status, perhaps even survive, if its members take a "sale at all cost" attitude.

Both these issues have and will be the target of new company compliance procedures and new regulatory standards. These efforts, however, have been pursued more in a "broad brush" fashion with an emphasis on concerns such as fraud, misrepresentation and twisting.

Many professional agent groups feel that sales conduct should include a new dimension: fair and understandable illustrations and quotes. Most insurance purchasing decisions are made by clients who rely upon an agent's sales illustration. Minor variations in the assumptions that go into these projections can produce dramatically different results (especially if they are spread over long periods of time).

With the advent of computers, multiple page illustrations with graphics literally predict results a client can expect from almost any given product, at any given time in the future using an almost unlimited choice of assumptions. Agents also use mass mailing technology that can tap public records, such as property values, ages, names to personalize and customize a quote without even visiting the property or client. Stiff competition has made the use of computerized quotes and illustrations widespread.

Given the sophistication and high quality of these proposals, agents and clients are depending more and more on the face value of the illustration, rather than the actual policy itself. In many instances, clients and agents alike completely pass on reading the policy. This, in turn, has resulted in some surprises for clients and the call for greater scrutiny of sales presentations from professional associations and some regulators.

The problems that surface with most illustration sales relate to the disclosure of assumptions made in illustrations (e.g. interest rates that went down instead of up), insurer insolvencies that could not meet minimum policy rates and/or return of principal, surrender values well below projected results, premiums that were expected to "vanish" simply continued, premium quotes well below replacement value of the property, quotes that do not reflect necessary endorsements, etc.

For the most part, the responsibility of misleading illustrations lie with insurer actuaries and marketing departments that produce them. Some agents have also manipulated quotes to specifically avoid true comparisons (e.g. presenting only projected cash values not guaranteed values. In recent cases, the misuse of illustrations has led to significant charges of questionable sales tactics by state regulators.

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

While there is no one single solution to the problem, some remedies are underway in the areas of education, disclosure and better illustration design. In the MetLife case, the company has created a corporate ethics and compliance department which will audit agent offices in the area of sales techniques, including the use of illustrations.

Regulators have threatened to prohibit certain proposal techniques altogether, require specific "full disclosure" requirements. Others are launching new compliance orders requiring insurers to conduct internal investigations designed to uncover illegal illustration marketing practices. Further, the National Association of Insurance Commissioners has outlined the misuse of policy illustrations as a violation of their Unfair Trade and Practices Act.

MANAGING GENERAL AGENT (MGA) CONFLICTS

It is estimated that one in seven agents face an errors and omissions claim each year. Charges like these will challenge your reputation, waste enormous time and could threaten your financial well-being.

Basic measures to limit liability always begin by avoiding claims at the outset. Of course, this is easier said than done, since there is no foolproof method to sidetrack a lawsuit from a client or an insurer.

There are, however, some suggestions that agents can use to help reduce the possibility of a claim developing and present a reasonable defense if one does. Of course, this cannot be considered a complete list since special circumstances may require additional precautions.

- Know your basic legal responsibilities as an agent and only exceed them when you are absolutely sure what you're doing.
- Learn from other agent mistakes.
- Be aware of and avoid current industry conflicts that could develop into problems for your agency.
- Maintain a strong code of ethics.
- Be consistent in your level of "due care".
- Know every trade practice and consumer protection rule you can.
- Use client disclosures whenever possible.
- Get connected to the latest office protocol systems.
- Maintain and understand your errors and omission insurance.

KNOW YOUR AGENT & LICENSE DUTIES

Agent/Client Duties

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

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

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

Agent/Company Duties

In addition to agent/client duties, you have duties to your company. Again, your agency contract is a good source to review. The problems occur in areas of fiduciary duties and statutory duties fiduciary duties and statutory duties.

When agents are sued by their insurer it is most likely for a violation of the law of agency. Most agents are familiar with the term fiduciary duty. Between agent and principal (the insurer), fiduciary duty of the agent prevents him from competing with the principal concerning the subject matter of the agency or from making a "secret profit" other than what is stipulated or agreed as commissions.

Beyond this, however, agents are bound to his insurer by other statutory duties statutory duties. They include:

- Duty of Care and Skill, using standard care and skill
- Duty of Good Conduct or acting so as not to bring disrepute to the principal
- Duty to Give Information by communicating with the principle and clients
- Duty to Keep Accounts by keeping track of money
- Duty to Act as Authorized
- Duty to be Practical and not attempt the impossible
- Duty to Obey or comply with the principal's directions

A violation of these duties can be considered grounds for termination or legal exposure to the principal or insurance company. Areas of additional concern include clerical mistakes, erroneous policy limits, omissions of endorsement, misappropriating premiums, failure to disclose risk, failure to cancel or notify cancellation, authority to bind, premium financing activities and unfair trade practices.

Agent Integrity

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

Qualifications

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

Lack of Business Skills or Reputation

Licenses have been revoked where the agent is not of good business reputation, has shown incompetency or untrustworthiness in the conduct of any business, or has exposed the public or those dealing with him or her to danger of loss.

In one instance, an application for an insurance license was denied by one state on the basis of reports and allegations in other states involving the applicant's violations of laws, misdealing, mismanagement and missing property concerning "non-insurance" companies.

Activities Circumventing Laws

Agent licenses have been revoked or suspended for activities where the licensee:

1. Did not actively and in good faith carry on as a business the transactions that are permitted by law

2. Avoids or prevents the operation or enforcement of insurance laws
3. Knowingly misrepresents any terms or the effect of a policy or contract
4. Fails to perform a duty or act expressly required of him or her by the insurance code

In one instance, the state commissioner revoked a license because the agent misrepresented benefits of policies he was selling and had entered false answers in applications as to the physical condition of the applicants.

In another case, the state commissioner found a licensee guilty of making false and fraudulent representations for the purpose of inducing persons to take out insurance by misrepresenting the total cash that would be available from the policies.

Agent Dishonesty

Agents have lost their license because they have engaged in fraudulent practices or conducted any business in a dishonest manner. A licensee is also subject to disciplinary action if he or she has been convicted of a public offense involving a fraudulent act or an act of dishonesty in acceptance of money or property.

Furthermore, most Insurance Commissioners will discipline any licensee who aids or abets any person in an act or omission which would be grounds for disciplinary action against the persons he or she aided or abetted.
In one instance, a license was revoked after an agent made a concerted effort to attract "bad risk business" from drivers whose licenses had been suspended or revoked. The state commissioner found that the agent had sent out deceptive and misleading solicitation letters and advertising from which it could be inferred that the agents could place automobile insurance at lower rates than could others because of their "volume plan". Moreover, the letters appeared to be official correspondence of the Department of Motor Vehicles. Clients would be induced to sign contracts with the agents where the agent would advance the premiums to the insurance company. The prospective insured would agree to repay the agents for the amount of the premium plus "charges" amounting to an interest rate of 40 percent per annum. The interest rates charged were usurious and violated state law.

Catchall Category

In addition to the specific violations above, most states establish agent responsibilities that must not violate "the public interest.” This is an obvious catchall category that has been used where agents have perpetrated acts of mail fraud, securities violations, RICO (criminal) violations, etc.

License Responsibilities

There are agent responsibilities necessary to maintain licensing in "good standing":

License Authority

A person or employee shall not act in the capacity of an agent/broker without holding a valid agent/broker license. This becomes the "age-old test" of what activities constitute an insurance producer. It is generally assumed that anyone quoting premiums or terms of an insurance

contract should be licensed. However, insurance departments across the country have pushed to constantly expand the definition of who in an agency should be subjected to licensing as an insurance producer.

To avoid unintentional noncompliance, many agency principals have licensed almost all staff members, regardless of how limited and passive the functions they perform. By contrast, the staff of insurance companies are exempt from producer licensing for a wide variety of service functions such as collecting premiums, mailing and delivering insurance policies and taking additional information requested by the agent or the insurer concerning and applicant or other transaction over the phone.

At the agency level, some insurance departments require agencies to be licensed both as corporate entities and as individual agency owners and principals. Temporary licensing can be requested when the agency principal or owner dies or to fill a void in an insurer's marketing force. This allows the surviving family to conduct business with existing clients. These licenses are usually limited to 30-days with two renewals for a total of 90 days.

Notice of Appointment

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

License Domicile

Agent domicile is a rapidly changing area of law. Currently, many states will grant non-residents a producer license. The rules are fairly straightforward.

Agents and brokers of insured’s with exposures in several states must be licensed in those states before they can collect a commission for the coverage they have written. However, since a non-resident agent "exports" premiums and business outside a given state, many states are beginning to erect barriers to prevent outside solicitation.

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

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

Display of License

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

Records

Agents should maintain a record-keeping system that will provide a sufficient "paper-trail" to identify specific insurance transactions and dates. At a minimum, such record systems should track the name of the insurer, the insured, the policy number and effective date, date of cancellation, premium amounts and payment plans, dates premiums are paid and forwarded or deposited to a the insurer or trust account, commissions (and who gets them).

Where an agent trust bank account is used, agents should maintain all bank statements, deposit records and canceled checks. Most records should be kept for a total of 5 years after the expiration or cancellation of the policy. Some states require that records be maintained "on-site" for one year after expiration or cancellation or stored off-premises but available within two business days.

Agent Files

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

Agent Business & Marketing Practices

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

Concealment

Concealment is neglecting to communicate what the agent knows or ought to know to be true. Concealment can be intentional or unintentional. In either case the injured party is entitled to rescind the contract or policy.

Communication that is generally considered exempt from concealment includes matters that the client/insurer waives (refuses or declines to discuss), matters which are not material and matters which, in the determination of the "prudent man theory", the other party ought to know.

Presentations, Illustrations & Quotes

It is illegal to induce a client to purchase or replace a policy by use of presentation materials, illustrations or quotes that are materially inaccurate.

Misrepresentations

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

Twisting & Churning

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

Redlining

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

False Claims

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

Unfair Business Practices

It is a violation in most states for agent/brokers to:

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

Policy Replacement

Agents must clearly disclose in writing, signed by the client, their intention to replace insurance with a new policy and that the existing insurance will lapse, be forfeited, surrendered or terminated, converted to a paid-up or reduced paid-up contract, etc. A copy of this "replacement notice" shall be

sent to the existing insurer (by the new insurer). Additional requirements typically include the completion of specific sections of the insurance application where the agent must acknowledge that he or she is aware of the replacement.

Privacy

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

AGENT ETHICS

It is difficult to discuss matters of agent responsibility and reducing liability without exploring ethics. As it relates to insurance agents, ethics go beyond the maintenance of "moral standards". Insurance ethic involves the maintaining of honest standards and judgments that place the client first.

Someday, it may be very important for a court and jury to hear that you have a history of serving the client without consideration for how much commission you made or how busy you were (you are a person with good ethics).

For example, an agent sold his client a health insurance policy while in her 50's. After the client reached 65 he continued to collect premiums despite the fact that Medicare would have replaced most of the benefits of her policy. The court did not look favorably on the agent's lack of duty to notify his client.

Ethics exist to inspire us to do good. Having high ethical standards, can be more important than being right because honesty reflects character while being right reflects a level of ability. Unfortunately, the insurance industry, like many industries still rewards ability. There are, for example, plenty of "million dollar" marketing winners and "sales achievement awards". However, there are few if any "Ethics & Due Care" certificates.

For some, the very effort to be as ethical as possible brings its own rewards. Consider, for example, the satisfaction that agents realize when the interest of a client has been served by the proper placement of insurance:

- The capital needs of a family are met by a $1 million life insurance policy when the breadwinner dies prematurely.
- The estate of an entire family is left intact because an umbrella liability policy sheltered against a major accident claim.
- A business is able to survive after the death of a partner because a life policy payment provided necessary capital to replace the devastating loss.
- The retirement plans of a once young married couple are made possible through investments in pensions and annuities.
- The owner of income property financially survives a major fire because his liability policy included "loss of income" provisions.
- A family survives a mother's long-term bout with cancer because their health insurance carried a sufficient "lifetime" benefit.

The list can go on and on, but the point is made. The work of an insurance agent often impacts the entire financial well-being and future of businesses and families. Ethics place the interest of these clients above an agent's commission.

Being ethical is being professional but the gesture goes beyond the mere compliance with law. It means being completely honest concerning all facts. It means more than merely not telling lies because an incomplete answer can be more deceptive than a lie.

Perhaps this whole issue of ethics can be summed up in the very codes of conduct now in place for members of organizations like the American Society of CLU and ChFC, Chartered Property and Casualty Underwriters and the International Association of Financial Planning.
Instilling ethics is a process that must start long before a person chooses insurance as a career. It is probably part of the very fiber that is rooted in lessons parents teach their children. So, preaching ethics in this book may not be incentive enough to sway agents to stay on track. It may be easier to explain that honesty and fair play could mean cleaner sales and lessen the possibility of lawsuits.

AGENT DISCLOSURE

Client Disclosure

In response to frequent and often groundless claims, many agents have resorted to limiting contracts and disclosures for clients to review and sign prior to any purchase decision. It may be common, in years ahead, to attach such statements to each and every policy or even require clients to sign one prior to any insurance discussions, much like doctors have patients sign disclosures in advance of services.

Agents have successfully used disclosures to qualify a promise of coverage. For example, an agent's letter to a client regarding future coverage commitments included a very important disclosure:

> *"You will be covered subject to our normal underwriting requirements."*

Of course, when the time came, the client automatically assumed he was covered. However, on the strength of the disclosure, the courts disagreed.

Agents may also want to use disclosures to "narrow the scope" of their duties. For example, agents have been held liable for not securing "complete" coverage. If an agent is unwilling to assume responsibility and take the time necessary to provide "complete" coverage, it might be wise to disclose that coverage is for a specific property, condition or a specific insurance carrier. Further, it might be appropriate to say that the agent has not reviewed client coverage needs concerning leases, contracts, directors, product liability, estate taxes, etc.

For example, an agent proposal included the following disclosure:

> *"This proposal is prepared for your convenience only and is not intended to be a complete explanation of policy coverage or terms. Actual policy language will govern the scope and limits of protection afforded."*

While this seems to cover any omission the agent might make in his proposal, he was found liable for client losses because his proposal also listed eight specific exclusions of the policy. Unfortunately, the one he left out was the peril that damaged the client's policy.

While nothing will prevent legal action by a disgruntled client, an agent would be better ahead to be able to demonstrate client knowledge in advance of the sale. Further, some legal advisors recommend inserting a binding arbitration clause to hopefully circumvent the long, expensive process of a judicial proceeding. Only a competent attorney should prepare these types of disclosures and clauses.

Insurer Disclosure

As between agent and insurer, the obligations and duties of both should be fully disclosed in the agency agreement, general agency agreement or explicitly detailed in other written documents. Agents reading these documents should be clear on issues of authority (what the agent/broker can and cannot do), advertising (what compliance is the agent subject to), waivers, venue (governing law of state), materials and records, rules & regulations, supervision, audits, commissions, special conditions, indemnification, termination conditions, etc.

As accountability grows, some agent contracts are including aggressive hold harmless agreements that impose liability on agents for any claims, regardless of fault, while others contain personal indemnification clauses that place an agent's home and personal assets at risk. With all these disclosures present, it is a wonder how disputes develop between agents and their insurance companies. The answer lies in the interpretation of these agreements and circumstances that can be quite different for each transaction.

Agents and brokers have been sued by their insurers for failure to comply with terms of agency agreements ranging from gross misappropriation of premiums to seemingly small violations involving clerical errors. In many of these cases, the attorney for the defense had to go beyond the written disclosure by defending the agent or broker on various points of law.

Agency Relationship

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

Proximate Cause & Reliance

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

Estoppel

An insurer who has had a long course of dealing with a given broker/agent may well have been willing, over the years, to overlook shortcomings in the information a broker provided the insurer. In some cases, brokers are allowed to "bind" coverage and later provide additional information.

If the same insurer brings an action against the broker after a loss has occurred, the broker may be able to point to the insurer's past practices as the basis for an estoppel argument.

Ratification

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

ERRORS & OMISSIONS INSURANCE (E&O)

Like other professionals, insurance agents should carry their own errors and omissions insurance. One author suggests that the highest level of agent ethics occurs when errors and omissions insurance is purchased for the protection of clients. While this is indeed a noble gesture, it is more likely that agents purchase these policies for more selfish motives.

After all, we have entered an era of high accountability and cannot hope to survive a major claim without this protection. In some states, for example, the punitive awards can be as high as three times the amount of compensatory awards (some policies do not cover punitive damages).

Faced with these kinds of actions, insurers, who many times foot the bill for agent mistakes, are less timid about suing their agents and brokers for any malfeasance. Of course, to some extent, the very existence of errors and omissions insurance may be a factor in an agent being named in litigation that he may otherwise have avoided.

In a case involving several security salesmen, for example, a pre-trial judge asked for a show of agents who did not have errors and omissions insurance. They were excused from the case. This could happen again, or not at all. Do you want to take that chance?

There is no standard errors and omissions policy. Most policies are written on a claims-made rather than on an occurrence basis. Claims made means the insurer is only responsible for claims filed while the policy was in force. This could represent a problem down the road a few years, if the agent moves or retires.

Policies today also have some very significant limitations, caps, gaps, consent clauses and relatively high deductibles. So many loopholes, in fact, that an agent is likely to feel the financial impact of any litigation almost immediately and under certain conditions may receive no protection whatsoever.

Some older style policies even require the agent to pay the entire claim before the errors and omissions insurer has any obligation at all. These are referred to indemnification policies.

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

Exclusions

Aside from the primary limits of the policy ($1 Million seems to be the limit of choice for most agents) the cost of defense is the most important exclusion to watch. Does your errors and omission policy include defense costs as part of the limit? If so, the amount of money available to pay monetary or punitive awards will be significantly reduced.

Defense costs can also be limited to a percentage of policy limits. Here, when the number is reached, you start paying for the balance of defense costs. Obviously, the best errors and omission plan will pay for all defense costs in addition to policy limits.

The claims made exclusion is the next consideration. If you have one, you will be covered for only the claims that occur while the policy is in force. If so, how will you handle a claim problem that occurs down the road, say at retirement, when you have dropped your policy?

Actually, you may have little choice in the matter since most policies today are written on a claims made basis versus an occurrence basis. However, there are endorsements that can help protect you in the "down the road" scenarios.

Also, be aware of specific limitations. You may not be covered errors and omissions in the following areas:

- Punitive damages
- Business outside the state or country
- Failure to give notice if new employees or agents are added to your staff
- Fraudulent or dishonest acts of employees or agent staff
- Negligence may be covered, but bodily injury and property damage may not
- Judgments (some policies only pay if a judgment is obtained against you)
- Some exclude contractual obligations in the form of "hold harmless" clauses (watch them)
- Outside services like the sale of securities, real estate or notary work

Most errors and omissions policies are far from perfect. However, before losing interest in buying this valuable coverage, you should consider the high costs, and lost production time, associated in the defense of even one protected client claim and any subsequent judgment requiring an agent to pay any deficiencies and possible attorney/court fees.

The cost of the average errors and omissions policy is cheap when compared to these costs. If you want your errors and omissions to do more, you can pay more and upgrade your coverage. Critical policy options that you might consider include first dollar defense coverage, defense costs in addition to policy limits, adequate liability limits ($1 million minimum), the availability of prior-acts coverage and coverage carrier solvency.

Obviously, the concerned agent would do better to avoid malpractice claims at the outset by doing everything possible to investigate safety and solvency of any proposed carrier, acting professionally, keeping current, due care, etc. Further, there is no substitute for operating in a prudent, ethical manner rather than rely only on an errors and omission policy. After all, can there be any point to work and build a practice to lose everything to the dissatisfaction of one client?

Working With E&O Claims

If you feel you have a potential errors and omissions claim, you should first review your policy to follow the reporting requirements that need to meet. Most E & O carriers want you to report an incident right away. However, it is important to know what your company determines to be an "incident".

Is it an actual claim? Is it a threat of a claim? If in doubt, you might want to call the company anyway and discuss it with them. Generally, it is in your best interest to cooperate fully with the company by assisting in any evidence gathering and witness lists. However, this same spirit of cooperation does not always extend to your client.

Most errors and omissions insurers do not want you or any staff member to make any voluntary admission of guilt to the client. Never blame the insurance company in any way or make any statement that might lead them to believe that the situation will be cured. While you can be cordial and calm in dealing with the client, be careful not to give any advice, legal or otherwise. If you are absolutely positive the claim is wrong, you can deny it, but never offer to settle.

If the situation involves a claim between the agent and a represented insurance company, the same precautions must be taken. In essence, you can't afford to "prejudice" your case in any way. Violating this errors and omissions contractual promise is the sure way for coverage to be canceled.

Cooperation also extends to any settlement offer proposed by your errors and omissions company. If your E&O insurer suggests a settlement offer that you do not agree with, and the case ended with a higher judgment than the settlement, you could be held liable for the difference as well as any amounts that exceed policy limits.

OFFICE PROTOCOL

Properly used, an agent's office automation and procedures can help to avoid costly claims or at least control E&O losses. For example, a sound basis for a defense can be established if an agent produces documentation, records of phone conversations regarding binding and specific coverage or records that show a client's decision to reject a recommended coverage. The client would have a hard time proving otherwise. Some liability claims have hinged on a hastily scribbled note confirming that a disputed conversation took place.

The legal purpose of documenting client transactions is to establish evidence.

Evidence can be parole evidence which is oral (difficult to prove in court), or it can be hearsay evidence (behind the scenes notes) which are written but not generally admissible unless it is collected under ordinary business rules.

You should develop standard operating procedures that require the following evidence rules for the best protection possible:

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

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

Automated Equipment

Computers and the diary capabilities they present provide up-to-date documentation that can be used to verify an agent's defense. Electronic "date stamping" can also be valuable as can fax messages concerning any client/agent contact concerning the dispute.

Application For Insurance

Complete and legible copies of the original application for coverage are extremely important. They presumably show the "intent" of the insured when he took out the policy, what he communicated to the agent regarding his wishes, whether the agent followed his wishes as to coverage requested and whether the insurance company followed the wishes of the agent who requested a policy of insurance pursuant to the wishes of the insured.

Also, a material misrepresentation of fact by the insured in his application may cause the policy to be declared void.

The Agent's File

In a legal action involving an agent or his insurer, a client's attorney will always attempt to secure a copy of the agent's file. It will show his knowledge of the insured's intent for specific coverage, communications between the agent and the insured about securing these coverages and the communications between agent and the underwriting department of the insurer.

For example, lack of notation regarding a client conversation three years before the loss was evidence upon which a jury concluded that the agent misrepresented the terms of the policy to the insured. By law, insurance companies generally have access to your files. So, it would be wise to never make a derogatory comment about a client in these files. Also, when a claim or potential claim situation surfaces, it is always a good idea to check with your errors and omissions insurer before turning over any documents.

As the industry edges closer to “paperless” filing it is important to understand that all files (paper, electronic, fax, post-it notes, etc.) are considered evidence and can be used on your behalf or against you. Certain documents, such as applications with original signatures still need to be kept in paper form.

Correspondence

Clients will often say they never received a letter or cancellation notice or that it was not in the envelope you sent. Experts suggest that using window envelopes and various methods of proven delivery, like Western Union, certified mail or UPS overnite will provide you with a tracking record. Additionally, if the insured acknowledges receipt of a window style envelope he cannot say there was nothing inside since the address was on the letter showing through the envelope window.

E-Mail

E-mail messages and correspondence are fast replacing written memos, faxes, phones calls and more. The ease of use, however, may hide liabilities that you need to address. For instance, confidential notes or information can be unintentionally sent without saving a copy, or worse yet, sent to the wrong party.

E-Mail users often hit the “enter” key before they think, and just hitting “delete” doesn’t automatically eliminate a message or derogatory remark. The system may “back-up”. E-Mail communications are just as binding, admissible and prohibitive in court as other communications. Attorneys are finding damaging information in E-Mail files that they can’t find elsewhere.

That is why it is imperative to have use guidelines for E-Mail. For liability purposes, all parties who have access to E-Mail in your company should apply good judgment. They should communicate with E-Mail as they would in a public meeting. Sensitive information should be encrypted to protect it from being transmitted via the Internet. For the best protection, use software that requires passwords.

Operations Manual

Standard operating procedures are steps that you follow consistently in selling and serving client. Standard procedures can be critical in establishing your notes and records as usable evidence in a trial. Further, it can be suggested that an agent who is careful to follow set procedures is usually found to be more credible in his own defense. Both are important reasons to document procedures in an operations manual.

Some errors and omission insurers are requiring agents to maintain (and allow the E&O carrier to review) an operations manual before coverage can commence. You should also be aware that in an insurance dispute, the existence of such a manual may be uncovered. From a defense standpoint, the manual and your adherence to it may prove that you are a diligent agent. From a plaintiffs vantage, non-compliance of policy procedures that you establish may work against you.

Your operations manual should cover procedures for dealing with client applications, claims, policies and certificates, insurance companies and any special services you plan to offer. Because agencies and insurances differ widely, you will want to add issues that are specific to your business before implementing any procedures, such as:

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

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

MARKETPLACE PROTECTIONS – AGENT RESPONSIBILITY

Rules and regulations vary from state to state. There are, however, widely accepted codes of behavior expected from licensed agents that fall under the category of consumer protection. Conflicts that surface here are usually the result of violations in advertising and deceptive or unfair trade practices.

Agents in the real world find it near impossible to know each and every consumer statute, yet a single mistake could jeopardize a career and personal assets. Sometimes, it is the tiny indiscretions in business that create the problem. For example:

- Placing a small and seemingly harmless “sub-title” on your letterhead that says “Professional Services Guaranteed” could hold you accountable for more than you bargained.
- Sending a withdrawal or surrender of cash value form to an insured to sign and mail back. This seems both efficient and convenient for the client, and a practice familiar with many agents. However, the client signature is not truly witnessed. Will a spouse or surviving family member who did not participate in any cash distribution deny the signature is real?

Such is the way that matters of simple mistakes grow to legal conflicts. Knowing what is expected of agents in the consumer protection arena is the best place to reduce and avoid these problems.

ADVERTISING

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

Advertising Defined

Advertising includes all materials designed to create public interest in an insurer, its products, an agent or broker. This may include, but is not limited to:

- Product Brochures
- Prospect Letters
- Sales Presentations
- Agent Recruiting Materials
- Newsletters
- Business Cards
- Trade Publication Ads
- Point-of-Sale Illustrations
- Radio – Television – Internet

Most insurance companies require agents submit these forms of advertising to compliance departments for approval prior to publishing.

Blind ads that do not identify product features or rates are particularly vulnerable to mistakes since they are typically not reviewed by compliance departments, although many insurers will look them over as a courtesy.

Due to violations in this area of advertising, many states now require an agent's license number be displayed in all forms of communication, including blind ads.

Not Advertising

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

Compliance

The consequences of using non-approved advertising are both severe and damaging. Insurance regulators concerned about an advertisement's content may require that all future advertising for the entire company be submitted for prior state approval. This would be disruptive and time-consuming.

Additionally, a violation in advertising may carry fines of $1,000 or more per violation. To avoid these kinds of conflicts advertising should comply on several fronts:

Identity of Insurer or Product

If advertising focuses on a specific company it is advised that the complete name of the company be used along with the home office address. Initials or abbreviations are not acceptable to most companies or insurance regulators.

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

Accuracy and Truthfulness

As a general rule, the advertising piece, when examined as a whole cannot lead a person of average intelligence to any false conclusions. These conclusions can be based on the literal meanings of words in the ad and impressions from pictures or graphics as well as materials and descriptions omitted from the advertising piece.

In one case, the agent lost his license for using prospecting letters that closely resembled official correspondence from the Department of Motor Vehicles.

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

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

Illustrations and Quotes

There are many proposals by states, professional groups and organizations like the National Association of Insurance Commissioners. Most require that agents disclose all assumptions in the illustration or quote and explain and highlight any guaranteed portions as opposed to anticipated results.

Almost as important is whether non-guaranteed elements of the policy are shown with equal prominence and close proximity to the guaranteed elements.

Representations concerning withdrawals cannot be made unless reference is also made to any prepayment or surrender charge. Where words like “tax free” or ”exempt” are used, they should be explained.

Comparisons, Ratings and Competition References

Comparisons made between policies and investment products (e.g. comparing an annuity to a savings account) must be complete, accurate and not misleading.

All statistical information should be recent, relevant and the source and date identified. Any reference to a commercial rating should be clear in describing the scope and extent of the rating. If an A.M. Best, S&P, Moody’s or other rating is advertised, the appropriate disclosures should be given.

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

Testimonials and Endorsements

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

MORE UNFAIR INSURANCE PRACTICES

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

Agents who are charged with committing unfair trade practice methods are typically subject to a hearing, usually before the State Department of Insurance, to show cause why a cease and desist order should not be made by the appropriate regulatory agency or board. After a hearing, if it is determined that the agent's actions violate the rules of unfair competition and practices, a formal cease and desist order may be served.

Violating such a cease and desist order is typically subject to various monetary penalties and administrative penalties such as injunctions, loss or suspension of license, and severe civil penalties

such as high dollar fines, damage awards, and court fees to the injured parties. In addition to advertising, discussed above, areas of specific importance include:

Identification

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

Defamation

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

Boycott, Coercion & Intimidation

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

False Financial Statements

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

Stock Operations

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

Discrimination

An agent clearly violates insurance law in making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or life annuity or in the dividends or other benefits payable by such contracts.

Similarly, there shall be no discrimination between individuals of the same class and of essentially the same casualty hazard in the amount of premium, policy fees, or rates charged

for any policy or contract of accident or health insurance or in the benefits payable under such contracts.

Discrimination can also occur where individuals of the same class and of essentially the same hazards are refused renewability of a policy, subject to reduced coverage or canceled because of geographic location.

Rebates

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

Deceptive Name or Symbol

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

DECEPTIVE BUSINESS PRACTICES

In addition to specified insurance codes, insurance agents must answer to generalized consumer protection laws carrying titles such as "Deceptive Trade Practices" or "Unfair Trade Practices." For the most part, these consumer laws apply to insurance and agents because an insurance policy is deemed a service and the purchaser of a policy is deemed a consumer. Therefore, insurance services fall within the meaning of widely adopted consumer protection acts.

Agents are also pursued under consumer protection laws because some insurance codes do not specifically address certain questionable acts by agents where the misrepresentation or fraud occurs outside the limits of insurance business. In such cases, the damaged insured’s or policy owners were not considered to be consumers.

By including the purchase of insurance services as a consumer transaction, the additional protection of deceptive or unfair trade practices acts can be invoked.

Unlawful Trade Practices

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

- Passing off services as those of another
- Causing confusion or misunderstanding as to the source, sponsorship, approval or certification of services offered.

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

Burden of Proof

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

Remedies

Whenever the courts or consumer protection division of an insurance department have reason to believe that any person is engaging in, has engaged in, or is about to engage in any act or practice that may violate a trade or practices act, and that proceedings would be in the public interest, the division may bring action in the name of the state against the person to restrain by temporary

restraining order, temporary injunction, or permanent injunction the use of such method, act or practice.

In addition, there may be a request by the consumer protection division, requesting a civil penalty for each violation, possibly $2,000, with a maximum total not to exceed an established amount (typically $10,000). These procedures may be taken without notification to such person that court action is or may be under consideration. Usually, however, there is a small waiting period, seven days or more, prior to instituting court actions.

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

INSURER'S UNFAIR COMPETITION AND PRACTICES

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

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

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

Unauthorized Insurer

Insurers not authorized to transact business in the state should not place, send or falsify any advertising designed to induce residents of the state to purchase insurance. This legislation is usually directed at "foreign or alien insurers" and defines advertising to include ads in the newspaper, magazine, radio, television and illustrations, circulars and pamphlets.

Violations can also include the misrepresenting of the insurer's financial condition, terms and benefits of the insurance contract issued or dividend benefits distributed.

Unfair Settlement Practices

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

- Knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverage.
- Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies.

- Failing to adopt and implement reasonable standards for prompt investigation of claims arising under its policies
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.
- Compelling policy holders to institute lawsuits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in the suits brought by these policy holders.
- Failures of any insurer to maintain a complete record of all the complaints that it has received during recent years (usually three years) or since the date of its last examination by the commissioner.

Handicaps

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

HIV Testing

In recent years, HIV related testing in connection with an application for insurance has become commonplace. If an insurer requests or requires applicants to take an HIV related test, he must do so on a nondiscriminatory basis.

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

An insurer may not inquire whether a person applying for insurance has already tested negative from a previous HIV test. The insurer may inquire if an applicant has ever tested positive on an HIV related test or has been diagnosed as having HIV or AIDS.

The results of an HIV test are considered confidential, and an insurer may not release or disclose the test results or allo w the test results to become known, except where required by law or by written permission from the proposed insured. Then and only then can results be released, but only to the proposed insured, a licensed physician, an insurance medical information exchange, a reinsurer or an outside legal counsel who needs the information to represent the insurer in an action by the proposed insured.

Rates or Renewal

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

Benefits Protection

Insurers are duty bound to protect all money or benefits of any kind, including policy proceeds and cash values to be paid or rendered to the insured or any beneficiary under a life insurance policy or annuity contract. In essence, these benefits must inure exclusively to the person designated in the policy or annuity contract.

They must be exempt from attachment, garnishment or seizure to pay any debt or liability of the insured or beneficiary either before or after the money or benefits are paid. They are also exempt from demands of a bankruptcy proceeding of the insured or beneficiary.

Health Policy Benefits

In the health insurance industry, benefit payments are commonly assigned to a physician or other form of health care provider who furnishes health care services to the insured. An insurer may not prohibit or restrict the written assignment of benefits.

When such an assignment is requested, the benefit payments shall be made directly by the insurer to the physician or health care provider and the insurer is relieved of any further obligation. Of course, the payment of benefits under an assignment does not relieve the covered person from any responsibility for the payment of deductibles and co-payments. Further, a physician or health care provider may not waive co-payments or deductibles by acceptance of an assignment.

Contract Entirety

Every policy of insurance issued or delivered within the state by any insurance company doing business in the state shall contain the entire contract between the parties. Furthermore, the application used to secure the insurance is usually made part of the contract.

Insurer Mergers

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

Reinsurance Assumptions

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

Despite the practice of assumption reinsurance, some members of Congress in recent years have objected to the process, since there is no requirement to inform policy holders in advance that the insurance company behind their policy is relinquishing responsibility to another company (reinsurer).

The reasoning behind their concern is that policy holders who have purchased coverage based on the financial condition and reputation of one company may suddenly find themselves insured by another company without warning or knowledge of the new company's abilities to pay their claims. To date, however, there is no definitive legislation passed to change reinsurance assumption.

INSURANCE FAILURE

Insurance can fail to insure in many ways. The source can be an agent's negligence in providing coverage or it can involve deeper issues such as inadequate or defective protection, coverage disputes, or the clear inability to pay (e.g. insolvency of the insurer). In any instance, the result is bound to disappoint a client and cause potentially harmful exposure to personal assets as well as liability for the agent.

Coverage Shortfalls

Many Americans consider themselves dutiful to purchase and maintain insurance often buying multiple policies with varying features and limits. Occasionally, situations arise where a liability surfaces from an unanticipated source, beyond the scope of these features and limits, resulting in an insurance shortfall. Such is the case where a breadwinner who bought a $50,000 whole life policy dies prematurely leaving a family with young children. Or consider a high wage earner who is the cause of a serious auto accident that disables a neurosurgeon for life.

When events like this occur the agent may find himself in the position of breaking the bad news or worse, liable for the shortfall. Sometimes, insurance shortfall cannot be helped. After all, nothing in life is guaranteed to work out right every time, and unexpected, freakish accidents and events can occur without warning. Unfortunately, there are also instances where the coverage provided by an agent was significantly less than needed and the agent paid the difference.

Then too, there are times when the coverage purchased or sold to a client exceeded what was needed in one type of insurance at the expense of another insurance coverage being underfunded and under covered (e.g. an auto policy with low deductibles is 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 broker agrees to obtain insurance for a client, with a view to earning a commission, the broker becomes the client's agent and owes a duty to the client to act with reasonable care, skill and diligence.

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 cove rage cases can be extremely complex. It is not unusual for these cases to involve numerous parties on both sides of the litigation. And, since policyholders usually buy insurance in many layers of coverage (i.e. life, health, casualty, excess, umbrella) from many different insurance companies over many years, the number of companies brought into one insurance coverage case can be quite large.

Coverage cases are also being consolidated by the courts where numerous policy holders and insurance companies have been found to be litigating coverage for the same underlying claims or addressing the same coverage issues. In one instance, a group of independent environmental coverage actions were ordered to collectively resolve many common contract issues and cooperate in case management and discovery procedures simply because they were similar.

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 founds 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 regularly use an operations manual or use stick “post-it” notes in your client files, these items are generally admissible.

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

Most suits settle before going to trial, so cooperation on all sides is generally desired. However, you should proceed with caution in any dispute or potential claim. Check with your errors and omissions carrier before discussing matters with clients or your represented companies.

Don’t try to settle the case, it could void your E&O policy. Don’t make any promises to clients about resolving the matter or give them legal advice of any kind. Don’t ever try to cover-up mistakes.

If your errors and omissions carrier wants to settle it is usually best to agree. If you don’t, you could be liable for court 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, have a much 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, is it qualified or non-qualified? LTC triggers of coverage are even more acute: often requiring a written declaration by a physician to verify a patient’s inability to care for himself.

Policy language in most property casualty policies centers around three primary triggers.

- 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.

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 that 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 an 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.

If there is any doubt as to whether the facts give rise to a duty to defend, it is usually resolved in favor of the insured, but it is the insured's burden to show that the claims come within the coverage. Claims related to acts of an insured in the area of crime, sexual misconduct, wrongful termination, contractual obligation, loss of profits or goodwill etc., have been ruled unacceptable ways to force an insurer's duty to defend.

Breach of Contract

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 that would defeat coverage. A majority of different courts have ruled that under such conditions, an insurance company is not bound to "defend" such claims simply because it cannot be bound to indemnify – in essence, the duty to defend can be disputed. Here, the insurer has the burden to prove that the facts of the insured's claim fall squarely within a policy exclusion.

Bad Faith

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

Choice of Law / Venue

Choice of law and venue, where to bring a suit, have become integrally tied together in coverage cases. There is general agreement that insurance coverage issues are state law questions even though most insurance policies do not contain any choice of law provisions. Courts, however, have also made venue decisions based on issues such as:

1. The place where policies were contracted
2. The location of the damage and/or

3. The principal place of business/residence of the policy holder

Lost Policies

Some claims between insured's and insurance companies have developed over the inability of the policyholder to prove coverage by producing an executed insurance policy. If a policy has been lost or destroyed, the policyholder 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.

Insurer Defenses

Much attention is devoted to the "rights" of policyholders. 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.

Again, the issue of bad faith enters the picture. Only when the insured conceals a fact in bad faith, knowing the fact to be material, will the policy be voidable. An example is a life insurance application which contains a question as to how many times the insured has been hospitalized and for what causes. If the insurer describes one hospitalization but fails to mention a second, the incomplete answer is considered material and grounds for voidance of the policy. However, if the insured had left the answer blank or merely given a date without specifying the cause, the incompleteness would be obvious and not grounds for voidance. The test is whether or not the reasonable insurer would be misled.

Once a contract of insurance becomes binding, the insured ceases to be obligated to disclose any material information. In the case of life insurance, for example, where there is an appreciable period of time between the submission of the completed application and the issuance of the policy, the duty of the insured to disclose new or forgotten material information continues. The duty to disclose applies only to facts, and not to mere fears or concerns of the insured about his health or the subject matter of the policy.

There is also no requirement that the insured disclose facts that the insurance company already knows, or which the insurer has waived. Nor, is the insured required to communicate events that are a matter of public record such as earthquakes, forest fires, etc.

Misrepresentations

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

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

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

On the other hand, a written commitment by an insured to install an alarm that is not followed can jeopardize the policy. Many insurance conflicts center around materiality. A representation is considered material if it served to induce an insurer to enter into a contract that would otherwise be refused or issued at a different premium.

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

Warranties & Conditions

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

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. 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, 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 insured’s 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 that is the subject of the clause is discoverable by the insurer at the time of inception of the policy, the clause will be classified as a warranty rather than a limitation. An example might be a policy condition that obligates the insurer when the policy is delivered to the insured "in good health" when, in fact, the insured is suffering from a discoverable disease.

Another test deals with risk. If a clause refers to a fact which potentially affects risk, but necessarily causes the loss, it is considered to be a warranty not a limitation. An example is a life insurance policy with a provision that excludes a death benefit while 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: (1) reproduction costs less depreciation and (2) 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 insured's, 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 insured's 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. Insured's may lose, however, if inflation and rising house prices cause the limit of coverage to wind up below the 80% figure at the time of loss, thereby nullifying the replacement cost provision.

Market Value

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

INSURER INSOLVENCY

When a state determines that an insurer is in trouble, the insurance commissioner usually files an application to the court. The court petitions the insurance company to show cause why the company should not be placed in rehabilitation or liquidation. Once a company is placed under supervision, an injunction is issued to restrain the insurer, its officers, agents and others from any disposition of property without court approval.

Liquidation is the more severe condition where the insurance commissioner must take title to the insurer's assets and use them to pay creditors and policy owners.

Rehabilitation allows for a restructuring of the insurer under the guidance of the commissioner. Unless the condition is extremely severe, companies are usually started in rehabilitation. If it is later determined that a restructuring will still not revive the insurer, a liquidation is ordered. If an insurer is liquidated, all policy owners and other potential claimants must be informed and permitted to file a proof of claim with the insolvent estate.

Recent failures have demonstrated that claim values can be less than the amount due the policy holder. Under these conditions, a policy owner can file an appeal and seek a court decision before the actual liquidation of the company occurs. In order to protect the overall insurer estate, there are time limitations for filing these appeals.

Once all appropriate values are determined, the assets of the insurer will be distributed under a statutory procedure. This process requires that certain priority lien holders be paid in full, while others may divide what is left.

State Guaranty Funds

The liquidation process can be extremely involved and lengthy. This is the reason that guaranty funds were established. They are an advance payment system to pay off individuals and groups who would be devastated by the liquidation process. A claim against a state guaranty fund is typically limited to residents of that state.

Payments are limited to certain amounts, depending on the type of insurance purchased. Once a claim has been paid, the guaranty association becomes subrogated to the claimant's rights to further payments. Thus, a policy holder who collected from a state fund forfeits his claim rights against the insolvent insurance company.

The guaranty associations are non-profit legal entities whose members comprise all insurance companies licensed to write insurance or annuities in the state. Each association is governed by a board of directors approved by the state's insurance commissioner.

Exclusions

In general, guaranty acts exclude from coverage policies issued by entities that are not regulated under the standards applicable to legal reserve carriers.

Insurance exchanges, assessment companies, fraternals, HMOs and, in many cases, the Blues (Blue Cross and Blue Shield -- especially where they have not been converted to legal reserve carriers), are commonly excluded.

Limits of Protection

Most guaranty associations limit their protection to policyholders who are residents of their own state. The trend toward adopting such a residents only provision follows a major amendment to NAIC's model guaranty act adopted in 1985. However, if the insolvent insurer's domiciliary state follows the NAIC model, coverage would be extended by the domiciliary state to residents of another state if that state also has a similar guaranty act and the impaired company was not licensed there and the policyholder is not eligible for coverage there.

An example of such a situation would be a New York resident who owns a policy of the Executive Life Insurance Company, which is domiciled (chartered) in California. Since New York has a life-health guaranty association but the company was not licensed to do business there, New York residents will be covered by the California Life Insurance Guaranty Association.

Dollar Limits

Typical payouts to policyholders who are victims of failed or financially strapped insurance companies might read as follows:

Life and Health Guaranty Funds

Maximum death benefit $300,000
Maximum cash value covered $100,000
Maximum Annuities $100,000
Maximum Health and Disability $100,000
Maximum Aggregate Per Person $300,000

Property/Casualty Guaranty Funds

Maximum Claim $300,000 - $500,000

Individuals who have several policies may have additional limits. For example, a person who owned a term life insurance for $500,000, a whole life policy with cash values of $150,000 and a single premium annuity with an accumulated value of $200,000, will collect only $300,000 (the maximum aggregate limit per person). The fact that these policies may be spread among three different insurers does not make any difference.

Triggers

Generally, the guaranty associations provide coverage when the company has been declared financially impaired or has been ruled to be insolvent by a court of law. There are some situations preceding such a judicial action when many associations may take measures to cover the impaired insurer's policyholder obligations, particularly for health benefits, death benefits, and immediate annuity payments. However, since the primary purpose of the guaranty associations is to protect policyholders, and not to bail out impaired or insolvent insurers, most associations are reluctant to provide coverage before an order of liquidation, unless it is clearly demonstrated that to do so in a particular case will be less costly over time.

Coverage Options

Guaranty associations may provide coverage directly, or through outside administration or other insurance companies. In many cases, the guaranty association will continue coverage for the full policy period. It may do this directly or it may transfer the policy to another insurer or administrator.