

COMMERCIAL INSURANCE

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Chapter 1

Commercial Lines Concepts and Terminology

Overview of Concepts

Replacement Cost vs. Actual Cash Value

“*Actual Cash Value*” is the replacement cost of property damaged or destroyed at the time of loss, with deduction for depreciation. Actual cash value cannot exceed the applicable limit of liability shown in the declarations of the policy, nor the amount it would cost to repair or replace such property with material of like kind and quality within a reasonable amount of time after a loss. Property can be valued in several different ways. Insurance companies commonly use two approaches to determine value, which also determines how a loss will be paid: the replacement cost method and the actual cash value method. Insurers consider replacement cost of a property item to be the cost to replace it with new property of like kind. Actual cash value is replacement cost minus the accumulated depreciation for age and condition.

Agreed Value

When the agreed value option is used, the co-insurance requirement is removed and the insurer agrees to cover losses for its agreed value. For example, the insured has property insured for \$100,000 and the agreed value is also \$100,000. If a loss occurs, any loss up to \$100,000 is covered at 100%. When this option is used, the insured and the insurance company agree on the value of the property before the policy is issued. This option is usually assigned to one-of-a-kind property.

Consequential Loss or Damage

Consequential loss or damage -- as opposed to direct loss or damage – is:

Indirect loss or damage resulting from loss or damage caused by a covered peril, such as fire or windstorm. In the case of loss caused where windstorm is a covered peril, if a tree is blown down and cuts electricity used to power a freezer and the food in the freezer spoils, if the insurance policy extends coverage for consequential loss or damage then the food spoilage would be a covered loss. Business Interruption insurance extends consequential loss or damage coverage for such items as extra expenses, rental value, profits and commissions, etc.

Limits of Insurance

All umbrella liability policies contain an each occurrence limit of insurance. Some umbrella liability policies may have a separate limit that applies to all personal and advertising injuries for one person or for the organization. Also, some policies are written with aggregate limits for only one type of loss. Other policies may have one or more aggregates for all losses. Umbrella policies can be written with several different variations of the aggregate limits. There are no standard umbrella policies.

Fire Damage Limit -- The fire damage limit provides coverage for fire damage caused by negligence, on the part of the insured, to premises rented to the named insured. If a fire occurs because of negligence of the insured and causes damage to property not rented to the insured, coverage is provided under the occurrence limit.

Medical Expense Limit -- Medical payments coverage pays medical expenses resulting from bodily injury caused by an accident on premises owned or rented by the insured or locations next to such property, or when caused by the insured's operations. These payments are made without regard to the liability of the insured.

Required Underlying Limits -- This is a requirement of the insurer. It requires the insured to have certain types and amounts of primary insurance before the umbrella policy can be written.

Subrogation

Subrogation is the legal term which usually involves the representation of insurance companies seeking to recover on paid losses from liable third parties, including lien negotiation and enforcement proceedings. An insurance carrier may reserve the "right of subrogation" in the event of a loss. This means that the company may choose to take action to recover the amount of a claim paid to a covered insured if the loss was caused by a third party. After expenses, the amount recovered must be divided proportionately with the insured to cover any deductible for which the insured was responsible.

Subrogation is the act of an insurance company seeking to receive payment for a paid loss from a responsible third party. This is often to an Insured's benefit, because if an insurer is able to reduce its loss via compensation from a third party, then the Net Loss that will apply to an insured's claim record is reduced.

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Active and fair subrogation by insurers can help clients maintain stable claims records with insurers, thus improving premium rates.

Additional Insured

Additional Insured is an individual or entity that is not automatically included as an insured under the policy of another, but for whom the named insured's policy provides a certain degree of protection. An endorsement is typically required to effect additional insured status. The named insured's impetus for providing additional insured status to others may be a desire to protect the other party because of a close relationship with that party (e.g., employees or members of an insured club) or to comply with a contractual agreement requiring the named insured to do so (e.g., customers or owners of property leased by the named insured).

Aggregate

A limit in an insurance policy stipulating the most it will pay for all covered losses sustained during a specified period of time, usually one year. Aggregate limits are commonly included in liability policies. While not often used in property insurance, aggregates are sometimes included with respect to certain catastrophic exposures, e.g., earthquake and flood. The dollar amount of reinsurance coverage during one specified period, usually 12 months, for all reinsurance losses sustained under a treaty during such period. The General Aggregate Limit is the most money the insurer will pay under a certain coverage for all claims occurring during the policy term.

Business Income

Business Income is the net profit or loss that would have been earned or incurred if the suspension of the business had not occurred, plus any normal operating expenses that must continue during the suspension of the business. Business income insurance pays the actual loss of business income sustained by the insured because of a necessary suspension of the insured's operation during the period of restoration following a loss. The suspension must result from direct physical loss or damage to real or personal property.

Coverage is provided against the same causes-of-loss covered under the insured's property policy. Under certain conditions, the policy also provides an extension of coverage for newly acquired property. The insured's operations are the business activities of the insured which occur at the location listed in the policy. The period of restoration is the period beginning on the date of the direct loss and ending when the damaged or destroyed property could have been

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restored. The business income and extra expense form provides the following additional coverages:

- **Extra Expenses** -- are any expenses over and above those that would have been incurred during normal operation of the business. Some of the covered extra expenses are: expenses incurred to avoid or minimize the suspension of operations, expense to repair or replace property, and expense paid for overtime work to speed up the restoration of the business.
- **Civil Authority** -- is when access to an insured's premises is denied by civil authority as the direct result of damage or destruction of a neighboring or adjacent property belonging to others. If the damage or destruction results from a cause of loss covered by the insured's policy, this coverage would apply. The insured's premises would be covered for the loss of income during the period of suspension up to a maximum of two weeks.
- **Alterations/New Buildings** -- provides coverage for loss of income resulting from a delay in beginning operations. The delay must be the result of damage to new buildings or structures, either completed or under construction. Damage to additions or alterations to existing buildings are also covered. The damage must be the result of a covered cause of loss.
- **Extended Business Income** -- This coverage provides the time needed for the insured's former customers to return, once the business suspension is over, by providing coverage for loss of income until sales return to normal or up to a maximum of 30 days.

General Liability Insurance

General liability insurance protects the insured business from money damages as the result of a civil wrong committed by the business or by someone for whom the business is liable. It's not unusual for judges or juries to award money damages in the millions so general liability insurance is vital for most businesses. In addition, general liability insurance provides unlimited DEFENSE COSTS for the insured business. The insured money damages may arise out of bodily injury, property damage, personal injury (insurance terminology for such offenses as libel, slander, invasion of privacy, etc.) or advertising injury. Such injuries may result from the business's premises, ongoing operations (away from the premises), completed operations or products.

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Liability arising out of the use of autos is insured under AUTO insurance. Liability for injuries to employees is covered under WORKER'S COMPENSATION insurance

Insurance Fraud

In the Property & Casualty insurance industry, fraud ranges from exaggerated losses to fabricated claims to organized racketeering. It has been noted on several occasions that if insurance fraud were a business, it would rank as a Fortune 500 company. Both insurance companies and customers suffer as a result of insurance fraud. Customers are penalized via increased premium rates that must be charged across all policies to compensate for insurance fraud losses. The average American household pays \$1,030 per year in out-of-pocket-costs as a result of insurance fraud. If insurance fraud were a business, it would be a top Fortune 500 company.

Auto, home and business insurance fraud cost Americans more than \$85 billion a year. Fraud could be as simple as misrepresenting facts on an insurance application or "padding" or inflating actual claims or as serious as submitting claims for injuries or damage that never occurred and "staging" accidents. At least 10% of all auto, home and business insurance claims are either fraudulent or highly inflated.

Research indicates that the public's attitude about insurance fraud has grown increasingly tolerant in recent years. Studies show that 1 in 3 Americans believe it is "all right" to pad claims to make up for premiums paid in previous years when they had no claims. Most people think that fraud is a victimless crime. Insurance fraud directly affects the amount paid for insurance premiums and increases the prices paid for goods and services.

Indemnity

This is the insuring agreement clause found in most umbrella policies as opposed to the pay on behalf agreement. When the indemnity insuring clause is used, the insurer will indemnify or reimburse the insured for those sums of money the insured becomes obligated to pay by reason of liability imposed upon the insured by law or assumed under contract.

Maximum Period of Indemnity is a restriction of the period of restoration provided under the policy. If this option is selected, the insured's loss payment is limited to the lesser of (1) the amount of loss sustained during the 120 days

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immediately following the loss or (2) the policy limit. The co-insurance requirement does not apply if this option is chosen.

Monthly Limit of Indemnity is an option that allows the insured to recover a percentage of the actual policy limit during each 30 day period of interrupted operations. If a loss occurs, payment would be made for the lesser of the actual amount of the loss or the maximum amount allowed to recover with this option. Under this option, the co-insurance requirement does not apply.

Extended Period of Indemnity is an option that extends the extended business income coverage over the standard 30-day period. The insured can extend the coverage to 60 days or up to a maximum of 360 days. The selected time would depend on the time the insured estimates it would take for revenues to return to normal after a suspension of the business.

Causes-Of-Loss

The term peril is used when discussing losses. A peril is a cause of loss. Basic property insurance policies are written to cover the perils of fire, lightning, explosion, windstorm, hail, smoke, aircraft or vehicle damage, riot or civil commotion, vandalism, sprinkler leakage, sinkhole collapse, and volcanic action. Other property insurance policies, often referred to as the Broad Form Policy, add coverages for water damage, weight of snow, ice or sleet, breakage of glass, and coverage for falling objects. The broadest coverage is the special form, which is best known as the All Risk Form. All risk covers all causes-of-loss, except those specifically excluded from coverage. It is possible for a commercial property policy to have more than one cause of loss form.

Commercial General Liability

Commercial General Liability provides the insurance protection needed to pay damages for bodily injury or property damages for which the insured is legally responsible. The policy provides coverage for liability arising from personal injury and advertising injury. Coverage for medical expense is provided. The policy covers accidents occurring on the premises or away from the premises. Coverage is provided for injury or damages arising out of goods or products made or sold by the named insured. The insured is the named insured and the employees of the named insured.

However, several individuals and organizations, other than the named insured, may be covered, depending upon certain circumstances specified in the policy. In addition to the limits, the policy provides supplemental payments for attorney

fees, court costs, and other expenses associated with a claim or the defense of a liability suit. There are two commercial general liability coverage forms available, the occurrence form and the claims-made form. Both forms are similar in the coverages offered. The main difference is the way claims are handled under the two forms.

The occurrence form covers bodily injury or property damage claims that occur during the policy term, regardless of when the claim is reported. The claims-made policy form only covers claims made against the insured during the policy term. A claim made after the policy expires is not covered by a claims-made policy unless the claim is covered by an extended reporting period. Only the claims-made policy form will have the extended reporting period. The following terms reflect both forms.

Overview of Coverages

Bailee Coverage

Bailee Coverage is coverage on property entrusted to the insured for storage, repair, or servicing. It is typically purchased by businesses such as dry cleaners, jewelers, repairers, furriers, etc.

Contractual Liability Coverage

It is common in construction and other agreements (written or oral) for one party to “assume” the liability of another. This is sometimes referred to as a “hold harmless” agreement. The extent to which one holds another harmless varies from contract to contract, job-to-job, etc. To assume the liability of another, regardless of extent, is a voluntary undertaking which increases exposure to loss. A standard Commercial General Liability policy does cover this additional exposure subject to certain exclusions.

Earthquake Coverage

The Earthquake Coverage endorsement extends the cause-of-loss to include damage that results directly from an earthquake. Coverage is provided for replacement of buildings only. All earthquake shocks that occur within a 168 hour period (one week) are considered to be a single occurrence. A separate deductible applies and it is determined by the value of the insured property.

Replacement Cost Coverage

This form of insurance provides coverage on the basis of full replacement cost without deduction for depreciation on any loss sustained, subject to the terms of

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the co-insurance clause. This coverage applies to both building and contents items as specified on the face of the policy. No deduction is taken for depreciation in arriving at the proper amount of insurance needed to comply with the co-insurance clause.

Time Element Coverage

Time element insurance provides insurance for a covered incident resulting in loss of use of property for a period of time. The loss is considered to be time lost, not actual property damage. Examples of time element coverage are Business Interruption, Extra Expense, Tuition Fees, Rents and Rental Value, Additional Living Expenses, and Leasehold Interest coverage.

Theft, Disappearance, and Destruction of Money and Securities Coverage

This provides insurance for loss of money and securities resulting directly from the following:

- Theft (any act of stealing)
- Disappearance
- Destruction

It applies while the money and securities are on the insured's premises, while in the custody of the insured or the insured's messenger while conducting business at the bank, and while off the insured's premises in the custody of the insured or the insured's messenger.

Umbrella Liability Coverage

This type of liability insurance provides excess liability protection. A business needs this coverage for the following three reasons:

- It provides excess coverage over the “underlying” liability insurance already carried.
- It provides coverage for all other liability exposures, excepting a few specifically excluded exposures. This is subject to a large deductible of \$10,000.
- It provides automatic replacement coverage for underlying policies that have been reduced or exhausted by loss.

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Umbrella Liability coverage provides excess liability coverage over several of the insured's primary liability policies. Most umbrella liability policies provide coverage that is broader than the insured's primary policies. An excess liability policy may be a "following form" policy, which means it is subject to the same terms as the underlying policies. It may be a "self-contained" policy, which means it is subject to its own terms only, or it may be a combination of these two types of excess policies. Umbrella policies have three functions:

- To provide additional limits above the each occurrence limit of the insured's primary policies.
- To take the place of primary insurance when primary aggregate limits are reduced or exhausted.
- To provide broader coverage for those claims that are not covered by the insured's primary insurance policies, which are subject to the policy retention.

Most umbrella liability policies contain one comprehensive insuring agreement. The agreement usually states it will pay the ultimate net loss, which is the total amount in excess of the primary limit for which the insured becomes legally obligated to pay for damages of bodily injury, property damage, personal injury, and advertising injury.

Valuable Papers Coverage

An "all risk" insurance coverage that covers the cost of research to reconstruct damaged records, as well as the cost of new paper and transcription. The term "valuable papers" refers to written, printed, or otherwise inscribed documents and records, including books, maps, films, drawings, abstracts, deeds, mortgages, and manuscripts.

Pollution Legal Liability Coverage

Coverage pays on one's behalf all sums he or she is legally obligated to pay as a result of emission, discharge, release, or escape of any contaminants, irritants, or pollutants into or on land, the atmosphere, or any water course or body of water, provided this results in "environmental damage." It also gives coverage to reimburse your expense for reasonable and necessary cleanup costs incurred in the discharge of a legal obligation validly imposed through governmental action, provided such expense is incurred because of "environmental damage." The coverage pays for defense of any claim or suit that is the subject of this insurance.

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“Claims made” coverage response which responds only to claims first made during the policy period and only for incidents that have occurred after the effective date of this coverage. Pollution “Environmental damage” is defined in the policy as “the injurious presence in or on land, the atmosphere, or any water course or body of water of solid, liquid, gaseous, or thermal contaminants, irritants, or pollutants.”

Leasehold Interest Coverage

Leasehold Interest insurance provides coverage for a tenant in the event his or her lease is terminated. The lease may be terminated due to (1) a clause in the lease specifying that the lease is terminated in the event of property damage causing the premises to be unavailable for tenancy, or (2) condemnation of the leased premises. It is a form of “time element” coverage that serves to provide coverage for the difference between the old rental and a new, likely more expensive rental

General Partners’ Liability Coverage

This type of insurance is also known as General Partners' Liability and Limited Partnership Reimbursement coverage. A general partner's management and fiduciary responsibilities to a limited partnership closely parallel the director's or officer's to a corporation. Exposure occurs when general partners become the financial managers of a limited partnership. The directors and officers of corporate general partners share this type of exposure. Some causes of claims are as follows:

- Untrue written or oral statements made by the general partners;
- Breach of fiduciary duty;
- Incomplete disclosure of facts;
- Omission or misleading statements in the offering memorandum;
- Selling of unregistered limited partnership interests;
- Conflict of interest;
- Failure to devote adequate time to the partnership;
- Appointment of drilling contracts without proper prior investigation as to their experience;
- Failure to minimize risk factors that prove detrimental.

Forgery or Alteration Coverage

This type of insurance covers loss sustained through forgery or alteration of outgoing negotiable instruments made or drawn by you, or drawn on your

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account(s), or made or drawn by one acting as your agent. This includes loss caused by any of the following:

- Checks or drafts made or drawn in owner's name, payable to a fictitious entity;
- Checks or drafts, including payroll checks, executed through forged endorsements;
- Alteration of the amount of a check or draft.

Employment Practices Liability Coverage

Protects the corporation, directors & officers and employees for claims resulting from wrongful termination, discrimination, sexual harassment, wrongful discipline and failure to employ or promote. Whether right or wrong in the eyes of the jury, the typical defense costs alone average \$100,000 - \$200,000 per case.

Employee Benefits Plan Liability Coverage

This coverage protects the insured employer against claims by employees or former employees resulting from negligent acts or omissions in the administration of the insured's employee benefits programs. The term "employee benefits programs" is defined to include group life insurance and group accident and/or health insurance; profit sharing plans; employee stock subscription plans; and workers' compensation, unemployment insurance, social security benefits, disability benefits, etc. Coverage is intended to extend to the "administration" of these plans, including counseling employees, interpreting employee benefits programs, handling records, enrolling/terminating/canceling employees in specified plans on a timely basis, etc.

Earnings (Business Interruption) Coverage

This form of insurance provides loss of income coverage (i.e., "disability income") for a business by replacing operating income during the period when damage to the premises or other property prevents income from being earned. It is by means of operating income that a business meets its expenses of payroll, light, heat, advertising, telephone service, etc., and from which profit is derived. If a business owner suffers a business interruption and has to close for several months or operate at a reduced pace because of fire or other perils covered by your Earnings insurance, this income will cease or be reduced.

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For the purpose of this insurance coverage, "earnings" are defined as the actual loss sustained by the insured as a direct result of business interruption necessitated by damage or destruction of real or personal property. The damage or loss must be caused by the insured perils. Furthermore, "business income" is defined as the sum of total net profit, payroll expense, taxes, interest, rents, and all other operating expenses earned by the business.

The amount of coverage your Earnings insurance provides is established on the basis of either amount of insurance or actual loss sustained for each 30-day period of necessary business interruption caused by damage or loss from covered perils. There are several ways to set up Business Interruption depending upon your particular business. Monthly limitations, coinsurance, maximum time period to be paid, etc.

Comprehensive Automobile Coverage

Brief Coverage Explanations:

- *Owned Automobiles* - Covers liability rising out of the ownership, maintenance or use of automobiles.
- *Hired Automobiles* - Covers liability for the use of hired automobiles in your business.
- *Non-Owned Automobiles* - Covers liability for the use of non-owned automobiles in your business. An example would be an employee using his/her own car on an errand for you.
- *Uninsured Motorists* - Protects insureds who are not contributorily negligent against bodily injury caused by negligent uninsured motorists.
- *Comprehensive* - Pays for damage to or the loss of automobiles from perils other than collision. A deductible applies.
- *Collision* - Pays for damage to or the loss of automobiles from upset or collision with another object. A deductible applies.

Coverage Extensions

Personal Injury Coverage

Even if standard personal injury coverage is provided in the primary policy, the coverage provided by the Umbrella Liability policy is broader as it provides coverage for mental injury, mental anguish, shock, disability, humiliation, discrimination, etc.

Advertising Liability Coverage

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Included in the definition of “personal injury”

Non-Owned Aircraft Liability Coverage

Also Owned Aircraft Liability coverage if included in the schedule of primary insurance.

Non-Owned Watercraft Liability Coverage

Also Owned Watercraft Liability coverage if included in the schedule of primary insurance.

Drop-Down Coverage

For occurrences within the scope of this coverage and in the absence of primary coverage, this will respond for your benefit subject to a \$10,000 self-insured retention.

Care, Custody, or Control Coverage

Excepting only liability assumed under contract, unless excluded.

Occurrence Coverage

This is matching the new standard primary policy definition.

Unit assessment coverage

Unit assessment coverage pays up to \$50,000 for one’s share of an assessment charged against all unit owners as a result of a covered loss.

Overview of Clauses

Selling Price Clause

This applies to the value of goods which have been damaged or destroyed by an insured peril. The purpose is to insure the profit that would have been incurred through a sale. It defines the insurable value of merchandise which has been sold, but not delivered, at the amount at which it was sold, less any charges not incurred. This applies to the value of goods which have been damaged or destroyed by an insured peril. The purpose is to insure the profit that would have been incurred through a sale. It defines the insurable value of merchandise which has been sold, but not delivered, at the amount at which it was sold, less any charges not incurred.

A property policy provision that pays at selling price (realized market value) losses to finished stock that is sold but not delivered. This includes the insured's

profit. Normally, such stock would be valued at its production or replacement cost, whichever is lower.

Debris Removal Clause

This pays for the insured's expenses to remove debris of covered property caused by a Covered Cause of loss. This does not include "pollutants" and must occur during the policy period and reported within 180 days of the occurrence. This clause extends insurance coverage to include the cost of debris removal resulting from damage caused by a covered loss up to a specified limit of loss. The clause is an additional property insurance coverage. A property insurance provision which provides coverage for the cost of clean-up and debris removal after a covered cause of loss has occurred, such as clean up after a fire or windstorm.

This is a provision that may be included in a Property policy contract to provide the insured with indemnification for expenditures incurred in the removal of debris produced by the occurrence of an insured peril. Ordinarily a Property policy covers only the direct damage caused by an insured peril.

Primary and Excess Clauses

There are two basic types of Other Insurance clauses found in the typical CGL policy: primary and excess. The purpose of the primary clause is to make it clear that the policy is intended to apply to all covered claims, and that if other valid and collectible coverage with a primary Other Insurance clause is available; the policy will still apply, but will share in the loss. The excess clause distances its policy from other available insurance.

One can view this as a passive transfer of financial responsibility to the primary insurer paralleling the transfer of financial responsibility between two contracting parties. If the adjuster finds that one CGL policy has a primary Other Insurance clause and the other an excess Other Insurance provision, the policy with the primary provision will apply without any sharing of the loss until the limits of liability are exhausted, regardless of what the parties originally intended. The insurance policies dictate which insurer pays and how much-not the contract between the two insureds.

Co-Insurance Clause

Coinsurance is simply an agreement between you and the insurance company, wherein, you agree to carry insurance on your property in an amount equal to at least 80% (90% or 100%) of its actual cash value (or replacement cost). In

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return for doing this, you receive a rate credit. A property insurance policy may contain a “co-insurance” clause.

This clause reduces the apparent amount of insurance when it is triggered, making the insured a “co-insurer” for his own loss. Generally, the co-insurance clause, which is expressed as a percentage, will be triggered when the policy limit for the insurance is less than the fair market value of the property multiplied by the co-insurance percentage. In short, the result derived by multiplying the fair market value of the property by the co-insurance percentage represents the minimum amount of insurance that must be carried if the insured is to receive a full recovery for his loss.

Example could be when a building valued at \$100,000 has a 90% coinsurance clause and is insured for \$45,000. It suffers a \$20,000 loss. The insured would recover $\$45,000 \div (.90 \times 100,000) \times 20,000 = \$10,000$ (less any deductible).

Chapter 2 **Commercial General Liability Insurance**

Introduction to General Liability Insurance

Liability insurance differs from property coverage in its basic concept. **Property coverage pays for direct damage to the insured's property.** Liability insurance pays for the *activities* of the insured, or the insured's business, which cause damage or loss. Liability insurance flowcharts an insured has to others, for example the "others" involved in an auto accident caused by the insured. These others are claimants.

Under property insurance, the insured is the claimant. In reviewing the meaning of liability under tort law, it would not make sense to have the insured be the claimant, or the party owed, under liability insurance. In essence, the insured would then be suing himself or herself in such a circumstance. Rather, liability insurance, following the laws surrounding liability, covers the suits or claims made by others against the insured.

The insured has liability for damage or loss caused by, or as a result of, property owned by the insured. In certain cases, the insured also has liability for property in the care, custody and control of the insured as well. A trucker carrying goods belonging to another has potential liability for these goods if they are damaged while in the trucker's care. However, such liability is often covered by property insurance. If covered by a liability policy, property in the care, custody, and control of the insured is often covered in specific, limited ways.

General liability insurance provides coverage for many types of liability risks. The coverage applies to claims against the insured from customers, tenants, members of the public, and more. Liability coverage has become more important in recent years as the public becomes more likely to pursue claims and suits against others. People today tend to expect monetary remuneration to compensate for discomfort as well as for tragedy. Society looks to government, businesses, other individuals, service providers, etc. to compensate them for everything from coffee which is served too hot, to an unfriendly work environment, to serious accidents caused by negligence.

It is more socially, and personally, acceptable to file a liability claim or suit today than it was twenty or even ten years ago. The need for liability protection has existed for centuries. In today's marketplace, the need is even greater.

Liability Loss Exposure

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

For example, a vital hospital executive or technician may have been sickened by toxic fumes and unable to come to work for the two weeks required to clean the parking lot, then each of these two organizations would have suffered a personnel loss. A risk management professional most frequently uses one or more of seven methods of identifying the particular loss exposures facing a given organization. These methods are:

- Completing a survey/questionnaire for the organization;
- Reviewing loss histories of this and comparable organizations;
- Analyzing its financial statements and accounting records;
- Reviewing the organization's other records and documents;
- Constructing flowcharts of the organization's operations;
- Personally inspecting its facilities;
- Consulting with experts within and outside the organization.

The purpose of any of these methods is to analyze loss exposures -- future possibilities of loss -- not to study past losses. Records of past losses can be helpful in projecting future losses. A survey/questionnaire, usually written to be generally applicable to every organization, poses probing questions for all risk management professionals about the organizations' real property, equipment, other personal property, other assets, products, key customer, neighboring properties, operations, and other sources of possible loss. Loss histories are a record of past losses for an important indicator of accidental losses that may strike an organization.

Prior accidents and lawsuits may well repeat themselves, unless the organization's operations have changed in some fundamental. For many

organizations, records of past losses and claims may be inadequate for identifying current loss exposures because the organization is too small or too young to have generated a credible loss record.

Commercial General Liability Declarations

The CGL declarations supplement the common declarations to provide information needed only for the liability coverage. The name and address of the named insured and the policy period are shown in both the common declarations and the CGL declarations for identification if the two documents become separated. Additional sections of the CGL declarations address policy limits, retroactive date, form of business being insured, the premium charged, and endorsements for the policy.

Comprehensive General Liability covers liability and property damage on behalf of an insured business up to the limit of the policy subject to certain exclusions. Some exclusions would include intended injury, liquor (covered by a different form), recall of products and so on. Protection includes defense up to the limits of the policy for an “occurrence” causing damages for legal liability, property damage, as well as medical payments (including death and loss of services) during the policy period, and within the coverage territory.

This policy should not be construed to cover injury to an employee (covered under workers compensation) or relative that may be employed. This form does insure against “personal injury” or “advertising injury” and the company has the right to defend or dispose of this litigation as it sees fit, but any obligation ends when the limits of the policy are used up. It is a key issue that coverages are available only for claims arising out of the operation of business.

Commercial General Liability Coverage Forms

The commercial general liability coverage part may include either of two coverage forms: the occurrence form or the claims-made form. The occurrence form will be discussed first, because the claims-made form involves some rather complex variables that will be grasped more easily after the discussion of the occurrence form. Commercial liability coverage used to be provided on a type of risk basis.

Coverage forms existed for premises and operations exposure and products and completed operations. Premises and operations exposure included coverage for owners, landlords, and tenants, and another coverage for

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manufacturers and contractors. Coverage also was available separately for contractual liability. Owners and contractors protective liability insurance was also available to cover risks related to hiring a contractor or subcontractor. Multiple coverages could be attached to a premises and operations coverage form or a products and completed operations form, but each coverage had to be scheduled and rated separately.

Comprehensive General Liability forms were then introduced. The comprehensive form included the most important general liability coverage provisions, other than those pertaining to contractual liability. Endorsements to the Comprehensive General Liability form were available to cover special risks, or to extend coverage. Each major coverage type was a separate subline of insurance, meaning it had different classification tables, rates, and exposure bases. Rating was complicated, because each of the different risk exposures within the sublines could each have a different rate.

In the 1980's, changes in the general liability field resulted in the Insurance Services Office (ISO) introducing two new Commercial General Liability Coverage Forms. These forms replaced the Comprehensive General Liability Forms which had been in use. The term "Comprehensive" was dropped for the new forms and replaced with the word "Commercial," because comprehensive indicated coverage that was more complete than the old forms really provided. The new commercial forms actually have broader coverage than did the comprehensive forms.

The new Commercial General Liability forms cover all of the major liability coverages, unless an endorsement excludes a coverage. Sublines were also consolidated under the new forms. Two major sublines remain. One is the premises/operations subline, which covers the liabilities under the old owner's, landlord's, tenants, manufacturer's and contractor's, and owner's and contractor's protective liability forms. The other subline is for products and completed operations.

CGL Coverage Form: Section 1 – Coverages

Three separate coverages are provided under a CGL coverage form:

- Coverage A: Bodily Injury and Property Damage Liability;
- Coverage B: Personal and Advertising Injury Liability;
- Coverage C: Medical Payments.

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Section I also includes Supplementary Payments provisions that are applicable to Coverages A and B. Separate insuring agreements for Coverages A, B, and C state the basic protection provided. Separate exclusions sections applicable to these coverages limit the broad scope of coverage granted in the insuring agreements. Exclusions serve various purposes. Some eliminate coverage that is available through other coverage forms. Other exclusions eliminate coverage that requires an additional premium beyond the basic premium. If the insured pays the additional premium, these exclusions can be removed or modified. Finally, some exclusions deal with exposures, such as war, that are generally thought to be uninsurable.

Coverage A: Bodily Injury and Property Damage Liability

Under the Coverage A insuring agreement, the insurer promises to pay damages for “bodily injury” or “property damage” for which the insured is legally responsible. The insurer has the right and duty to defend the insured in any “suit,” but it may, at its discretion, investigate an “occurrence” and settle any claim or suit that may result. Bodily injury means bodily injury, sickness, or disease sustained by a person. The term includes death that results at any time from such bodily injury, sickness, or disease.

Damages for bodily injury can include damages claimed by any person or organization for care, loss of services, or death resulting from the bodily injury. Property damage is physical injury to tangible property or loss of use of tangible property, even if the property is not physically injured. Loss of use that results from physical injury to the tangible property is deemed to occur at the time of the physical injury. In all other situations, loss of use is deemed to occur at the time of the occurrence that caused it.

An occurrence is an accident, including continuous or repeated exposure to substantially the same general harmful conditions. The definition of occurrence is especially important, because the CGL policy covers liability for bodily injury and property damage only if they are caused by an “occurrence.” A suit is a civil proceeding in which damage because of bodily injury, property damage, “personal injury,” or “advertising injury” to which coverage applies are alleged.

Also included in the definition of “suit” is an arbitration proceeding, or any other alternative dispute resolution proceeding in which such damages are claimed and to which the insured submits with the consent of the insurer. The coverage territory is the United States, its territories and possessions, Puerto Rico, and

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Canada; and international waters or airspace, provided the injury or damage does not occur in the course of travel, to or from, any place not included in the coverage. The territory includes all parts of the world if one of the following is true:

- The injury or damage arises out of goods or products made or sold by the named insured in the territory;
- The injury or damage arises out of the activities of a person who is away for a short time on the named insured's business, but whose home is in the territory.

Coverage B: Personal and Advertising Injury Liability

The Coverage B insuring agreement provided coverage for liability arising from "personal injury" and "advertising injury." The rights and duties of the insurer to settle or defend claims against the insured are the same as in Coverage A. Coverage B applies to "personal injury" caused by an offense arising out of the named insured's business, and "advertising injury" caused by an offense committed in the course of advertising the named insured's goods, products, or services. The exclusions are advertising, publishing, broadcasting, or telecasting done by, or for, the named insured. ***"Personal injury" means injury, other than bodily injury, that results from one or more of the following offenses:***

- ***False arrest, detention, or imprisonment;***
- ***Malicious prosecution;***
- The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling, or premises that a person occupies by or on behalf of its owner, landlord, or lessor;
- ***Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products, or services; or***
- Oral or written publication of material that violates a person's right of privacy.

Libel is written publication of inaccurate information that disparages the reputation of a person or organization. Slander is the oral publication of such inaccurate information.

Exclusions -- Only two sets of exclusions apply to Coverage B. Exclusion A applies to both personal injury and advertising injury. It excludes libel and

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slander if done by, or at the direction of, the insured with knowledge of its falsity; any liability arising from oral or written statements published before the effective date of the policy; the willful violation of a penal statute or ordinance committed by, or with, the consent of the insured; and liability the insured assumes in a contract or agreement (does not apply to liability the insured would have in the absence of the contract or agreement.) Exclusion B applies only to advertising injury.

Supplementary Payments -- The Supplementary Payments section, though shown separately in the policy, actually completes the insuring agreement for Coverage A and B. Both Coverage A and Coverage B require the insurance company to defend the insured against any claim or suit seeking damages, if such damages would be covered under the policy. The insurer reserves the right to investigate and settle any such claim or suit.

Amounts spent to investigate or defend the claim or suit are paid in addition to the limits of coverage stated in the policy. However, the insurer's obligation to pay defense costs ends when the policy limits have been exhausted by the payment of judgments or settlements. There are three categories of covered defense costs. First, any costs incurred directly by the insurance company are covered under the policy. Second, any court costs or other costs assessed against the insured in a suit are covered. Third, reasonable expenses incurred by the insured at the insurance company's request also are covered.

Coverage C: Medical Payments

Medical payments coverage pays medical expenses resulting from bodily injury caused by an accident on premises owned or rented by the insured, on ways next to such premises, or caused by the insured's operations. It covers only medical and funeral expenses incurred within one year of the accident, and only if the injured person agrees to an examination by a doctor designated by the insurance company. The accident must take place in the coverage territory and during the policy period. The payments under this coverage cannot exceed the applicable limit of insurance.

Exclusions -- There are seven exclusions applicable to the medical payments coverage:

- Exclusion A eliminates coverage for injury to any insured.
- Exclusions B and C exclude employees and tenants of the insured.

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- Exclusion D excludes coverage for any injury covered under any worker's compensation law, disability benefit law, or any similar law.
- Exclusion E excludes coverage for any person injured while taking part in athletics.
- Exclusion F eliminates coverage for any injury that would be included in the "products-completed operations hazard," as defined in the policy.
- Exclusion G states the insurer will not pay expenses for any claims for injury "excluded under Coverage A."

Rating CGLI Coverage

Once a risk is thoroughly profiled, underwriters assign rates to the risk. Generally, an insurer must develop rates using reasonable measures. The rates may be developed by a service organization, such as ISO, for certain lines of insurance. Underwriters use three different methods for determining rates:

- the judgment,
- manual,
- merit methods.

Judgment rating involves reviewing the individual risk. Reports, statistics, and analyses are not used. The underwriter uses his or her own judgment to determine the rate of the risk. Manual rating involves taking pre-set rates from a manual. The manual may be prescribed by a state insurance department, developed by a service organization, or developed by the insurance company. Merit rating begins with standard or manual rates, and then applies the characteristics of the specific risk to modify the risk's rating.

Merit rating includes experience rating, schedule rating, and retrospective rating. Under experience rating, the underwriter applies the insured's loss experience when determining the rate. Typically, a period of three year is used. This is why an insured under an auto policy is asked in the application whether he or she has had any traffic violations during the last three years. Risks submitted by applicants or insureds who have not had losses, or have losses below a specified frequency and/or amount, are given a lower rate than those submitted by applicants or insureds with a poorer loss record.

Retrospective rating involves adjusting rates based on loss experience during the policy period. Schedule rating uses a prescribed schedule of debits or credits to modify a risk based on its particular merits.

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General liability premiums are intended to reflect the actual exposure to loss during the policy period. The premium may be estimated at the beginning of the policy period, but the final premium determination involves a measurement of the actual exposure. To determine the premium, the formula used to determine the premium for a commercial general liability policy is $\text{Rate} \times \text{Rate Exposure} = \text{Premium}$.

The rate depends on the nature of the insured organization and its susceptibility to liability losses. The rate exposure reflects the size of the business operations to be insured, not the type of losses to which the business is susceptible. A toy manufacturer of 1,000,000 toys is more likely to be sued for products liability than the manufacturer of only 100,000 toys. There is a higher likelihood that a customer will slip and fall in a store that has 1,000 customers a day than in a store that has only 100 customers. This difference is reflected in the rate exposure. The unit in which the rate exposure is measured is called the premium base.

Class Codes

The commercial general liability rates for an organization can be determined from the class code of the organization in the ISO Commercial Lines Manual Classification Table. The classification table lists more than 1,000 types of operations, each assigned an identification number. The class code for a particular organization represents the description in the classification table that best fits the operations of the organization. Within a given state, the same rate applies to all organizations in that classification.

Two rates apply for most businesses. Both a premises-operations rate and a products-completed operations rate are used because business organizations generally have very different susceptibilities to loss from those two hazards. For organizations that have little or no risk of incurring products liability losses, only a premises-operations rate is used. The small cost of providing products liability coverage is included in that single rate.

Premium Bases

The premium base used in rating commercial general liability coverage for any given business is also indicated in the classification table. In general, organizations of the same kind have the same premium bases—mercantile businesses are rated using a premium basis of gross sales; contracting businesses are rated on the basis of payroll; building and premises risks may

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be rated on the basis of area, gross sales, or the number of units in the building; special events might be rated on the number of admissions to the event. Other, more specialized, liability risks have their own individual premium bases. Once the premium base to be used in the rating of a particular policy is known, information about the organization has to be gathered carefully and completely in order to measure rate exposure accurately. There are specific procedures for measuring each of the five most often used premium bases—area, gross sales, payroll, total cost, and units.

Rating Claims-Made Policies

Occurrence and claims-made versions of the commercial general liability policy are rated the same way, with one exception. Because of the nature of the coverage, claims-made premiums must be modified for businesses that have been covered on a claims-made basis for less than five years. An individual could assume that a new claims-made policy is issued to insure a business. The retroactive date of the policy is the inception date, meaning that coverage exists for injury or damage during the policy period that results in claims made during the policy period. The policy is renewed for a second year and the original retroactive date is retained.

Coverage now exists for injury or damages during the previous year and the current year if the injury or damage results in a claim made during the current year. The policy is renewed again for a third year of coverage and now applies to injury or damages during the present policy period and either of the previous two years back again to the retroactive date, as long as the claim is made during the current policy period. Since a policy providing the fifth year of an insured's claims-made coverage will apply to more losses than a policy providing the first year of claims-made coverage, it is natural to expect the fifth year to cost more, and it does.

Commercial Umbrella Liability and Coverage

The Commercial Umbrella Liability Program consists of the commercial umbrella/excess liability coverage form UM 0200; various optional endorsements; and manual rules and rating information. Commercial umbrella/excess liability terms are structured for use with underlying policies that include either AAIS commercial liability forms or other comparable general liability coverage forms. The underlying auto, employer's liability, professional, liquor, miscellaneous, watercraft, or recreational vehicle coverage may be

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provided by any policy, subject to company underwriting rules and minimum underlying limit requirements.

The Commercial Umbrella Liability Manual consists of sample rules and rating information that may be used as the basis for a company manual. Each affiliated company using the sample manual as the basis for a company specific manual will need to finalize rating information, establish minimum premiums, and possibly amend the rules to reflect company requirements for eligibility, minimum underlying limits, retained limit, and other aspects of the program.

Excess Liability Coverage

A business may be exposed to legal liability because of its premises and operations, its use of motor vehicles, or other exposures. Although a business can obtain liability policies covering these exposures, the policies are subject to limits of insurance that ordinarily do not exceed \$500,000 to \$1 million. Policies that provide this first “layer” of coverage are generally referred to as primary policies. Even if a business is never faced with a verdict that exceeds the each-occurrence limit of its liability insurance, the business could have several liability losses during one policy year that could reduce its aggregate limit, leaving a subsequent loss underinsured or uninsured.

The large liability loss exposures can be insured with additional policies known as excess liability policies and umbrella liability policies. Awards to injured persons can, in severe cases, exceed the limits of primary liability policies. Although many insureds are not likely to experience such a large liability loss, the possibility of a large liability loss exists for virtually any business. Each insurer offering these types of insurance uses its own forms, calling them whatever it wishes. What one insurer calls its “excess liability policy” could, in fact, be what this text defines as an umbrella liability policy, and vice versa.

Functions of Umbrella Coverage

The term umbrella liability policy is generally used to describe a type of excess insurance that is broader than ordinary excess liability policies. While ordinary excess policies may apply in excess of only one underlying policy, an umbrella liability policy provides excess coverage over several primary policies, such as CGL, auto liability, and employer’s liability. Moreover, umbrella liability policies usually contain coverage that is broader in some respects than that of the underlying policies, thus providing primary coverage for certain occurrences that would not be covered by any of the underlying policies.

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Ordinary excess liability policies tend to be on the same terms as the underlying coverage or even on narrower terms than the underlying. An umbrella liability policy has three functions. Like an ordinary excess liability policy, it provides additional limits above the each occurrence limits of the insured's primary policies, and it takes the place of the primary insurance when primary aggregate limits are reduced or exhausted. In addition, it covers some claims that are not covered by the insured's primary policies, subject to a retention.

Features of the Commercial Umbrella Policy

Coverage under this policy will pay on behalf of the insured those sums in excess of the retained limit (primary policy limit) that the insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the insured as the result of bodily injury, property damage, personal injury or advertising injury that takes place during the policy period and is caused by an occurrence happening anywhere up to the limit of the policy including defense costs.

This policy is written in multiples of \$1,000,000 and they are subject to certain exclusions. One of the most recent of these relates to the Year 2000 Computer question, because it was neither sudden nor unexpected. Coverage can also be limited to a specified location. Other exclusions would cover obligations of the insured under workers' compensations or similar law including ERISA.

Drop-Down Coverage

The first function of a drop-down coverage applies when a manufacturer has a CGL policy with an each-occurrence limit of \$500,000 and a products-completed operations aggregate limit of \$1 million; and an umbrella policy with each occurrence limit of \$5 million and a products-completed operations aggregate limit of \$10 million. During one policy period, the primary CGL insurer pays two products liability claims totaling \$800,000, leaving only \$200,000 for additional products claims during that policy period. When the insured is held liable in the same policy period of an additional judgment of \$300,000, the CGL insurer will pay only \$200,000 and the umbrella policy will "drop down" to pay the additional \$100,000 that would have been payable by the CGL insurer if the aggregate limit had not been reduced by prior claims.

The second function could be explained when a contractor has CGL coverage and an umbrella policy and the contractor is presented with a claim alleging injury for which the contractor assumed liability under a construction agreement

with a railroad. Liability assumed under this type of agreement is excluded from CGL coverage. However, if the umbrella policy does not contain the same exclusion, it will “drop down” and pay the claim as though it were the primary policy.

Broad Insuring Agreement

Many umbrella liability policies contain one comprehensive insuring agreement instead of several specific ones. A common approach is for the insurer to promise to pay “ultimate net loss” in excess of the “underlying limit” that the insured becomes legally obligated to pay as damages for bodily injury, property damage, personal injury, or advertising injury arising out of an occurrence to which the policy applies. Bodily injury, property damage, personal injury, and advertising injury are defined in an umbrella policy and may differ from those in the underlying policies. Instead of naming various types of injury and property damage in the insuring agreement, some umbrella policies simply state that the insurer will cover “injury” for which the insured is legally liable, and contain a definition of “injury” that includes bodily injury, property damage, personal injury, and advertising injury.

Chapter 3 The Commercial Package Policy

Understanding the Basics of the Commercial Package Policy

Most commercial risks are insured under ISO's Commercial Package Policy (CPP) or its Business Owners Policy (BOP). Eligibility under a BOP is fairly restrictive and limited essentially to small, non-hazardous retail, service and processing risks, or apartment buildings and offices—coverage under a BOP is usually quite broad, with relatively few options. On the other hand, ***almost any risk is eligible under the CPP except for properties eligible for coverage under ISO's Homeowner's Program.*** The commercial property conditions form contains conditions that apply to all commercial property coverage forms, unless a coverage form contains a condition to the contrary.

Like the common policy conditions form, the commercial property conditions form eliminates the need to repeat these conditions in each coverage form. The purchase of property insurance is a critical business decision for virtually all commercial and non-commercial enterprises.

Commercial property insurance protects businesses from pure loss exposures so that those businesses can pursue speculative ventures. It enables them to protect their assets and ensure their economic survival. It allows them to purchase real property under mortgage agreements. It serves as collateral in securing business loans and lines of credit. It results in lower and more stable prices for consumers. Unfortunately, some businesses are not adequately or properly insured. Following a major fire loss to an office building in one downtown area, it was determined that only about four of 75 tenants were insured.

A coverage plan that includes a wide range of essential liability and property coverages for a commercial enterprise is the Commercial Package Policy. The package policy usually features common policy conditions, common declarations, and two or more coverage sections. A commercial property coverage part can be included in a monoline policy or in a commercial package policy. In either case, the commercial property coverage part consists of commercial property declarations, one or more commercial property coverage forms, the commercial property conditions form, one or more causes-of-loss forms, and any applicable endorsements.

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The ISO Commercial Package Policy

The ISO commercial package policy is the “industry standard” for commercial package policies. Many insurers sell package policies that contain either AAIS or independently developed forms.

Many smaller insureds are covered by “businessowners” package policies--the ISO version or an independent policy. Regardless of the particular forms used, packaging has distinct advantages--to insurers, insureds, and producers alike. A producer may be an insurance agent, an insurance broker, or a sales employee of an insurance company. For the insurance company, one advantage of packaging is reduced administrative expense.

It costs the insurer less to underwrite and issue one package policy instead of two or more monoline policies for the same insured. Also, an insurer will increase its premium volume if it can write a package policy covering a number of an insured's exposures instead of writing a monoline policy. Package policies can also help insurers avoid adverse selection.

If an insured has one particularly hazardous exposure, the higher likelihood of a loss resulting from that exposure can be mitigated to some degree by the insurer's obtaining a premium for other exposures of the insured that are less likely to result in loss. For the insured, an advantage of packaging is that there are fewer policies to buy and maintain. Packaging reduces the chance of delay in loss settlement due to disputes between different insurers.

For example, losses involving loading of automobiles sometimes fall in a “gray area” between auto liability and general liability. If one insurer provides both coverages, payment of a claim will not be delayed as it might be if each coverage were written by a separate insurer and each insurer felt the claim was covered under the other's policy. Finally, insureds, like insurers, benefit from reduced administrative expense in writing package policies.

Packaging is advantageous to producers for two reasons. First, the availability of packages facilitates account selling, or obtaining a customer's entire account instead of only a piece of it. Second, some packages are more easily sold and rated than separate monoline policies. This allows the producer to more quickly provide quotes for prospective customers, and it increases the producer's efficiency.

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Components of an ISO Commercial Package

Under the rules and forms of Insurance Services Office (ISO), a commercial package policy (CPP) **must include a common declarations page, common policy conditions, and two or more “coverage parts.”** The common policy declarations page shows the policy number; the names of the insurance company, the producer, and the named insured; the named insured’s address and business description; and the effective date and expiration date of the policy.

There is a general statement, known as the “in consideration” clause, whereby the insurance company agrees with the named insured to provide the insurance as stated in the policy in return for the payment of premium and subject to all the terms of the policy. The premium for each coverage part included in the policy is shown along with the total policy premium. The insured may cancel the policy at any time by mailing or delivering written notice of cancellation to the insurance company. If two or more insureds are listed in the declarations, only the one listed first (called the first named insured) can give notice of cancellation.

The insurance company may cancel the policy by mailing or delivering written notice of cancellation to the insured listed first in the policy declarations. In order to provide a reasonable time for the insured to obtain other insurance, the insurance company is required to give advance notice of cancellation. Notice of cancellation must be mailed or delivered to the insured at least ten days before the date of cancellation if the cancellation is for nonpayment of premium or at least 30 days before the date of cancellation for any other reason. This provision may be superseded by state law, in which case an endorsement would be added to the policy, modifying the cancellation provisions to conform with the applicable law.

Commercial Property Declaration

The declarations page of the commercial property coverage part contains the following information pertaining specifically to property insurance: The description of the property insured, kinds and amounts of coverage provided and covered causes-of-loss (basic, broad, or special), a list of mortgagees, if any, the deductible amount, and a list of the property coverage forms and endorsements attached to the policy.

The declarations also indicate the applicable coinsurance percentage and any optional coverages. Provision is made for including a scheduled supplemental

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declarations on a separate sheet of paper. For example, if an insured such as a fast food franchise has too many locations to show on the declarations page, a supplemental schedule would be added to show all locations.

Commercial Property Coverage Forms

A commercial property coverage form contains an insuring agreement, describes the property covered and not covered, sets forth additional coverages and coverage extensions, and includes provisions and definitions that apply only to the coverage form. Commercial property coverage forms do not list the causes-of-loss for which the described property is covered. That function is performed by the causes-of-loss forms. Depending on the nature of the insured's loss exposures, more than one commercial property coverage form may be included in a commercial property coverage part.

Causes-of-loss Forms

The causes-of-loss forms specify the perils covered by the commercial property coverage part. The three forms available--termed "basic," "broad," and "special"--allow the insured to select from a range of covered perils. A commercial property coverage part may contain more than one causes-of-loss form. One causes-of-loss form (such as the special form) may apply to buildings, and another causes-of-loss form (such as the broad form) may apply to personal property.

The commercial property declarations will indicate which form applies to each type of property at each location. The three most common causes-of-loss forms are the basic form, broad form, and special form. The basic form provides the narrowest coverage, and the special form provides the broadest coverage. There also is a causes-of-loss form for the single peril of earthquake.

Causes-of-loss – Basic Form

The basic form covers losses resulting from the causes-of-loss of fire, lightning, explosion, windstorm or hail, smoke, aircraft or vehicles, ***riot or civil commotion***, vandalism, sprinkler leakage, ***sinkhole collapse***, and volcanic action. Fire and lightning are not defined or explained in the form, but the other causes-of-loss are explained or restricted.

- *Aircraft or Vehicles* ~~ In order to be covered, damage caused by aircraft must result from actual physical contact with the aircraft or objects falling there from. Spacecraft and self-propelled missiles are considered to be aircraft, but the war exclusion would eliminate

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coverage for damage by missiles in time of war. Covered vehicle damage must result from physical contact with a vehicle or an object thrown by a vehicle. There is no coverage for damage by vehicles owned or operated by the insured.

- *Explosion*~~The form contains no formal definition of explosion. However, the form clarifies that the term includes the explosion of gases in a furnace or flues, but it does not include rupture of pressure relief valves or rupture of a building resulting from the expansion or swelling of its contents caused by water
- *Fire*--Although the form does not define fire, the courts generally have held that fire insurance covers only damage by hostile fire (fire that is not in a place where fire is supposed to be). Therefore, the policy would not cover damage caused by a fire in a stove, but it would cover damage caused by a fire that escaped from a stove.
- *Riot or Civil Commotion*~~Riot and civil commotion are not defined in the policy. However, the policy does state they include the acts of striking workers while occupying the insured premises as well as looting occurring at the time and place of a riot or civil commotion.
- *Sinkholes* ~~ Sinkholes result from underground water dissolving stone and creating an empty space or cavern under the ground. When the roof of the cavern gets too close to the ground surface, the surface collapses, causing damage to buildings or other property located over or near the resulting sinkhole. Damage to buildings or other property is covered, but the cost of filling the sinkhole is not.
- *Smoke*~~Covered smoke damage must be sudden and accidental. There is no coverage for damage by smoke from agricultural smudging or industrial operations.
- *Sprinkler Leakage* ~~ Sprinkler leakage means the escape of any substance from an automatic fire protection or extinguishing system. It could use carbon dioxide, halon, or any other extinguishing agent. The collapse of a tank constituting a part of such a system caused the sprinkler leakage or if it was caused by freezing. Also covered is the cost to tear out and replace any part of the building or structure to repair damage to the automatic sprinkler system.
- *Volcanic Action* ~~ Volcanic action damage is covered if it is caused by lava flow, ash, dust, particulate matter, airborne volcanic blast, or airborne shock waves resulting from a volcanic eruption. Since such losses may occur over a relatively long period of time, the form stipulates all eruptions that occur within any 168-hour period are considered a single occurrence. Cost to remove dust, ash, or

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particulate matter is not covered except for ash, dust, or particulate matter that caused loss to insured property.

- **Vandalism** ~~ Vandalism means the willful or malicious damage to, or destruction of, property. There is no coverage for breakage of glass, other than glass building blocks constituting a part of a building, but damage to other property resulting from glass breakage is covered. Loss by theft is not covered, but damage to the building caused by the entry or exit of burglars is covered.
- **Windstorm or Hail**~~Covered wind or hail damage does not include damage caused by frost, cold weather, ice (other than hail), snow, or sleet, even if driven by wind. Also, damage by rain, snow, sand, or dust to the interior of a building or property inside the building is not covered unless the building first sustains exterior damage by wind, and rain, snow, sand, or dust enters through such damaged part.

Causes-of-loss -- Broad Form

The causes-of-loss--broad form covers all of the perils covered under the basic form plus. The itemized list of the perils that it covers is breakage of glass, falling objects, and damage to personal property in the open. The glass coverage is limited to glass constituting a part of the building and specifically excludes neon tubing. Coverage is limited for any one occurrence. When glass breakage is caused by some other covered cause-of-loss, such as fire, the dollar limitations which do not apply are falling objects, weight of snow, ice or sleet, and water damage.

Weight of Snow, Ice, or Sleet ~~ The coverage for damage by the weight of snow, ice, or sleet does not cover damage to gutters, downspouts, or personal property in the open.

Water Damage ~~ The water damage coverage protects against loss from leakage of water or steam resulting from the breaking or cracking of a part of an appliance or system containing water or steam. This does not include an automatic sprinkler system.

Causes-of-loss – Earthquake

All three of the causes-of-loss forms exclude loss by earthquake and volcanic eruption, other than volcanic action as defined in the forms. Coverage for these causes-of-loss can be added by using the causes-of-loss--earthquake form. The earthquake form is an endorsement that can be used only in conjunction with one of the three causes-of-loss forms. ***Under the earthquake form, all***

earthquake shocks that occur within a 168-hour period (one week) are considered to be a single occurrence.

The deductible is stated as a percentage of the value of the insured property (2% to 10%), either actual cash value or replacement cost depending on how the policy is written. Commercial property insurance may be written as a single coverage (monoline) or as part of a commercial package policy. In either format, common declarations and common conditions are required. A commercial property coverage part consists of property declarations, commercial property conditions, a coverage form, and a causes-of-loss form.

Common declarations are used to identify the insured, a mailing address for the insured, dates of coverage, a general description of the business, and the premium for all coverages provided. Common conditions describe the general provisions relating to coverage. The causes-of-loss forms indicate the causes-of-loss, or perils, that are covered under the commercial property policy.

Causes-of-Loss -- Special Loss

The causes-of-loss special form, instead of listing the perils covered, states that it covers “risks of direct physical loss,” subject to the exclusions and limitations expressed in the form. This type of coverage has long been known as “all-risks.” However, the possibility for court decisions making the term “all-risks” broader than intended resulted in a switch to the new term “risks of direct physical loss.” The shorthand phrase “all-risks,” still widely used by insurance people, will be used here to mean “risks of direct physical loss.”

“All-risks” coverage is more expensive than named causes-of-loss coverage, but it offers two distinct advantages to the insured. First, it avoids the necessity for guessing in advance which perils will cause loss. Second, it shifts the burden of proof of coverage. Under a named causes-of-loss form, the insured must show that the loss was caused by a covered cause. Under an “all-risks” form, an accidental loss is presumed to be covered unless the insurer can show that it was caused by an excluded peril.

Both the exclusions and limitations sections of the special form contain all of the exclusions of the broad form plus some additional exclusions required by the “all risks” approach. The special form does not cover loss caused by delay, loss of market, or loss of use, smoke, vapor, or gas from agricultural smudging or industrial operations, or wear, tear, rust, corrosion, fungus, decay, deterioration, smog, pollution, settling, cracking, shrinking or expansion, insects,

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birds, rodents, or other animals. There is no coverage for loss or damage to personal property caused by dampness or dryness of atmosphere, changes in or extremes of temperature, or marring or scratching.

However, if loss by “specified causes-of-loss” or building glass breakage results, the resulting damage is covered. Specified causes-of-loss means the causes-of-loss insured under the causes-of-loss broad form, other than glass breakage. The special form excludes loss or damage resulting from continuous or repeated seepage or leakage of water over a period of 14 or more days. The form also excludes damage caused by water, other liquids, powder, or molten material that leaks from plumbing, heating, air conditioning, or other equipment, if the leakage is caused by freezing.

However, this exclusion does not apply if the insured has tried to maintain heat in the building or, if the heat is not maintained, the insured has drained the equipment and shut off the supply.

The special form does not cover dishonest acts of the insured, or partners, directors, or employees of the insured. It also does not cover voluntary surrendering of possession of property as the result of a fraudulent scheme. Damage to personal property in the open caused by rain, snow, sleet, or ice is excluded. Damage by collapse is excluded, but some coverage for collapse is provided by an extension of coverage elsewhere in the form. Also excluded is release, discharge, or dispersal of pollutants, unless the release is caused by any of the “specified causes-of-loss.” A final exclusion eliminates coverage for loss caused by:

- Weather conditions that contribute to other excluded causes-of-loss;
- Acts, failure to act, decisions or failure to decide of any group, organization, or governmental body;
- Faulty or inadequate planning, zoning, surveying, citing design, specifications, workmanship, repair, construction, renovation, remodeling, grading, compacting, materials, or maintenance.

The exclusions section is supplemented by additional exclusions and limitations in the limitations section of the form. Some of the exclusions and limitations in this section are intended to make some of the covered causes-of-loss under the special form consistent with the covered causes-of-loss named in the broad form. For example, there is an exclusion of loss to steam boilers and other steam equipment resulting from conditions or occurrences inside the boiler;

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however, coverage is provided for explosion of gases in the firebox or flue. Also, damage to hot water boilers or water heaters is not covered if it results from conditions or events within the vessel other than an explosion.

Damage to the interior of a building by rain, snow, sleet, ice, sand, or dust is not covered unless the roof or walls of the building are first damaged by a covered cause-of-loss, or unless the damage results from the melting of ice, sleet, or snow on the building or structure. Damage to gutters and downspouts is not covered if the damage results from the weight of snow, ice, or sleet. Theft loss to construction materials is excluded and there is no coverage for loss of property that is simply missing without explanation, or for loss of property transferred outside the described premises on the basis of unauthorized instructions. Loss to the following kinds of property is covered only if it is caused by "specified causes-of-loss:"

- Animals, but only for death;
- Builders' machinery owned or held by the insured unless held for sale;
- Fragile articles such as glassware, statuary, marble, chinaware and porcelain;
- Valuable papers and records.

Payment for breakage of building glass is limited to \$100 for each plate or pane and \$500 for all breakage in one occurrence. However, these limitations do not apply to breakage by any of the "specified causes-of-loss," except vandalism. An example could be that the limitations do not apply to breakage of building glass caused by a fire or windstorm. Payment for loss by theft is limited for certain kinds of property:

- Fire, lightning, explosion, windstorm or hail, smoke, aircraft or vehicles, riot or civil commotion, vandalism, leakage from fire extinguishing equipment, sinkhole collapse, volcanic action, falling objects, weight of snow, ice or sleet, water damage, breakage of building glass;
- Hidden decay;
- Hidden insect or vermin damage;
- Use of defective material or methods in construction remodeling, or renovation if the collapse occurs during the construction, remodeling, or renovation;
- Weight of rain that collects on a roof;
- Weight of people or personal property.

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Settling, cracking, shrinkage, bulging, and expansion are not considered to be collapse. This clause does not increase the amount of insurance. Rather, it adds another cause-of-loss. This section of the form extends the policy to cover two kinds of losses not otherwise included which is loss to property in transit and certain repair costs related to damage caused by water or other specified substances.

Commercial Property Conditions

The conditions include a clause relative to making changes in the policy. It states that the policy constitutes the entire contract between the parties. It can be changed only by a written endorsement, issued by the insurance company. Such changes may be made, with the insurance company's consent, upon the request of the insured named first in the policy declarations. Only the first named insured has the authority to request policy changes, and the insurance company is authorized to make changes upon the request of the first named insured without specific permission of any other insured.

The contents of the commercial property conditions relates to the mandatory endorsement that modifies the cancellation clause of the common policy conditions. The cancellation changes endorsement like the other commercial property conditions, affects any commercial property coverage form included in the same policy.

The Broadening Amendment

If the insurance company adopts any revision that would broaden the coverage under the commercial property coverage part and for which there is no additional premium charge, the broader coverage is extended automatically to outstanding policies. This automatic coverage applies only if the broadening amendment is adopted during the policy term or within 45-days before the effective date of the policy. It applies only to amendments that broaden coverage and not to those that restrict coverage.

This clause is beneficial to insureds because it provides them with broadened coverage automatically and immediately upon adoption, even if they are not aware of the broadening amendment. However, it applies only to broadening amendments for which there is no additional premium charge. The liberalization clause is beneficial to producers because it relieves them of the necessity of searching their client files to find insureds who would benefit from adding the amendments. Insurance companies are relieved at the same time of

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the cost of issuing numerous individual endorsements to add the broader coverage to outstanding policies.

The Commitment of Fraudulent Acts

The commercial property coverage part is void when the insured commits any fraudulent act related to the coverage. A void contract means one never actually existed because the parties to the contract did not have a “meeting of the minds.” So the submission of a fraudulent claim would void the coverage part. When the insured conceals or misrepresents any material fact relative to the coverage part, covered property, or the insured’s interest in covered property, the coverage part is void.

A misrepresentation is an active misstatement of a fact. Concealment, on the other hand, does not involve an active misstatement of fact. Concealment is also a passive failure to disclose a material fact. A fact relative to an insurance contract is considered to be material if knowledge of it would cause the insurer to refuse to write the coverage or to charge a higher premium for it.

The Control of Property

The control clause consists of two parts. The first part states coverage under the policy shall not be affected by acts or omissions of persons other than the insured if the others are not acting under the direction or control of the insured. It is doubtful this part of the clause changes the coverage under the policy in any way. The second part of the clause says a violation of a policy condition at one location does not affect coverage at any other location. The second part of the control clause can be important to the insured if the policy provides coverage at more than one location. In the absence of this part of the control clause, failure to maintain the alarm system at one location might suspend coverage at all locations, even though the alarm systems are properly maintained at the other locations. Under this provision, only the coverage at the location with a defective alarm system would be affected.

The Insurance Under Two or More Coverage Parts

This policy condition is necessary because it is possible to include several coverage parts in a single CPP. It is possible that some property might be covered under two or more of the coverage parts. This clause prevents double recovery by the insured in such instances. The total payment under all applicable coverage parts is limited to the actual loss sustained. An insured may have more than one policy covering a given loss.

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The Lack of Benefit to Bailee

A bailee is a person or business organization that has possession of the property of another. Examples of this could be railroads, trucking companies, dry cleaners, television repair shops, laundries, and fur storage firms. Bailees may be liable to bailors for damage to the property they hold. Bailees sometimes try to limit their liability by contractual provisions stating the bailee is not liable for damage if the damage is recoverable under insurance carried by the bailor. The “no-benefit-to-bailee” clause is intended to defeat such provisions in the bailment contract, and to reinforce the insurance company’s right of subrogation against the bailee.

The Mandatory Endorsement

A mandatory endorsement to the commercial property coverage part modifies the cancellation provisions of the common policy conditions. This endorsement permits the insurer to cancel the policy with only five days’ notice if any of the following incidents occur:

- Fixed or salvageable items have been or are being removed from the building, unless they are removed for remodeling or renovation.
- Necessary heat, water, sewer service, or electricity has not been furnished to the premises for a period of 30, or more consecutive days.
- Property taxes on the insured property are more than one year past due.
- The building has been damaged by a covered cause-of-loss, and permanent repairs have not been started or contracted for within 30 days of initial payment of loss.
- The insured property has been vacant or unoccupied for 60 or more consecutive days.
- The building has been declared unsafe, ordered vacated, or ordered demolished by governmental authority.

A building is considered “vacant” if it does not contain enough business personal property to conduct normal operations. For cancellation purposes, if a building containing rental units has 65% or more of its rental units or floor area vacant or unoccupied, the building is considered unoccupied. The provisions of the mandatory endorsement do not apply if the building is vacant or unoccupied because there is a normal pattern of seasonal occupancy, the building is under construction or is being renovated or remodeled, or a vacancy permit endorsement is attached to the policy.

The Policy Period & Coverage Territory

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The insured property is covered only while it is located within the United States of America, Puerto Rico, or Canada. Commercial property conditions state that coverage begins at 12:01 A.M. on the effective date and ends at 12:01 A.M. on the expiration date shown in the common policy declarations. The beginning and ending time is determined by standard time at the insured's mailing address as shown in the common declarations, even though some or all of the insured property may be located in a different time zone. A few states require that 12 noon be used, rather than 12:01 A.M.

Transfer of Rights of Recovery Against Others

Transfer of Rights of Recovery Against Others enables the insurance company, after it has paid a loss under the policy, to recover the amount paid from any party who caused the loss or is otherwise legally liable for the loss. This process is known as subrogation, though that term is not used in the policy. When a building owner enters into a contract to have the building renovated by a contractor and the contractor allows the building to be damaged by a fire caused by his negligence, the owner has the right to recover the fire damages from the contractor.

However, if the owner collects instead from his or her insurance policy, the owner's insurance company, after payment of the fire loss, would take over the right of recovery from the contractor, and the insured would be obligated to assist the insurance company in its efforts to recover the amount paid.

If the insured takes any action that impairs the insurer's right of recovery, the insurer may not be required to pay the loss. The policy specifically authorizes the insured to waive the right of recovery against any other party, provided such waiver is made in writing and prior to loss. Such a clause would preclude the insurer from seeking recovery from a contractor, but it would not have impaired the owner's right to collect from the insurer, since the "waiver" was in writing and given prior to the loss.

Waiver of recovery may be given by the insured after loss only to another party insured under the same policy, a parent or subsidiary company, or a tenant of the insured property. Any other waiver given by the insured, after loss has occurred, may impair the insured's right to collect from the insurer for the loss. The insured cannot transfer any rights or duties under the policy to any other person or organization without the written consent of the insurance company. For example, if the insured sells the property covered by the policy, the coverage cannot be transferred to the new owner of the property without the

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written consent of the insurer. Such a transfer of coverage is usually referred to as an assignment of the policy, but that terminology is not used in the common policy conditions.

The clause provides specifically for automatic transfer of coverage upon the death of an individual named insured. Upon death, the insured's rights and duties under the policy are automatically transferred to the insured's legal representatives, or, if the insured's legal representatives have not yet been appointed, to any person having proper custody of the insured property.

Two or More Policies for One Loss Consideration

An insured may have more than one policy covering a given loss. In keeping with the principle of indemnity, this policy condition limits the total recovery from all applicable insurance to an amount not in excess of the actual loss sustained. If the other insurance is provided under all of the terms and conditions of the ISO commercial property coverage part, then each policy pays in the proportion its policy limit bears to the total policy limits of all applicable policies. If the other insurance is not subject to all of the conditions of the ISO commercial property coverage part, then the policy subject to the commercial property coverage part is excess coverage and pays only to the extent the covered loss exceeds the amount due from the other policy.

Rights of the Insurance Company

Insurance companies have years of legal experience litigating the terms of their contracts -- contracts written by skilled lawyers which have been carefully upgraded as new decisions are handed down by appellate court. The law often has to determine what the rights of the insurance company are. Because companies make it their business to know how standard terms have been defined by judges, carriers have the upper hand in drafting policies and selecting the language they find most advantageous for making a profit.

Insurance law routinely provides that should there be an ambiguity or uncertainty in a policy, an uncertainty in choice of wording or ambiguity in meaning would be resolved in favor of the policyholder and against the insurer. In the absence of a misrepresentation regarding coverage or exclusions, if the language of the policy is clear and explicit, the clear meaning will be enforced. Insurance contracts are interpreted by judges and courts to effectuate only the objectively reasonable expectations of the insured.

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Any personal, or subjective, expectation of a policyholder which cannot be reasonably supported by the language of the contract is unenforceable. It matters not what the policyholder/customer truly and honestly believes in his or her own mind. That subjective opinion is never in issue in a court of law.

Exclusions and limitations in a policy often result in denying coverage when there is a loss, so they must be in clear and unmistakable language. This is the reason exclusions and limitations are always narrowly, or strictly, construed. If there is more than one meaning to be given to an exclusion or a limitation, the narrowest interpretation will be adopted by the court.

Any exclusionary clause that is not clear and conspicuous will be interpreted in the interests of the insured. In cases where a policyholder's lack of knowledge could result in the loss of benefits or the forfeiture of rights under a policy, an insurer is required to bring such fact to the insured's attention and to provide relevant information to enable the insured to take action to secure rights provided by the policy. Unfortunately, an insurance agent is not obligated to advise a policyholder on the adequacy of the limits of coverage selected by the policyholder. The term "limits" refers to the amount of insurance coverage.

Examination of Books and Records

The insurance company reserves the right to examine and audit the insured's books and records relative to the policy at any time during the policy period and for up to three years after termination of the policy. This provision is included because many commercial property and liability coverages are issued with estimated premiums. The final premium is determined after the policy expires, based on reported values of the insured property, the amount of the insured's sales or payrolls, or some other variable premium base.

The insured is required to report the variable premium base to the insurance company, and the insurance company may accept the insured's reports without verification. However, this provision permits the insurance company to make an on-site verification whenever it is deemed necessary. The insurer's right under this provision also may be exercised during the loss adjustment process.

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Inspections and Surveys

This provision gives the insurance company the right to inspect the insured's premises and operations at any reasonable time during the policy period. The inspections may be made by the insurer's own personnel or by a rating bureau, service bureau, or other organization acting on behalf of the insurer. Such inspections are important in the determination of the insurability of the insured's property and operations and in determining the proper insurance rates to apply. The insurance company may inform the insured of the results of such inspections and may recommend changes.

However, it does not have a duty to do either. This policy provision makes it clear that the insurer is not obligated to make safety inspections; does not guarantee that conditions are safe or healthful; and does not guarantee that the insured is in compliance with safety or health regulations. The disclaimer clauses have been included in the policy in an effort to protect the insurance company against suits by persons who allege that they were injured as a result of the insurer's failure to detect a hazardous condition or by the insured alleging that the insurer failed to detect a violation of laws or regulations, with a resulting fine or other penalty against the insured. There have been several such suits against insurers in recent years.

Premiums

The P&C insurance segment represented 41% of global industry premiums collected in 1998. Global insurance premiums grew by 9.7% in 2004 to reach \$3.3 trillion. The compound effect of insured catastrophe losses of \$27.5 billion in 2004 and \$56.8 billion in 2005 has strained reinsurance market capacity and driven up the prices carriers pay for this coverage as much as 200%. Corporate financial ratings for property and casualty (P&C) carriers heavily exposed to catastrophic loss are dropping, with resulting adverse marketplace impact. Primary carriers and reinsurers need immediate solutions to manage their exposure to catastrophe losses and reduce the negative effect on profitability. This covers technology solutions that allow carriers to make meaningful changes to core business practices to meet profit goals.

The Property & Casualty Insurance Carriers Industry report features 2007 current and 2008 forecast estimates on the size of the industry (sales, establishments, employment) nationally and for all 50 U.S. States and over 900 metro areas. The report also includes industry definition, 5-year historical trends on industry sales, establishments and employment and estimates on up to 10

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sub-industries, including fire, marine and casualty insurance, automobile insurance, workers' compensation insurance, and property damage insurance.

The insured named first in the declarations is responsible for the payment of the premium under the policy. Also, any return premium under the policy will be paid to the first named insured by the insurer.

Property of the Insured

The property of the insured could include many things. Natural disasters such as earthquakes, hurricanes and other storms, cause substantial property damage and loss of life in many parts of the world. The relative infrequency and importance of extreme cases leads to a preferential use of simulation models over historical statistical/actuarial models in studying the impact of such catastrophes on insurance systems. Given the increasing awareness of the highly intermittent nature of geophysical phenomena, modelers need to revisit their assumptions not only of the geophysical fields, but also of the geographical distribution of insured property as well.

Newly Acquired or Constructed Property

Newly Acquired or Constructed Property is a coverage extension providing automatic coverage for a new building being constructed at the premises described in the declarations. Automatic coverage also is provided for newly acquired building at other locations provided the newly acquired building will be used for a purpose similar to the use of the building described in the declarations or the newly acquired building will be used as a warehouse.

The coverage is limited to 25% of the limit of insurance for buildings stated in the declarations or \$250,000, whichever is less. The extension also provides automatic coverage for business personal property at newly acquired locations, but this automatic coverage does not apply to property at a fair or exhibition. This coverage is limited to 10% of the limit of insurance for business personal property stated in the declarations or \$100,000, whichever is less. The coverage for buildings and business personal property provided by this extension is temporary.

It terminates automatically 30 days after the acquisition of the new location or the start of construction of the new building; on the expiration date of the policy; or on the date the insured notifies the insurer of the new location or new building, whichever comes first. Premium for the coverage is calculated from

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the date of acquisition or start of construction, regardless of when the insurer is notified.

Business Personal Property of the Insured

Business Personal Property of the Insured covers direct loss or damage to personal property owned by the insured and used in the insured's business. It includes furniture and fixtures, machinery and equipment, stock, and other similar personal property except those items excluded under Property Not Covered. The form defines stock as "merchandise held in storage or for sale, raw materials and in-process or finished goods, including supplies used in their packing or shipping."

Business personal property of the insured also includes labor, materials, or services furnished by the insured on personal property of others. The insured's interest in improvements and betterments also is insured as business personal property, although improvements and betterments are actually a part of the building.

The form defines improvements and betterments as fixtures, alterations, installations or additions that are made a part of the building or structure one occupies but does not own or an individual has acquired or made at his or her expense but cannot legally remove. The business personal property item of the 1990 edition of the building and personal property coverage form also includes leased personal property for which the named insured has a contractual responsibility to procure coverage.

Personal Property of Others

Personal Property of Others is designed to protect the insured against loss or damage to the personal property of others while such property is in the custody of the insured. It is intended for businesses that usually have non-owned property in their care, such as lawnmower repair shops, furniture reupholstery shops, and other bailee-type businesses. Such property is covered only while it is (1) in the insured's care, custody, or control and (2) in or on the building described in the declarations or within 100 feet of the described premises. This property is not covered while being transported away from the premises.

Property Not Covered

All three classes of covered property may be modified by this section of the form. The Covered Property section and the Property Not Covered section must be read together in order to determine whether a specific kind of property

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is insured. There are several reasons for excluding some kinds of property from coverage. First, it may be illegal to insure some kinds of property, such as narcotics being held for sale outside of normal medical channels. Second, some property, such as foundations of building, may not be subject to loss by the perils insured against.

Finally, some kinds of property are excluded from coverage under the commercial property policy because they can be insured more advantageously under other coverage. Automobiles and aircraft are examples of such property. The commercial property forms do not provide satisfactory insurance for automobiles because the coverage would apply only while the insured property (the automobile) is on described premises or within 100 feet thereof but the most serious loss exposures for automobiles are off premises.

The building and personal property coverage form lists sixteen classes of property or kinds of property loss that are not covered:

- Accounts, bills, currency, deeds, evidences of debt, money, notes or securities;
- Animals owned by the insured unless they are held for sale and are inside a building (animals owned by others are covered only if they are boarded by the insured);
- Automobiles held for sale;
- Bridges, roadways, walks, patios, or other paved surfaces;
- Contraband, or property in the course of illegal transportation or trade;
- The cost of excavations, grading, backfilling or filling;
- Foundation of buildings, structures, machinery or boilers if such foundations are (1) below the floor of the lowest basement or (2) if there is no basement, below the surface of the ground;
- Land, water, growing crops, or lawns;
- Personal property while airborne or waterborne;
- Pilings, piers, wharves or docks;
- Property otherwise insured, if such other insurance describes the property more specifically;
- Retaining walls that are not a part of the insured building;
- Underground pipes, flues or drains;
- The cost to research, replace or restore the information on valuable papers and records, including those which exist on electronic or magnetic media

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- Vehicles or self-propelled machines (including aircraft or watercraft) that are (1) licensed for use on public roads or (2) operated principally away from the described premises;
- The following property while not in a building: (1) grain, hay, straw or other crops, and (2) fences, radio or television antennas including their lead-in wiring, masts or towers, signs not attached to buildings, trees, shrubs or plants.

The Package Modification Factors

An important element of the commercial package policy program is the package discount the insured may receive. The premium for a CPP is determined using the same rules and rates from the ISO Commercial Lines Manual (CLM) that would apply if each coverage part were being issued as a monoline policy. If both property and liability coverages are provided in the CPP, the application of package modification factors often provides a premium discount for the insured.

This discount is determined by applying the appropriate package modification factors to the premiums for the various coverage parts included in the policy. The factors reflect the type of business, the division of the CLM under which the particular coverage part is being rated, and other eligibility requirements. The package modification factors may range from as low as .60 to as high as 1.00 depending, of course, on the preceding variables, as well as state variations.

For example, a package modification factor of .75 means the premium for that coverage part will be three-fourths of the premium that would apply if the coverage part were issued in a monoline policy. In most states, a factor of 1.00 means the CPP insured receives no discount on the coverage part to which that factor applies.

Exclusions

The Ordinance or Law exclusion refers to when some cities have building codes that require all new buildings in specified areas to be of fire resistive construction, sprinklered, or both. Old buildings that do not comply with the codes may continue to be used. However, if a building that does not comply with the code sustains major damage by fire or other perils, the code may require that it be demolished, and any replacement building would then be required to comply with the code. Such codes impose additional losses on the property owner in three ways. First, what would otherwise have been partial loss is converted to a total loss. Second, the property owner must incur the

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expense of demolishing the remaining part of the building and clearing the site. Finally, the cost of the new building to comply with the code is greater than the cost of a building like the old one. These additional consequential losses are not covered under the policy because of this exclusion. However, they can be covered by endorsement for an additional premium.

Earth Movement -- No coverage is provided for damage caused by earth movement, other than sinkhole collapse. Earth movement includes earthquake, landslide, mine subsidence, and similar movements. Damage by fire caused by earth movement is covered. Earthquake coverage can be added for an additional premium.

Government Action -- Seizure or destruction of property by government action is not covered. This exclusion does not apply to destruction of property by government order to stop the spread of a covered fire.

Nuclear Hazard -- There is no coverage for loss caused by nuclear reaction, radiation, or radioactive contamination. Loss by fire resulting from these causes is covered.

Power Failure -- There is no coverage for loss caused by power failure or failure of other utility service, if such failure occurs away from the described premises.

War and Military Action -- There is no coverage for loss caused by war, revolution, insurrection, or similar actions.

Chapter 4 E-Commerce Liability

Elements of Electronic Commerce

Internet commerce covers a wide variety of e-commerce operations. We are seeing new techniques applied to existing tried-and-true business and the development of completely new forms of electronic commerce. Internet electronic commerce is growing extremely fast. The entire Internet and all related industries are moving at an unbelievable pace. America's economy and society has been transformed by new information and communications technologies.

The information technology sector has accounted for almost one-third of U.S. economic growth, and has helped spark an increase in U.S. productivity and global competitiveness. Electronic commerce is an emerging model of new selling and merchandising tools in which buyers are able to participate in all phases of a purchase decision, while stepping through those processes electronically rather than in a physical store or by phone. The processes in electronic commerce include enabling a customer to:

- ***access product information;***
- ***select items to purchase;***
- ***purchase items securely;***
- ***have the purchase settled financially.***

Today more than 50% of Web users are from outside the U.S.—and they have money to spend. Experts predict non-U.S. Internet commerce will explode worldwide spending more by 2007. Shortly thereafter spending will overtake that in the U.S., meaning if one's site is available only in English, he will be effectively ignoring more than half of the market. Of course, lots of people living outside of the U.S. speak English, but countries in which English is the native language represent only 8% of the world's population. Forrester found that visitors spend twice as long and are three times more likely to buy from a site with information in their native language. That has relevance for the U.S. market as well, where companies are increasingly seeking new markets.

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Insurance Issues for E-Commerce Activities

More insurance brokers, lawyers, and commentators are writing about insurance issues for e-commerce activities. There is chaos in this arena, because there is no consensus among the insurance industry, brokerage industry, or policyholder community with respect to how best to address these issues. Everything is in a state of fluctuation. But other insurers are responding in a different way---by saying either the new policies are not needed, or it is impossible to underwrite risks being underwritten by these new policies (especially in the first-party context).

Global Basis

Globalization is the broad term encompassing everything one needs to make his e-business, including Web sites, capable of meeting the needs of users in different countries. He will consider different languages, currencies, logistics, and even specialized support issues. Now that e-commerce is crossing cultural and international boundaries, commerce sites will obviously be more effective if they are written in a user's native language. But there is more to globalization than translation. Beyond using the right vernacular to name and promote one's products, globalization is a means of explaining one's features and benefits in a way that makes sense to his target market. Globalization is a marketing tool that will help the business owner sell his business around the world.

Perhaps more than any other insurance issue that has materialized before (except maybe the Y2K issue), these e-commerce insurance issues must be analyzed on a global basis. All multinational corporate insureds, regardless of where they are headquartered, should be demanding the same breadth of coverage that other multinationals based in other parts of the world are obtaining.

The only way to attempt to achieve that goal is to obtain and review the e-commerce insurance wording offerings both in the stand-alone market and by endorsement to traditional policies in the major insurance markets of the world. Without doubt, e-commerce insurance wordings are developing differently around the world. One large global insurer, for example, sells stand-alone e-commerce insurance in the United States and the United Kingdom. What serves as an exclusion in the U.S. policy offering of this insurer serves as an insuring agreement in the U.K. policy. And this is just one example.

In sum, a multinational corporation, regardless of where it is headquartered, can no longer afford to limit itself to a review of the insurance wordings, and

capacity, offered in the country in which it is headquartered. For any e-commerce insurance issue it tries to address, it must conduct an international comparative analysis of wordings available, at least in the key marketplaces of the world. And if the multinational company does not have the means to conduct such an international comparative analysis, then it needs to “partner” with an insurance professional, whether broker, consultant, or lawyer, who can advise the company on such issues.

Exposures

The exposures generated and policy forms necessary to cover these exposures are probably not all known and certainly not all ready to be marketed. The insurance industry moves at a slow pace in the development of new products, and they are years behind the Internet industries at this time. Successful Internet insurance placement today is based upon a thorough working knowledge of both industries and an ability to adapt current insurance technology to fit the needs of a rapidly growing risk segment.

New policy forms will be coming out and one’s exposures will be increasing. Regular business operations with e-commerce present modern challenges. Cyber entertainment operations present huge challenges. There is a great similarity in the needs of all types of operations and they must be approached in the same methodical manner. Cyber Entertainment operations usually consist of the development and broadcasting of passive and interactive content.

Because of this, they have a large amount of property value in the form of content, servers, co-located servers, and a very large exposure to loss of income if the system goes down. In addition, they have the normal and not so normal commercial liability exposures found in an adult Internet business.

E-Commerce Risk

There is a growing awareness of risks inherent in the use of the Internet to conduct business and continued reliance on internal computer systems, networks, etc., to keep operations running. Responses to this increased awareness include the following. First, the insurance industry has responded with the development of insurance products expressly designed to insure third-party liability and first-party risks related to e-commerce activities. A handful of insurers have developed these liability policies, which cover, among other things:

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- claims for injury or damage because of a wrongful act, error;
- spread of a computer virus;
- infringement of some form of intellectual property right;
- invasion or infringement of right of privacy or publicity, and defamatory conduct.

One reason for much of the debate about coverage for e-commerce risks among risk and insurance professionals is liability programs of many corporate insureds do not include all of the coverages needed to respond to liability risks associated with e-commerce activities. This is markedly different than with insurance for first-party risks, where most corporate insureds already have the necessary basic coverages in their programs. At a minimum, insureds will need some form of the following three coverages, or their equivalent, in their liability insurance program to respond to e-commerce liability risks:

- ***commercial general liability (or umbrella liability);***
- ***professional liability;***
- ***multimedia errors & omissions.***

However, many corporate insureds have only standard CGL, umbrella, and excess liability coverage in their programs. These corporate insureds have the most issues to address if they want their liability risks for e-commerce activities more fully covered. In contrast, some corporate insureds do have all three of these coverages, either in stand-alone policies or rolled into one manuscripted liability policy at a primary or umbrella layer. The risk managers of such organizations are the most vocal in their opinion that they have no need for any of the new stand-alone e-commerce insurance policies. They might be right, but the point for them to recognize is many U.S. Fortune 1000 companies have only standard CGL, umbrella, and excess liability coverage, and stand-alone e-commerce insurance might be a viable option for those companies.

Risk of Infringement of Intellectual Property Rights

E-commerce activities pose a risk of liability for infringement of intellectual property rights, such as infringement of patent, trademark, copyright, right of publicity, and the like. Some of these risks are covered under standard CGL and umbrella wording. However, some of these risks are not covered for any of the following reasons. First, the claimed injury must be “causally connected” to the insured's advertising activities. That is because much of the coverage for such risks will be provided by the “advertising injury” coverage in a CGL or umbrella policy.

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But that coverage only responds if the injury arises out of the insured's "advertising activities." One of the problems associated with e-commerce activities is an insured could be faced with liability because a third person's advertisement on its Web site is the source of infringing material. For such claims, CGL and umbrella insurers are denying coverage, on the basis such a claim does not arise out of the insured's advertising activities.

Second, even if the claimed injury does arise out of the insured's advertising activities, the injury still must fall within one of the specified "offenses" set forth in the standard definition of "advertising injury" in the CGL or umbrella policy. Some intellectual property risks associated with e-commerce activities likely fall outside of such definitions. For example, the risk of infringement of the right of publicity likely does not fall within the scope of the definitions. Many courts also do not recognize coverage for patent infringement under newer standard CGL wording (i.e., the wording does not include "piracy" and "unfair competition," but rather includes only "infringement of copyright, title, or slogan").

Third, many CGL insurers are issuing their policies with very narrow "advertising injury" coverage. Such narrow provisions limit coverage to infringement of trademarked or copyrighted advertising materials, and specify the infringement must be caused by the insured's paid advertisement in a newspaper, magazine, television ad, or other medium. Such language severely restricts the extent of coverage for intellectual property risks posed by e-commerce activities.

These potential "gaps" for the risks are not new. One solution is to purchase some form of media errors and omissions insurance, typically termed something like "multimedia" liability insurance. Although these forms cover the types of risks discussed here, coverage for Internet activities have to be added by endorsement, because other forms of media (CD-ROM, video games, and the like, in addition to standard forms of broadcasting, publishing, and advertising) have been the main concern of insurance products. Interestingly, those older multimedia forms serve as part of the platform for many new e-commerce liability insurance products.

E-commerce activities pose a risk of liability for causing damage to another person's computer data, software, programs, computer network, and the like. This could occur, for example, by infecting a customer's or supplier's computer system with a virus. If that customer or supplier suffers damage, it could present

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a claim against the insured for that damage, and all consequential losses suffered because of that damage.

Pure financial losses sustained by a customer or supplier are to be considered a real risk. In addition to the scenario outlined above (where the insured causes the spread of a computer virus to a customer or supplier), there are other risks of loss faced by the insured's customers and suppliers. For example, what if the insured's computer network or Web site "crashes," sustains a "denial of service" attack, or for some other reason is inaccessible by the insured's customers and suppliers?

The Risk of Privacy Invasion

E-commerce activities pose a risk of liability for invasion, infringement, or interference with rights of privacy that could be problematic for traditional CGL and umbrella insurance wording. That is because traditional wording provides coverage for invasion of rights of privacy caused by the publication or utterance of information that violates a person's right of privacy. In other words, the "triggering" language in the policy is the information must be disseminated. But the risk posed by e-commerce activity is not so limited--the "big" privacy risk being discussed is risk of liability for merely gathering information about someone who visits a Web site without them knowing information about him or her is being gathered--there is no need for any dissemination of the information for the company' conduct to be actionable.

First-Party Perspective

"First-party risks" are the risks generally covered by commercial property policies; commercial crime policies; fidelity bonds; and kidnap and ransom policies. It is true these types of policies can also provide liability coverage in the context of such first-party losses, when a third party seeks to impose liability on the insured for a loss recognized as a first-party loss under the policy. However, focus of the discussion here is on the first-party loss itself. The first-party policies cover, among these things:

- lost income and extra expenses because of the "crash" of the insured's computer system or web site;
- the denial of access to the insured's web site or computer system;
- or other type of loss of computer data, software, and programs.

The policyholder community has responded to the insurance industry response to these issues in different ways. For the most part, Fortune 1000 companies

are taking the position they do not want more stand-alone policies which they have to negotiate, buy, and administer, and for which they have to maintain a separate tower of insurance.

Professional Liability

It should be noted that risks of such “pure financial loss” also are not new to many corporate insureds. The insurance “solution” in times past to fill the gap in insurance programs for such risk typically has been some form of professional liability/errors and omissions coverage. Professional liability coverage typically is intended to work hand-in-glove with an insured’s CGL and umbrella program. For example, if the insured’s activities or products cause physical injury to property, then the insured’s CGL or umbrella policy should respond, but not the professional liability policy.

However, if the insured’s activities or products do not cause physical injury to property, then the professional liability policy should respond, but not the CGL or umbrella policies. Finally, it also is important to note that, as with the older multimedia E&O insurance forms, these professional liability insurance forms serve as part of the platform for many of the new e-commerce liability insurance products.

Prior Acts Coverage

Believe it or not, some insurers are not willing to offer “prior-acts” coverage on this line of insurance. So do not assume the quote is offering prior-acts coverage. If a business wants this coverage, it is important to make sure to specifically confirm—in writing—that it is provided. Because most of these policies are “claims-made” policies, prior-acts coverage can be very important. A common issue for professional liability policies is determining the breadth of “professional services” covered by the policy.

There are several different ways to address this issue. Some forms require the insured to specifically list in the declarations or by endorsement the services intended to be covered. Other forms use defined terms to describe which services are covered. In both cases, if the insured gets hit with a claim arising from services not described, coverage likely will be denied. However, some forms simply state “professional services” are “all services performed by or on behalf of the insured.” That appears to be a “blanket professional services” provision. Obviously, such a provision is preferable over the other two options. The Insuring Agreement may refer to “Negligent Act, Error, or Omission” or “Any Act, Error, or Omission.”

Professional liability coverage, and to a lesser extent media errors and omissions coverage, can come in one of two forms. The first version covers claims for any “negligent act, error, or omission.” The second version covers claims for “any act, error, or omission.” The key difference is absence of the word “negligent” in front of the word “act.” Many courts interpret insuring language of “any act, error, omission” to provide broader coverage than that afforded by the language “negligent act, error, or omission.” Accordingly, the word “negligent” should be stricken from the insuring language.

Liability Risks

This will not provide a comprehensive listing of third-party liability risks associated with e-commerce activities. Rather, it is intended to illustrate the types of risks at issue, to show how such risks fit within three types of coverages:

- CGL and umbrella insurance;
- Multimedia errors and omissions insurance; and
- Professional liability insurance.

Understanding these three types of coverages and how they insure different types of risks is essential to understanding not only key features of new stand-alone e-commerce liability insurance policies, but also to understanding how to amend an insurance program to better respond to e-commerce liability risks.

E-Commerce Liability Risks

First, they need to realize their choices are not limited to forgoing coverage or buying one of these new e-commerce insurance policies. They could insure risks by adding amended professional liability and multimedia errors and omissions coverage to their programs (discussed below). Second, new e-commerce insurance policy forms and endorsements must be carefully reviewed to make sure quoted coverage covers all the professional liability and media errors and omissions risks that otherwise would be insured by buying professional liability and multimedia errors and omissions coverage.

Some policy forms come up short in one coverage area or the other, either focusing on professional liability aspect to the detriment of media errors and omissions aspect, or leaving out one of the coverages altogether. And some

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insurers with policy forms that contain both coverages are quoting with exclusionary endorsements that delete one of the coverages.

These two realities occur because the market for this insurance is young, and some insurance underwriters are not experienced in, or comfortable with, both professional liability or media errors and omissions underwriting. Third, regardless of which course of action a company takes, it must also realize in any event, it should try to amend its CGL and/or umbrella policies to address some of the gaps mentioned above for any risks it actually wants to be covered under those policies.

Extortion Risks

E-commerce activities invite extortion risks, so let's consider the following scenarios. A computer hacker demands money or something else of value from an insured under threat of unleashing a denial-of-service attack against the insured's computer system or web site. A computer hacker threatens to attack an insured's computer system or web site with a virus that will delete, destroy, or otherwise corrupt key-operating data, software, or programs necessary to operate such system or web site. A computer hacker threatens to hack into the insured's computer system and delete important information, perhaps not information necessary to run key operations, but important information nonetheless.

Obviously, such wording does not respond to the risk mentioned here. Some policies do extend coverage to threat of damage to property. However, it is not clear whether such wording will respond to threats of denial of service attacks and other computer viruses that do not damage or destroy computer data, software, or programs, but instead merely render such property useless.

Closing the Gaps with Traditional Insurance Policies

As with first-party e-commerce risks, the question must be asked: "Does an insured have to buy one of these new e-commerce insurance policies to insure its e-commerce liability risks?" The answer with respect to first-party e-commerce risks is "in theory, no, but in practice perhaps yes for now," the answer with respect to liability e-commerce risks is "in practice, no."

As noted above, in many ways the new e-commerce liability insurance policies are nothing more than a combination of one old standard coverage-professional liability insurance-with one newer standard coverage-multimedia errors and omissions. Thus, those insureds who have a program using only standard

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CGL, umbrella, and excess liability insurance should be able to simply add traditional professional liability and multimedia errors and omissions coverage to their program, making some adjustments to confirm coverage for e-commerce exposures. Some of the issues that also will need to be addressed include the following:

- Does the insured want to have such coverage on a primary level?
- If so, should such coverages be bought separately or in a combined policy, and can the coverage be scheduled as underlying insurance on the umbrella policy, or must the insured maintain a separate tower of insurance for the coverage?
- If the insured does not want such coverage on a primary level, can coverage be built into the insured's umbrella program?

And regardless of how such coverage is built into the program, an insured still should consider whether there are any adjustments that should be made to the CGL or umbrella program to better insure e-commerce risks the insured prefers to run through that coverage. Finally, all of these coverages should be reviewed to minimize coverage overlaps. In other words, risks can be covered in more than one place; the job for the insured is to determine where to place coverage in the program to maximize coverage with least cost and inefficiencies.

With respect to liability insurance issues, all of the foregoing scenarios are being played out in the U.S. market (as well as several other insurance markets around the world, such as the United Kingdom and Australia). Some insureds already have the basic coverages needed in their liability insurance programs to respond to e-commerce liability risks and are merely reviewing their programs to confirm coverage intent with their insurers and/or are amending some of the policies where necessary.

Some insureds have only standard CGL, umbrella, and excess liability policies in their programs and are either adding standard professional liability and multimedia errors and omissions coverage into their programs, or are buying one of the new e-commerce insurance policies.

E-Commerce and Commercial Property Coverage

With respect to commercial property policies, one gap relating to e-commerce risks comes in the form of the requirement in most all-risk policies that there be “physical loss or damage” to property to trigger both property damage and time

element (e.g., business interruption and extra expense) coverages of the policy. Some e-commerce risks involve “nonphysical events,” where it is not clear that “physical loss or damage” to property has occurred. Another gap for e-commerce risks has to deal with valuation issues for stolen computer data, software, or programs.

Whereas standard commercial property policies that have been slightly amended contain detailed valuation provisions for lost or damaged data, software, or programs, standard commercial crime policies and fidelity bonds do not. Such policies typically provide coverage for the lesser of actual cash value of the stolen property or replacement cost. It is not clear how much, if any, coverage will be provided for stolen EDP media under such valuation provisions.

Denial of Service Attacks

The most frequently referenced example of a “non-physical event” e-commerce loss is a denial of service attack, where an insured’s web site is bombarded with millions of e-mails from a bogus source, thereby blocking access to the site by legitimate users. Technically, the computer server hosting the web site is what has been attacked. Does such an event constitute “physical loss or damage” to any property? Insurers say, “No.” Courts most likely will side with the insurance industry on this issue. If so, such a loss probably will not trigger either property damage coverage or time element coverage in a traditional commercial property policy.

E-Commerce and Third-Party Liability

Much written on the subject of liability risks associated with e-commerce activities provide a lot of the different types of third-party ability risk exposures for e-commerce activities. Here, risk issues are discussed in the context of potential coverage gaps in traditional insurance programs for many corporate insureds. Therefore, the discussion of liability risks set forth is intended not to be comprehensive, but rather illustrative, and to help one to better understand how to review any insurance program with respect to e-commerce risks, as well as to review new e-commerce insurance policies.

Managing Cyber Liabilities

Libel, slander, invasion of privacy, and other law suits are going to be as great a problem in cyberspace as they are for print publishers. Hackers, chat room rowdies, and the alarming ease of electronic text copying are just some of

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things making the Internet as potentially risky for news publishers as it is attractive for their insurance companies. Many publishers are just beginning to appreciate they can be vulnerable to liabilities created by credit card information stolen from their e-commerce areas, malicious rants in the chat rooms they sponsor, and copyright infringements contained in the vast amounts of material now being amassed on their sites. And, quick to recognize a new business opportunity when they see one, insurance companies are cobbling together new policies and policy extensions to cover legal hazards faced by participants in the burgeoning online news business.

Indemnity Period Provisions

Another gap occurs via the "indemnity period" provisions of a commercial property policy. These provisions are "key" for time element coverage provided by such a policy, because they determine the time period from inception of a loss for which the insured claims coverage for lost income, extra expenses, and other time element losses. However, the indemnity period provisions in standard commercial property policies are not well suited for all e-commerce risks, even if the event at issue triggers coverage in the first instance.

For example, some traditional policies provide the indemnity period relating to losses involving computer data, software, programs, etc., is the time involved copying lost or destroyed media from backup tapes or the previous generation of such media. If that time period is minimal (e.g., a few hours or so), it might not encompass the full period which the insured sustained time-element losses. It is true some traditional policies provide broader indemnity period provisions for electronic data processing (EDP) media, such as the time it takes to replace or restore lost or damaged media, including research and engineering costs.

However, what if the loss at issue does not involve lost or destroyed computer data, programs, software, etc., but rather simply involves rendering of a web site or computer system useless for a period of time to eradicate a computer virus or respond to other problems that do not involve the actual destruction or corruption of computer data, software, or programs?

Computer Viruses

Computer viruses are very "hot" issues in the United States as well as the United Kingdom. Many e-commerce forms expressly exclude coverage for errors in computer programming. Some of the forms expressly cover the risk, but only for property loss. Some of the forms cover the risk only for third-party contractor errors, but not for employee errors. And only one or two of the forms

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provide both property and business interruption/extra expense coverage for this risk, regardless of whether an employee or third-party contractor caused the loss. Interestingly, most policies offered in the United States expressly exclude natural peril losses and limit coverage to losses caused by employee dishonesty or third-party malicious conduct.

In addition to denial of service attacks, this issue might also arise with certain types of computer viruses, such as an “I Love You” virus. Early reports showed the virus did cause damage to computer data, software, and/or programs. However, it also appeared that in most if not all cases, damage was not to critical operating systems, and insureds shut down their computer systems to prevent the spread of the virus. In other words, viruses like the “I Love You” virus appear to be conceptually different than viruses that cause a system or web site to go down because they delete, destroy, or otherwise corrupt data, software, or programs essential to running the system or web site. The system or web site is thereby rendered inoperable unless, and until, the lost, damaged, or corrupted data is restored or replaced.

E-Commerce Coverage Policies

The focus here is on stand-alone e-commerce liability insurance policies. More specifically, if an individual is thinking of buying one of the new stand-alone e-commerce policies, there are some issues which should be considered when negotiating coverage, or even comparing one off-the-shelf form to another. Risk and insurance professionals should not be led astray by the hype surrounding the new e-commerce insurance policies. Nor should they ignore the issue, believing those risk managers who say there is no need to address e-commerce insurance issues with new policies or amended traditional policies. Rather, insurance professionals should gain an understanding of the issues and develop the knowledge to review the options and choose the best alternatives for their companies.

Different sectors of the policyholder community appear to respond to e-commerce insurance issues in different ways. Most large companies are not buying any of the new stand-alone e-commerce policies. This is because their current insurance programs contain most, if not all, of the different types of policies needed to cover much of the risks posed by e-commerce activities. They need only “tweak” such policies to more fully respond to e-commerce risks. Using the terms “liability” e-commerce insurance and “first-party” e-commerce insurance is a bit of a misnomer. Employee dishonesty and third-

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party malicious conduct exposures have liability risks associated with them. And coverage for the insured's liability arising from employee dishonesty and third-party malicious conduct can be provided by crime policies. The same is true with respect to the risk of liability to others for lost or damaged property in the insured's care, custody, or control. To varying degrees, such liability can be covered under commercial property policies.

Products to Close Coverage Gaps

The insurance industry has responded to potential gaps with new e-commerce insurance products intended to respond to liability risks. The names of these policies are quite fanciful, even if, as will be explained below, the liability insurance coverages provided by them are not really all that novel. These are just examples of new e-commerce insurance policies for liability risks being offered in the United States. There are a host of other policies available in the United States from several different Lloyd's facilities and several other U.S. insurers. These policies are designed to insure some or all of the risks.

For those companies whose liability insurance program consists of only standard CGL, umbrella, and excess liability policies, buying one of these new e-commerce insurance policies is a viable option. This observation leads to two very important considerations for companies attempting to address their e-commerce liability risks when their insurance programs currently consist only of standard CGL, umbrella, and excess liability insurance.

Methods of Purchasing Stand-Alone E-Commerce Insurance

There are at least two different ways to buy stand-alone e-commerce insurance for liability risks. A business can purchase one of the new combined forms that provide both first-party coverage and third-party liability coverage. However, it is important to buy only the third-party liability coverages of that combined form. The other way is to buy one of the policies that provides only third-party liability coverage. Insureds buying stand-alone e-commerce policies seem to be focusing on the latter buying strategy.

There are a couple different ways to sell stand-alone e-commerce liability insurance. The third way to offer e-commerce coverage is by "modules." An individual can buy the basic "platform" policy (lots of terms and conditions, but no insuring agreements), and attach different modules as endorsements (each module is a different insuring agreement, with any additional definitions, terms, conditions, and exclusions needed to address an activity).

First-Party Coverage

Several insurers are offering stand-alone e-commerce insurance policies for first-party e-commerce risks. There are several different ways to buy stand-alone e-commerce insurance because the market is divided into endless variations. Some new forms provide coverage only for employee dishonesty and third-party malicious conduct, such as crime and extortion (both for loss of property, money, securities, etc., as well as for business interruption and extra expense).

But within that market are several different variations, the difference being what amount, if any, of liability coverage is offered for indemnity and defense, because of theft of or dissemination of data, information, etc., of others, for which the insured is liable. Some of the new forms provide coverage for not only employee dishonesty and third-party malicious conduct, but also for loss caused by natural perils, as well as by a computer programming negligent act, error, or omission by the insured's employee or independent contractor. However, many of the forms exclude both of these perils.

First Party Risk

Companies that engage in e-commerce face the risk of sustaining damage to their own property, namely their computer systems and electronic data. Among other risks, confidential information can be stolen; hackers can damage or hijack Web sites; and computer-system viruses can be spread, damaging a company's products or services. There are also specific areas of risk associated with e-commerce that need to be identified and treated.

First-party risks include traditional perils, such as fire or earthquake that involve loss or damage to physical assets security risks, both internal and external, pertaining to unauthorized access or use of a company's computer system and data by an outsider or insider dependence and reliance risks, which apply to damage at a supplier, business partner, service provider.

Liability Coverages

Looking beyond the labels and "buzz words" used in the policies and focusing on the substance of the coverage being provided, one is almost immediately struck by the following observation. With respect to the liability insurance coverages provided, these policies are not much more than combined multimedia errors and omissions and professional liability coverages. Indeed, some of the policies are blatant in this respect, by setting forth different insuring agreements, one entitled something like "professional services coverage" and

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the other entitled something like “media errors and omissions coverage’ or publisher’s errors and omissions coverage.”

Liability Claims

There are some limits being offered and certain features in the fundamental structures of the policy forms that affect claims on policies. Many policies are structured much more like standard policies for large companies, with a lot of the “bells and whistles” one looks for or tries to negotiate in “off-the-shelf” coverage. The following are examples.

- Omnibus named insured wording;
- Automatic subsidiary coverage;
- Some blanket additional insured coverage;
- Some contractual liability coverage;
- Some separation of insured’s language.

An exception is the insured versus insured exclusion for claims by additional insureds. In contrast, the other policies appear structured much more like policies for small companies. Few, if any, of the above provisions are contained in these forms, and insurers really are not very interested in amending their forms on these issues to match the wording provided by other policies.

Policy Exclusions

Some insurers have denied coverage for a claim by such an additional insured against a named insured by reason of the insured-versus-insured exclusion. To preclude an insurer from even making such an argument, as a matter of clarification, the insured should consider amending this exclusion to expressly except claims by additional insureds. Some policies do this to a certain extent, but other policies do not, and insurers selling those other policies are very resistant to amending this exclusion when asked. Obviously, if the named insureds are going to be entering into contracts where they are required not only to maintain this type of insurance but also to add other parties to such contracts as additional insureds on the policy, this issue must be addressed.

Fraud/Dishonesty Exclusion

Most “wrongful act” type policies are worded to include some sort of exclusion for claims arising from the fraud or dishonesty of an insured. Such an exclusion can be worded any number of ways. The more favorable wording expressly says the insurer owes a defense, until such time as the excluded activity is actually adjudicated in the underlying claim. Other policy forms, however, say

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that a defense is not provided for a claim if it alleges fraud or dishonesty by any insured. And only if there is an adjudication in the underlying claim of no fraud or dishonesty will the insurer reimburse the insured for the costs of the defense.

Some policies provide severability, so that if one insured commits fraud or dishonesty, coverage is not automatically barred for all other insureds. The other policies do not provide such severability, and insurers are resistant to making a change to the policy to address this issue. In addition to the severability issue discussed above—for the fraud/dishonesty exclusion—there also is the issue of severability for all exclusions and for the application for insurance.

To address this issue, some insureds request that a standard ISO form of the “severability of interests” or “separation of insureds” clause be added to the policy form. The intent in doing so is to provide severability as to the entire policy, for all terms, conditions, exclusions, and the application for insurance.

Amending Traditional Policies

Fortune 1000 companies in the United States are taking the position that the insurance industry should respond to first-party e-commerce risks by amending traditional policies to cover the gaps. These firms do not want to buy and administer yet another stand-alone insurance program. In contrast, startup and middle market companies, especially dot-com companies, which lack a sophisticated risk manager and premium clout, are buying the new policies to address these risks.

The insurance industry to date has not shown much interest in the desires of most Fortune 1000 companies in regard to these issues. Commercial property insurers do not want to insure “non-physical events.” Commercial crime and fidelity insurers do not want to insure time element losses. The insurance brokerage community appears to be assessing the situation. Smart brokers appreciate the different policyholder markets and are selling the new products to smaller/startup companies, while helping their Fortune 1000 clients try to amend their current policies or otherwise finance e-commerce risks with alternative risk transfer solutions.

Although it is anyone's guess how these issues will play out, Fortune 1000 companies will probably eventually be successful in persuading insurers to amend their policies to cover first-party e-commerce risks. By that time, however, there will be an established market for stand-alone e-commerce

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policies that are being purchased by middle market and startup companies, and brokers will respond accordingly.

Policy Amendment vs. New Policy

There is an alternative to buying one of the new e-commerce policies, at least theoretically. In brief, an insured could amend one or more of the policies to cover the gaps at issue. For example, an insured could add express language to its commercial property policy describing all the different types of loss events it could experience with respect to its computer systems, web site, data, software, programs, etc., and then stating all of such events shall be deemed physical loss or damage for the purposes of coverage under the policy.

The insured can also amend the “indemnity period” provisions to more closely tie into such special “physical loss or damage” language. Coverage should match up with e-commerce risks. Also, the insured will want to make sure the employee dishonesty exclusion is limited to employee theft and excepts all other forms of “physical loss or damage” to property caused by an employee. An insured also could delete the potential income or indirect loss exclusion in its commercial crime policy or fidelity bond.

The insured might want to consider adding express language for time element losses (both business interruption and extra expense at a minimum), rather than relying on the deletion of the exclusion. The insured also might want to amend the valuation provisions to more closely mirror the valuation provisions in its commercial property policy. In this way, whether the property is stolen by a third person or by an employee of the insured, the coverage provided by the different policies in the insured's program should be the same.

E-Commerce Insurance Market

By and large, companies are just now building their insurance programs and deem it viable to include such a policy in their program on a primary basis and build around it. This is opposed to buying such a policy on a difference-in-conditions/difference-in-limits (DIC/DIL) basis, which is what is being offered, for the most part, to large companies with sophisticated insurance programs that already respond to a lot of e-commerce risks.

Also, many smaller companies do not have the size, premium volume, or risk management expertise necessary to make “tweaking” traditional policies viable. Insurers are not willing to make any changes to off-the-shelf policies in regard

to e-commerce risks for such companies-a concession often rendered to large customers. Several insurance insurers are offering stand-alone e-commerce insurance policies. When buying a stand-alone e-commerce liability policy, it is important to understand the state of the market.

Fighting Cybercrime

The International Chamber of Commerce (ICC) Commercial Crime Services has a cyber crime unit, which is building a database on criminal methods in cyberspace and will act as an interface between law enforcement and the private sector. The unit provides expert advice to companies on steps to reduce the risk of falling victim to cyber crime by practicing due diligence - setting up defensive procedures and alarm systems, and exercising prudence in choice of commercial partners. As business moves forward into the brave new world of e-commerce, it needs effective law enforcement and judicial networks to ensure Cyberspace does not become a criminal's charter.

Personal E-Mails

The International Chamber of Commerce (ICC's) Cyber Crime Unit recommends that companies discourage employees from using company computers for personal e-mails and has advised organizations to tighten security on every system linked to their network. The widespread use of company networks for personal e-mails is the kind of practice that allows viruses to spread. The Cyber Crime Unit is part of ICC's London-based Commercial Crime Services, leading the global fight against maritime crime, counterfeiting and commercial fraud.

According to the Cyber Crime Unit, the best practice requires more than regular updating of the existing security systems. The Unit said it is important to involve individual users, promoting vigilance amongst staff and discouraging use of the network for personal e-mails. As viruses and hacking techniques evolve so must the security systems that are in place to protect against them. Many firewalls offer fair protection against conventional hackers.

Computers security experts appear to be in agreement that effective security against disruptive e-mail-borne viruses has to be built into the infrastructure of corporate networks. Good security blocks suspicious e-mails and alerts the network administrator before they are distributed to individual users. The Internet and e-mail are an integral part of the modern business environment

and as e-commerce grows, companies will depend on reliable and secure computer systems.

International Cooperation

Because cyber crime is an international problem, it calls for heightened international cooperation, particularly between business and law enforcement. When criminals are in a different country from the physical location of their crime, it becomes difficult for national police authorities to arrest them. Scams on the Internet are anonymous and can be committed by e-mail on a huge scale. Hackers, fraudsters, industrial spies, gangsters, and terrorists are exploiting the Internet to attack vital information systems or conceal criminal activities. Estimates of the magnitude of cyber crime vary wildly.

The greatest obstacle to global e-commerce may be the myriad legal restrictions. Italy, for example, bans online auctions that sell used goods. In Singapore, it's illegal to post ads for Viagra. Germany bars retailers from offering guarantees beyond fourteen days. China does not allow sites to carry telephone traffic over an IP network, so a company with a call center as a part of its Web could be locked out of doing business in China

Chapter 5 Commercial Crime Liability

The Basics of Commercial Crime

White-collar crime or commercial crime involves crimes such as fraud, bribery, corruption, etc. Although it does not receive as much publicity as other forms of crime, it costs a lot more as it robs an economy of much needed capital. Every time a company is defrauded of money, they have to recover this from somewhere such as price increases, fewer jobs, or even less research and development. Commercial crime is a lot easier to hide than other forms of crime, and therefore much harder to stop.

The fact is, crime is a significant cost of doing business. Embezzlement and employee theft are far more common in virtually all types of business than most people realize. Current estimates indicate these dishonest activities cost American firms around \$100 billion a year. Having to make good on theft or misuse of company assets can cause financial hardship for any business. Unlike fire and auto losses, a loss due to employee dishonesty can accumulate over time and reach devastating proportions before being discovered.

Many employers leave themselves open to this risk because they have many misconceptions concerning employee dishonesty. While most incidents of employee dishonesty involve theft of cash, anything else of value may be stolen from office equipment to warehouse merchandise. The average embezzler is usually a trusted employee and considered a friend by their coworkers. Many employers do not want to consider the possibility of employee theft and believe fidelity bonds are unnecessary.

Commercial crime insurance includes several forms for covering money, securities, and property other than money and securities for various crime-related causes-of-loss. In contrast, commercial property coverage forms exclude money and securities, and commercial property causes-of-loss forms do not cover as many crime-related losses as commercial crime coverage forms. A crime is a violation of law punishable by some governmental body. Not all types of crime losses are insurable (theft by a partner of property belonging to the partnership), and some are covered under other insurance forms (vandalism or malicious mischief coverage in the commercial property forms).

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Financial Impact of a Crime Loss

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

The amount of loss may include the premium on a bond required to issue duplicates of the securities. There are two ways of determining the value of property other than money or securities. If such property is lost or damaged, its value is either the actual cash value on the day the loss was discovered or the cost to repair or replace the property.

Commercial Crime Loss Exposures

Commercial crime insurance includes several forms for covering money, securities, and property other than money and securities for various crime-related causes-of-loss. In contrast, commercial property coverage forms exclude money and securities, and commercial property causes-of-loss forms do not cover as many crime-related losses as commercial crime coverage forms. A crime is a violation of law punishable by some governmental body. Not all types of crime losses are insurable (theft by a partner of property belonging to the partnership), and some are covered under other insurance forms (vandalism or malicious mischief coverage in the commercial property forms).

Elements of Exposure

The three elements of exposures to crime losses are the item(s) subject to loss; covered causes-of-loss; and financial impact of the loss.

Items Subject to Loss -- Commercial crime insurance policies cover three broad categories of property--the items subject to loss. These categories of property are money, securities, and property other than money and securities. As used in crime coverage forms, "money" is:

- currency, coins, and bank notes that are in use and have a face value;
- travelers' checks, register checks, and money orders held for sale to the public.

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“Securities” are negotiable instruments, non-negotiable instruments, and contracts representing either money or other property. Also included in the definition of securities are:

- tokens, tickets, and stamps in use;
- charge slips issued in connection with charge cards, provided the charge cards were not issued by the named insured.

The term “securities” does not include “money.” In the crime coverage forms, “property other than money and securities” is tangible property that has intrinsic value. However, the term does not include

- money;
- securities; and
- property listed in any crime coverage form as property not covered.

Crime coverage forms do not cover certain types of property, such as motor vehicles, because such property is covered under other forms of insurance.

White-Collar Crime

White-collar crime usually involves illegal acts to obtain money, property, or services, or to secure a business or professional advantage. Federal laws governing all levels of business activity cover much of white-collar crime. White-collar crimes are governed by the general principles of criminal liability—each crime requires:

- a bad act;
- a criminal intent;
- causation.

The defenses to white-collar crime are the same ones applicable to all crimes and include incapacity, insanity, intoxication, and duress. ***White-collar crime cases often invoke the defense of entrapment.*** Entrapment refers to situations when the government has enticed a person to commit a crime he or she otherwise would not have committed. The courts, through the eyes of the individual defendant, usually view entrapment. The defense focus becomes the propensity of that defendant to commit the crime in determining whether they have been entrapped. In some cases, the government's conduct is outrageous in terms of convincing a person to commit a crime.

Types of Computer/Internet Crimes

Computers have revolutionized the way in which we do business in the world today, with companies becoming dependant upon these machines not just for business, but for survival. Computers are commonly used in our society and are part of everyday life. Technology performs numerous functions in society ranging from entertainment to critical life-support systems.

In the same fashion technology enhances our lives, so it intensifies the success of those who would use it to break the law. While the scale of the threat is real, its exact nature is prone to misconception. The media has been quick to seize upon stories of "high-tech" crimes, especially those involving hacking, while other forms of less glamorous computer crime go unreported. Computer-instigated crime covers those crimes which are carried out by using computers, including fraud, theft, and distribution of pornography etc.

Of these types of crime it is probably fraud that companies fear most. It can be the most difficult to detect and particularly damaging. Computer-targeted crime can be regarded as an offence, which in some way is directed at the computer itself. Examples of this include theft of hardware/software, invasion of privacy, hacking, sabotage (as in recent "denial of service" attacks on major web sites), and probably the most widely known, virus attacks.

Computer Hacking

A hacker will access computer networks, without authorization, to read, copy, alter, or destroy information. Sometimes hackers transmit destructive programs such as viruses, worms, or e-mail bombs, which spread rapidly over the Internet and cause significant damage. The Department of Justice prosecutes hacking under the Computer Fraud and Abuse ("CFA") Act, as amended by the National Infrastructure Protection Act of 1996.

The CFA Act protects almost every computer connected to the Internet from unauthorized users who intentionally access a computer and obtain information from a financial institution, government agency, or "protected computer." For example, a former employee who used his old password to access and disable servers on his employer's computer system was convicted under this Act.

It is also a crime under the Act to damage a protected computer by intentionally accessing it or by knowingly transmitting an injurious program, information, code, or command. In the seminal hacking case of *United States v. Morris*, the

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defendant released a harmful computer program known as a “worm” over the Internet to demonstrate the inadequacies of security measures on computer networks. The program caused catastrophic damage, and the court convicted Morris to three years of probation and 400 hours of community service.

As evidenced in Morris, law enforcers rely primarily on the CFA Act to prosecute hacking offenses. The Federal Wiretap Act, as amended by the Electronic Communications Privacy Act (“ECPA”) may also impose criminal liability for these activities. The ECPA criminalizes intentional interception of electronic communications and unauthorized access of electronic communications in electronic storage.

Domain Name Hijacking

A unique name can be of great benefit to a company's ability to communicate with customers and potential customers. On the Internet, there is no substitute for a unique name because there cannot be -- for technical reasons, each domain name must be unique. When this uniqueness is combined with a simple “first-come, first-served” registration process for domain names, disputes arise.

Millions of domain names already have been registered with Network Solutions, Inc. (NSI), the registrar of “generic” or global domain names, and more are registered each day -- all on a first-come, first-served basis requiring little more than the payment of a modest fee. ***Some domain name disputes involve clear abuses of the registration system, such as “cyber squatters,”*** who hijack or reserve scores of domain names in the hope of extorting hefty payments from trademark owners in exchange for relinquishing the names.

Other disputes are more legitimate, as companies compete for use of the same domain name. NSI does not resolve domain name disputes, however, and at most will, in certain circumstances, suspend use of a domain name. As a result, unless one party gives way, domain name disputes ultimately must be resolved in the courts.

Criminal Liability on the Internet

Technological advances in computers and the Internet have created a new forum for criminal activities. Traditional crimes such as fraud and copyright infringement have become easier to commit, and novel crimes such as hacking and e-mail violations have emerged. The absence of geographical barriers and

the relative anonymity provided by the Internet enhance the damaging effects of these acts. With the growth of the Internet, many companies have set up their computers too quickly. In their rush for a presence on the Internet, they fail to adequately prepare the security on those computers. In 1996 a survey was presented at the Senate hearing on "Security in Cyberspace." A small group of security firms were able to account for \$800 million in losses worldwide. In that same year, the American Bar Association did a survey of 1,000 companies and discovered that 48% of them had lost money because of computer fraud. The damages ranged from \$2 million to \$10 million. With the dramatic increase in Internet commerce, this will only get worse.

Traditional legislation has failed to restrict Internet behavior. As a result, governments--both domestic and foreign--have responded with a flood of legislation criminalizing various types of Internet conduct. Such legislation authorizes criminal penalties for acts, such as hacking and e-mail crimes, where a computer is the subject of the attack and acts, such as fraud and intellectual property violations, in which a computer facilitates the crime.

Internet Fraud

Internet fraud involves the use of a computer to facilitate acts such as embezzlement, funds transfers, credit card fraud, or credit repair fraud. The CFA Act criminalizes unauthorized access of a protected computer, with the intent to defraud, if the perpetrator obtained anything of value, unless the object of the fraud and the thing obtained was only the use of the computer with a value of less than \$5,000 in any one-year period.

For example, unauthorized browsing of confidential taxpayer records for personal use has not been considered computer fraud, because the defendant did not obtain anything of value. It is also unlawful to traffic in passwords or similar information through which a computer may be accessed, or to transmit with the intent to extort something of value a communication in interstate commerce containing a threat to cause damage to a computer. Fraud is also illegal under federal wire and mail fraud statutes if the defendant used a computer in interstate commerce to commit theft or fraud.

To establish criminal liability, the government must prove the defendant's knowing and willing participation in a scheme or artifice to defraud, and use of interstate wire communications to further the scheme. For example, defendants who accessed an airline computer and fraudulently transferred frequent flyer

miles to obtain free flights have been convicted of wire fraud. In addition, the wire fraud statute may apply to the interstate transfer of copyrighted computer files obtained through fraudulent means. The National Stolen Property Act also criminalizes computer fraud, including the electronic transfer of confidential business information in interstate commerce. This Act authorizes criminal penalties for anyone who transmits in interstate commerce any goods or wares worth \$5,000 or more, with knowledge they were stolen, converted, or taken by fraud. The law is uncertain as to the applicability of this statute to the transfer of intangible computer programs or files. The ECPA may also criminalize computer fraud involving the interception or access of electronic communications.

Internet Gambling

A recent development in criminal liability on the Internet is the prohibition of Internet gambling. It is a crime to conduct, manage, or own an illegal gambling business, or use wire communications in interstate commerce to transmit bets on sporting events. Although Congress recognized the growth in electronic and Internet gambling when it established the National Gambling Impact Study Commission, Congress failed to amend the statutes to specifically address the use of a computer or the Internet to facilitate gambling. Despite this, law enforcers have attempted to prosecute such acts. For example, in 1998, a United States Attorney charged several offshore managers and employees for operating Internet sports betting businesses that illegally accepted wagers over the Internet.

Internet Content Crimes -- Child Pornography

To combat use of the Internet and computer technologies to produce and distribute child pornography, Congress enacted several laws that impose criminal liabilities for these acts. First, the Child Pornography Prevention Act ("CPPA") criminalizes reproduction, sale, or distribution by computer of material containing sexual images of minors. Although challenged several times, courts have upheld the CPPA as constitutional. Second, the Communications Decency Act of 1996 ("CDA") continues to criminalize the transmission of obscene materials to minors over the Internet, despite the Supreme Court's invalidation of two of its key provisions. Under the Act, it is a crime to:

- persuade a minor to engage in a sexual act which is criminally prosecutable;

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- bring into the country, take or receive, or knowingly use an interactive computer service for carriage in interstate commerce any “obscene, lewd, lascivious, or filthy” item;
- transport or use a means of interstate or foreign commerce or an interactive computer service to sell or distribute such unlawful items;
- create or solicit and transmit by means of a telecommunications device an obscene image or communication with knowledge that the recipient is a minor.

To supplement these laws, Congress recently enacted the Child Online Protection Act (“COPA”), informally termed “CDA II.” Although subject to permanent injunction enjoining its enforcement, COPA would make it illegal for anyone, including commercial web sites, to knowingly transmit to children over the Internet, material “harmful to minors.” The United States District Court for the Eastern District of Pennsylvania is currently considering constitutionality of this statute against claims it is vague and infringes on protected speech.

Methods of Control

Increased criminal activity involving computers and the Internet has induced Congress to modify search and seizure legislation. In addition, many of the statutes criminalizing Internet conduct include exceptions for lawful government investigations. The Department of Justice also issued Guidelines for Searching and Seizing Computers to aid investigators in pursuing Internet crime. The guidelines review general principles of Fourth Amendment search-and-seizure law, and address the application of this law to modern computer crimes. ***Through use of warrants, subpoenas, court orders, or subscriber consent, the government may obtain information about e-mail subscribers, their transactions, and Internet sites they visit.*** Due to the government’s interest in privacy rights of the recipient, the law is more lenient with respect to seizing e-mail which is stored, than e-mail which is intercepted during transmission.

Despite these enactments, the Privacy Protection Act maintains its limit on search and seizure for work product or documentary materials held by a person in connection with the intended dissemination of the materials to the public. This protects computer files, bulletin boards on network computers, and e-mail otherwise subject to seizure when publishers for legitimate First Amendment activities use it.

State Approaches

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Most states have enacted legislation criminalizing acts over the Internet. These laws include intellectual property statutes, expanded definitions of "property" to include electronic and computer technologies, statutes criminalizing the unauthorized taking possession of a computer system, and hacking and computer fraud statutes similar to the CFA Act. At least 14 states and the United States Federal Trade Commission have recently targeted credit repair fraud, an illegal business conducted over the Internet. Under this scheme, consumers with poor credit pay fees to learn how to create fake credit histories. Some states have also criminalized on-line threats by including electronic communications under "unconsented contact" in anti-stalking statutes and including computers and electronic communications devices in telephone harassment statutes.

Although states have enacted legislation against computer crimes, federal preemption may limit the effect of these laws. For example, a state statute that criminalizes conduct over the Internet involving copyrighted works may be held invalid because copyright law is exclusively in the domain of the federal government. The Circuits have conflicted over the resolution of these issues.

International Approaches

Although domestic legislation extends to acts involving foreign commerce, it is often ineffective against Internet crime. The absence of geographical barriers on the Internet, combined with jurisdictional hurdles to enforcement, creates obstacles for law enforcement agencies. To effectively regulate behavior over the Internet, countries must agree certain conduct is impermissible. This has been the case with respect to hacking laws; computer fraud; and intellectual property statutes.

With respect to Internet content, however, governments disagree as to what should be legal. While this may not appear problematic for U.S. citizens, recent cases demonstrate that despite jurisdictional difficulties, U.S. entities may be held criminally accountable in foreign countries. Hacking is an international problem because a perpetrator can reside in one country and access or damage a computer in another country. As a result, many countries have enacted legislation similar to the CFA Act that criminalizes unauthorized access of computer systems. For example, the United Kingdom prosecutes hackers under the Computer Misuse Act of 1990, under which it is a crime to access or modify, without authorization, material on a computer.

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Foreign governments, including Singapore, Thailand and Italy, have also enacted statutes that criminalize intellectual property violations. The European Union's 1991 Software Directive requires Member States to legislate special penalties for software piracy and illegal copying and to implement procedures for seizing illegally copied software. Great Britain, among others, subsequently passed a statute criminalizing software piracy and copyright infringement. Other countries, such as Belgium and France, prosecute intellectual property piracy under general theft laws. Despite these similarities, foreign and domestic laws regulating Internet content diverge. While U.S. citizens enjoy First Amendment guarantees of free speech, this is not general practice. Many countries, including Saudi Arabia, Singapore, Germany and China restrict content on the Internet, even when the content originates from a country where it is legal. In China, information relating to politics is illegal, and it is a crime to distribute or access "harmful information" over the Internet. As a result, the Chinese government also blocks access to many web sites, including those concerning democratic movements and political dissident groups.

Foreign laws limiting Internet content will generally not affect U.S. citizens because domestic courts refuse to enforce foreign criminal judgments. Germany is a notable exception. In two cases, Germany has managed to enforce its laws prohibiting neo-Nazi speech and pornography against U.S. citizens and Internet Service Providers. In one instance, German authorities circumvented jurisdictional barriers and apprehended a U.S. resident, who had sent written neo-Nazi material into Germany, when he entered Europe.

Danish officials arrested and extradited the traveler to Germany, where a court sentenced him to four years in prison. In the second case, Germany recognized conduit liability for Internet Service Providers by prosecuting CompuServe's managing director in Germany, of "abusing" the Internet by allowing child pornography and Nazi literature to enter the country. In convicting the managing director, the German court ignored both the First Amendment of the United States Constitution and Germany's own "Information and Communication Services Bill" which makes Internet Service Providers liable for the content of messages only if they have the "technical ability" to delete or deny access.

The unique attributes of the Internet, such as the relative anonymity, lack of geographic barriers, and low cost of mass distribution enhances criminal activities and render traditional legislation ineffective. Governments have addressed these issues by enacting criminal legislation against hacking and e-mail violations, computer fraud, and intellectual property misconduct. However,

despite similarities in foreign and domestic laws, prosecution of Internet content varies.

Information Theft

Risks abound when personal information is transmitted over the Internet or stored in databases with multi-party access. Credit-card numbers sent over the Internet can fall into the wrong hands. Marketers on the Internet can record users' travels on the Internet via "cookies" and build a profile of purchases, personal information, and interests. Crooks may use a fake website to collect hundreds of credit-card numbers from unwary shoppers. Companies and individuals may be sued for misappropriation of data and personal information or invasion of privacy. Allegations of corporate espionage, even among companies that regularly do business with each other, could lead to claims of fraud; theft of trade secrets; interference with contractual relationships piracy; and other torts. Both corporations and individuals confront privacy issues when using the Internet.

Security breaches include any unauthorized access or use of a company's computer system and data. For example, a hacker may break into a company's computer system and steal or destroy data. With use of the Internet expanding, the risk that an outsider will invade a computer system increases. Perhaps more common is damage caused unintentionally by either employees or independent contractors hired by the company. Some of the most serious damages are intentional acts of disgruntled former or even current employees, particularly those with knowledge of the firm's network.

Almost all large businesses and increasingly even small businesses today rely heavily on computers for day-to-day operations. Breaches of a company's computer or information security system are a risk to all such computer-reliant businesses. Commercial crime insurance policies or computer crime policies may cover fraud or theft of electronic fund transfers or other financial transactions occurring over the Internet. A company's general liability insurance policies may include or be purchased with credit card and depositor's forgery endorsements.

Property insurance policies also may cover theft through endorsements. Theft of important data, damage to a company's hardware or software from hardware or software problems, or damage from more mundane causes like weather, fire, power surges, and exposure to electro-magnetic fields can literally shut a business down. Computer viruses, from exchange or transmission of data by

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diskette, over the Internet, or by outside intervention, cause millions of dollars in damage to hardware, software, and databases.

Equipment Theft

Businesses suffer millions of dollars in losses yearly from computer fraud and theft, including a variety of property injuries and deprivations that may not meet the legal definition of theft. Fortunately, a variety of insurance policies presently available protect businesses from loss or liability from computer fraud and theft. For example, fraud over the Internet may arise with transfers of electronic funds. Computer-crime insurance covers fraud or theft through misappropriation of electronic fund transfers or other financial transactions over the Internet. Policyholders may have insurance coverage under many other types of policies, including:

- commercial crime insurance policies;
- dishonesty, disappearance, and destruction insurance policies;
- blanket insurance policies;
- financial institution bonds;
- all-risk insurance policies covering loss of property;
- property insurance policies covering theft, possibly through endorsements;
- comprehensive general liability insurance policies with credit card and depositor's forgery endorsements.

Businesses may also suffer fraud and theft at the hands of employees. Employees know how to access and manipulate the company's financial information and assets, and can do so more easily than thieves that break or hack into a company's systems from outside the company. These losses increasingly may involve use of computers and the Internet.

Companies may purchase bonds and similar types of insurance to protect against these types of potential losses from employees. Bonds pay the insured company or person for money or property lost because of dishonest acts of bonded employees, named either by name or by position. Bonds protect only against losses caused by theft or fraud by named employees or persons in those positions. As a result, companies require other types of crime insurance.

Property Destruction

Companies conducting commerce in cyberspace, operating a website, or even sending e-mail over the Internet face the risk of damaging the property of others

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or sustaining damage to their own property. Among other things, confidential information can be stolen, hackers can damage or hijack websites, and computer system viruses can be spread, damaging the companies' own property or that of others. CGL insurance covers liability for claims of property damage made by people or companies unrelated to the policyholder. Property insurance covers loss or damage to the policyholder's own property. Computer, website designers, and other consultants should be protected from claims by unrelated people and companies by their errors and omissions ("E&O") insurance. Directors and officers ("D&O") insurance should protect a company's directors and officers and even the company itself from claims for breach of duties to protect against such losses or liability. New cyberspace and hacker insurance also may provide protection from such expenses.

Employee Dishonesty

Employee dishonesty is a criminal act committed by an employee acting alone or in collusion with others. There must be intent by the employee to cause the employer a loss and to obtain a financial benefit for the employee or someone else. Intent to cause a loss merely because the employee is angry with the employer is not enough. Although employee dishonesty usually involves the taking of cash, it can also be the taking of property such as equipment or stock, or even allowing unauthorized discounts on merchandise to friends.

Economic Fraud Risk

Any prudent organization will plan its response to white collar crime so when it strikes, it can be dealt with in an organized and efficient manner. Key decision makers should have no doubts about what needs to be done, and the likely effect of their decisions. As white collar crime frequently involves swift movement of money, the need for quick decisions and action is a vital ingredient of the plan. Clearly any contingency plan must be consistent with the organization's policy. Although this document concentrates on the response to white collar crime, the plan could be written to encompass all serious crime.

Types of Economic Fraud

Companies whose trade secrets may have been stolen were saved from a dangerous Catch-22 situation, when the U.S. Third Circuit overturned a district court's decision. Bristol-Myers Squibb had developed a secret formula for Taxol, a powerful anti-cancer drug. Two alleged thieves attempted to steal the formula, but they were caught. The alleged thieves claimed they needed the trade secret information to prepare a proper defense, and a U.S. District Court

Judge agreed. Judge Dalzell believed their rights to a fair trial overrode Bristol-Myers' rights to protect its trade secrets. A company in this situation can turn over their trade secrets, which may result in their trade secrets being made public during trial, or fight the request and risk the thieves going free. The Third Circuit held that thieves can be guilty of conspiracy to steal and attempted theft of trade secrets even if no trade secrets are taken, therefore the trade secrets do not need to be turned over. Some courts have required production of trade secrets under the terms of the protective order. The new Economic Espionage Act is a powerful tool to help protect U.S. companies' trade secrets, but the Act still has many areas of uncertainty.

As with all high-tech security matters, the best solution is to close the barn door before the horse gets out. Putting formal protection measures in place and documenting these procedures will be useful regardless of whether the action is a criminal or civil action. An important part of a company's protection measures is to review their insurance policies with an eye for coverage of economic espionage claims.

Copyright and Trademark Infringement from Employees

Ongoing advances in computer and related communications technology mean intellectual property rights will continue to grow in importance both in business and legal terms. Companies must not only do more to protect and productively use their own intellectual property, but also to ensure they do not infringe, even unintentionally, the intellectual property rights of their competitors. Computer-based technology has made it easier to reach more people directly in more places and at more times.

Today, a business can communicate with potential customers at any time in virtually any country in the world, all without need of traditional avenues of advertising and communication. As more people gain access to computer technology and as existing technologies are refined and others introduced, the ability to communicate will improve in terms of scope, speed, content control, and cost.

The infringement of intellectual property rights nearly always involves, to some degree, the communication of information, most commonly in selling or offering a product or service for sale. Consequently, the greater a company's ability to communicate with potential customers, the higher the stakes both in terms of their ability to generate revenue and potential liability exposure. Should a company infringe upon the trademark, copyright, or patent rights of another

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company, both criminal and civil penalties can be incurred. This technological capability, in turn, raises questions concerning not only potential liability, but also such litigation issues as “personal” jurisdiction and venue and “subject-matter” jurisdiction. Depending on the facts and type of infringement, a company may be covered by the advertising provisions of the company’s comprehensive general liability policy. Depending upon circumstances, it may also be covered by errors and omissions insurance. These claims can be tricky, so no one should assume that he is or is not covered without first checking his policy. Also, insurance companies have begun to develop and sell new insurance policies designed to cover liability for intellectual property infringement. A company should carefully review the provisions and cost of such insurance before purchase.

Disclosure of Trade Secrets

A company's trade secrets may be disclosed, either intentionally or inadvertently, over the Internet by a company's own employees. Alternatively, an employee may disclose, again either by design or accident, the trade secrets of a competitor over the Internet. If this information were disclosed before introduction of the new product, a competitor might seek to hold the disclosing company liable. ***The advertising injury coverage in a company's comprehensive general liability (CGL) insurance may apply to pay for the defense and liability in such claims. These claims may fall within the provisions for piracy, unfair competition, and infringement included in the advertising injury coverage.*** Errors and omissions (E&O) coverage and directors’ and officers’ (D&O) insurance also may apply.

Chapter 6 Commercial Crime Insurance Coverage

The Commercial Crime Insurance Policy

Commercial crime insurance falls generally into the category of insurance referred to as fidelity coverage. “Insurance” spreads the risk of an unknown loss but is statistically certain to happen over a large number of individuals or companies, so the cost of protecting against such a loss becomes economically feasible (“the law of large numbers”). In true insurance, a policyholder exchanges a known “loss,” in the form of a fixed amount of money, or “premium,” for the insurance company’s promise it will pay for a future, potential loss. In “self-insurance,” the policyholder does not buy insurance but, by various mechanisms, pays the claim itself.

Though claims on commercial crime policies are often described as fidelity bond claims, modern commercial crime coverage is actually first-party insurance as opposed to a true bond, the latter of which involves a three-party relationship. ***The terms “fidelity insurance” and “fidelity bonds” often refer to coverage for losses caused by the dishonest acts of an insured’s employees; however, the terms can also refer to various protection offered for fraudulent acts of non-employees, certain acts of directors of an insured company, failures of public officials to faithfully perform official duties,*** and other bonds designed to protect certain classes of people, such as probate bonds and motor vehicle dealer bonds.

Employee dishonesty coverage typically falls within the coverage provided by Commercial Crime Policies, which policies fall within the broadly defined area of fidelity coverage. A crime is a violation of law punishable by some governmental body. This section is concerned with two kinds of crimes: those committed by employees of the insured and those committed by outsiders. Not all types of crime losses are insurable and some are covered under other insurance forms. Though claims made under commercial crime coverage are often described as fidelity bond claims, and evolved out of a standard surety bond background, there are a number of differences between a crime coverage claim and a contract surety claim.

In particular, notable differences exist in the following areas: (1) limits of liability; (2) singular vs. multiple claimants; (3) fixed vs. changing circumstances; and (4)

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limited vs. varied information sources. From the moment notice of a claim is provided to the insurer, the two primary considerations that underlie claims professional's review are coverage and recovery. The insurer should structure its investigation of the claim in such a way that it promptly investigates the claim, while at the same time keeping an eye on issues of salvage and means of protecting its rights to obtain salvage, if a covered loss is ultimately determined to exist and a claim is paid. These dual objectives require careful attention to policy provisions, the specifics of the claimed loss, and any related criminal investigations.

Although every commercial crime claim is unique, there are a number of common coverage issues fidelity insurers face including: who is considered an "employee" under the policy, application of the term "anifest intent" in the employee dishonesty coverage clause, cancellation of coverage for past dishonesty, and limits of liability and loss discovery issues. Familiar recovery issues include use and availability of criminal restitution for satisfaction of a loss and potential liability of banks and accountants.

By the very nature of acts covered by commercial crime insurance, a dishonest employee will take steps to hide the dishonesty and resulting loss to the employer. Consequences of the dishonesty can be hidden for months, if not years, and significant losses can mount quickly.

For these reasons, the claims adjuster must be vigilant to issues raised in the fidelity claim arena and must be prepared to promptly and thoroughly investigate the claims, apply coverage where it is found, but also invoke appropriate defenses and exclusions when necessary. Finally, the claims representative, from the very outset of the claim must, keep an eye on recovery because of time sensitivity of the nature of the loss and potential need to put third parties on notice of the loss.

Crime General Provisions

Provisions in the crime general provisions form apply to all coverage forms included in the crime coverage part. ***These provisions fall into three categories: general exclusions, general conditions, and general definitions.*** There are six general exclusions in the general provisions form. They apply to all crime coverages included in the policy. The insurer will not pay for dishonest acts of the named insured or, if the named insured is a partnership, any partner. The exclusion applies whether the dishonest act is

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committed by the named insured or partner acting alone or in collusion with others. There is no coverage for loss resulting from the seizure or destruction of property by order of governmental authority. The impact of this exclusion appears to be small, since such losses are not likely to result from the covered causes-of-loss.

Indirect Loss

The policy does not cover any indirect loss resulting from a covered loss. Three specific kinds of indirect loss are listed in the exclusion, but the exclusion applies to all indirect loss and not just to those listed. The indirect losses specifically listed in the exclusion are the inability to realize income that would have been realized if the direct property loss had not occurred; payment of damages of any type for which the named insured may be held liable except direct compensatory damages arising from a loss covered under the policy; and expenses incurred by the insured to establish either the existence of a loss or the amount of loss under the policy.

The insurer will not pay expenses related to any legal action. Unlike liability policies, crime policies generally do not provide coverage for defense costs. The general provisions form also contains the war and nuclear exclusions common to commercial property policies. Additional exclusions appear in the various crime coverage forms.

General Conditions

The general crime provisions form includes eighteen policy conditions. These conditions apply to all crime insurance included in the coverage part. Coverage extensions do not increase the limit of insurance stated in the declarations. Such extensions merely provide coverage for additional causes-of-loss. However, extensions in some coverage forms may modify these conditions to provide additional insurance. The insurer will pay for loss only if the loss is discovered during the policy period or within one year after the policy termination date. The insured's duties after loss under a crime policy are essentially the same as under any other property policy.

Crime Coverage Forms

Letters A through Q identifies the crime coverage forms. Forms A, B, O, and the Surety Association of America developed P. The Insurance Services Office (ISO) developed the other coverage forms. Although each coverage form insures against a specific type of crime loss, many of the additional conditions,

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exclusions, and definitions are the same in all forms. These similar provisions are described below. The limit of insurance applicable to a coverage form is the most that will be paid for an “occurrence,” which is an act or a series of related acts. The territory covered by the crime coverage forms is stated in the crime general provisions form, but individual forms may include additional conditions regarding the territory in which property is covered. All crime coverage forms exclude losses caused by the named insured or a director, trustee, or authorized representative of the named insured.

Forms A, O, and P cover only losses caused by employees of the named insured; the other forms exclude such losses. Most coverage forms require the insured to notify the police if there is reason to believe the loss involves a violation of law. If coverage is provided for property other than money and securities, such property does not include motor vehicles, trailers, or semi-trailers or equipment and accessories attached to them.

Form A – Employee Dishonesty

The only covered cause-of-loss under the employee dishonesty coverage form is dishonest acts of employees of the named insured. Therefore, detailed definition of “employee” in the crime general provisions form is important. Employee dishonesty coverage can be provided on either a scheduled basis or a blanket basis. The scheduled form provides coverage only for dishonest acts of employees specifically listed in the policy, either by name or by position.

The **blanket form** provides coverage for dishonest acts of all employees. **Coverage Form A** insures against loss to money, securities, and property other than money and securities. **The blanket form extends coverage to losses caused by employees who are temporarily outside the covered territory for not more than ninety days.** There is no coverage on any employee for whom coverage has been canceled under similar prior coverage and not reinstated. There is also no coverage if the only proof of a loss is an inventory computation or a profit-and-loss computation.

Coverage is automatically canceled on any employee as soon as a dishonest act by the employee is discovered by the insured or any partner, officer, or director of the insured not in collusion with the employee. The cancellation does not affect coverage for prior dishonest acts committed by the employee.

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Form B – Forgery or Alteration

The forgery or alteration coverage form insures against loss caused by the forgery or alterations of a “covered instrument” drawn against the insured’s accounts. A covered instrument is a promise, order, or direction to pay a certain sum in money drawn or purports to be drawn by the insured or against the insured by person acting as the insured’s agent. A covered instrument might be a check, draft, promissory note, bill of exchange, or similar instrument. The form covers loss sustained anywhere in the world. Coverage applies only if

- The document is false,
- A genuine document has been altered to change the payee or amount payable, or
- The signature endorsing the document has been forged.

A coverage extension provides that reasonable expenses will be paid to defend the insured if the insured is sued for refusing to pay a covered instrument on the basis it has been forged or altered. These legal expenses will be paid in addition to the applicable limit of insurance.

Form C – Theft, Disappearance, and Destruction

This form covers money and securities against loss by theft, disappearance, or destruction. There are two insuring agreements in the theft, disappearance, and destruction coverage form:

- Section 1--Inside the Premises covers money and securities inside the “premises” or a “banking premises”
- Section 2--Outside the Premises covers money and securities in the care and custody of a “messenger.” The terms in quotation marks are defined as follows:
 - “*Premises*”--the interior of that portion of any building occupied by the insured in conducting its business;
 - “*Banking premises*”--the interior of that portion of any building occupied by banking institution or similar safe depository;
 - “*Messenger*”--the insured or any partner or employee of the insured while having care and custody of the property outside the premises.

Coverage is extended in Section 1 to loss or damage to a locked safe, cash register, or other container when damage results from actual or attempted theft of, or from, unlawful entry into such containers. Coverage is also extended to damage to the premises resulting from actual or attempted theft of covered

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property, if the insured owns the property while it is outside the premises in the custody of an armored car service. There is no coverage for losses resulting from accounting errors, exchanges or purchases, unauthorized transfer or surrender of property, or voluntarily parting with title to, or possession of, any property. Property contained in any money-operated device is not covered, unless an instrument in the device continuously records the amount of money deposited. Damage to the premises by fire or vandalism also is not covered.

Form D – Robbery and Safe Burglary

This form covers property other than money and securities, both inside and outside the premises. ***There is no coverage for money and securities.*** Coverage inside the premises is for loss or damage resulting from robbery of a "custodian" or from safe burglary. A "custodian" is the insured, or a partner or employee of the insured having care and custody property inside the premises. The term does not include a janitor or a "watchperson."

The form defines "watchperson" as a person retained by the insured whose only duty is to have care and custody of property inside the premises. Damage to the insured's premises, or to a locked safe or vault inside the premises, is covered if damage results from actual or attempted robbery or safe burglary. Property other than money and securities is covered while outside the premises, in the care and custody of a messenger. Through a coverage extension, property is also covered while in the care and custody of an armored car service.

There is a special limit for precious metals, precious or semiprecious stones, pearls, furs, or articles made from them. This special limit also applies to manuscripts, drawing, or records of any kind. Losses caused by fire are not covered, unless the fire damage is to a safe or vault. Losses resulting from the transfer or surrender of property or from vandalism are not covered.

Form E – Premises Burglary

Like Form D, the premises burglary coverage form also does not cover money and securities. This form covers property other than money and securities inside the premises. It also covers damage to the insured's premises resulting from a covered cause-of-loss. The covered causes-of-loss are (1) actual or attempted robbery of a watchperson, and (2) actual or attempted burglary. If a covered loss occurs, coverage is suspended until the premises is restored to the same condition of security which existed before the loss occurred.

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However, if at least one watchperson is on duty while the business is closed, this coverage restriction does not apply.

Form H – Premises Theft and Robbery Outside the Premises

Coverage Form H can be used as an alternative to coverage provided by Forms D and E. **Section I** of Form H covers property other than money and securities inside the premises for loss caused by actual or attempted theft. Damage to the insured's premises is covered if the damage results directly from the actual or attempted theft. Because theft is any act of stealing, this form provides broader coverage than Forms D and E provide.

Section 2—Outside the premises covers property other than money and securities while it is outside the premises in the care and custody of a messenger or, through a coverage extension, an armored car service. The covered cause-of-loss under Section 2 is actual or attempted robbery. As in Form E--Premises Burglary, coverage under Form H is suspended after a loss until the premises are restored to the same condition of security that existed before the loss occurred. This restriction does not apply if at least one watchperson is on duty while the business is closed.

Commercial Crime Coverage and Policy

The crime coverage part consists of commercial crime declarations, the crime general provisions form, one or more crime coverage forms, and any applicable endorsements. The crime coverage can be issued in a monoline policy or as part of a commercial package policy. There are two declarations forms for commercial crime insurance. They are Form A used with monoline crime policies and Form B used when crime coverage is included in a commercial package policy. Both declarations forms provide the policy number; a list of crime coverage forms attached to the policy as well as the applicable limits and deductibles; a list of endorsements attached to the policy; and a description of any policies or bonds that are canceled upon issuance of the new policy. In addition, Form A provides the name and address of the insured; name of the producer; policy term; and space for a countersignature.

Rating Commercial Crime Coverage

All of the coverage forms included in a crime coverage part of a monoline policy must be rated separately. ***The Surety Association of America, the organization having jurisdiction over fidelity bond forms, develops rules and statistics used*** for rating employee dishonesty coverage and forgery or

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alteration coverage. The Insurance Services Office (ISO) develops rules and statistics for rating all other crime coverages.

Form A--Employee Dishonesty Coverage -- Rating employee dishonesty coverage, written on a scheduled basis, is governed by the number of individual employees or positions to be covered and amount of coverage applicable to each. When coverage is written on a blanket basis, it is important for the insurer to know the scope of employee dishonesty exposure, that is, the number of employees having an opportunity to cause a loss. Such "ratable" employees are identified through a list of positions generally associated with the handling of money or valuable property, such as accountants, auditors, paymasters, stock clerks, and truck drivers.

Form B--Forgery or Alteration Coverage -- Rates for forgery or alteration coverage, are determined in a manner similar to that used for blanket employee dishonesty coverage. The basic premium is determined by the limit of insurance for forgery or alteration coverage, however, and is modified by a discount factor. A discount factor is used because the forgery or alteration loss exposure is not as great as the employee dishonesty exposure.

Coverage Forms C and D--Theft, Disappearance and Destruction -- Robbery and Safe Burglary -- These are rated with similar factors. For each form, separate premiums are developed for coverage inside and outside the premises. Premium discounts are available for Form C or Form D if the insured has an approved alarm system. **Inside the Premises** -- Three factors are considered in calculating the premium for coverage inside the premises. These factors are the type of business conducted by the insured; fire resistance and crime resistance of the safe or vault used to store cash, checks, securities, and other covered property; and location of the covered premises. **Outside the Premises** -- The basic premium that applies to coverage for a messenger outside the premises is determined by the type of business conducted by the insured, location of the covered premises, and number of guards accompanying the messenger. To this basic premium are added separate rates for each category of property that can be covered under either Form C or Form D--that is, cash, securities, payroll checks, and checks other than payroll.

Chapter 7 The Principles of Professional Liability

History of the Law of Professional Liability

The history of law has meaning only if it can be assumed that at any given time the vital part of it is new and ever changing. The history of law is not a search for fossils, but a study of social development which has been unfolding throughout time. American social development and law have a long history. The Indians first inhabited this land; the Europeans came in force followed by the Spaniards and many others as well, each bringing its own laws. With this in mind, it is not easy to say which law is the immediate forbearer of what is now practiced as law. The evolution of law sometimes took place through the use of shortcuts called *legal fictions*.

The history of law has meaning only if it can be assumed, that at any given time, the vital part of it is new and ever changing. The challenge would now be to develop tort in a way that the power-holders of the day would consider socially desirable. The new tort law showed rules to put limits on the liability enterprise could be held to, which was the thrust of the developing law of negligence. Because of the significant degree to which railroad accidents were occurring, tort was forced to grow. Laws governing railroad activities grew up together with tort law. In a real sense of the word, the two had become one.

Legal fictions were pleading – papers filed in court – that told a story which was based on a factual dispute. Fictional events were thrown in to this story so that the case may be solved in a more timely and just, or what was felt to be just, manner. Professional liability was rarely thought of as a part of law, but as part of the law of contract. The law of contract held a special place in 19th century American law. A contract was identified as the single most important hallmark of modern law and was defined as a meeting of the minds. This phrase cannot be taken too literally though, because the law still emphasized the document itself, providing there was one. The document and its plain words held as the ultimate evidence as to whether or not negligence played a part in the dispute. A case was brought before the courts in 1806 stating that the buyer of a ship had bought the ship under false pretenses.

The buyer of the ship complained that he had been orally promised that the ship was completely copper-fastened. The bill of sale contained no such promise. The parole-evidence rule – a rule that excluded any evidence that may

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contradict the terms of a written contract providing it had been drawn up in final form, was the defendant's defense. One could remark that free contract was and is a pillar holding up the palace of ordered liberty. To the students and teachers of law, it was, and is, the great gate into which the palace of law may be entered. Still, there was no real sense of professional liability.

Should two people enter into an agreement where a good was sold as though it were useable and that product was, in fact, unusable, the case would be brought under the heading of caveat emptor. Even into the 19th century it was argued the concept of negligence was quite different from its later form. It referred to failures to perform a specific duty of contractual nature and not as a failure to measure up to a general standard of care, i.e. the behavior of the reasonable man.

Crimes of this nature did little to provide work for the criminal courts. People were quick to render justice for such offences in a means deemed appropriate at the time. The rise of economic crime was probably an external sign of a very real change in the base of criminal law. A crime which may have been determined to be one of a sinful nature – fornication, blasphemy – before the Revolution, soon lost the people's interest. The focus slowly shifted to concern for the protection of one's private property and even more, of the furtherance of the community's economic business.

Tort Law

The old law treated contract and tort cases under entirely different rules, which reflected this fairly intuitive line between choice and coercion. It also places enormous confidence in individuals to manage the risks of their personal environments. The new, tort-dominated jurisprudence prefers universal rules with no provisions for choosing to opt-out. ***Tort law now defines acceptable safety guidelines in lawn mower design, vaccine manufacture, heart surgery, and ski slope grooming,*** without regard to the preferences of any individual consumer or provider. In a similar notion, the old law relied on the political branches of government to make those safety choices that only a community as a whole can responsibly oversee.

The new law likes control through the instrument of the lawsuit. The new tort message is one of misinformation in matters not only of safety, but also of financial protection. The notion that tort liability provides a reliable safety net for accident victims would be an exceptionally cruel myth if potential victims took it seriously. The aim of providing more and better insurance against accidents

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has fared no better than the goal of improving safety. Every change in legal rules implemented by the founding lawyers aggravated problems of exactly this kind, by requiring a looser definition of risk and responsibility, which led to higher rates, which led to lower coverage.

Though we have come a great distance, there is no reason to believe that the journey is over. In the first place, the momentum of accumulated logic is likely to keep the system moving for the indefinite future, as newly established legal principles are sent to open up fresh areas of litigation. There is also great financial momentum in the system. The tens of thousands of plaintiffs' lawyers who advertise for clients, dig up the cases, gather the evidence, and take the claims to court, now have considerable economic muscle on their side.

Considering the Need for Professional Liability Insurance

Professional liability insurance, also known as Errors and Omissions Insurance or E&O Insurance, insures a person and/or an entity against claims made by third parties (clients, patients, customers, etc.), alleging liability insurance was designed for a core group of professionals including doctors, lawyers, CPA's, architects and engineers. These are professions that require an advanced academic degree, licensing, etc.

In recent years, however, the scope of professional liability coverage has broadened significantly, and now includes such professions such as allied healthcare, mental health or substance abuse counselors, business managers, marketing or technology consultants, software designers, public relations professionals and environmental consultants. Just about anyone who claims to be an expert in any field and is then compensated for his/her expertise, can be held liable in the event that things don't turn out as they should. The insurance industry has responded to this issue by expanding its professional liability capacity to embrace many negligence in the rendering of, or the failure to render, professional services.

Exactly what constitutes negligence is difficult to define, however, loosely defined, negligence refers to the failure to provide the degree of knowledge, care or skill of the average professional peer in good standing, under similar circumstances. Essentially, any person or any business that claims to be expert in a particular field can be held responsible for work, advice or counsel. Some policy forms are tailored to a single profession. Others insure the acts of the

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professional by describing them in a space on the policy declaration page or in an endorsement.

At any time and in any given situation, a dissatisfied individual can choose to bring a complaint against another individual. When people sue, they usually name everyone they perceive as having had anything to do with the situation—a person, his or her business, those with whom this person shares office space. Routinely, claimants sue as many individuals as possible. Regardless of who is negligent, it can take years for litigation to be dismissed. While this individual may be exonerated from liability, attorney's fees can be staggering. Professional liability insurance helps relieve a professional from the financial burden of defending himself or herself in a malpractice lawsuit.

If an individual is providing a professional service or rendering a professional opinion, this coverage is highly recommended. In fact, many professions require one to have professional liability insurance before allowing him or her to practice. Of the suits that could be brought against someone, the two most common are for negligence in the performance of services and breach of contract.

Negligence suits, which occur more frequently, arise from damages sustained due to failure to perform according to known standards of conduct in a specific field. The financial consequences of such suits, including the costs to defend them, can be severe. As a result, it is critical that professionals recognize their exposures to financial losses, and adopt effective means to deal with them.

Even if it were to be assumed that an individual or his or her business would never make an error or omission, it is still a fact that one cannot ignore the fact that anyone can allege virtually anything—and drag an individual into court. The issue may not even have anything to do with the professional. If the professional were even remotely involved in the disputed work, he or she is likely to face a legal suit. Even if it turns out that the individual has done nothing wrong, he or she could still be faced with thousands of dollars in defense costs.

Additionally, it's important to note that having professional liability insurance does not make one more likely to be sued. It simply makes an individual more prepared if a lawsuit is brought. Whether employed or self-employed, work full-time or part-time, or are a student practicing in a supervised setting, having a professional liability policy will give peace of mind and the protection needed.

Existing Professional Liability

There are any number of ways that a professional can find himself or herself faced with a problem in obtaining professional liability or malpractice insurance coverage. ***These situations can range anywhere from malpractice claims/lawsuits; disciplinary actions;*** license restriction, suspension or revocation; ***felony conviction;*** substance abuse; sexual misconduct, and even to non-accepted medical practices and procedures. The professions subject to the need of professional liability are as vast as the scope of one's imagination which rang from lawyers to accountants, auditors, and even ***claims adjusters.*** Engineers, architects, and clerics can become involved in a lawsuit either directly or indirectly, as the result of another's lack of insight or as the result of an honest error or omission. In this chapter the discussion will revolve around various occupations or professions as it were, and how each is subject to claims of malpractice selective in and of itself. Ways and means of avoidance of said situation will also be discussed as well.

Accidents

Many real collisions happen on a daily basis and although this was merely an imagined car accident between two strangers; it is comparatively rare in the larger realm of accidents and injuries. Just as most intentional assaults involve assailants and victims who already know each other well, most unintended injuries occur in the context of commercial acquaintance.

That is to say, most incidences happen at work, on the hospital-operating table, following the purchase of an airplane ticket, or even due to a home appliance. It is thought that unintentional accidents are often a subject of advance understanding between the victim and the assailant. Not that there is already advance understanding between any two parties who may or may not be involved in an accident, but that said accident is merely often a subject of advance understanding.

More often than not, both parties involved in a transaction recognize that there is some chance of misadventure, and prudently take steps to address any incident before it ever happens. Advance understanding is the unspoken awareness that there is the possibility of an incident involving a company, despite the degree to which one goes to in order to provide caution to avoid such an occurrence.

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Negligence

Due to the growing frequency of professional negligence suits and the sympathies of courts, professional people are now held more accountable for their mistakes than ever before. It is difficult, if not impossible, to say how much insurance a company might need in the event of an actual claim. What constitutes negligence is a bit ambiguous, but can be loosely defined as the failure to provide the degree of knowledge, care or skill of the average professional peer, in good standing, under similar circumstances. Negligence lends hand to the law of tort.

Tort law is the law of accidents and personal injury. The example that comes to mind is a two-car collision at an intersection. The drivers are utter strangers. They have no advance understanding between them as to how they should drive, except perhaps an implicit agreement to follow the rules of the road. Nor do they have any advance arrangement specifying who will pay for the damage that will be incurred.

Human nature being what it is, the two sides often have different views on this same incident. Somebody else has to step in to work out each party's rights and responsibilities. This has traditionally been a job for the courts. They resolve these cases under the law of torts or civil wrongs.

Lawsuits

For instance, should another firm be sued by a client, who, in turn, files a cross-complaint against anyone and everyone who was even remotely involved in the disputed work; any company could very likely be served with a lawsuit as well. Even if it turns out that said company had not done anything wrong, that same company could still be faced with thousands of dollars in defense costs.

One must remember that good professional liability defense attorneys are not inexpensive. Not only do they expect to be paid, regardless of the outcome, they usually also require that a substantial retainer and deposit against costs be paid - prior to formally representing a client. Until quite recently, the law permitted and even promoted advance agreement in regard to advance understanding. It searched for understandings between all involved parties and respected them where and when found.

Most accidents were handled under the broad heading of contract – the realm of human cooperation – and comparatively few moved on to the annex of tort which is the realm of unchosen relationship and collision.

Professional Malpractice

Whatever circumstances lead to a claim of legal malpractice, the reality is that such claims have risen significantly over the past 10 to 15 years, in terms of both sheer numbers, and financial magnitude. Even when the client is completely satisfied with the quality of the representation, lawyers and law firms can find themselves named as defendants in shareholder lawsuits - even class actions - or those actions brought by government agencies, alleging some breach of duty to the public.

There are people that think it an oxymoron to say there is an ethical lawyer. Indeed from what is portrayed daily in the media, it appears that finding a lawyer who is also ethical would be as likely as finding an ice cube in a 500 degree Fahrenheit oven. Whether one is a solo-practitioner or a small to mid-size firm, it is critical that protection of one's being, practice, and assets are sought, with a properly underwritten policy of professional liability insurance.

The best way is to be certain that one has the broadest possible coverage; tailored specifically for the nature of one's practice, and at the most competitive premium. The area of professional liability is fascinating due to the complexities that make it important for a professional to stay up-to-date on the latest changes.

Insurance Agents and Brokers

Historically and generally speaking, an insurance broker principally represents the insured in an insurance transaction. ***Some state statutes and regulations make no distinction between agents and brokers with reference to legal responsibility for wrongdoing.*** Ordinarily, the type of wrongdoing performed when it is committed establishes such responsibility. ***The broker may, in a specific action, be the representative for the insurer, and the insured and both may be held liable for the same wrongdoing.***

Brokers have been held liable for failing to procure insurance for an insured under various circumstances. In some cases concerning an ambiguity in the policy, a broker may have been involved in the controversy. Failure to make sure that a policy covered the insured adequately has also been a controversial issue. However, failure to notify the insured concerning cancellation may not be held against the broker if the insured knew or should have known of the cancellation.

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Generally speaking, the insurance agent is not ultimately responsible for determining how much coverage should be purchased. Here however, is one of the most distinguishable factors between the duties of an insurance agent, who may be an agent for both the insurer and the insurance company at the same time, and a broker, who is primarily the agent for the purchaser of insurance, and, if he or she is consulted about it and if there is no clear-cut understanding to the contrary.

Ordinarily however, the decision concerning the amount of insurance to be purchased rests with the insured since he, she, or it is the one to decide how much money is to be spent on insurance. If the agent or broker is only a producer of insurance, he cannot make the ultimate decision as to the amount of coverage to be purchased. That is solely up to the insured. A general agent or a managing general agent usually stands in the shoes of the insurance company by contract and generally assumes all of the duties that an insurer owes to an insured, including the disposition of claims.

They usually represent small insurance companies, and their numbers are gradually diminishing. While many courts fail to make the distinction between insurance agents and brokers, the general rule is that an insurance broker is the agent of the insured, although the broker may be, and usually is, the agent for both the insured and the insurance company.

Insurance laws usually limit the time within which a binder is effective, and agency authorizations often limit an agent's authority to issue binders. Any such limitations must be reported to the client, if applicable. It is important that there is agreement on all of the essential terms of the policy to be issued and that confirmation be sent to the client and the insurer, with all essential information including the exact time of the day on which the binder was issued. By agreeing to bind a risk, the agent impliedly warrants that he or she has the authority to do so. The issuance of binders creates a serious legal responsibility. Oral binders are subject to the ordinary legal requirements of valid contracts.

Actions Brought Against the Agent by Third Parties -- While it is still uncommon, a few cases have held that an agent may be liable for malpractice against innocent third parties. For example, should one be a passenger in a vehicle that rear ends another vehicle. Said passenger could bring suit against the driver of the vehicle he or she was in. Another example would involve an action

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brought by a widow against an agent who persuaded an insured to cancel a life policy as a result of his false statements. As an agent, one should take every precaution to insure himself or herself against the chance of a malpractice suit being brought by anyone. Below is a checklist for agents to prevent some actions for malpractice. This is not to assure any one person of not being sued should he or she decide to abide by these measures, but it is intended to be an aid in preventing suits.

Actions Brought Against the Agent by the Company -- Actions brought by an insurance company against an agent are, for the most part, indemnity suits brought to recover payments made by the insurer because of the malpractice of the agent, since knowledge of the agent is usually imputed to the insurer. While for business reasons, indemnity actions are not of the greatest concern to the average agent, such suits are not at all unusual for the following reasons:

- Fraud involving intentional concealment of material facts concerning a risk;
- Binding unauthorized risks;
- Failure to follow instructions;
- Failure to disclose adverse information to company.

Actions Brought Against the Agent by the Insured -- The area of greatest danger and exposure to malpractice actions for insurance agents involves suits brought about by the clients or prospective clients against them for a number of reasons:

- Failure to procure or renew insurance that the agent had contracted to obtain;
- **Failure to advise client promptly concerning inability to obtain renewal, rejection, or cancellation;**
- **Failure to apply for coverage promptly with a solvent and authorized carrier;**
- Failure to explain the boundaries and exclusions of coverage – misrepresentations of coverage;
- Failure to advise insured about differences in coverage because of renewal changes, or mistakes of which the agent was, or should have been aware of;
- **Failure to obtain adequate coverage.**

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The standard of care required of insurance agents is the usual one applied to professional liability; to exercise the degree of skill and knowledge of the reasonably prudent insurance agent under similar circumstances. Locality plays a very minor part in determining the professional liability of an insurance agent. Again, as with other professional liabilities, an agent does not undertake to render perfect service, and mere errors of judgment, where negligence or fraud are not involved, should not warrant recovery against him for malpractice.

The authority of an insurance agent to act on behalf of the insurance company that he or she represents is determined by the agency contract, the underwriting rules of the company, and past relationship with it. An agent is usually granted specific written authority and, in addition, has implied authority to act in a proper manner to accomplish the usual purposes of an insurance agent where it does not contradict his or her written authority, with some exceptions to be noted hereafter.

Claims Adjusters

It is stated that an independent insurance adjuster was within the meaning of persons engaged in the business of insurance and is subject to liability for violations of the Unfair Claim Settlement Practices Act. But, as agents for a disclosed principal, it has been held that the claim adjuster is acting for, and on behalf of, the insurance company and is not held personally responsible for any malfeasance.

That is to say that as long as the principal was disclosed, the claim adjuster remained immune from professional liability even when he exceeds his authority. Plaintiff's lawyers seem to see some strategic advantage to the inclusion of claim representatives who actually handle settlement negotiations for the insurer, and when necessary have been known to make them party defendants. As a result, the exposure of claim representatives is increasing and in addition, the enactment of Unfair Claim Settlement Practices Acts has permitted personal actions against insurers and claim representatives in some states which has increased that exposure. Claim representatives who are insurance company employees, however, have for the time being remained exempt from liability under this statute.

Three hazards that cause errors and omissions problems for claim adjusters are:

- unclear communications,

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- procrastination, and
- improper documentation.

For those who are meticulous with their time, it could be said that all three are symptoms of procrastination, not just the second. There are actually many hazards that could cause errors and omissions problems. Listed below are just a few:

- Failure to properly reserve insurer's rights where there is a conflict of interests with the insured;
- Failure to make honest recommendations to supervisors and home office;
- Failure to use defense attorney's services properly and within proper economic bounds;
- Failure to keep insured and company supervisors properly and promptly advised and failure to respond properly to home office inquiries;
- Improper or incomplete investigation;
- Improper evaluation and failure of continued reevaluation of settlement values;
- Incorrect coverage interpretation leading to improper disclaimers of coverage;
- Lack of courtesy and diplomacy to all with whom the adjuster comes in contact.

Architects and Engineers

It is generally agreed that any distinction between an architect and an engineer is irrelevant to the question of tort liability. Both are required to be certified by the state before being permitted to practice their professions. The standard of care for both professions is similar to that of other professions except for the greater duties assumed by contract.

In the later part of 1957, courts confirmed the demise of privity of contract as a defense for an architect or builder as to a structure erected on real property. It also decided, as a matter of law, that neither the architect nor the builder was liable to third parties for defects in buildings or other structures on real property. Once the owner, where the defect or danger was known and could have been discovered by reasonable inspection, accepted them.

But, by the early 1970's nearly every jurisdiction had discarded the privity of contract defense for architects and engineers. More than in any other

profession, architects and engineers may be held liable for their professional liability to third parties as well as to their first-party clients. The following areas of possible liability for architects and engineers include aspects of both first and third-party liability. ***Liability for defects attributed to plans and specifications. This usually involves dangerous conditions that could cause injury or death resulting from:***

- ***Foundation of a building being inadequate;***
- Roof, floors, or walls that may crack, buckle, or collapse;
- ***Fixtures that may be inadequate or badly installed;***
- ***Waterproofing, heating, or air conditioning inadequacies;***
- Liability arising out of improper certification of partial or total completion;
- ***Improper specification of materials;***
- Improper supervision of construction, if called for in the contract;
- Deviations from plans or specifications without previous agreement.

Statute of Limitations

Until recent years, it had generally been held that the statute of limitations in professional liability cases involving architects and engineers ran from the date of the malpractice. More recently, however, the discovery rule has become much more prevalent. Discounting any statutory enactment on the subject, the statutory period would also be affected by whether the action was brought in contract or tort. Some cases hold that the statute begins to run from the time of completion of the construction. As a result of pressure brought by architects and engineers through their professional organizations, many states have adopted special periods of time limitation within which an action may be brought against architects and engineers for malpractice.

While most of them have been declared constitutional, the time period (usually four to seven years) was felt to be inadequate by the organizations representing the architects and engineers, since many malpractice actions are brought many years after the completion of the buildings involved. Architects and engineers do not warrant that their plans and specifications are foolproof, nor do they warrant the durability of the structures involved, under ordinary circumstances. Some suggested avenues for the investigation of accidents allegedly caused by the professional negligence of architects and engineers follows:

- Find out who drew up the plans and specifications.
- Obtain complete details concerning the names and correct legal entities of all parties to the suit, including the names of their attorneys.

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- Obtain copies of all progress reports and certifications of work completed and check these against the contract requirements.
- Read the contracts and other papers attached carefully.
- Determine the correct legal names of all contractors, both general and subcontractors, and their insurance carriers.
- Check any alleged negligence thoroughly and make a determination as to whether any alleged defect was hidden or open and obvious.
- Find out if there were any “hold harmless agreements” between any of the parties and, if so, obtain copies and refer for legal advice.
- Determine whether the construction involved any deviation from the plans, blueprints or specifications and, if so, obtain complete explanation and details.
- Find out exactly what supervision was called for and what the insured did and get complete details. Determine whether there was any failure to properly supervise the operation.
- Determine whether all proper and required permits were obtained and whether the work was done in compliance with all local, state, and federal laws.

Many of the duties assumed by architects and engineers are based upon the oral or written contract between them, their clients, contractors, and subcontractors. Accordingly, the first and prime duty of the attorney representing the architect or engineer in the event of suit for professional malpractice is to obtain and carefully review all contracts and agreements. In recent years, the law concerning the liability of architects and engineers for their professional liability has, to quite a degree, paralleled the development in the law of products liability. Privity of contract has ceased to be an important factor in both fields of law.

Directors and Officers

The great difficulty in handling errors and omissions claims involving corporate directors is the common misconception that a board of directors actually manages a corporation. While such an impression is created in most corporation acts, including Section 35 of the Model Business Corporation Act, nothing is further from the reality of the situation. In all actuality, most directors know very little about the day-by-day operation of the corporation with which they are involved as directors, and yet some courts have held directors to a high standard of knowledge and responsibility for such daily operations.

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The courts have generally held directors to be obligated to act in good faith, and with diligence and loyalty. The degree of skill and care is the usual one required of the prudent person under similar circumstances in the conduct of their personal business affairs. They are regarded as fiduciaries of their corporations and stockholders. Some directors perform special duties requiring specific skill or knowledge, and such directors are held to a much higher degree of responsibility. Some of the grounds upon which actions have been brought against corporate directors and officers involved the following:

- Conflicts of interest;
- Misuse of funds;
- Inefficient administration;
- Payment of unwarranted dividends;
- Failure to comply with state and federal laws and regulations;
- Failure to attend meetings regularly;
- Misstatements of financial reports.

In view of the ever-increasing degree of accountability to which directors were being held, the situation was fast becoming untenable for any individual who assumed such a responsibility. Accordingly, the by-laws of most corporations now state that an officer or director will, in certain circumstances, be indemnified for expenses and even some damages for which a director has been held personally responsible. Many states have also enacted statutes agreeing with this position where fraud or illegal gain was not involved. The statutes involved are not uniformed to say the least. Some authorize corporations to make indemnification, some require indemnification, and others require court approval on an individual basis.

A few even permit indemnification for expenses involved in criminal defense, where the defendant has been successful. Where civil defense is successful, it is obviously just a matter of reimbursing a director or officer for legal expenses involved in defending himself or herself. However, where a director is held responsible, his acts may run the gamut where indemnification may be mandatory to the other extreme, where indemnification could be outrageously unjust.

Directors and Officers Liability for Clean-Up Costs -- There is a growing judicial trend of imposing liability for Superfund (CERCLA) clean-up costs on directors and officers of corporations and financial institutions where such individuals may have had some authority over, or involvement in, cleaning-up of

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hazardous waste sites. Under CERCLA, there are four categories of potentially responsible parties:

- Current owners and operators of a facility;
- Past owners and operators of a facility at the time of disposal of hazardous substances;
- Generators and others who arranged for the disposal of hazardous substances; and
- Transporters of hazardous substances who selected the disposal or treatment sites.

Most of the case law has focused on the first category listed above. CERCLA has an exemption from liability for entities or individuals whose ownership interest in a site does not involve participation in the management of a facility, but consists only of a security interest in the property site. Once the problem of the legality of indemnification has been hurdled, it becomes obvious that the hazards of personal liability by directors and officers are insurable. It has been argued that since the law imposes certain duties and obligations on directors, it should not permit them to evade those obligations by the purchase of insurance. This is a very untenable position to take. All liability insurance could be subject to the same liability, products, or any other coverage of this nature. Why should insurance for directors and officers be different? The obvious answer is that it should not. Some states have specifically enacted statutes permitting corporations to purchase insurance for the protection of officers and directors from financial disaster resulting from actions brought against them in their capacities as such. Other states permit such insurance without specific legislation on the subject.

Dentists

Dentists' Professional Liability insurance is provided on the Physicians and Surgeons form, and the rules involving dental malpractice are the same rules of medical malpractice applied in a dental context. As with other medical practitioners, dentists are not insurers or guarantors (unless they contract to do so) of a specific result. Dentists can also be held liable for the negligence of their employees.

For example, extraction of teeth is a very vulnerable area involving great possibilities for allegations of negligence because of the very nature of the procedure. In dentistry, as well as in other forms of medical malpractice, the courts are usually strict in interpreting release forms that are tendered to a

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patient before a procedure or treatment without full explanation and without giving the patient time for consideration. The general duty of care owed by a dentist is that usually applied in professional liability cases, which is that degree of care and knowledge exercised by others in the same profession or area of specialized practice. However, obviously a higher standard of knowledge and experience is expected from specialists.

Remember, unlike malpractice insurance programs offered through associations & societies, impaired-risk coverage is individually underwritten. Underwriters carefully review each application so that the policy is properly priced in relation to the history. In addition, most policies of this sort include deductibles, limitations, and certain restrictions - all of which are designed to not only keep the premium as reasonable as possible, but also to make the insured a partner in the coverage. Assuming that the professional remains free of further claims or incidents, it can be expected that each year will bring more competitive terms, conditions, and rates. Some carriers, for instance, won't write the first year of impaired-risk coverage, but are willing to quote from the second year on.

Veterinarians

Lawsuits against veterinarians have increased dramatically in recent years as the numbers of pets in this country have increased, and as have the number of suits in general. While malpractice claims against veterinarians may be brought for breach of contract, bailment and breach of warranty, most by far, are brought on the basis of negligence. Recent cases require the veterinarian to have used the standard of care of practitioners on a national rather than a regional basis. A higher standard is, as can be expected, from specialists. The general standard of proof and care do not differ much from the other malpractice suits. Humans can also bring claims for injuries allegedly received from improper handling, care or medical treatment of pets, although coverage for worker related injuries are not usually covered.

Physicians and Surgeons

A person visits a doctor's office due to a prolonged illness. Despite all the physician's efforts, the symptoms have not diminished and are getting progressively worse. Has the doctor failed in his or her duties, or is it a case of whatever is wrong is simply out of his or her field of expertise? Should the doctor realize or even suspect this to be the case, chances are – for many reasons – he or she will advise the patient to seek further aid. After all, a physician is held to a standard of performance representative of accepted

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professional skills, but not all physicians are held to the same level of performance. This is a common understanding among physicians and should be among the general public, once the reality of a doctor's education and training is considered.

A general practitioner cannot be expected to be as knowledgeable about the fine points of cardiac diagnosis or treatment as the cardiologist who has trained for as many as six additional years in the specialized field of cardiology. Should the patient determine that someone, somewhere along the way, was negligent in his or her duties as a physician, the courts would fall into the play.

There is a general rule applied by the courts to determine if an incident of malpractice has been committed. It is to ask if the doctor has performed in a manner consistent with his or her education level and training, and in a manner consistent with the work of doctors of similar education and training in the work of the community. With the ability and frequency of travel now days, there has been more of a tendency by the courts to disregard the community clause. The community clause or locality rule states that initially, the standard for evaluating the conduct of a professional in a malpractice suit was that degree of skill and care of a reasonably skilled professional in the same or similar locality.

The outcome of a medical, malpractice suit has an effect on all parties involved. But for the purposes of this text we will focus on how a malpractice suit affects the physician from the professional aspect. Lawsuits are brought for many reasons ranging from being just, to frivolous, and out of seeking vengeance. Indifferent as to the outcome of the suit, being sued in and of itself can and often times does make a difference in the way a doctor will approach his patients from that point on.

Fearing future lawsuits may even affect a doctor's choice of treatment, causing him or her to second-guess oneself. It is clear to see that a physician whose suit has become public knowledge has already suffered some harm to their professional reputation, despite the reasoning for the suit. Hence, a tainted view of what was once a love. To add to that, the physician now has the potential of having his or her malpractice insurance cancelled and to reinstate such a necessity may not only be difficult, but costly.

The usual medical professional liability policy is written on either an occurrence or a claims-made basis, though the trend is increasingly towards occurrence forms. Limits are customarily \$1 million per occurrence and \$3 million

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aggregate, though other options are available. The process to become insured again may mean an increase in each of these.

Hospitals

In making a determination of the malpractice liability of a hospital, it is sometimes necessary to make a distinction as to whether the alleged negligence, involved the sale of a product or providing a medical service. This differentiation is very important, since strict liability is often imposed in products liability cases and rarely in medical malpractice. A good example would be as such; a person sustained an injury to one of his eyes following the fitting and sale of contact lenses.

Said contact lenses were prescribed for him by one of their many optometrists. The same price was charged regardless of the possible involvement of eye problems and the number of subsequent eye examinations. In such a case, there would be little doubt that the charges were made for the product, as was advertised, and not for the services of the optometrist. However, the decisions on this subject have no uniformity at all, and what is or is not a product sold or a service rendered seems to be at the whim of the particular court involved.

In hospital professional liability policies, the insured has the option of purchasing either the claims-made policy forms or the usual occurrence forms, although not all states have as yet approved the latest Insurance Services Office (ISO) forms. Both of these policies, for reasons outlined in differentiating general liability coverage from malpractice, contain protection from both types of claims.

The general liability coverage comes into play when injury arises out of such general activities as housekeeping, the making and serving of meals, and other hospital responsibilities not connected directly with medical care and treatment of patients. Liability arising out of food served to patients is covered, but food served to relatives or other visitors, is not. Licensing and review procedures provide some measure of quality control of the physicians who are connected with a hospital, but the burden is on the hospital to make its' own investigation concerning the competency of any doctor who is accepted on its' staff.

Today's hospitals are larger and more complex than ever before and operate as highly integrated systems utilizing a team approach to medical care. As the larger hospitals treat more patients, the potential for negligence, by the hospital, increases. A patient commencing a malpractice action will probably sue the

hospital in addition to the treating doctor. The changing nature of hospitals has not gone unnoticed by the courts. These changes have precipitated a reevaluation of the traditional legal analysis regarding hospital's liability for the negligence of their physicians.

Hospital Liability -- The liability of a hospital may rest on its corporate responsibility (administrative acts), or on the doctrine of agency or master and servant. Responsibility for its administrative or corporate acts usually falls within three categories:

- Defective equipment;
- Selection or retention of incompetent personnel; and
- Unsatisfactory maintenance of buildings, grounds, furnishings, medical, and other equipment, and defective food and drink.

Hospitals may be government owned, privately run for profit, or privately run on a nonprofit or charitable basis. Hospitals run for profit are responsible for the wrongdoing of their employees, generally to the same degree that ordinary corporations, partnerships, or other business entities would be held accountable. In the area of maintenance responsibilities, a hospital has a duty to all invitees to use reasonable care in the maintenance of buildings, grounds, and furnishings, which are usually referred to as administrative duties, as distinguished from medical duties.

The Professional Liability Policy

Professional liability insurance is sometimes referred to as errors & omissions, or *E&O* insurance. In the case of medical professionals, it is often referred to as malpractice insurance. To clarify how professional liability insurance is and of its own, product liability should be very briefly touched on. Product liability insurance is coverage that is designed to provide protection against financial loss arising out of the legal liability incurred by a manufacturer, merchant, or distributor because of injury or damage resulting from the use of a product that is covered under one's product liability insurance policy.

While product liability and liability may, and often do, make wonderful bedfellows, it is important to remember that they are two different entities and are usually not included in the same policy. However, property and liability insurance can be combined into one policy, and it can be cheaper to buy a combination policy. That fact is not mentioned in order to suggest that one

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does purchase the combination package, only to make it known that such can be bought. Also, saying that such a policy can be bought cheaper, does not in any way guarantee that it will be found to be so. When discussing professional liability insurance coverage, other intriguing issues must be discussed also. Are defense costs provided within limits or outside limits or maybe somewhere in-between? What about the specifics of the deductible? Does it apply to defense costs?

Does the policy provide coverage for administrative or disciplinary proceeding brought by a governmental or regulatory body? These and many more fine points of a policy need to be ironed out as soon as is possible. It is also good to know. What triggers coverage? Does a simple allegation, such as a statement made by a client, or does an actual written demand have to be made, or maybe a lawsuit must be filed and served before protection is provided? Does the insured professional have any input in settlement negotiations? Is one's consent required in order for an insurance company to settle? If so, and if the decision is made to decline to settle, what happens at that point?

There are no right or wrong answers to any of these questions, but it is critical that the insured professional know what level of coverage his or her premium dollars are buying. Getting these questions answered should be part of the process. After all, once a claim has been filed, it is too late to find out what coverage is included in a policy.

One may wonder what the history a business has in regard to claims. It is good to keep in mind that there are people out there who make a living from suing. That is to say that the longer one is in business the greater the chance that his or her company will be served with a lawsuit at some time. The question at this point is whether or not the fact that a professional liability claim (or claims) in the past disqualify one from getting good coverage. In mostly every case the answer would be, absolutely not.

While, obviously, each applicant's situation must be reviewed individually, prior claims experience is not necessarily a big problem. Even if past-claims experience puts one into a category deemed as hard-to-place, an experienced, creative insurance professional should be able to find good, affordable coverage. Many of the initial costs of proving the innocence of the accused are reimbursable. It is best to check with one's agent to verify the exact exclusions and limitations of the policy which was chosen is concerned. Once a claim or a lawsuit has been brought against an individual or company the proceedings will

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begin to fall into place. Here is where the research the business owner did in choosing a policy comes into play, with having the best agent and policy available for a company.

Policy Features

Some policies include a clause stating one's consent to settle, while others give the insurer the sole right to determine when to settle. Some carriers also include a clause requiring the policyholder to consent to a common defense with any other defendant insured by the same company. While this has certain advantages, it also has certain risks, and the acceptance of any such clause should be given very careful consideration. Most professional liability policies are written on a claims-made basis, though sometimes coverage is available on an occurrence basis.

Knowing which one has - or needs - can be absolutely critical in preventing dangerous gaps in coverage. Professional liability policy coverage is sometimes provided only for work produced during the policy period and, only those claims that are first made against the business owner and are reported during the policy period will be covered under the policy when a policy is written in this manner. Claims-made coverage is most common in the computer consulting industry.

Covered Participants -- Professional liability insurance covers a person or an organization (partnership, corporation, etc.) for claims made by third parties (clients, patients, customers, etc.), alleging negligence in the rendering of, or the failure to render, professional services. Coverage extends to both W2 employees and 1099 subcontractors as well as one's self. To be more precise it could be said that a company's insurance coverage includes all employees not exclusive to full-time employees. The way in which coverage is provided for the employees is to cover them in the case of sexual misconduct, or commonly referred to as sexual harassment, breach or neglect of duty, honest error, misstatement, or omission that occurred during the course of a normal day of work.

The only statement that needs to be made at this point is to clarify the inclusion of sexual misconduct in the reasons and ways in which one's employees are covered. Sexual misconduct or harassment is included, providing the action was not intentionally meant to cause harm or injury to the victim. To clarify, if indeed such an occurrence did take place and it can be shown that the harasser did intend to cause harm or injury, be it physical or mental, to the

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victim, then said harasser is not entitled to coverage for intentional acts as a matter of law. Coverage is also extended to the company owner by means of providing protection in the case of an actual breach of duty, whether honestly or not an error, neglect, misstatement, or omission committed in the rendering of one's professional services. The business owner is also covered for defense costs, charges, and expenses incurred in conjunction with a claim or suit filed against his or her company.

Covered participants include anyone who holds himself out to the business community as a specialist who has knowledge peculiar to his or her field of endeavor, thus qualifying him or her as a professional. The professional person or business owner is also expected to provide reasonable care and diligence to see that the customer or patient receives the best care or service at one's disposal. Employees can be included in this description to a slight degree, because said employer has trained them in respect to the specific field of endeavor.

Policy Benefits and Provisions

The business owner may also choose to look for a comprehensive package that includes a full range of coverage. This is more often than not cheaper than buying coverage piecemeal from several different companies. Group plans often offer these packages. Trade associations in one's particular field of endeavor may be a source of good insurance coverage. Trade associations often get very good insurance rates that are affordable and available for members because they have superior bargaining power.

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Co-Pays -- The everyday consumer naturally associates insurance with deductibles and co-payables. In referring to professional liability and general liability the aspect of co-pays can be thrown out of the window. The reason for this can be found in the definition of co-pay itself. Co-payment means the amount to be paid by the insured person toward the cost of each separate prescription or refill of a covered drug, when dispensed by a pharmacy. Co-pays also are to be applied toward each visit to one's healthcare provider. Co-payments are also known to go hand in hand with what is called *out-of-pocket* expense limit. A maximum out-of-pocket expense limit is the amount of covered expenses, excluding expenses used to satisfy deductibles and co-payments, that must be paid by each insured person before a benefit percentage will be increased.

Deductible -- Insurance companies have different ways of saying the same thing. For example, one company may define deductible as an annual deductible which is a specified dollar amount that an insured must pay for covered expenses per calendar year before benefits will be paid. Expenses incurred by an insured, which may be applied to any applicable deductible referenced in one's policy, will be applied equally toward the satisfaction of the deductible. Another company may define deductible by saying that it is an item or expense subtracted from adjusted gross income to reduce the amount of income subject to tax. Examples include mortgage interest, state and local taxes, unreimbursed business expenses, and charitable contributions. These are also called tax-deductible items. Perhaps the reason for the differences is due to the fact that one is termed an *annual* deductible while the other is not.

For the purposes of this course, we are going to look at another type of deductible. It is the amount of a loss that an insurance policyholder has to pay out-of-pocket before reimbursement begins in accordance with the coinsurance rate. More simply stated, a deductible is an amount that a policyholder agrees to pay, per claim or per accident, toward the total amount of an insured loss. Deductibles are used primarily for real and personal insurance, including motor vehicle collision coverage.

The difference between the cost of a policy with a \$250 deductible and a policy with a deductible of \$500, \$1000, or higher still is quite significant. This is especially true if the premium savings over a five or ten year period are added up. Take for example the difference between a deductible of \$250 and a deductible of \$500 which may be 10% in premium costs, and the difference between a \$500 and a \$1000 deductible may save an additional 3% to 5%.

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Most businesses can afford to be \$500 or even \$1000 out of pocket, especially if taking this risk means paying a significantly lower premium. It is good to consider using money saved with a higher deductible to buy other types of insurance where it is really needed. Consider this, the amount saved by having a higher deductible might pay for business interruption coverage.

Generally, small to mid-size firms most often take a deductible of between \$2,000-\$10,000, and carriers vary in terms of whether claims' costs are to be charged against the deductible. Obviously, all of these issues will impact upon the premium. There is no right or wrong choice; it really depends upon what the potential customer wants, needs, and is comfortable with.

Limits of liability are available from as little as \$100,000, to as much as \$25 million. Many policies include coverage for expenses in connection with disciplinary actions. Claims expenses are sometimes included within the limits of liability; though a number of carriers will offer claims expense outside of limits, or caps the offset at, say, 50% of the liability limit. As far as deductibles are concerned, these range from as low as \$1,000 to \$50,000. Differences include the limits of liability, scope of the coverage, deductible, size and nature of the client, location, and so on.

Premiums -- The insurance industry helps our economy grow by providing funds for community investment. The premiums collected by insurance companies are used to pay out claims and support business expenses, but legally required cash reserves are invested in Federal, State, and Municipal Bonds (to build schools, parks, etc.), commercial construction, housing developments, and stock market investments. These investments stimulate economic growth. Good safety and security measures may eliminate the need for some types of insurance or lead to lower insurance rates. It is a good idea to ask an insurance agent what to do in order to get a better rate. Sometimes something as simple as installing deadbolt locks or buying two more fire extinguishers could qualify a company for a lower premium. Following are some other ideas that can aid one in cutting losses and lowering premiums:

- Install a fire alarm system, if one can be found at a reasonable cost;
- Install fireproofing materials to minimize fire damage in susceptible areas of the premises;
- Isolate and safely store flammable chemicals and other products;
- Provide adequate smoke detectors;
- Install a sprinkler system.

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It should also go without saying, that professional liability extends beyond just fire safety. One would be very wise to consider placing bars on doors or windows. While a necessity in some areas, in other communities this may create a negative impression, even so much as to deter business prospects. Contacting an innovative architect or contractor is another very good idea. They may be able to help the business owner design and install these security devices in ways that are not unsightly.

Although how to protect against some types of risks may be obvious, how to protect against many other types will not be so obvious. Persons experienced in identifying as well as dealing with these specific types of risks are of invaluable help. One excellent resource is the safety inspector of the insured's insurance company. The chosen insurance agent will know how to get in touch with this individual. Another very good approach is to ask all employees to identify any safety risks, regardless of how small. Ask them, also, to propose cost-effective ways to eliminate or minimize these risks.

Insurance premiums can vary widely, depending upon the exact nature of the insured risk. We all know someone who pays almost nothing for automobile insurance, and we probably know someone else who pays a small fortune for the exact same coverage. The difference can be due in part to, 1) location, 2) driving record, 3) whether or not there are other drivers - such as a 17-year old son, who just got his license, 4) the car itself, 5) past claims history, and yes, it could also be, 6) their insurance company - some companies charge more than others.

Conditions of A Professional Liability Policy

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

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

Coverage Provided

A well-designed insurance program can protect a business from many types of perils. Consider the following incidents:

- A fire destroys all the furniture, fixtures, and equipment in one's business;
- Burglars steal thousands of dollars worth of computer equipment used in the company;
- A customer visiting one's business slips on the floor and shatters a bone;
- On the way to an office supply store for company errands, one of the employees runs a stop sign injuring a child;
- A house painter has a severe allergic reaction to a chemical from one's company;
- An employee is hospitalized for four weeks with a severe back injury received while trying to lift a heavy package;
- The building where one's company is located is severely damaged by a windstorm forcing a company's doors closed for two months while repairs are made. In addition to having to pay thousands of dollars for continuing business expenses, over \$20,000 is lost in profits that had been expected for that time period;
- A client installs a lawn sprinkling system based on specifications recommended by one's company of landscape architects. The soil conditions had not been checked out carefully which caused the system to malfunction. The client's basement flooded, even going so far as to ruin the antique furniture stored therein.

Maybe none of these situations will ever happen to one's business, but with Murphy's Law being what it is, taking such a chance is not the most sound

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move financially. Thankfully, insurance is available to cover each of these events and for many, if not most of them, it is reasonably cost effective. Not every business is in need of every type of coverage. To be perfectly honest, a business that would try to buy insurance to cover all insurable risks probably would not have enough money left over to do anything else.

Deciding on insurance coverage usually involves some difficult choices. One of the most important issues to consider, when deciding upon professional liability insurance coverage, is that of defense. Even were we to assume that an individual or his firm would never do something that could be considered an error or omission, one simply cannot ignore the fact that anyone can allege virtually anything.

However, as a rule, most of a client's companies will require minimum limits of \$1,000,000 in General Liability and \$1,000,000 in Professional Liability coverage. The amount of insurance needed by a company depends on the specialty, the size of the company, and the size and type of the largest client companies. Limits of liability are available from as little as \$100,000, to as much as \$25 million. Many policies include coverage for expenses in connection with disciplinary actions.

Claims expenses are sometimes included within the limits of liability; though a number of carriers will offer claims expense outside of limits, or caps the offset at, say, 50% of the liability limit. As far as deductibles are concerned, these range from as low as \$1,000 to \$50,000.

In legal terms, sexual harassment is any unwelcome sexual advance or conduct on the job that creates an intimidating, hostile, or offensive working environment. That is a much shorter version of the definition used by the federal government and in most states; but it is really not necessary to belabor the point in legal lingo.

Simply stated, sexual harassment is any offensive conduct related to an employee's gender that a reasonable woman or man should not have to endure. Sexual misconduct, or harassment, is a very heated issue in dealing with professional liability. Legally, sexual harassment on the job is a form of sex discrimination prohibited by federal law – and many state laws. Sexual harassment comes in two basic varieties: *Quid Pro Quo*, a Latin phrase meaning something in exchange for something; i.e. a superior demands sexual

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favors in exchange for job security. Harassment of this sort is also present if an employee's pay or assignment is dependent on submission to sexual requests.

The other variety is in the form of a hostile work environment. This is more subtle, but equally illegal. This occurs when unwelcome sexual conduct interferes with an employee's work performance or creates an intimidating or offensive environment. Regarding the field of medicine, the courts have agreed that where the act was clearly not a part of any alleged diagnosis or treatment, such acts were not covered by a professional liability policy.

Another recent development is that more and more insurers are less and less willing to continue providing coverage in their standard or preferred markets to those policyholders with even relatively minor claims histories, or out-of-the-norm practices. Even if an individual is not a history buff, it is worth taking a brief look at how the laws against sexual harassment have evolved. When the Civil Rights Act was adopted in 1964, sexual discrimination in employment became illegal in the United States.

That Act established the Equal Employment Opportunities Commission, which later issued important regulations and guidelines on sexual harassment. This is very interesting, since the virtually all-male congress never really intended on passing a law against sex discrimination or on sexual harassment.

The Civil Rights Act prohibited discrimination in employment based on race, color, religion, or national origin. Discrimination on the basis of sex was not included. It was attached to the bill at the last moment, when opponents of the measure introduced an amendment prohibiting discrimination on the basis of sex. It was thought that by adding sexual equality the whole idea would become so obviously preposterous that it would scuttle the entire bill when it came to a final vote. Still, nothing was done about sexual harassment on the job, or the broader problem of sex discrimination, until the re-fueled women's movement began pushing the issues in the 1970's. Pushing is not really the right word; it was more like running and jumping the high hurdles.

Women's groups kept pressing the issue, however, urging the EEOC to rule that sexual harassment is indeed a form of sex discrimination. Then in 1980, the EEOC; under the leadership of Eleanor Holmes Norton, issued regulations defining sexual harassment and stating that it was a form of sex discrimination prohibited by the Civil Rights Act. Still, it was not until 1986 that the United States Supreme Court acknowledged that progress, holding that sexual

harassment on the job was definitely a form of sex discrimination – and illegal. Here are some factors to consider when evaluating behavior in the workplace to determine whether it is likely to be considered by the courts to be sufficiently outrageous to support a claim of intentional infliction of emotional distress.

Loss Exposures for the Professional

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

Legal Disaster

Professional Liability insurance protects ones business from potentially catastrophic litigation caused by charges of professional negligence or failure to perform his professional duties. Whether the claim is baseless or not, mounting a legal defense can bankrupt a company. Professional Liability insurance protects a company and its future by responding to professional liability claims and helping the professional keep his business operating as potential law suits move through the courts.

Without it, a company could be financially overwhelmed. Professional Liability insurance is especially essential in today's legal environment where the boundaries and definitions of professional requirements and duties are largely legally undefined. Unlike lawyers and other professionals who have an established body of tort, or contract law from which to draw, computer professionals are often in legally uncharted territory.

What this means for the professional is that he may be liable tomorrow for actions which are today completely in line with present consulting expectations. Professional Liability insurance protects against the unknown and the unforeseeable. Professional liability insurance covers crucial aspects of ones business and his interactions with clients.

Alleged Negligent Acts

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

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Damage to or Loss of Client Data

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

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

- determine whether separate insurance is carried and, if so, obtain the name of the carriers and see that proper notification is given;
- determine whether any medical practitioner made any promise of definite cure or made any statement or took any action which might have broadened the scope of his or her liability;
- determine whether the professional was under the influence of intoxicants or narcotics at the time of the alleged malpractice;
- find out if any equipment failure was involved, and if warranted, put the retailer, wholesaler, or manufacturer on notice;
- obtain the opinion of legal practitioners in the same profession in order to determine whether the services performed or the treatment rendered was in accordance with ordinary good practice. If medical malpractice is involved, enlist the aid of local medical societies. This is ordinarily more easily obtained by the defense than by the plaintiff;
- determine if the insured held out any promise of definite results and, if so, get full details.

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

- The doctor, surgeon, hospital, etc. to the injured referred to;
- If surgery was performed, determine whether consent was obtained and, if so, how, when, and from whom along with a written consent;
- Find out whether the injured followed the doctor's, the surgeon's, or the nurse's instructions. Obtain complete details;

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- Determine when the injured made the first complaint after the alleged malpractice, and why such complaint was directed at the specific doctor, surgeon, or nurse involved;
- Determine what subsequent treatment was received, and obtain complete medical reports from all available sources as previously outlined in making a medical investigation.
- Find out whether the injured received a settlement or was awarded compensation or a judgment as a result of an injury that necessitated the medical treatment presently being investigated. Obtain full details including copies of all releases, checks or drafts issued, court orders, or other records.
- Determine whether the injured ever made a previous medical malpractice claim, and, if so, obtain complete details.
- Determine the advisability of obtaining a physical examination by a specialist. Make a complete background investigation of the injured, including complete medical history as previously outlined.
- Determine if the hospital and/or the doctors and nurses were accredited. Find out when the hospital was last inspected and get a copy of the report and recommendations. Check to see if all recommendations were complied with. Check to determine if the hospital's own regulations were followed. Determine the hospital has had previous experience with similar incidents and equipment.

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

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

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

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

General Principles and Rules of Professional Liability

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

- **Benefits of Parenthood** – argues that the benefits of having a healthy, normal child defy precise measurement. Deciding in favor of the parents – according to the courts – would be incompatible with contemporary views concerning one of life's most precious gifts – - the birth of a normal and healthy child.
- **Continuing Negligence** – Medical treatment that was subsequently received after an accident and then aggravated the initial injury. It has been held that a separate action may be brought against the doctor who was guilty of medical malpractice despite the fact that a previous verdict was rendered or a settlement made of the underlying case. This doctrine was developed in medical malpractice cases for the purpose of tolling the applicable statute of limitations, until the time when medical treatment by the defendant ceased.
- **Contributory and Comparative Negligence** – Defenses of contributory and, more often, comparative negligence are usually available in cases involving dental malpractice. Dentists can also be held liable for the negligence of their employees.
- **Discovery** – which appears to be the majority rule, give the broadest interpretation of when the limitation period begins. This rule overrides the statute of limitations where foreign substances were left in the body of a patient after an operation.
- **Expert Testimony** – Generally, the only situation in which an absence of expert testimony is excused, is when the lack of skill or care of the professional is so apparent that the average layman could understand and recognize it, and where express warranties of results were made.
- **Good Samaritan** – Before the Good Samaritan laws were enacted, a doctor was under no duty to help an injured person in the event that he was fortuitously present when an emergency situation arose. On the

contrary, if he did volunteer to help, he could be held accountable for his negligence in rendering medical assistance.

- **Honest Error in Judgment** – It has been held that in order to fully state the standard of care applicable to a professional, the jury must be instructed that one is not responsible for an honest error in choosing accepted methods of care. Some jurisdictions, however, have discarded the honest error in judgment wording in the instructions to a jury under the belief that such wording is potentially misleading and exculpatory.
- **Last Act** – holds that the date of the last act of the treatment, which can be after the regular course of treatment and post-treatment check-up have been completed, is the date from which the statute should toll.
- **Locality Rule** – Most jurisdictions have now abandoned the locality rule as a standard in judging the negligence of a nurse. It is generally recognized in medical malpractice that the locality rule has become obsolete.
- **Standard of Care** – Initially, the standard for evaluating the conduct of a professional in a malpractice suit was the degree of skill and care of a reasonably skilled professional in the same or similar locality. The locality rule was initially promulgated in order to protect those doctors who were practicing in rural communities, who did not have the education or skill of urban doctors. Because of state medical licensing, many of the more recent cases have accepted instead, the national standard.
- **Wrongful Birth** – These are actions brought by the parents of healthy, normal children who were unwanted and usually resulted from the failure of contraceptive devices, or as a result of unsuccessful sterilization operations, and even ineffective abortions. Such an action may also be brought against a doctor who negligently gives incorrect advice regarding the possibility or probability of the birth of a defective child, born as a result of failed or improperly made tests, or failure to make proper tests initially.
- **Wrongful Life** – These claims usually involve the birth of a defective or disabled child and are ordinarily brought by the parents or guardian on behalf of the child. However, confusion reigns supreme in this. In many cases, jurists have either made no distinction in their decisions concerning wrongful birth and wrongful life or have confused them. Most jurisdictions do not even recognize an action for wrongful life or wrongful birth.
- **Wrongful Pregnancy** – Some cases that are called wrongful pregnancy or wrongful conception have created another category of wrongful birth cases. In some courts, the physical well being of the child at the time of

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birth has a great bearing on how the case is decided. Most cases hold that the nonexistence of a child cannot be held to be a benefit, and do not permit recovery where the child is born normal and healthy.

Exclusions

Exclusions can be defined in such a way; *X, C, and U Exclusions*: Exclusions to property liability forms aimed principally at contractors and excavators. The exclusions deny payment for loss due to Explosion (X), Collapse (C), or Underground Damage (U). Explosion includes property damage arising from blasting or explosion.

Collapse includes structural property damage and property damage to any other property rising out of grading of land, excavating, burrowing, filling or backfilling, tunneling, pile driving, or coffer dam or caisson work, or moving, shoring, underpinning, razing, or demolishing any building or structure. Underground damage includes damage to wires, conduits, pipes, mains, sewers, tanks, tunnels or any similar property beneath the surface of the ground or water. It is also caused by and occurring during the use of mechanical equipment for the use of mechanical equipment for the purpose of grading land, paving, excavation, drilling, burrowing, filling, backfilling, or pile driving.

This applies to any claim or claim expenses based upon or arising out of any dishonest, fraudulent, criminal, intentional or malicious act, error or omission, or those of a to an insured who did not commit, participate in, or have knowledge of any of the acts described. In accordance with the present mores concerning the bringing of legal actions and the increase in sexual misconduct, or at least discovery and awareness of it, litigation here also, is increasing with the same proliferation rate of litigation in general.

Since the perpetrator of the sexual misconduct is very often without a deep pocket of his own, the pressure on insurance companies to provide coverage increases as politicians and attorneys refuse to take statutory action against insurance coverage. Third parties are increasingly bringing suit for such alleged negligence in hiring practices, retention of employees guilty of sexual misconduct and failure to properly train them against such practices, in the field of vicarious liability.

Most courts have sensibly ruled that defendants who were involved personally in sexual misconduct are not entitled to insurance coverage for intentional acts

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as a matter of law, and have not accepted the argument that knowingly wrongful nature or the willful violation of any statute, regulation, ordinance, or administrative complaint, notice or instruction of any governmental body or agency, committed by an individual. This exclusion will not apply there was no intent to harm or injure. Most applicable liability policies contain an exclusion for intentional acts either directly or by definition of accident or occurrence.

A few courts require evidence of actual intent to injure and, some courts also insist that there is at least a duty to defend where negligence is alleged. Still, others refuse to recognize such allegations of negligence. A few courts simply hold that coverage for sexual misconduct was not within the reasonable expectations of the parties to the insurance contract. This is one of the very few times where the reasonable expectations doctrine used makes sense. The Physicians', Surgeons', and Dentists' Professional Liability policy contains five exclusions:

- To injury arising out of the performance by the insured of a criminal act;
- To injury for which the insured may be held liable as a proprietor, hospital administrator, officer, stockholder, or member of the board of directors, trustees or governors of any hospital, sanitarium, clinic with bed and board facilities, laboratory, nursing home or other business enterprise;
- Under Coverage M – individual Professional Liability – to injury arising out of the rendering or failure to render professional services of any other person for whose acts or omissions the insured may be held liable as a member, partner, officer, director or stockholder of any professional partnership, association or corporation;
- To bodily injury of any employee of the insured arising out of or in the course of that person's employment by the insured.

Coverage for Errors and Omissions

Errors and Omissions (E&O) insurance is a basic safeguard for a business. This insurance protects technology businesses against potentially catastrophic ***litigation involving professional negligence or charges of failing to perform professional duties.*** E&O coverage can make the difference between the survival and failure of a business when faced with these types of legal threats. Errors and omissions insurance protects technology companies if they are faced with the two most common forms of liability risks:

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

Either one of these types of errors and omissions allegations can tie up company funds, personnel, and attention for years. E&O insurance is especially necessary in the new technology age where the law is still being formed. In many cases, courts are defining what a computer professional is and what the expectations are for services and contracts.

The laws around computer consulting and contracting are too new to have established legal precedents. With no precedents, the legal waters are murky and dangerous for the company or consultant without E&O coverage. E&O coverage is a very important form of liability coverage that protects an individual or a company when a product or service fails to do what it was intended to do and the client suffers monetarily from that failure, most often through loss of productivity.

E&O Insurance protects from claims if a client holds one responsible for errors in a project, or the failure of the work to perform as promised in a contract. Coverage includes legal defense costs regardless of how baseless the allegations may be.

Most liability policies do not respond to suits involving professional services. Nor do they cover any legal disputes involving pure financial losses. E&O insurance complements the Commercial General Liability coverage - filling in these dangerous gaps. E&O Insurance will pay for any resulting judgments, including court costs, up to the coverage limits on a policy. The coverage extends to both W2 employees and 1099 subcontractors, and can cover worldwide interests.

E&O Liability insurance coverage can provide legal defense, as well as financial coverage in the case of a judgment. And, it tells clients and business partners that the company is a stable company with the resources to be sure it is successful. It is generally recommended that an E&O insurance policy be at the foundation of every company’s insurance portfolio. Usually it is wise to purchase the coverage prior to a new product launch, or when one has customers. Some investors require it.

Common Coverage

Wrap-Around Coverage

The policy can provide coverage around your existing errors and omission coverage. A program may provide coverage for certain products. The NAIFA sponsored program can 'wrap' around the existing coverage to provide coverage for activities not covered under the existing E&O. This is subject to underwriting approval.

Coverage for an Individual Agent or for Agency

This coverage is for a life/ accident/ health agent, general agent, or broker and includes a non-producing clerical employee. Coverage for the Agency would extend to owners, principals, partners, employees, sub-agents even part-time and temporary clerical employees at no additional premium. Coverage is also available for non-employee producers writing business through an agency. The main benefit of the policy is that if the policy is taken by a group of professionals or clubs, group discount is allowed depending upon the number of individuals in the group. There is also provision that the defense of a lawsuit for damages can be taken over and conducted by the insurers themselves, as they are ultimately responsible for the outcome. This policy is designed for individual professionals only.

Exclusions

Dishonest or criminal acts by professional -- A fraudulent, dishonest, criminal, intentional, willful or malicious acts, or assault or battery would be the items included here. However, the company should provide a defense for such a claim, unless or until a judgment or final adjudication adverse to the insured establishes the behavior that occurred as an essential element of the cause of action so adjudicated.

Claims regarding polluted property -- Pollution can be referred to as "bodily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants:

- At or from any premises, site, or location which is, or was, at any time owned or occupied by, or rented or loaned to, any insured;
- At or from any premises, site, or location which is, or was, at any time used by or for any insured or others for the handling, storage, disposal, processing or treatment of waste;

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- Which are or were at any time transported, handled, stored, treated, disposed of, or processed as waste by or for any insured or any person or organization for whom you may be legally responsible;
- At or from any premises, site or location on which any insured or any contractors or subcontractors working directly or indirectly on any insured's behalf are performing operations if the pollutants are brought on or to the premises, site or location in connection with such operations by such insured, contractor or subcontractor.

Or it could be if the operations are to test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of pollutants. Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up, removing, containing, treating, detoxifying or neutralizing, or in any way responding to, or assessing the effects of pollutants. Pollutants means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned, or reclaimed.

Bodily harm or death caused by professional -- Expected or Intended Injury refers to “bodily injury” or “property damage” expected or intended from the standpoint of the insured. “Occurrence” definition’s phrase, “neither expected nor intended from the standpoint of the insured,” severely limited the scope of coverage, explaining that the policy effectively read: “the company will pay for damages by an accident, event, or error or omission which results in intentional (and other) acts not expected or intended.”

Chapter 8 Understanding the Principles of Product Liability

Defining Product Liability

Liability is generally defined as the condition of being bound in law and justice to do something that may be enforced in the courts, and includes the probable cost of meeting that obligation. The field of product liability, over the past 30 years, has been one of constant change, evolving from a contract theory into a negligence arena and more recently into the field of strict liability.

Product liability insurance provides protection against financial loss arising out of the legal liability incurred by a manufacturer, merchant, or distributor because of injury or damage resulting from the use of a covered product. It also encompasses the liability incurred by a contractor as a result of improperly performed work following job completion. Product liability can be further defined into absolute liability and contingent liability.

Absolute Liability arises from extremely dangerous situations or operations, under which the party responsible for those operations is liable, without exception or excuse, for all subsequent resulting harms. **Contingent Liability** focuses on the damages arising out of the acts or omissions of others, who are not employees or agents of the entity held liable. Product liability policies are purchased by individuals and corporations, usually those that manufacture a product. Generally, these policies are added to existing coverage. The terms vary from one year to multiple years.

Potential liability is a product liability action remains with all involved parties in the production, distribution, and marketing of a product. This includes the manufacturer, including those who might manufacture a defective component, and the seller of the product. When a product liability claim is under investigation, all possible responsible parties must be identified and pertinent information gathered.

Types of Product Liability

Insuring for liability claims can be divided into four basic types; protective liability insurance, joint and several liabilities, strict liability, and vicarious liability.

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- **Protective Product Liability** -- Protective liability insurance protects against claims that may arise out of the insured's contingent liabilities for the conduct of others, e.g., insurance, which protects member companies from the financial burden of any loss for which a claimant has filed.
- **Joint and Several Product Liability** -- Joint and Several liability functions in cases where each of several joint wrongdoers are responsible either on a combined, undivided basis, or on an individual basis, for the full amount of damages for which the several wrongdoers are collectively responsible.
- **Strict Liability** -- Strict Liability insurance covers manufacturers and merchandisers who may be subject for defective products sold by them, regardless of fault or negligence. A successful claimant must prove only that the product was defective, and therefore unreasonably dangerous when relinquished by the defendant. Issues of strict liability are product-oriented. The elimination of fault has been a significant advantage to consumers since the fault standard was difficult to prove among several manufacturers and distributors. Many cases of design defects are termed strict liability due to the difficulty of proving negligence in defective designs. It is commonly thought that a manufacturer is not under a duty of strict liability to design a product that is completely incapable of injuring anyone who could conceivably come in contact with the product. A basic foundation of product-liability law is that a manufacturer is not an insurer of its product. In the case of medical devices that are implanted in the body, the question of strict liability for design defect may be the same as that of prescription drugs in many states. Those products such as pacemakers, breast implants, heart valves, and intrauterine devices, if medically needed, could possibly fall under other product-liability areas than that of strict liability.

Warnings Liability

Inadequate instructions or warnings describing a potential for danger must be specific enough for the general consumer to understand and heed in order to avoid the danger or possible injury described. The liability that is derived from poor illustrative information of the potential for danger can be just as damaging to a manufacturer during product-liability litigation as a defective product itself.

Defective Warnings

The absence of a warning regarding the potential hazards of a product may also present the background for a defective-product claim. In determining the

quality of the product warning, courts examine the likely number and severity of accidents that may have been avoided by a more complete or understandable warning. The court then assesses these components against the difficulty of issuing pertinent warnings or instructions. For example, in the event a manufacturer does not adequately warn of a known potential defect in a product or product line, any subsequent product liability litigation would most likely be found in favor of the injured claimant.

Furthermore, in product liability cases after 1996, Congress specified the exact text to be used on cigarette packages. Litigation claiming inadequate warning was not upheld in light of the 1996 federal statutes imposing certain labeling requirements upon the tobacco industry. Additionally, federally mandated labeling requirements preempt state common-law causes of action.

Duty to Warn

The duty to warn of any dangerous properties of a product applies to any individual whom the manufacturer or distributor might reasonably expect, might use or consume the product or be endangered by its use including customers, users, consumers, and handlers of the product. In some cases, this would apply to any that might conceivably come in contact with the product at any stage in production or after delivery.

Any product-liability action based on duty to properly warn may be brought in negligence or strict liability, but the difference appears to be that in strict liability, there is no requirement of proof of fault that conversely would be an integral part of any negligence case. However, while a manufacturer has a duty to warn of dangerous properties of a product, there is not such duty to warn of product conditions that are open and obvious to even the most careless users.

However, it is commonly thought that when a product is well designed or manufactured, and the potential for injury occurs from a dangerous property of the product that is open and obvious, there is no duty to warn about the danger in the product use. This knowledge is thought to be common to all users of a product or to a specific industry, profession, or group of which one injured may belong.

Liability of Vendors or Other Suppliers

Recently, it has become increasingly common for vendors to be held to the same degree of liability for a product as the manufacturer. A seller of a product

is equally responsible in strict liability with the manufacturer for injury incurred by a defective and dangerous product, used correctly or consumed as the product manufacturer. This is especially important if the product was reconstructed or changed by the vendor without the express knowledge of the manufacturer. Vendor liability may be examined on warranty, negligence, or strict liability.

Since such actions against a vendor must prove a product or component part has not been altered, with the manufacturer's knowledge and permission, with his instructions or with manufactured parts, it is difficult to prove. The seller's ability to exert pressure on the manufacturer to augment the safety of a product is backed by the fact that, in strict liability, the ultimate fault lies with the wrongdoer who also bears the primary risk.

Suppliers and Users of Component Parts

A supplier may not be the vendor who sold the product to the plaintiff. With the complicated interrelated commerce in existence today, the supplier may be any one of a number of steps between the manufacturer and distributor. A manufacturer who uses component parts made by others may be liable, if reasonable care is not taken in the manufacture or inspection of the component part. A supplier could be a provider of component parts, a trademark licensee, a wholesaler, jobber, retailer, or the repairer of a product.

With products the center of such intricate relationships, the liability of suppliers is equally complicated involving holding corporations and their subsidiaries. For instance, if an automobile manufacturer who assembles a chassis system using component parts does not make adequate inspection of the component parts before incorporating them, then that manufacturer may be held liable for product failure in the course of legal investigation.

The trend through the Uniform Products Liability Act (1979), and more recently the Product Liability Reform Act (1997), has been to limit the liability a vendor may be responsible for through the distribution of a product that has been determined to contain a manufacturer's design defect. Protection against liability for vendors has also been strongly supported by states in favor of limiting liability for vendors in the products manufactured by others.

Warranties and Guarantees

Frequently, warranties are meant to boost consumer confidence and are not intended as legally binding documents, defining and verifying specific and implied features of a product. In fact, many warranties state more features that are not covered in the manufacturing process than are covered. A warranty is commonly understood as a guarantee concerning the fitness, quality, or durability of a product.

Manufacturer's Written Warranty

The essential rights under a manufacturer's warranty usually covers the liability of a product within "reasonable" use and over a set time period. In the case of a vehicle warranty, the dealer must replace or repair parts that are defective in design, workmanship, or materials. The claimant, however, has certain obligations under a manufacturer's warranty, such as following a specified service or maintenance schedule. Such warranty language and tenets make it clear that the manufacturer is limiting its liability. For example, the Chevrolet Motor Division Limited Warranty on Chevrolets has stated, "Chevrolet does not authorize any person to create for it any other obligation or liability in connection with these cars." That is, advertising claims and promises which are not specified in the manufacturer's warranty will not be upheld by the manufacturer.

Full vs. Limited Warranty

There are two basic tenets to warranty information. Full product liability warranty means:

- ***A defective product or part must be fixed or replaced for free;***
- ***The duration of an implied warranty is not limited;***
- ***Warranty coverage is extended to whoever owns the product during the warranty period;***
- defective product/part to be fixed within a reasonable period of time after defect is noted;
 - warranty service is provided free of charge including free shipping;
 - manufacturers will replace/issue refund for product not fully repaired after attempts;
 - claimant cannot be required to do anything unreasonable to obtain warranty service;

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- additional duties are not imposed on purchaser, as condition of receiving warranty service;
- warranty must cover anyone who owns the defective product during the warranty period.

If the car cannot be, or has not been, fixed after a reasonable number of attempts, a purchaser would get the choice of a new replacement or money back. A “full” warranty also provides product coverage to secondary owners. It should be noted that a “full” warranty does not have to cover the entire vehicle. A full warranty may only cover selected components or systems such as the engine or exhaust system. A “limited” vehicle warranty does not have to meet any federal standards as a “full” warranty does. This includes the significant lemon provision detailed above. A “limited” warranty is any warranty that provides anything less than a “full” warranty.

Limited warranties must specifically state the limitations of the warranty, but they may not override state law. For example, they cannot remove any pertinent implied warranty, but may restrict the duration of the implied warranty to the duration of the limited warranty. The same vehicle may have both types of warranties. For example, a car may be fully warranted on the engine, but only have limited coverage for liability on the drive train. Additionally, a limited warranty may cover only parts, but no labor or handling charges, and it only applies to the original owner.

Implied Warranty

Implied warranties are legal rights created by state law, not by the manufacturer. Implied warranties create legal rights above and beyond what is provided in the written warranty. With the provision that the owner takes appropriate steps, implied warranties allows one the right to free repair, replacement, or refund if the vehicle is defective and does not operate in the basic manner it is supposed to work.

In this case, state law provides consumers rights similar to those given to vehicle owners with a “full” warranty under federal law. No business is required to offer a written warranty. A product without a written warranty is covered then by implied warranties. Warranty terms do not apply in all states and in that event the product information must state, “Some states do not allow limitations on how long an implied warranty lasts, so the above limitation may not apply to some individuals.” There are two types of implied warranties: an implied

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warranty of merchantability and an implied warranty of fitness for a particular purpose.

Of these, the most common type of implied warranty is that of merchantability. A warranty of merchantability is implied in a contract for the sale of products if the seller is a merchant in the regular business of selling the type of products in question. According to the Uniform Commercial Code, Section 2-314, for products to be considered merchantable, they must:

- Be “fit for the ordinary purposes for which such goods are used.”
- Be “within the variations permitted by the agreement, of even kind, quality and quantity within each unit and among all units involved.”
- Be “adequately contained, packaged, and labeled as the agreement may require.”
- “Conform to the promises or affirmations of fact made on the container or label, if any.”

This type of implied warranty comes with each sale automatically and is the seller’s authentication that that product is fit for ordinary use. This means simply that the vehicle must be fit for its reasonable and ordinary uses, which include safe, efficient, and comfortable operation and transportation from point A to point B.

This also applies to the individual components that may fail within the larger whole of a product, such as the transmission listed as warranted for 100,000 miles on a vehicle with only 80,000 miles. Implied warranties are especially important when one purchases a used vehicle and an extended warranty. In this instance, the extended warranty will serve in much the same way as the original warranty for compensation of repairs.

Moreover, if an accident occurs due to a defect covered under manufacturer liability and/or warranty, then all the accompanying costs would be required including medical, pain and suffering, lost wages, etc. Once implied warranties are automatic with every sale, they need not be mentioned by the seller to be valid.

Express Warranty

An express warranty means “expressly stated”, not speedy. Although a manufacturer’s written warranty comes with new vehicles, it is only one type of “express” warranties. Though unwritten, state laws and manufacturers also

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have created “express” warranties to cover other events of liability for which they may be legally liable. With an express warranty, a seller expressly represents that the products purchased possess certain qualities. ***An express warranty may be established in three ways:***

- ***An “affirmation of fact or promise” regarding the product;***
- ***A description of the product;***
- ***Use of a sample or model of the product.***

Under state law, “express” warranties may be created by the manufacturer or dealer through oral promises, advertisements, pamphlets, or other media. Any affirmation of fact, promise made by the seller, description, sample, or model that serves to convince the buyer to make a purchase creates an “express” warranty that the vehicle will conform to the affirmation, promise, description, sample or model. If any of these factors are met during the course of the sales pitch, then an “express” warranty is created.

Even though a seller may not use the word “warranty” specifically, the perception of it is made and therefore must be backed. For example, a seller may describe the product as being water resistant, or may use a model to demonstrate how a product works, therefore indicating to the purchaser how the product purchased would also function. However, a manufacturer is not liable if during the course of a sale, such general comments as, “it’s a fine automobile” and “you are sure to love it” are made, then an express warranty has not been created. This language is viewed more as glowing salesmanship than statement of fact. It is related rather to opinion and affirmation of value than fact.

Breach of Warranty

Most warranty claims for defective products can be settled through negotiation, however, if the seller refuses to repair or replace a defective product one has three options:

- Rejection of the product;
- Revoking acceptance;
- Suing for damages.

A product can be rejected if the delivered product is not the same as advertised, or if it bears minor defects observed upon inspection. For example, if a maple dining room table is ordered, and one crafted from cherry is delivered, the product can be rejected. Breach of express warranty is a type of strict liability claim. The purchaser needs not show that the seller’s product information was

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true or that the express warranty was even defined, but only that the product representation was false.

If a product is initially accepted, but found to contain flaws after a reasonable time of operation, especially in the case of vehicles, then the product's acceptance can be revoked. If the transmission of a new vehicle fails to operate properly as advertised due to a defect, then after allowing the seller a chance to remedy the problem, one can revoke acceptance of the vehicle. The purchaser may revoke the purchase of a product if all of the following conditions are met:

- The product does not conform to the contract;
- The non-conformity substantially impairs the value of the product;
- The purchaser accepted the product without knowledge of the defect, or after the seller agreed to repair the defect;
- The revocation takes place within a reasonable amount of time after the purchaser discovered the defect;
- Revocation is made before the condition of the product, not affected by the defect, has been substantially altered.

The third option in seeking settlement of breach of warranty is that of a product-liability suit. Even if the product has been rejected or revoked, one can still sue for damages depending on the nature of the defect, any injuries incurred from the use of a defective product, and long term affects of product use (e.g. medical device use).

Product Liability Insurance

Product liability insurance covers the legal liability resulting from injuries to persons or damage to their property. Product liability insurance then, protects individuals and manufacturers up to a specified amount under the terms and statutes of state and federal law. Product liability insurance may also be required for clinical trials. During the testing of certain medical devices and procedures, liability resulting directly from study results may be at issue. Clients who must defend the integrity of a product, whether pharmaceutical, industrial, or medical, require insurance to defend against challenges to design and manufacturing. Product liability must also cover issues of regulatory compliance, preventative practices, and indemnity agreements.

All Coverage Product Liability

The difference between product liability insurance and other types of liability insurance is that product liability insurance is based on a defect-based liability principle instead of fault-based liability principle. Product liability coverage is defined as that insurance which covers the policyholder's liability for occurrences resulting from actual or alleged defects arising from the handling, use or existence of any condition in goods or products manufactured, sold, or distributed by the manufacturer after the products have been delivered to the buyer. Additionally, it covers accidents resulting from the mis-delivery of products.

Excess Product Liability Insurance

Excess insurance is the backup protection companies buy in the event of catastrophic accidents, such as oil spills, airplane accidents, or hurricane damage. In Texas, one of the largest markets for excess policies, legal accountability for backup support of policyholders is coming into question. Currently, Texas law requires a regular liability insurer to settle claims reasonably and quickly and to defend its policyholders in court if they are sued for instances covered in their policies. However, excess carriers have generally been exempted from that requirement. Two cases before the Texas Supreme Court may delete that exemption. Both involve excess insurance carriers who are denying their responsibility for not helping policyholders and who refuse to accept charges of negligence.

In one case, the policyholder argues the insurer acted too slowly in resolving a claim; in the other, the insurer did not take part at all in the defense prior to and during the policyholder's trial. These cases are sure to involve multimillion-dollar legal actions and are a significant landmark for carriers of excess product liability insurance. Excess insurers and their supporters maintain that if the Texas Supreme Court mandates excess carriers to settle quickly and provide legal defense for policyholders, the excess insurance lines will increase in price and become less available.

They insist that they should not be involved in a case until the primary carrier has settled or cannot handle a claim. Manufacturers disagree and insist on the importance of excess carriers having the same responsibilities as other carriers. Their legal counsels agree that businesses want proof that premiums paid to their insurer will result in an appropriate payoff, not stagnation of settlements,

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which cost manufacturers extra money, manpower, and filing of additional lawsuits.

Features of Product Liability Insurance

Since the risk that the behavior of an individual or manufacturer could result in injury to another person or damage to someone's property is valid, it is understandable that one is responsible for the results of one's behavior. What is unique about liability risk is that it has no maximum predictable limit. Large liability suits and judgments won for claimants could take all the valuable assets of an individual or manufacturer along with their insurance policies. Negligence need not be premeditated to occur. To be negligent means that an individual or manufacturer failed to exercise the proper degree of care required under a certain set of circumstances.

The minimum product liability insurance recommendation may be adjusted based upon what is available to the individual/manufacturer, the lifestyle, and public profile. The higher the standard of living or public image of an individual or company, the more the public expects and the more people who will react negatively to the perception of personal or corporate negligence.

Time Limitations on Liability

The requirement regarding two-year statute of limitations for filing product liability complaints begins when the claimant discovers, or should have reasonably discovered, the harm and its cause. A 20-year statute of repose for workplace durable goods (products used in the workplace with an economic life or greater than three years) should not be brought for harm caused by a product more than 20 years after delivery of the product. Manufacturers could be held liable under a product liability policy only if the guarantee of its product's safety was listed to be 20 years or greater in duration.

Liability Reduction

A product liability insurance policy would not be held responsible for the entire insured amount of liability in the event that there was evidence of misuse or alteration of a product. A defendant's liability would be reduced in proportion to the amount of harm attributable to misuse or alteration of the product.

Punitive Damages and Bifurcation

The current federal standard for punitive damages limits the damages to three times the amount of economic damages or \$250,000, whichever is greater. It is possible for the punitive damages phase of a product liability proceeding to

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occur separately from the proceedings on economic/compensatory damages. Evidence involving punitive damages (i.e. a manufacturer's flagrant disregard for claimant's safety) would be inadmissible in the initial procedure regarding the final determination of liability.

Liability for Rented or Leased Products -- Recommendations by the Senate Commerce Committee have allowed that businesses that rent or lease products should be subject to the same rights and responsibilities as product manufacturers with respect to product liability actions. Therefore, the product liability insurance sellers would be liable for these products, though not the harms caused by others using the products in an unsafe manner.

Comprehensive Personal Product Liability Insurance

Comprehensive personal liability coverage can be acquired by purchasing a separate comprehensive liability policy or by purchasing a rider on an individual homeowner policy. A property casualty insurance agent will tailor the policy for the personal circumstances. Under this type of policy, the insurance company would register to pay, up to the limits of liability set in the policy, all payments that become the insured's legal obligation because of bodily injury or property damage falling within the scope of the coverage provided by the policy.

Under a personal comprehensive liability policy are the insured, relatives who are residents of the household, and any other person under age 21 who is in the care of the resident of the household. The policy would pay all medical expenses, including funeral expenses, incurred by persons who are injured while on the premises with the permission of any insured, or injured away from the premises if injury results from activity of an insured or member or the insured's family.

In addition to claim costs, the policy will also pay for the first-aid expenses incurred by the insured, related to any bodily injury covered under the policy. The policy may even pay some minor amount, usually up to \$500, for damage to the property of others for which there is no legal obligation on the part of the insured, but which the insured might feel a moral obligation to pay.

For example, if a neighbor were to burn himself on a gasoline powered leaf blower, would the homeowner be liable, or would the manufacturer of the leaf blower be liable? If the design were found to be dangerous, then the product liability of the manufacturer may cover what might otherwise be covered under

a personal product liability policy. The courts will increasingly be asked to clarify the differences in liability between the coverage of an individual who has purchased a product with possible design defects and that of the manufacturer that produced the product.

Product Liability Regulatory Agencies

Food and Drug Administration (FDA)

The United States Food and Drug Administration (FDA) is one of the nation's oldest consumer protection agencies. It regulates approximately 95,000 businesses in the United States and employs about 1,100 investigators and inspectors who monitor those businesses. It also employs approximately 2,100 scientists in its laboratories who oversee the testing of products and review manufacturers product test results.

It is a public health agency responsible for providing protection to consumers through the enforcement of the Federal Food, Drug and Cosmetic Act and other associated public health laws. The FDA functions under the jurisdiction of the U.S. Department of Health and Human Services and operates district and local offices in 157 cities throughout the nation. When there is a problem with a product, a consumer reports to the FDA for investigation. If the product is thought to have caused injury or illness, the following questions must be answered:

- Was the product used correctly?
- Were the product instructions followed precisely?
- Was the product still viable (i.e. used prior to its expiration date)?
- Was there a prior medical condition involved that may have attributed to the illness or injury?

If these questions could be answered in the affirmative, then a report to the FDA would be filed and any remaining product that is suspect should be retained for testing.

Food -- The FDA oversees food (excluding meat and poultry which is regulated by the U.S. Department of Agriculture), cosmetics, medicines and medical devices, feed and drugs for pets and farm animals, and radiation emitting products. The FDA certifies that these items are safe, and include accurate labeling information for their correct use. A recent example of this labeling includes the mandatory manufacturer requirement to utilize a food label format

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that contains complete and accurate nutrition information which must set forth mandatory dietary components of a product.

The National Highway Traffic Safety Administration (NHTSA)

Established under the Highway Safety Act of 1970, under the jurisdiction of the United States Department of Transportation, the National Highway Traffic Safety Administration (NHTSA) is responsible for reducing fatalities, injuries, and economic losses resulting from motor vehicle accidents. The NHTSA fulfills its tasks by researching accident prevention, enforcing notification of defects and safety performance standards for motor vehicles, investigating safety defects in motor vehicles and sponsoring state and local highway safety programs.

Between the years of 1967 to 1989, over 1,000 investigations of safety defects unknown to, overlooked by, or covered by the vehicle and vehicle equipment manufacturers were conducted by the NHTSA. While a defect investigation is going on, the NHTSA checks consumer mail, data on failures and other information from automobile manufacturers, checks with consumer groups and repair facilities, and issues Consumer Protection Bulletins or Public Advisories to the media to gather additional reports of failures from the general public.

After gathering information pertinent to the defect, the NHTSA makes an initial finding of whether or not there is a safety defect. The manufacturer is informed and given notice of the time and place a public meeting is to be held for the manufacturer and others to present their opinions. The notice is also published in the Federal Register and released to the media.

Upon completion of the public meeting, the NHTSA reviews all presented material and makes a final determination. If it is determined that a design or safety defect does exist, a final letter is sent to the manufacturer requiring the recall of all other vehicles, tires, or vehicle affected. In the event that a manufacturer refuses to recall the automobiles cited, the NHTSA administrator could go to the courts for legal enforcement of recall action and the imposition of fines up to \$800,000. When one has an automobile safety problem, like stalling or faulty brakes, the NHTSA can be contacted directly or through their Auto Safety Hotline.

Although the NHTSA cannot take direct action in resolving individual complaints, a consumer call may generate a recall where the manufacturer has to repair a vehicle and others like it without charge. At times, a consumer and

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manufacturer are better able to resolve a problem with ensuing product liability after the NHTSA has forwarded a complaint to the manufacturer. The NHTSA additionally provides consumers with information related to safe motor vehicle use. The Federal Highway Administration is concerned with improving highway safety and conducting highway safety research relating to trucks and busses.

United States Consumer Product Safety Commission (CPSC)

The Consumer Product Safety Commission (CPSC) was established in 1972 under the Consumer Product Safety Act and can enforce set standards on consumer products under the law with accompanying civil and criminal penalties. The CPSC has jurisdiction over approximately 15,000 types of consumer products including everything from toys and games to appliances. Its primary goal is to protect the public against unreasonable risk of injury and death associated with the products purchased. The CPSC can require product recall, repair, replacement, or refund.

The CPSC operates a hotline that provides consumers with information on product recalls and safe product use. The hotline additionally accepts and investigates complaints received by consumers. Its National Electronic Injury System, which monitors and records hospital emergency-rooms admissions related to product-related injuries, serves to maintain a database on the safety of products. Moreover, it maintains an Information Clearing House to investigate and disseminate data relating to the cause of injuries associated with consumer products. However, much of the watchdog capability of the CPSC has been taken on by the enactment of the Federal Product Liability Fairness Act of 1992 that made product liability rulings more uniform.

Coalition for Consumer Health and Safety (CCHS)

A joint organization, the Coalition for Consumer Health and Safety, coordinated by the Consumer Federation of America (CFA), includes members as disparate as the American Academy of Pediatrics, Americans for Democratic Action, the American Lung Association, and the Public Voice for Food and Health Policy as well as consumer groups, insurance companies, and insurance industry associations.

At CFA's invitation, insurance companies join with consumer groups to work for change in the areas of health and product safety to benefit consumers. Except for issues in litigation, CCHS members discuss a variety of subjects providing input and sharing information from their individual areas of expertise and experience.

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The Occupational Safety and Health Administration (OSHA)

The Occupational Safety and Health Administration (OSHA) operates under the jurisdiction of the United States Department of Labor. OSHA's mission is to prevent injuries, protect the health of the American workforce, and save lives under the auspices of the Occupational Safety and Health Act of 1970. OSHA protects just about every individual working with the exception of miners, transportation workers, some public employees and self-employed workers. In combination with its state partners, OSHA utilizes inspectors, complaint discrimination investigators, engineers, physicians, educators, standards writers, and other technical staff.

This team of OSHA personnel establishes and enforces protective standards to be used in the workplace, and sponsors workplace safety and health programs for manufacturers employees. Additionally, OSHA publishes numerous regulations and pamphlets on workplace safety and health standards, the use of industrial substances, and safety in industrial and construction operations.

The Hazard Communication Standard -- This standard was written to ensure that all employers receive information necessary to inform and train their employees on the hazardous substances they work with, and to help design and begin employee protection plans. The hazard communication standard additionally provides necessary information to employees to further aid them in taking appropriate safety steps within the workplace.

Blood-borne Pathogens Standard -- The Blood-borne Pathogens Standard is designed to protect health care workers from exposure to the Hepatitis B Virus (HBV), the Human Immunodeficiency Virus (HIV), and other blood-borne pathogens. It is important to establish sterile procedures so that these viruses and other potentially infectious organisms found in the blood and body fluids, are not directly contacted by employees. Employers have a significant responsibility to ensure that health care workers are trained in protective methods against such contact with these and other infectious material.

Federal Trade Commission (FTC)

The FTC educates the public and investigates and prosecutes on behalf of the nation's consumers. It does not litigate individual complaints, but relies on consumers' reports to uncover abuses. In the event that evidence mounts against a manufacturer, company, or industry, the FTC can act in several ways including: holding hearings, creating new rulings, or enforcing those already on the books. This large and powerful agency monitors the marketplace to prevent

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misleading and deceptive advertising, package labeling, credit practices, and other types of consumer fraud or abuse. Its Bureau of Consumer Protection publishes a series of informative pamphlets on a variety of consumer and product problems.

Under full and limited warranties, the FTC does not require that the product be replaced, that the claimant be compensated for a defective product or lost work time, but only that the manufacturer specify its obligation in the case of product defect or failure and how the claimant may obtain these services. It is only when the manufacturer is perceived to have ignored the written conditions on the statement of warranty that mediation, arbitration or litigation is sure to ensue. The FTC serves the same function as the state's attorney general. When a high volume of consumer complaints are received, then the commission will take steps to enforce a manufacturer's product warranty.

Chapter 9 Industrial Fire Liability and Insurance

Understanding Industrial Fire Liability

Not very long ago fire protection in many communities was limited to the amount of water in a tank on a wagon pulled by horses. As technology advanced to central systems with high-pressure hydrants, people became more secure, but this was not enough. There were conflagrations, including total losses of large factories and businesses. People were left without jobs, or homes, or both. The need for a spread of risk, including financial guarantees to enable rebuilding, became evident. Farmers helping one another to rebuild barns or homes fell short of providing all that was necessary. At first, the approach was cautious, with insurance provided only against loss caused by fire. Policies were written by hand, with language varying from one insurance company to another. Later, lightning became an insured cause-of-loss, and with time, a progression of insured causes-of-loss became known as the “extended coverage perils.”

Types of Exposure

Risk is generically defined as the uncertainty of loss. Fire loss is usually measured as number of deaths or dollars of property damage, but includes significant intangible losses such as business interruption, mission failure, degradation of the environment, and destruction of irreplaceable cultural artifacts. The concept of safety itself is one of uncertainty. Absolute safety does not exist. Human activity will always and unavoidably involve risks. The concept of fire is also uncertain. Unwanted combustion is perhaps the least predictable common physical phenomenon. Reliability of manufactured or fabricated systems for fire suppression and confinement is another source of uncertainty or risk. To make meaningful decisions regarding these risks, they must be analyzed. Fire Risk Analysis is a generic phrase that covers many approaches to decision making about uncertainties of losses from fire. Within this general structure are techniques for both qualitative and quantitative fire-risk analysis. The approach may be as simple as a check list of fire safety features, or it may involve mathematically complex probabilistic analysis. Application is variable according to the nature of the risks or hazards involved and according to the experience of the analyst. Each application needs individual consideration to determine the level of mathematical sophistication appropriate to meet objectives. Risk has always been a part of human

endeavor, but we increasingly expect protection against risk, thus governments around the world are mandating risk analysis in areas of health and safety. Computations of the odds of harm are becoming a powerful force in decisions about activities involving risk. These decisions have here-to-fore been largely politically based, but we are learning to debate from a more scientific and quantitative perspective.

Measure of Industrial Fire Losses

Fire is the largest single cause of property loss in the United States. In the last decade, fires have caused direct losses of more than \$120 billion and countless billions more in related costs. On average, communities with superior fire-protection services — and therefore good Public Protection Classifications — have lower fire losses than communities whose fire-protection services are not as comprehensive. ISO reviewed the cost of fire claims per thousand dollars worth of insured property by PPC for communities around the country. Studies of five years of data for homeowners and commercial property insurance show communities with better classifications experienced noticeably lower fire losses than the communities with poorer classifications. The dollar value of a better PPC varies by state. But on average across the country, the cost of fire losses for homeowners policies in communities graded Class 9 is 65% higher than in communities graded Class 5. If a community improved from Class 9 to Class 5, homeowners could expect their premiums for fire insurance to drop substantially.

Risk and Hazard Analysis

Every year, fires injure more than 20,000 people. And every year, more than 3,000 Americans die in building fires. ***In the battle against fire losses, one of the insurance industry's most important weapons is the Public Protection Classification (PPCTM) program from ISO.*** The PPC program provides important, up-to-date information about municipal fire-protection services throughout the country. A community's investment in fire mitigation is a proven and reliable predictor of future fire losses. Insurance companies use PPC information to help establish fair premiums for fire insurance — generally offering lower premiums in communities with better protection. By offering economic benefits for communities that invest in their firefighting services, the PPC program provides a real incentive for improving and maintaining public fire protection. And that incentive produces results.

In fire safety we most often rely on empiricism and intuitive heuristics to make decisions. Increasing computational capabilities and modeling techniques from

fields such as decision analysis, management science, operations research, and systems safety now allow us to identify the framework or structure of our decision-making process, with varying levels of mathematical sophistication. Fire Risk Analysis is a generic phrase that covers many approaches to decision making about uncertainties of losses from fire. Within this general structure are techniques for both qualitative and quantitative fire-risk analysis. The approach may be a check list of fire safety features, or it may involve mathematically complex probabilistic analysis. Application is variable according to the nature of the risks or hazards involved and according to the experience of the analyst. Each application needs individually to consider the level of mathematical sophistication appropriate to meet objectives.

Risk has always been a part of human endeavor, but we increasingly expect protection against risk, thus governments around the world are mandating risk analysis in areas of health and safety. Computations of the odds of harm are becoming a powerful force in decisions about activities involving risk. These decisions have been largely politically based, but we are learning to debate from a more scientific and quantitative perspective.

Industrial Fire Insurance

Industrial fire insurance policies are issued by insurers writing fire and allied lines of insurance through agents operating on the debit agency system. This is under which system a weekly or monthly collection percentage is paid based either on actual weekly or monthly premium collections or weekly or monthly increases of premium collections.

Features and Provisions of the Industrial Fire Insurance Policy

Indemnity Limits

The face amount of the insurance provided by an industrial fire policy covering buildings and other structures or contents under the same ownership shall not exceed \$7,500 for a weekly policy. For a monthly industrial fire policy, the maximum face amount covering a building or dwelling is \$40,000 and for contents \$20,000. This provision should not prohibit a company from making application to write amounts of insurance in excess of \$7,500 on a weekly mode equal to those on a monthly mode, if such rating plan is approved.. No insurer shall issue both a weekly and a monthly industrial fire policy covering the same subject of insurance.

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Method of Payment

No such policy shall be issued except upon a weekly or monthly premium payment basis. No discount for premiums paid in advance shall exceed five percent for premiums paid for six months in advance, or 10% for premiums paid for 12 months in advance. In no event shall premiums be collected for more than 12 months in advance.

Annual Statistical Reports

Every industrial fire insurer should file annually on or before July 1 with the State Department of Insurance, a statistical report showing a classification schedule of its premiums and losses covering the preceding year's industrial fire business. Written premiums and paid losses, by protection classification and by policy items are to be shown separately for buildings and for contents. Separate statistics are to be reported for fire and lightning, extended coverage, and all additional coverages the company may be authorized to write under an approved industrial fire-rating system. Each insurer is urged to maintain adequate statistics in additional form to be used in the future to support a continuation of its rating plan, or such modification as experience might indicate to be necessary. An insurer may apply to the State Department of insurance for exceptions to the statistical plan, provided it can show that its method of operation is not compatible to the policy item amounts, and such exceptions will not reduce the credibility of such company's statistical data.

The Insured

This policy offers protection against loss or damage of property/materials caused by fire. The insurance should be taken for a maximum amount of its current value after considering factors of wear and tear, as well as depreciation. This policy is vital for every individual or corporate body with respect to the property where they have insurable interest. Since insurable interest signifies the right to insure, the person or corporate body must be legally competent to enter into a fire insurance contract.

- Policies A and B are intended for householders, office establishments, hoteliers and shopkeepers.
- Policy A is also ideal for small manufacturing units and cottage-scale industries.
- Policy C is apt for industrial/manufacturing concerns, as well as warehousing establishments.

If additional premium is paid, then extraneous perils like deterioration of stocks due to power failure, leakage and contamination, sprinkler leakage, spoilage of

material, subterranean fire, forest fire, missile testing operations can also be covered. The policy pays for cost of repairs and replacement/reinstatement of the item lost/damaged based on actuals. However, the market value of the item lost and the adequacy of the sum insured will govern the settlement. Buildings, plant and machinery are covered on a reinstatement value basis, the “Cost When New” of the building. Plant and machinery erected on the same site would be the basis.

Process Safety Management

Critical to employee safety is fire emergency-preparation planning. The effectiveness of response during emergencies depends on the amount of planning, training, and drilling previously performed. Identifying key elements of a fire emergency-preparation plan starts with the development of a written plan. The emergency-preparedness plan should address all potential emergencies that can be anticipated in the workplace (e.g., floods, earthquakes, and windstorms) and recovery plans. This guide is limited to fire emergency-preparedness planning. The written emergency preparedness plan should be provided to all departments and be accessible to all employees. Managers and supervisors should be familiar with all elements in the written plan, and have conducted training/drilling to assure that their department employees clearly understand their roles in fire emergencies.

The effectiveness of a fire-prevention and emergency-preparedness program is directly related to management's commitment and involvement. Management must establish policy, procedures and actively participate in fire drills, training, and inspections. Failure to do so can mean that the lives of employees, and the business itself, are at risk.

Fire Safety and Prevention

Fire safety is an important responsibility for everyone. The consequences of poor fire-safety practices and a lack of emergency planning are especially serious in properties where processes or quantities of stored materials could pose a serious threat to the community and environment in the event of an emergency. In an effort to prevent fires and minimize the damage from fires when they occur, owners and operators of industrial occupancies are encouraged to develop and implement Fire Safety Plans for their property.

Chapter 10
Boiler, Machinery, and Glass Insurance

Boiler and Machinery Insurance is purchased by businesses to protect against loss due to damage caused by boilers and other machinery. It covers direct damage to covered property when caused by a covered cause-of-loss. Covered property is any property owned by the named insured or is in the named insured's care, custody, or control, and for which the named insured is legally liable. A covered cause-of-loss is a sudden and accidental breakdown of the insured's boiler and machinery equipment or any part of the equipment described in the policy. Boiler and Machinery insurance is necessary because commercial property policies exclude explosion of steam boilers and breakdown of machinery. ***The standard Boiler and Machinery policy contains three extensions of coverage. The three extensions are:***

- ***Expediting Expense coverage - which pays reasonable extra cost incurred to expedite progress after a loss;***
- ***Automatic Coverage - which covers accidents to objects at newly acquired locations for up to ninety days after the named insured acquires the property; and***
- ***Defense Cost and Supplemental Payments - which applies when the insurer is defending the insured against claims or suits alleging liability for damage to property of others.***

Defense Cost and Supplementary Payments are payable in addition to the policy limit. Expediting Expenses are included in, and not in addition to, policy limits. In addition to the three extensions, the policy has three interior limits of \$5,000 each:

- the cost of cleanup, repair or replacement, or disposal of hazardous substances;
- damage resulting from contamination of covered property by ammonia; and
- damage by water to covered refrigerating or air conditioning vessels and piping.

These limits are part of, and not in addition to, the limit specified in the policy. A benefit of boiler and machinery insurance is the inspection service insurers provide to the insured. Endorsements can be added to the standard boiler and machinery policy to provide coverage for business income, extra expense, and consequential losses. This coverage covers loss to, and damage caused by, air conditioning and refrigeration units, heating boilers and steam cookers,

electric motors, generators, pumps, compressors, sterilizers, switchboards, pipes, and other equipment. Steam power is an effective source of energy. However, it can cause a great deal of damage if the equipment containing it explodes. Steam power results from pressure caused by fast-flying molecules put into motion when water boils in a closed container. Steam is then led from the closed container through pipes to exert pressure on machinery, such as pistons within the cylinder of a steam engine. Modern boilers and engines use steam pressures of hundreds or thousands of pounds per square inch. Steam power was a major source of power in the 1800's during the industrial revolution. In those days, the equipment used to create and harness steam power had deficiencies which sometimes allowed steam engines and boilers to explode, causing devastating loss of lives and large amounts of property damage. These losses were prevalent enough to start businesses in the area of loss control and insurance related to boilers and machinery. The Hartford Steam Boiler Inspection and Insurance Company wrote the first policy in 1860, and continues to be a major boiler and machinery insurer.

Boiler and machinery coverage can be written on a monoline basis, or is included as part of a commercial package policy. ISO has created boiler and machinery forms, and many insurers use these forms as developed, or with a few variations. Today, boiler and machinery insurance does not just cover steam related equipment, but also other machinery used in businesses, even items such as switchboards. An aspect of boiler and machinery insurance that has survived from the 1800's is the emphasis on loss control. Insurers generally provide regular inspections of covered machinery, will perform required state and municipal inspections, and create loss control plans for the insured. This service makes good business sense for the insurer, since loss from an explosion can cause huge amounts of damage.

Defining Boiler and Machinery Insurance

Boiler and machinery policies focus on risk exposures from steam-related machinery and other machinery used in businesses. Property policies normally exclude such risks, or provide coverage on a limited basis. The many property policies do not cover loss by explosion, rupture or bursting of steam boilers, steam pipes, steam turbines, steam engines or flywheels if owned, operated or controlled by the insured. If a fire results from such an explosion, property policies may not cover losses due to the fire. Typical exclusions from boiler and machinery coverage include wear and tear, erosion and corrosion. It is assumed certain equipment parts naturally wear out and will be replaced.

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Also excluded are losses caused by or resulting from lightning, fire, earthquake and other perils covered by property insurance. Uninsurable risks such as those of war and nuclear reactors are also excluded. Boiler and machinery insurance can include equipment protection coverage. If equipment breaks down, the insurance can provide business interruption and extra expense insurance. However, if such coverage is not purchased, the policies exclude consequential losses after an accident due to lack of power, light, heat, steam or refrigeration, loss due to delay or interruption of any business, and any other indirect result of an accident.

Loss Exposures

Steam boilers and some types of machinery contain tremendous amounts of potential energy. In the rare event that a steam boiler explodes or a piece of machinery undergoes a sudden and accidental breakdown, several types of loss may result. The owner of the boiler or machinery can suffer the following losses:

- 1) damage to the boiler or machinery;
- 2) damage to other property of the owner;
- 3) loss of income resulting from either, or both, of the above;
- 4) legal liability for damage to property of others in the owner's care, custody, or control, such as customers' property on which the boiler owner is working;
- 5) legal liability for damage to property of others that is not in the owner's care, custody, or control, such as personal property of a tenant in the owner's building;
- 6) legal liability for bodily injury to members of the public.

Previously, boiler and machinery insurance covered all six types of loss. Currently, however, boiler and machinery insurance covers only the types of loss described in items 1 through 4. Items 5 and 6 describe losses that are insurable under commercial general liability insurance.

Boiler and Machinery Insurance

Boiler and machinery insurance is one of the most specialized of all insurances, and several companies control over 50% of the market. For the most part, premiums remain very low for this policy, but it can prove vital in an emergency. Boiler and Machinery policies have averaged almost 300 million since 1978. There are two basic functions that boiler and machinery insurance serve. Besides the main function of protecting against financial losses, they also help

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keep safety standards of machinery and boilers high. The policy requires periodic inspections of the boiler or pieces of machinery. Since the insurance companies employ or subcontract technicians to inspect the boiler or machinery, many imperfections are caught before they become accidents. This in turn has brought about a large decrease on the number of accidents in this field. This policy contains four sections and also a list of endorsements and exclusions.

Section 1 -- This section covers the actual insured object and all damages that may result from the failure or an accident involving this object. Usually, insurance companies will pay damages based on an actual cash-value basis, with a form of deductible applied to the settlement. All policies have a damage limit equal to the policy face value.

Section 2 -- *This section helps to accelerate repairs resulting from the accident involving the insured object.* If the damages awarded under section one do not exceed the policies limits, then the remaining funds left under the policies' maximum payoff limit can be used to speed up the repairs. This may involve paying overtime to the repair workers and the use of express mail to get the needed repair materials. These extra funds, in conjunction with the actual damage funds, cannot exceed the policy's maximum damage limit.

Section 3 -- If the face value of the policy has not been depleted from usage in the previous two sections, then the remaining funds will be used to cover the property of others that is stored or is being used in the premises of the insured. This is a good addition to the policy, because it helps others with their damages, should they not be insured themselves.

Section 4 -- This last section is devoted to legal costs involving an accident involving a boiler or machinery accident. If an outside party sues one for damages resulting from a boiler or machinery accident, this section of the policy will pay the legal defense costs. This section of the policy is not affected by the maximum limit from the other sections. Section 4 will pay as much as it takes to see the legal conflict resolved, including the costs of the settlement of the suit. Sections 1 through 4 offer more than adequate protection of one's financial situation should an accident occur involving a boiler or a piece of machinery.

Boiler and Machinery Coverage Part

A boiler and machinery coverage part consists of boiler and machinery declarations, a boiler and machinery coverage form, and any applicable endorsements. The coverage part can be combined with common declarations and common policy conditions and issued as a monoline policy, or it can be included in a CPP. Any of three coverage forms can be used in an ISO boiler

and machinery coverage part. The three coverage forms are the boiler and machinery coverage form; the small business boiler and machinery coverage form; and the small business boiler and machinery broad coverage form. The last two forms are only for use with the small business boiler and machinery program, which limits eligibility according to both the size and type of insured and the boilers and machinery that qualify for coverage. The following section describes only the boiler and machinery coverage form, which can be used to cover a wider range of situations than the small business coverage forms.

Boiler and Machinery Coverage Form

The boiler and machinery coverage form promises to pay for direct damage to “covered property” caused by a “covered cause-of-loss.” The policy definitions of the two quoted terms are essential. A “covered cause-of-loss” is defined in terms of two other words with specific policy definitions – an accident to an object shown in the declarations. An accident has occurred when a boiler suddenly and accidentally explodes during its operation, resulting in damage that necessitates its repair or replacement. The ISO boiler and machinery forms will be discussed as an example of boiler and machinery coverage. If included in a commercial package policy, the policy will consist of:

- Common Policy Declarations;
- Special State Provisions, if any;
- Common Policy Conditions;
- Coverage Forms.

There are three boiler and machinery forms: a general form and two forms for small business coverage. The general form is the Boiler and Machinery Coverage Form. It can provide coverage for most business and industrial risks. Manufacturer and processors must be covered under this form. Businesses with equipment risks that do not have insured property with an 80% replacement value amount of over \$5 million can obtain coverage through one of the small business coverage forms, either the Small Business Boiler and Machinery Form or the Small Business Boiler and Machinery Broad Form.

Insuring Agreement

The insuring agreement of the boiler and machinery coverage form states the insurer agrees to pay for direct damage to covered property caused by a covered cause-of-loss. A covered cause-of-loss is an accident to an object shown in the declarations. The coverage applies only while an insured object is in use or connected ready for use at the locations in the declaration schedule. Coverage is provided for loss to property of the insured, and loss to property for

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which the insured is legally liable belonging to others in the care, custody, or control of the insured. Under this form, property is covered on a replacement-cost basis, unless the actual cash value endorsement is attached, providing actual cash value insurance. The insurer may repair or replace property with property of like kind, capacity, size and quality. If property is obsolete or useless, coverage does not apply. Automatic coverage is provided for locations acquired during the policy period. The property applies for 90 days if the object at the new location is the same type that would be included in the object definition form attached to the policy (described below). The insured must report the new location to the insurer within 90 days and pay additional premiums.

Under supplementary payments coverage, the insurer will pay reasonable expenses incurred at the insurer's request, premiums for bonds to release attachments and for litigation costs taxed to the insured; interest on a judgment required by law until the insurer offers the amount due under the insurance; and expenses the insurer incurs and all interest on judgments against the insured after the entry of the judgment and before it is paid by the insurer.

Declarations

The three coverage forms each have a different declarations form, but each form has similarities to the others. Each form includes the insured's name and address; insurance company name; policy number; agent or producer's name; policy period; limit of insurance; premium amounts; deductibles; description of insured business; mortgagee, if any; loss payee name and address; schedule for listing locations and description of property; and the producer name and signature of authorized representative. If optional coverages are purchased, details of the premium, property, and applicable deductibles are also included in the declarations.

Endorsements

This policy offers endorsements should an extension of the policy be necessary. There are two frequently used endorsements of the boiler and machinery insurance policy. This first endorsement is used to handle business interruptions. If the business is interrupted by the lack of machinery and sustains extensive financial losses, this endorsement will help to minimize those losses or eliminate them entirely. The second most common endorsement is used if the piece of machinery is of extreme importance to the business. If the business is practically destroyed because of the loss of the piece of equipment,

this policy would lend aid to get the equipment repaired as quickly as possible and would lend aid to help the business.

Object Definitions Endorsements

There are six object definitions endorsements that may be attached to the boiler and machinery coverage form. These six endorsements are as follows:

- ***Object Definitions No. 1 – Pressure and Refrigeration Objects;***
- ***Object Definitions No. 2 – Mechanical Objects;***
- Object Definitions No. 3 – Electrical Objects;
- ***Object Definitions No. 4 – Turbine Objects;***
- Object Definitions No. 5 – Comprehensive Coverage;
- Object Definitions No. 6 – Comprehensive Coverage.

Boiler and machinery insurance covers damage to, or loss of, property resulting from “accidents” to insured “objects.” The insurance applies to resulting loss or damage to both the object itself and other property owned by the insured or in the insured’s care, custody, or control. Boiler and machinery insurance is necessary because commercial property policies exclude explosion of steam boilers and breakdown of machinery. A benefit of boiler and machinery insurance is the inspection service that insurers provide to the insured. Endorsements can be added to the boiler and machinery coverage form to provide coverage for business income, extra expense, and consequential losses. Business income and extra expenses coverage can be added to the boiler and machinery coverage form by various endorsements. Business income coverage is provided on either a “valued” or an “actual loss-sustained” basis. When the valued approach is used, the insured is able to collect a predetermined amount of coverage for each day business is interrupted as a result of an accident to an insured object, subject to a per-accident limit and a deductible expressed as either a specified time period or dollar amount. The daily amount of insurance is paid regardless of the actual amount of loss.

Exclusions in the Boiler and Machinery Coverage

The coverage excludes payment for interruption of a business that would not or could not have been carried on if the accident had not occurred, or due to the insured’s failure to use all reasonable means to resume business operations, or for the part of any loss resulting from cancellation or suspension of a contract which results in business being suspended beyond the time business would have resumed if the contract had remained in force. The form includes the other exclusions found on the boiler and machinery coverage form: Government ordinance or law, nuclear hazard, war and military action; explosion other than

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explosion of a steam boiler, steam generator, steam piping, steam turbine, steam engine, gas turbine, or moving or rotating machinery caused by mechanical breakdown or centrifugal force; fire or explosion that occurs concurrently with an accident or ensues from it; an accident resulting from a fire or explosion, water or other means used to extinguish a fire; lightning, if that "cause-of-loss" is covered by any other insurance policy; flood, except if an accident results from a flood, damage caused by the accident is covered; an accident to any object while the object is being tested; or an accident caused directly or indirectly by earth movement. The policy also generally excludes consequential losses after an accident due to lack of power, light, heat, steam or refrigeration, and other indirect result of an accident. The broad form includes the same exclusions as the other small business form. The exclusion due to lack of power does not apply to loss due to spoilage. However, the insurer will not pay for loss that results from the insured's failure to use all reasonable means to protect perishable goods from damage following an accident.

Glass Insurance

Glass insurance is one of the oldest forms of comprehensive insurance on the market today. It reached its peak volume around the 1930's and has since been in decline. Two reasons for this decline are most insurers offer a comprehensive homeowner policy that covers glass breakage in many instances, and also because many policy owners consider the cost of glass replacement negligible and decide to be wholly responsible for any financial responsibilities that are by-products of glass breakage. Breakage to glass parts of a building is often excluded from property coverage, limited to coverage for glass building blocks, or subject to relatively small limits of liability. However, glass coverage for plate glass, frames, lettering, and ornamentation can be written under glass coverage forms. In most states, ISO commercial glass coverage forms can be written as part of a Commercial Package Policy, or as monoline policies. Terms of eligibility for glass coverage is generally quite broad. Normally, as long as the insured is an owner of property which includes glass plates, letters and ornamentation, or has an insurable interest in such property, glass coverage can be issued. The insurer may insure small risks based on the documentation submitted at application. Larger risks are insured based on inspection of the premises.

Glass coverage indemnifies the insured for loss or damage caused by breakage of glass. The terms of loss vary by policy, but generally include replacement

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value of the glass, plus any expense of “boarding up” the damaged area pending replacement of the glass. The glass coverage information is listed on a schedule or a declarations page. Glass insurance also includes coverage for:

- Debris removal of covered property;
- Payment for expenses to board up openings or install temporary plates;
- Removal of obstructions (except window displays);
- Repair or replacement of frames encasing the damaged glass.

Payments for these coverages are in addition to the limits of insurance. Coverage for removal of obstructions is necessary because windows are often installed before other parts of the building are completed, so walls, pillars, or other parts of the building may be in the way when a large pane must be replaced. Automobiles and construction equipment that have caused the damage may also be considered obstructions in some cases. The schedule includes the size and type of glass, position and use, and information regarding glass lettering and ornamentation, if any. The coverage may include a deductible. Glass coverage is typically written on a replacement basis. Higher priced or specialty glass is written with a limit of insurance, but other covered glass is not, since it is replaced, not paid for. When glass is broken, normally it needs to be replaced rapidly. During the past five years, glass insurance premiums averaged about \$32 million a year. Glass insurance also includes coverage for debris removal of covered property; payment for expenses to board up openings or install temporary plates; removal of obstructions (except window displays); and repair or replacement of frames encasing the damaged glass.

Conditions and Provisions of Glass Insurance

The glass form pays for direct physical loss or damage to covered property at the described premises caused by, or resulting from, a covered cause-of-loss. “Covered property” means glass described in the glass schedule, including lettering and ornamentation that is also described in the schedule.

Covered Causes-of-loss

The glass coverage form includes two covered causes-of-loss. It covers breakage of glass and chemicals accidentally or maliciously applied to glass. The policy includes four additional coverages. ***These coverages are in addition to the limits of insurance: expenses incurred to remove debris of covered property caused by a covered cause-of-loss; expenses incurred for any temporary plates used to board up openings if repair or replacement of damaged glass is delayed; necessary repair or***

replacement of the frames immediately encasing the damaged glass; and expenses to remove or replace obstructions, other than window displays when repairing or replacing covered property.

Insured's Duties After Loss

After a loss, the insured must promptly notify the insurer or its agent, notify the police if the loss is due to theft, describe how, when, and where the loss took place, protect the property from further damage, provide the insurer with access to the damaged property, with pertinent records and documents requested and allow the insurer to make copies, submit to examination under oath and sign and swear to it. A proof-of-loss statement must be sent to the insurer or its agent within 60 days of such loss, the insured's signed, sworn proof of loss.

Loss Payment or Replacement

In the event of loss or damage, the insurer will pay the actual value of the loss, or pay the cost to repair or replace the lost or damaged property, or will take possession of damaged property at an agreed upon or appraised value, or will repair, rebuild or replace the property with other property of like kind and quantity. The insurer must give notice of its loss payment intent within 30 days after receiving a sworn statement of loss. Normally, the insurer will pay for prompt replacement of damaged glass. The insurer can often purchase glass at prices which are discounted from those the insurer would have to pay under an actual cash value payment.

Exclusions in the Glass Insurance

Excluded from coverage is loss or damage caused directly or indirectly by fire, nuclear hazards, including nuclear reactions, radiation or contamination, and war, meaning any act of war or defense taken by a military force, including insurrection, rebellion, and revolution. Glass damage by fire is covered under fire insurance. Nuclear hazards and war are considered uninsurable risks. Unlike boiler and machinery insurance and most other types of insurance, glass insurance has no actual face value on the policy. This means damage payment is always total once the insurance company has agreed the claim is legitimate. The premium charge for glass insurance is dependent on five major factors:

- **1st factor:** dimensions and type of glass that is to be covered;
- **2nd factor:** location of the glass on the building. Many policyholders elect to have the glass on the first floor covered because it is the most exposed to losses;

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- **3rd factor:** the policyholder's business. If the policyholder worked in manufacturing, there might be a greater chance of breakage and that would affect the premiums;
- **4th factor:** use of the glass. This includes display case, door, or a structural function;
- **5th factor:** location. Insurance companies review the area where the building is located to determine if the threat of vandalism, or weather damage warrants raising premiums.

The glass insurance business as a whole prides itself on the quick service it offers its policyholders. Most glass insurers not only cover the costs associated with glass replacement, but also arrange for the repairs themselves. Many insurers have a glass company "on call" in a contractual agreement. This costs the insurance company a small fee, but goes a long way for customer satisfaction. The normal comprehensive glass insurance policy covers damages caused by breakage or chemicals, whether purposeful or accidental. "Breakage" is defined as a fracture that penetrates the thickness of the glass; scratched or pitted glass generally is not covered. This policy also covers indirect expenses covered by glass breakage. Examples of indirect expenses include replacing frames of the broken glass, should they require repair, and also boarding up windows where replacement of the glass cannot be done immediately and a delay cannot be avoided.

Chapter 11 **Commercial Inland Marine Insurance**

History of Commercial Inland Marine Insurance

Inland marine insurance developed out of ocean marine coverage in the early 1900s, when insurers were restricted to writing one general kind of insurance—fire, casualty, or marine. Companies which wrote marine insurance began insuring personal property transported on inland waterways. Then, they began providing coverage for personal property subject to risks of different forms of transportation. From this coverage, policies were created to cover personal property not being transported, nor was permanently fixed in a location. Such policies are known as “Personal Property Floater Policies,” the term “floater” referring to the way the coverage floats, moving with the property, rather than being tied to a “described premises” or “insured location” as typical property insurance does. Marine insurers also began to write coverage that was in substance property and liability insurance. Marine insurers are not subject to the regulation property and liability insurers are under, so were able to write multi-line policies covering these risks without having to follow the same rules as traditional property and liability insurers. These regulated insurers objected to the marine insurer’s ability to write multi-line policies when they could not, and that marine insurers were in essence writing property insurance.

By the 1930s, inland marine insurance had grown to include so many types of property that marine insurers and fire insurers were competing for the same properties. Because of these objections, in 1933 the National Association of Insurance Commissioners adopted a Nationwide Marine Definition that restricted the underwriting powers of marine insurers to specified types of property. Following legislation in the 1950s that permitted a single insurer to offer fire, casualty, and marine coverages, the Definition was no longer needed for restrictive purposes. However, many states continue to use an updated Marine Definition for purposes of determining whether a particular coverage is a marine coverage under their rating laws.

Defining Inland Marine Insurance

Inland marine insurance is defined and classified as non-regulated imports. Imports may be insured under inland marine policies, when such property is not subject to import risk under marine (ocean) policies. Imports on consignment may be covered wherever the property may be and

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without restriction as to time, ***provided the coverage of the issuing companies includes hazards of transportation. A shipment on consignment*** means property consigned and entrusted to a factor or agent to be held in his or her care, or under his or her control for sale, for account of another, or for exhibit or trial or approval or auction, and if not disposed of, to be returned. Such policies may also include the same coverage in respect to property purchased on cost-insurance-freight terms or spot purchase for inclusion with, or in substitution for, bona fide importations. An import, as a proper subject for inland marine insurance, is deemed to maintain its character as such so long as the property remains segregated in the original form or package in such a way that it can be identified and has not become incorporated and mixed with the general mass of property in the United States, and shall be deemed to have been completed when such property has been:

- sold and delivered by the importer, factor, or consignee; or
- removed from place of storage as described in this subparagraph and placed on sale as part of importer's stock in trade at a point of sales distribution; or
- delivered and accepted for manufacture, processing, or change in forms to premises of the importer.

Inland marine policies may cover property for export, when such property is not subject to export risk under marine (ocean) policies, as follows. ***Export property may be covered wherever the property may be without restriction as to time, provided the coverage of the issuing companies includes hazards of transportation. Export property is deemed to acquire its character when designated as such, or while being prepared for export and retains that character unless diverted for domestic trade, and when so diverted, the provisions of these sections respecting domestic shipment shall apply;*** provided, however, these provisions do not apply to long established methods of insuring certain commodities, e.g., cotton. Domestic shipments (non-regulated) on consignment for consignor and/or consignee may be written as follows provided that in all events the policy shall cover while in transit: "...on consignment for sale or distribution for account of consignor, with no restriction as to time in storage or deposit, while in the custody of others and including return shipments, provided that in no event shall the policy cover on premises owned, leased, or controlled by the consignor;" or "...on consignment for sale or distribution for account of consignee, while in the custody of others and including return shipments, provided that in no event shall coverage be granted in excess of 120 days at premises owned, leased, or

controlled by consignee; further provided that if coverage be issued jointly to consignee and consignor the same limitation of **120 days for coverage at premises owned, leased, or controlled by consignee** shall be applicable only with respect to the interest of the consignee;" and "...on consignment for account of consignor and/or consignee for exhibition, trial, approval, or auction, without restriction as to time in storage or deposit or on exhibition and while in the custody of others and including return shipments."

Inland Marine Exposures

Inland Marine loss exposures have three elements. These elements are the item subject to loss, the causes-of-loss, and the economic or financial impact of a loss.

Causes-of-Loss

The kinds of property eligible for inland marine insurance are very diverse. Consequently the causes-of-loss to which such property is exposed are also diverse. The common thread that runs through most of the inland marine policies is an "all-risks" approach. Often the unique situation or high value of the property exposes it to different causes-of-loss than property that is generally at a fixed location and insured under commercial property coverage. Even if the property is not exposed to different causes-of-loss, the degree of exposure to loss may be different. The merchandise of a jeweler is exposed to fire, but it is much more likely that a loss will be from theft. Compact, high-valued property like jewelry or furs is more vulnerable to theft than bulky items of low value like cement or lumber. The probability of loss from the perils of transportation, particularly breakage and theft, is extreme when the property is on the move. Property in the custody of a bailee exposed to processing damage. Electronic data processing equipment is subject to electrical injury and mechanical breakdown. Mobile equipment and agricultural equipment are exposed to the elements as well as earthquake and flood, and can be found at hazardous work sites. Instrumentalities of communication and transportation may be more likely to collapse than other types of stationary property.

Items Subject to Loss

Inland marine insurance covers the types of property designated in the Nationwide Marine definition. Specifically, inland marine policies provide coverage for goods in domestic transit, goods of bailees' customers, movable equipment, and unusual property, property of certain dealers, and instrumentalities of communication and transportation.

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- **Goods of Bailees' Customers** -- Almost any person or business that accepts the property of others for storage, service, repair, or processing is faced with liability, as a bailee, for the value of the goods received. Appliance repairers, furniture upholsterers and refinishers, and industrial equipment repair facilities are all bailees as are furriers, cleaners, laundries, and warehouse operators. A bailment exists when goods are left to be held in trust for a specific purpose and returned when that purpose has ended. The bailor is the owner of the goods, and the bailee is the one in possession of the goods. Bailment can be gratuitous for the benefit of the bailor; bailment can be gratuitous for the benefit of the bailee; and bailments can be for the mutual benefit of the bailor and bailee.
- The **Contract Carriers** have the liability defined by the contract between the carrier and shipper. Such contracts may release the carrier from some liability, except in the case of extreme negligence. Generally a contract carrier has some liability to the shipper.
- **Goods in Domestic Transit** -- Domestic shipments by rail, motor truck, aircraft, or while in the custody of the U.S. Postal Service are exposed to loss while in transit. The exposure can be faced by the originator, the transporter, or the recipient depending upon the type of carrier, their exposure for liability, and any terms of sale of the goods being shipped.
- **Terms of Merchandise Sale** -- "F.O.B." means "free on board" and indicates that the shipper is responsible for arranging to have the cargo delivered on board the vessel. Once this has been accomplished, the responsibility for, and title to, the goods changes hands from the seller to the buyer. In domestic transactions, the term "F.O.B." is used more loosely to indicate the point at which ownership and exposure to loss shift from seller to buyer. A contract of sale might stipulate "F.O.B. shipper's loading dock." In this case, the transit exposure would be that of the buyer once the goods are on the shipper's loading dock. Other terms of sale have specific points at which the exposure shifts from the seller to the buyer.
- **Movable Equipment and Unusual Property** -- Certain types of equipment are eligible for inland marine insurance whether or not they are situated at a fixed location. Agricultural equipment or mobile equipment may be constantly moving from location to location. Other equipment, like physicians' and surgeons' equipment, is usually located at one site. Even computer equipment is classified as being eligible for inland marine insurance. Certain kinds of property not thought of as "equipment," like livestock or fine arts, also can be insured with inland

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marine coverage. Goods on exhibition or in the custody of sales representatives are eligible for inland marine treatment, as are valuable papers, and records and records of accounts receivable.

- ***Property of Certain Dealers*** -- Dealers in mobile or agricultural equipment can buy specialized inland marine “block” policies to cover their property including their stocks of merchandise. Jewelers, furriers, and dealers in fine arts, musical instruments, and cameras also have specialized inland marine policies designed for their unique combinations or “block” of exposures. Another type of property eligible for inland marine insurance is specific items of merchandise that have been “floored” or sold on a time payment plan. Flooring is a financing plan under which a dealer borrows money from a lending institution to buy merchandise. The merchandise must be specifically identifiable as encumbered to the lending institution.

Financial Impact of Loss

The economic or financial impact of loss to property covered by inland marine policies is not any different from the impact on property covered by commercial property forms with one exception. This exception is bailments. Lost property must be valued, and the loss may include the loss of use to the property. The valuation of the property itself can be at either replacement cost or actual cash value. In cases where the exposure to loss is of short duration, such as inventory that turns over rapidly, valuation based on selling price, or invoice price, is most appropriate. Another technique is to add a percentage of the value to cover the handling costs associated with the loss. Usually the exposure of property in transit is measured in this way so if it is lost, the financial impact of the loss is not just the cost of the property, but the amount that would have been received had it reached its destination. There may be a statutory obligation like regulations that mandate the liability of a common carrier to the shipper. Such laws could limit liability to a specific dollar amount per pound or per parcel for certain kinds of property, and this would be the extent of the loss to the common carrier. The loss to the shipper or the consignee could be much greater.

Commercial Inland Marine Policies and Clauses

The Insurance Services Office (ISO) and the American Association of Insurance Services (AAIS) file inland marine coverage forms and related statistics on behalf of their member and subscriber companies. The ISO developed forms

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can be included in monoline policies, or they can be part of a commercial package policy. If inland marine coverage is provided through a commercial package policy, the policy must contain the common policy declarations and common policy conditions. There are two types of conditions in the commercial inland marine forms. In addition to any specific form conditions and the common policy conditions, there are loss conditions and general policy conditions. Commercial inland marine coverages include protection for property such as salesperson's samples, contractor's equipment, goods or merchandise lent or rented, merchandise sent on approval, etc. -- in short, property that is moving about regularly. Most commercial property insurance policies do not cover money and securities. Many commercial property policies also exclude such causes-of-loss as burglary, robbery, and employee dishonesty. Commercial crime insurance fills these coverage gaps. Such measures as alarms, safes, vaults, locks, lighting, etc. are important in the prevention and reduction of crime losses -- as well as lowering the cost of crime insurance for the business.

The coverage is often provided by a "floater" endorsement attached to another commercial policy owned by the insured. Coverage can be written against certain limited perils such as fire, lightning, windstorm, flood, transportation, theft, etc.; or "all-risk" with certain items excluded. The categories of inland marine policies are filed and non-filed. Filed policies are standardized as to form and rate. Non-filed policies are not standardized and may vary from one insurance company to another and also from one insured to the next within an insurance company. The filed inland marine coverage forms developed by ISO can be included in a commercial package policy.

Valuation Clause

Inland marine policies can also differ with valuation clauses. An example would be the inland marine transportation insurance policy which has a valuation clause at invoice cost. However, if there is no invoice, valuation can be the actual cash value of the property. Some insurers state if there is no invoice, valuation will be the market value of the property once it reaches its destination. Another example of a valuation clause would be the valuable papers and records policy form. This form states the agreed valuation on specifically declared items will be the limit of insurance stated in the policy. Valuation for all other valuable papers and records will be determined by the lesser of its cash value, cost of restoring the property to its original condition prior to the loss, or the cost of replacing the property with similar or identical property. This last method is usually the valuation method used on this form.

Coinsurance Clause

Coinsurance is an important concept in property insurance. ***Most inland marine insurance policies have an 80% coinsurance clauses.*** Others have no coinsurance clause. This is the case with the transportation policy and the valuable papers and records policy. An insured may believe he or she has sufficient coverage on certain property if they purchase insurance which would cover a relatively small portion of the property's total value, such as 30%. The insured's reasoning may be based on past experience, the experience of others, or the installation of safety devices, such as a sprinkler system or warning devices. The insurer discourages such coverage because the insurer generally makes less profit on lower amounts of insurance, since the premium charged is generally an equal proportion of each thousand dollars of insurance purchased. Claims tend to be for relatively small amounts. The requirement of coinsurance is the insurer's response to the potential problem small coverage percentages create.

Coinsurance is similar to the historical method of insuring ships. The ship owner or shipper who wanted to insure a cargo or a vessel would get several individuals to agree to insure a portion of the property. Together, these underwriters provided the total amount of insurance the ship owner or shipper needed. Coinsurance requires if the insured does not purchase coverage up to a certain percentage, normally eighty percent, of the total value of the property, the insured must purchase insurance from another insurer, or will be considered to be coinsuring the property himself. The required percentage of the total value which must be purchased in insurance is known as the "coinsurance percentage." Although 80% is a common coinsurance percentage, an insurer may require 90%, or even 100% on certain types of property.

Deductibles

The deductibles in inland marine policies vary just as the limits do. An example would be the transportation policy. Since there are no standard policies, there are no standard deductibles. However, most policies are written with a per-occurrence deductible. Even though most deductibles are written on a per-loss basis, the wording in a deductible clause can put restrictions on the policy limit. As an example, some insurers state they will subtract the deductible amount from the amount they are obligated to pay. This type of clause prevents the insured from ever collecting the full policy limit of insurance. Other insurers might have a deductible clause similar to the one found in the valuable papers and records coverage form, which states that the insurer will pay the amount of

the loss--less the deductible-- up to the policy limit of insurance. This deductible clause would allow the insured to collect up to the policy limit.

The Declarations, Conditions, and Forms

The inland marine declarations contain the name and address of the insured; the effective date and expiration date of the policy; the premium; a description of the insured's business; and a list of the commercial inland marine coverage forms attached. The commercial inland marine conditions apply in addition to the common policy conditions and the conditions in any applicable commercial inland marine coverage form. There are eleven loss conditions and five general conditions.

- **Pair, Sets, or Parts** – If part of a pair or set is lost or damaged, the insurer may elect to repair or replace the lost or damaged part, or pay the difference between the value of the complete pair or set and value of the remaining part of the pair or set. The insurer cannot be required to pay a total loss. If an item, other than a pair or set, consisting of several parts is lost or damaged, the insurer is obligated to pay only the value of the lost or damaged part.
- **Privilege To Adjust With Owner** – If a loss involves property of others in the care of the insured, the insurer reserves the right to adjust that part of the loss directly with the owner of the property. If the insurer cannot settle the claim with the owner, it must, at its own expense, defend the insured against any legal action brought by the owner. This condition is most likely to apply to a bailment situation where a customer's property is lost or damaged by the insured.
- **Reinstatement of Limits After Loss** – A loss to items insured on a blanket basis does not reduce the amount of insurance available for future losses. However, a total loss to scheduled property terminates the coverage on the destroyed property, and the insurer will refund the unearned premium for that property. Scheduled property is listed item by item on the policy, with a specific amount of insurance on each item, particularly with items of high value.
- **Other Insurance** – The inland marine policy is excess over any other insurance available to cover the loss, even if the other insurance is not collectible. Because of this condition, liability of the inland marine insurer is not increased if another insurer covering the loss becomes insolvent.
- **Abandonment**—The first of the loss conditions says there can be no abandonment of property. Therefore, the insured cannot abandon damaged property to the insurer and insist on payment of a total loss.

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Abandonment is permitted for total losses or constructive total losses in ocean marine insurance.

- **Recoveries** – Any recoveries or salvage on a loss go to the insurer until it has recovered all amounts it paid on the loss. Any recoveries after the insurer has been made whole go to the insured.

Loss Conditions

The first condition prohibits abandonment of property to the insurer. The second condition provides appraisal process. If the insurer and insured cannot agree on property value or amount of loss, either party may make a written demand for an appraisal. Both the insurer and insured then select a “competent and disinterested” appraiser and notify one another of the appraiser selected within twenty days of the demand. The appraisers then select an umpire. If the appraisers cannot agree upon an umpire within 15 days, the insured or insurer may request the choice be made by a judge of a district court of a judicial district where the loss occurred. After the umpire is selected, the appraisers appraise the loss, and submit any differences to the umpire. The amount of the loss will be accepted by the insurer when either the two appraisers, or one appraiser and the umpire agree on the loss amount and submit the appraisal in writing to the insurer. Each appraiser is paid by the party who selected the appraiser. The expenses of the appraisal and the umpire are paid by the parties equally.

The third condition applies to the insured’s duties after loss. The insured must promptly notify the insurer or its agent, notify the police if the loss is due to theft, protect the property from further damage, make reasonable and necessary repairs to protect the property, and keep an accurate record of repair expenses. The insured must also furnish a complete inventory of damaged personal property showing the quantity, description, and amount of loss. The insured must also provide the insurer with access to the damaged property, submit pertinent records and documents requested by the insurer, allow the insurer to make copies of these documents, submit to examination under oath, and sign and swear to such examination. A proof of loss statement must be sent to the insurer or its agent within 91 days of such loss. The fourth condition explains how the insurance applies when the loss is covered by two or more of the coverages within the policy. The insurer will not pay more than the actual amount of loss in such a circumstance.

The fifth condition applies to the timing of the loss payment. The insurer will pay the loss within 30 days after reaching an agreement with the insured in

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writing, or the date of entry of a final judgment, or date of the filing of an appraisal award at the insurer. The sixth condition applies when there is other insurance which covers the same loss as this policy. If a loss covered by the policy is also covered by other insurance, the insurer will pay the excess over the payment due by the other insurance, whether collectible or not. The seventh condition provides the loss conditions when there is loss to a part of a set or a pair or parts. The insurer may repair or replace any part of the pair, set, or parts in order to restore the pair or set to its value before the loss, or pay the difference between the value of the pair or set before and after the loss. If the loss involves only part of property made up of several parts, the insurer will only pay for the value of the lost or damaged part of the property. The eighth condition includes the circumstances for payment for a loss to property in the care, custody, and control of the insured. The insurer may reach a settlement directly with the property owner. The insurer will also pay for the defense against any legal proceedings brought by the insured.

The ninth condition states that any recovery or salvage on a loss accrues entirely to the benefit of the insurer, up to the amount of payment the insurer has made. The tenth condition provides for the reinstatement of limit after a loss. The limit of insurance is not reduced by payment of any claim, unless there is a total loss of a scheduled item. In such a circumstance, the insurer refunds unearned premium on the claim. The final condition is a subrogation clause. An insured may waive before a loss rights of recovery against any person. The waiver must be in writing. If not waived, the insurer will require an assignment of rights of recovery for a loss to the extent that payment is made by the insurer.

Accounts Receivable Conditions

The accounts receivable form has a valuation clause that replaces the valuation clause in the general conditions. If the insured is unable to accurately establish the amount of accounts receivable outstanding at the time of loss, the average monthly amounts receivable for the preceding 12-month period is used. The average amount is adjusted for normal fluctuations in the amount receivable or demonstrated variance from the average for the month in which the loss occurred. Once the amount is determined, the amount of accounts for which there is no loss, amount of accounts which the insured is able to reestablish and collect, amount to allow for probable "bad debts," and all unearned interest and service charges are subtracted. The policy also includes a coinsurance clause of at least 80%. If the insurance carried is less than 80% of the accounts receivable value at the time of loss, the insurer will pay only the

proportion of the loss the limits of insurance bears to 80% of the total value of the accounts. The coinsurance clause does not apply to property in transit.

Commercial Articles Coverage Form

The commercial articles coverage form covers the owner of commercial cameras, musical instruments and related equipment. Covered property includes cameras, projection machines, films and related equipment and accessories, musical instruments and related equipment and accessories, and similar property of others in the insured's care, custody, and control. Excluded property is contraband and property in the course of illegal transportation and trade. The form includes an additional coverage for loss related to the collapse of a building or structure, when caused by the perils specified. No extensions of coverage are included in this policy form.

Covered Causes-of-loss

The form includes coverage from all causes of direct physical loss, except that which is excluded. The form excludes the following loss causes:

- **Government action;**
- **Nuclear hazard;**
- War and military action;
- **Delay, loss of use, loss of market or other consequential loss;**
- Voluntary parting with any property if induced to do so by any fraudulent scheme, trick, device or false pretense;
- Property transferred outside the premises to a person or place based on unauthorized instructions;
- Weather conditions, but if loss by a covered cause-of-loss results, the additional loss is covered;
- Acts or decisions, or the failure to act or decide, of any person, group, organization, or government body, but if loss by a covered cause-of-loss results, the additional loss is covered;
- Faulty, inadequate or defective planning, zoning, development, design, workmanship, repair, construction, building materials, or maintenance, but if loss by a covered cause-of-loss results, the additional loss is covered;
- Collapse, other than as provided in the additional coverage, but if loss by a covered cause-of-loss results, the additional loss is covered;
- Wear and tear, any quality in the property that causes it to damage or destroy itself, gradual deterioration, depreciation, insects, vermin, or rodents, but if loss by a covered cause-of-loss results, the additional loss is covered.

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Conditions

The conditions under this coverage include a coinsurance clause. All items covered, but not individually scheduled, must be insured for their total value at time of loss. If not, the insurer will pay only the proportion of the loss the limit of insurance bears to the total value of these items at the time of loss. Additional acquired property is covered automatically for up to 30 days, as long as it is a property type that is already covered by the form. The insurer will pay the lesser of 25% of the limit of insurance or \$10,000 if a loss occurs to additional acquired property. The insured must report the additional acquired property within 30 days and remit additional premium for the property.

Equipment Dealers Coverage Form

The Equipment Dealers coverage protects a dealer of mobile and construction equipment. It is designed for those who deal in mobile agricultural equipment and construction equipment, and includes coverage for merchandise in the care, custody, and control of the dealer. Other types of mobile equipment are excluded from coverage, such as automobiles, trucks, motorcycles, aircraft, and watercraft. Also excluded from coverage are:

- accounts, bills, currency, deeds, money, notes, securities, evidences of debt;
- property in the course of manufacture;
- property leased, rented or sold;
- furniture, fixtures, office supplies;
- improvements and betterments;
- machinery, tools, fittings, patterns, dies, molds and models;
- property of others listed in the declarations;
- contraband or property in the course of illegal transportation or trade.

The coverage is extended to cover debris removal, pollution clean up and removal, and theft damage to buildings. Under debris removal coverage, the insurer will pay expenses to remove debris of covered property is damaged by a covered cause-of-loss. The limit on this insurance is 25% of the amount paid for direct physical loss, plus the amount of the deductible. The insurer will pay an additional \$5000 per occurrence for debris removal if the sum of the debris removal expense and direct loss exceeds the limit of insurance, or if debris removal expense exceeds 25% of the direct physical loss limit. Under pollution clean up and removal expense, the insurer pays for expenses to extract pollutants from land or water if release or discharge of the pollutants results from a covered cause-of-loss during the policy period. The most an insurer

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pays for this coverage extension is \$10,000 for all related expenses during each separate 12-month period of coverage under the policy. Theft damage to buildings extension pays for damages caused directly by theft or attempted theft to part of any building that contains covered property, or equipment within the building used to maintain or service the building, if the insured owns the building or is legally liable for the damage to it.

Covered Causes-of-loss Form

This form is another all-risk form, and covers all risks of direct physical loss to covered property, except excluded losses. The form excludes losses due to government action; nuclear hazard; war and military action; water, flood, surface water, waves, tides, overflow of a body of water, or spray whether driven by wind or not; delay, loss of use, loss of market, or other consequential loss; unexplained disappearance; shortage found upon taking inventory; dishonest acts committed by the insured, or the insured's employees or representatives, or anyone entrusted with the property, other than a carrier for hire; processing or work upon the property; artificially generated electrical current creating a short circuit or other electrical disturbance within an article covered by the insurance, but direct loss caused by any resulting fire or explosion is covered; and voluntary parting with any property if induced to do so by any fraudulent scheme, trick, device, or false pretense.

The form also excludes property transferred outside the premises to a person or place based on unauthorized instructions; weather conditions, but if loss by a covered cause-of-loss results, the additional loss is covered; acts or decisions, or failure to act or decide, of any person, group, organization, or government body, but if loss by a covered cause-of-loss results, the additional loss is covered; faulty, inadequate or defective planning, zoning, development, design, workmanship, repair, construction, building materials, or maintenance. If loss by a covered cause-of-loss results, the additional loss is covered collapse, other than as provided in the additional coverage. If loss by a covered cause-of-loss results, the additional loss is covered; and wear and tear, any quality in the property that causes it to damage or destroy itself, hidden or latent defect, gradual deterioration, depreciation, mechanical breakdown, insects, vermin, rodents, corrosion, rust, dampness, cold or heat, but if loss by a covered cause-of-loss results, the additional loss is covered.

Limits of Insurance

The limits of Insurance section of the policy states the most the insurer will pay for loss in any one occurrence is the applicable limit shown in the declarations.

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There are several limits shown in the declarations. In addition to a limit for property on the insured's premises, the insured may select a limit applicable to property off premises in the care, custody, or control of an employee; property in transit; or property at some other location. The insured may also select a limit applicable to all covered property at all locations.

The limit of insurance in an inland marine policy will always vary depending on the type of inland marine policy. For example, transportation policies can have two limits of insurance. One limit could be per unit or per conveyance. A catastrophe limit could also be included, which would apply to losses of more than one unit or conveyance. It is also possible for a transportation policy to be written with a single per occurrence limit. The inland marine valuable papers policy form is another example of varying limits. The limits of insurance on the declaration page states per-occurrence; however, the policy is structured to indicate the insured has one limit for specifically described valuable papers on the insured's premises and another limit for all other valuable records on the insured's premises.

Rating Commercial Inland Marine Coverage

The rates for the filed commercial inland marine lines are based on rate factors, loadings, and credits contained in the ISO Commercial Lines Manual. In most cases, base rates for these filed lines are derived from the contents rates that apply to standard commercial property coverage and are increased or decreased for use in inland marine premium coverage and are increased or decreased for use in inland marine premium determination.

Rating Non-filed Inland Marine Coverages

Use of non-filed inland marine forms allows for greater flexibility in coverage terms and provisions, which makes these non-filed lines a more appropriate way to insure a variety of unusual or specialty properties. Flexibility is also apparent in the methods used to rate these non-filed coverages. Many non-filed inland marine lines are widely written so both their coverage provisions and rates have become standardized to an extent. Motor truck cargo insurance, for example, is an important form of inland marine coverage and rates for it are based on many years of loss experience. Insurance companies active in insuring truck shipments have developed their own manuals and rate schedules for this coverage, making it possible to rate a motor truck cargo policy in much the same way standard commercial property insurance is rated. Property may be so unusual that is being insured or the coverage terms may be so

specialized, there is not enough previous loss information to give the insurance company a statistically accurate idea of what the coverage should cost. However, when faced with questions such as these, inland marine underwriters must rely on their best judgment to set rates.

Expansion Coverages

Aviation insurance policies are not standardized. Each company develops and submits its own wording to each state. All policy forms must be approved by each state insurance department for states where the company plans to write insurance. State insurance departments are very consumer conscious and receptive if a company requests broader policy forms. Therefore, it is not difficult for a company to get state approval when they want to broaden or include additional coverage. There are obvious similarities among policies since all are designed to provide a similar product - aviation insurance. Some exist as a result of subtle plagiarism over the years. Often it is easier for a new company to use wording already tried and proven. In spite of some similarities there are numerous differences in policy wording among companies and each policy and endorsement should be read and understood when evaluating their provisions.

It is advantageous to the aviation insurance buyer that policy wordings are easily changed over time when the result is broader coverage. As a result of competitive market conditions, companies will offer broader coverages in certain areas. Once that is done, competing insurers must consider adjusting their product accordingly in order to remain competitive. Expanded coverages usually begin as an endorsement to the policy rather than appearing in the basic policy wording. For example, in the early days of aviation insurance all policies were written on a "named pilot" basis, meaning only pilots named in the policy were approved to operate the aircraft. Then, a company figured they could provide a more attractive policy by granting approval to anybody who met certain requirements.

Exclusions & Limitations of Inland Marine Insurance Coverage

The exclusions section indicates the cause-of-loss not covered by an inland marine policy. Some exceptions to the exclusions provide limited coverage in certain situations. There is no coverage under this form for loss or damage to property caused directly or indirectly by any of the following situations:

- unauthorized instructions to transfer property to any person or place;

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- nuclear hazard, including nuclear weapons, nuclear reaction or radiation, or radioactive contamination, except loss by resulting fire;
- governmental action including seizure or destruction of property by order of governmental authority, except destruction of property at the time of a fire to prevent its spread;
- shortage found upon taking inventory;
- earthquake loss to property on the insured premises, except loss by resulting fire;
- war and military action;
- dishonest acts by the named insured, employees of the named insured, anyone else with an interest in the property and their employees or authorized representatives, or anyone entrusted with the property, excepting a carrier for hire;
- water loss to property on the insured premises by flood, surface water, tides, tidal waves, waves, overflow of a body of water, or their spray, all whether or not driven by wind, except loss by resulting fire, explosion, or theft;
- marring, scratching, exposure to light, breakage of tubes, bulbs, lamps, or articles made of glass, except loss by fire, lightning, explosion, windstorm, vandalism, aircraft, rioters, strikers, theft or attempted theft, or accident to the vehicle carrying the property;
- unexplained disappearance;
- artificially generated current that creates a short circuit or other electric disturbance within an article of covered property, except loss to that article by resulting fire or explosion;
- delay, loss of use, loss of market, or any other consequential losses;
- theft of property from unattended vehicle unless all windows, doors, and compartments were closed and locked, and there are visible signs theft was the result of forced entry;
- voluntary parting with property by the named insured or any person entrusted with the property if induced to do so by a fraudulent scheme or false pretense;
- processing or work upon property, except loss by fire and explosion.

Aviation Insurance

Aviation insurance is a highly specialized field because of the complex nature of risks involved, and the relatively small statistical base upon which rates are calculated. Risks are largely “judgment rated” in accordance with a company’s overall underwriting standards and philosophy. An individual underwriter usually

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has a broad range of rating latitude on a given risk and can be influenced by his personal evaluation of a risk. Aviation insurance provides physical damage and liability coverage for risks associated with owning and operating aircraft. The coverage was originally based on Ocean Marine insurance. There are no standard forms for this type of insurance. It contains its own unique risk coverages and unique terminology of the aviation field. An aviation policy normally includes:

- hull coverage;
- third party liability coverage;
- medical payments coverage;
- airport liability.

Aviation insurance is a specialized field of insurance. Liability coverage is often provided by aviation “pools” such as the Associated Aviation Underwriters and the United States Aircraft Insurance Group. A pool system is necessary because the potential for loss related to one aircraft can be too large for one insurer to handle. If a single insurer offers policies, normally the policies cover single aircraft or other relatively small risks, rather than for a large airport or an airline. Insurers who write coverage for major airlines are primarily marine insurers in London, where the large marine insurers and reinsurers are located. All aviation insurance policies are very different. Even different policy forms issued by the same company can have great variations in coverage. Some items that must be read and understood are the basic coverages that a policy offers. Some of these are to

- understand the pilot requirements;
- confirm the hull value;
- define the purpose of use.

It is important that all policy variables are clearly defined and understood by the aircraft owner and operator. Ignoring such detail can lead to disappointing and expensive lessons after a loss has occurred. There is nothing more confusing than the policy territorial limitations. The policy detail is poorly defined by the industry regarding the territory of operation. So let’s try to define it with some degree of clarity. If an aircraft is operated only within the 48 adjacent United States, it is covered by every basic policy issued by domestic aviation insurance underwriters. Different underwriters provide different territorial coverages, and the designations they use for the same geographical location may vary among them. By examining each individual policy and the actual territories covered, one can obtain a better understanding of the geographical scope of coverage.

The 48 Contiguous United States and Mexico

The normal aviation insurance policy applies within the 48 contiguous United States and Mexico. There are no known exceptions to this statement. There is one word of caution, however. When traveling to Mexico, the Mexican government does not recognize a policy issued by a U.S. aviation insurance underwriter. As a result, the insured must have proof of Mexican liability insurance in their possession, issued through a Mexican insurance company. Some U.S. underwriters purchase these certificates from a Mexican insurance company and include them with the U.S. issued policy at no additional cost to the insured. Some underwriters will sell this certificate at a premium that will just cover their cost. Others do not provide the service at all.

Hull Insurance

The hull coverage covers damage to the aircraft. Policies may apply different deductibles for the aircraft while “in motion,” or “in flight” than when “not in motion.” Insurance may also be provided on an all-risk basis; an all-risk basis for risks when the aircraft is not in motion and named peril basis for in flight coverage, or an all risk basis for risks when the aircraft is in flight and a named peril basis for not-in-motion coverage.

Hull insurance protects the insured against physical loss or damage to the aircraft, including engines and other components. It typically covers against perils of fire, theft, and collision. War and associated risks, including hijacking and acts of terrorism, are excluded. Because these risks are more present in aircraft insurance than in most other types, the policies are usually very specific in defining war and associated risks. ***The exclusion clause for airline craft can include exclusions for war, invasion, hostilities, civil war, rebellion, revolution, insurrection, martial law, hostile detonation of atomic weapons, strikes, riots, civil commotion or labor disturbances, acts of a political or terrorist nature, sabotage, confiscation, nationalization, seizure and hijacking.*** To obtain hull insurance, the insured must warrant the airworthiness of the aircraft. Typically, a certificate of airworthiness is issued by the FFA. If the certificate states the aircraft has an airworthiness below standard, the insurer may reject the risk, or charge a higher premium. Other warranties the insured must make pertain to:

- the territory in which the aircraft will be flown;
- the pilot, including the pilot’s certifications and ratings, medical condition, and hours flown by type of aircraft;

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- type of aircraft, including the make, model, year, seating capacity, whether it can travel on land, sea or is amphibious, the aircraft's market value, and number of hours flown in the last 12 months.

If an aircraft is used for pleasure, the policy will normally exclude coverage for "use for which a charge is made." Like automobile policies which do not consider use of an auto as "business use" when the insured is reimbursed for gas, many aviation policies do not consider use of an aircraft as business or commercial use when a passenger shares some expenses, but not others. Generally, the insured under a policy covering an aircraft used for pleasure may be reimbursed for fuel and oil for the flight in question, hangar and tie down costs away from the aircraft's home airport, insurance obtained for the specific flight, and landing fees or airport taxes for the flight. However, the specific policy language varies from policy to policy. Hull coverage can be written on an agreed value basis or actual cash-value basis. It often includes coverage for expenses of renting a substitute aircraft. If a lender has an insurable interest in the aircraft, the lender is generally protected under a breach of warranty provision similar to a mortgagee clause of property insurance. The lack of warranty by an insured will not harm the lender's insurable interest.

War Risk Hull Insurance

Following the September 11 terrorist attack, all aviation insurers ordered the mid-term cancellation of war risk insurance from all aviation policies that were endorsed to include the coverage. They then offered to sell the coverage back for an additional and more expensive premium charge. This action stirred a variety of questions. Many bought back the war hull coverage. If an individual operates aircraft outside the United States into less stable countries, confiscation and seizure protection offered under the war endorsements is well worth the cost. There are 28 perils included in the war write-back endorsement. War and terrorism are just two. In addition, coverage for malicious acts, strikes, and labor unrest are also included.

Hull War Risks

The hull "All Risks" policy will contain the exclusion of "War and Allied Perils". Generally speaking, throughout the aviation insurance world, "War and Allied Perils" have a defined meaning. In the London Aviation Insurance Market the standard exclusion is called the War, Hi-jacking and Other Perils Exclusion Clause (currently known by its reference - AVN48B for short) this lists and defines these so-called war and allied perils.

War Definition

1. War - this includes civil war and war where there is no formal declaration.
2. The detonation of a weapon of war employing nuclear fission or fusion.
3. Strikes, riots, civil commotions and labour disturbances.
4. Political or terrorist acts.
5. Malicious or sabotage acts.
6. Confiscation, nationalization, requisition and the like by any government.
7. Hi-jacking or any unlawful seizure or exercise of control of the aircraft or crew in flight.

The exclusion also applies to any loss or damage occurring whilst the aircraft is outside the control of the operator by reason of any of these "war" perils.

The majority of the excluded "War and Allied Perils", other than the detonation of a nuclear weapon and a war between the Great Powers (the aviation insurance world identifies these as the U.S.A., the Russian Federation, China, France and the UK), can normally be covered by way of a separate "War and Allied Perils" policy. Aircraft deductibles are not normally applied in respect of losses arising out of "War and Allied Perils".

Other exclusions insurers will usually apply are, as follows:

1. Confiscation etc. by the "state" of registration (this exclusion can often be deleted in respect of financial interests - albeit, in some instances at an additional premium charge)
2. Any debt, failure to provide bond or security or any other financial cause under court order or otherwise;
3. The repossession or attempted repossession of the Aircraft either by any title holder or arising out of any contractual agreement to which any Insured protected under the policy may be party;
4. Delay and loss of use. (Although there is often an extension to the policy for a limited amount for extra expenses necessarily incurred following confiscation or hijacking).

The aircraft hull "War and Allied Perils" policy will cover the aircraft on an "Agreed Value" basis against physical loss or damage to the aircraft occasioned by any of these perils. This statement is made carefully and deliberately in order to highlight the essential difference from a "Political Risks" Insurance

Extension of Policies

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In general, the policies extend through December 31, 2008, the termination date of any insurance policy the Department of Transportation issued to an air carrier under subsection (a) and is in effect on the date of enactment of this subsection on no less favorable terms to the air carrier than existed on June 19, 2002; except the Secretary of Transportation shall amend the insurance policy, subject to such terms and conditions as the Secretary may prescribe, to add coverage for losses or injuries to aircraft hulls, passengers, and crew at the limits carried by air carriers for such losses and injuries as of such date of enactment and at an additional premium comparable to the premium charged for third-party casualty coverage under such policy.

The cost for War Risk Hull Insurance currently is a percentage of the aircraft's value. Depending upon the value of the aircraft, this could be quite expensive. War-risk coverage can be cancelled in the event of a new round of terrorist attacks. The endorsement form offered by most companies follows the Lloyd's form and allows for seven-day notice of cancellation following an increased hazard such as a terrorist attack. War-risk liability coverage is designed to protect one if he or she is negligent. Of course, a liability policy would come into play if this individual were alleged to be negligent. The cost is a surcharge of 20% of a liability premium, with a maximum coverage of \$50 million or a policy's liability limit, whichever is less. This is an annual aggregate limit.

Airline hull "All Risks" policies are subject to a standard level of deductible (that is an uninsured amount borne by the Insured) applicable in the event of partial (non-total) loss. Currently, this deductible can range from \$50,000 in respect of a Twin Otter to \$1,000,000 in respect of a wide-bodied jet aircraft, such as a Boeing 747.

Liability Insurance

In many cases, changes in other areas of our society have a great influence over aviation. This is the case with our court system. The trend toward unreasonable verdicts and ridiculous awards has forced many aircraft owners to create shell corporations to "front" as the registered owner of their aircraft. Owners today are uncertain as to how much liability insurance is adequate protection, a situation made far worse by the growing reluctance of insurance underwriters to offer higher limits of liability protection at any price. The underwriters explain it is impossible for any aviation insurance company to predict an adequate liability premium rating structure when the court decisions are so volatile and erratic. All aviation insurance companies are heavily reinsured by companies in London and other foreign markets, and those foreign

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insurers usually charge passenger liability premiums for aircraft operated in the United States that are three to five times as much as those paid by non-U.S. operators. And so it goes for the owner of general aviation and commercial aviation aircraft in the United States. Aircraft owners seem to be trapped between inadequate coverage limits, high-priced liability insurance premiums, and the perils of the U.S. court system.

Third Party Liability Insurance

The other category of liability covers premises, hangerkeepers and products liability and is called "Airline General Third Party" -- the liability for damage done to property or people arising from other than the use of aircraft. Many airlines cover their "Airline General Third Party Liability" within their main liability program.

It is called "Airline General Third Party Liability" these days since the insurers took steps specifically to exclude all non aviation activities (for example hotel ownership or management) from "Aviation" Policies a few years ago. Basically for a risk to be considered as "Airline General Third Party Liability" it must arise from what are described as "aviation occurrences" being those involving aircraft or parts relating thereto, or arising at airport locations or arising at other locations in connection with the airline's business or transporting passengers/cargo or arising out of the sale of goods or services to others involved in the air transport industry. This means that there is a definitive language detailing what is considered as "aviation exposure" such that any other (non-aviation) exposure is excluded.

Most policies are placed on a Combined Single Limit Basis. This means Bodily Injury and Property Damage combined. In the past, personal injury was included but now this has been separated. It should be mentioned, however, that these days the term "bodily injury", in addition to bodily injury, sickness and death resulting at any time, will include shock and mental anguish. "Personal Injury" on the other hand is defined as "offences against the person", such as false arrest, malicious prosecution, invasion, libel or slander and the like.

In respect of Personal Injury the full policy limit, whatever that may be, is not available and is usually limited to US\$25,000,000 any one offence and in the annual aggregate.

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Excluded from a liability insurance are such things as:

1. Damage to the Insured's own property. (It is after all a third party liability policy).
2. War and Allied Risks although these are "written back" by a device called "The Extended Coverage Endorsement - AVN 52E".
3. Radioactive Contamination.
4. Noise and Pollution - unless caused by or resulting in a crash, fire, explosion or recorded "in flight" emergency

Both the Aircraft and General Liability policies usually includes the "war and allied perils" exposure by way of a "write back" and will probably provide for such things as search and rescue expenses, first aid and other humanitarian expenses and also defense costs.

Passenger Liability Insurance

Passenger liability insurance reimburses all sums which the insured is legally liable for as damages for bodily injury, including death, to passengers, up to limits of coverage. Liability coverage includes bodily injury which occurs while the passenger is boarding, on board or disembarking, and may include coverage for bodily injury occurring outside the aircraft.

Non-Owner Aircraft Liability Insurance Policy

A person who regularly rents aircraft can have need of non-owner aircraft liability insurance policy. Such coverage provides aircraft liability for bodily injury to persons outside the aircraft and property damage caused by the aircraft. Coverage can also be purchased for damage to the aircraft caused by renter negligence. This is known as "non-owned hull coverage." Although an aircraft owner renting the aircraft may have some insurance coverage for hull damage by the renter, it typically does not have a high limit of insurance. Often, it is an extension of coverage of the owner's policy with a limit of insurance insufficient for liability and property damage needs of the renter.

Airport Liability

Airport liability provides liability coverage for an airport. It covers liability arising out of the airport's premises and operations, contractual liability, and products liability. An airport may provide many different services, so premium will depend on what type of services are provided. For example, an airport may provide any of the following services:

- fueling of airlines;

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- fueling of other aircraft;
- fuel storage;
- operation or ownership of fuel trucks, tanks or fuel hydrant systems;
- aircraft service or maintenance;
- rental or lease of hangars or tie downs;
- hangaring of aircraft;
- towing, moving or parking of aircraft;
- operation of aircraft;
- airline passenger security screening;
- operation of control tower;
- ownership or maintenance of nav aids, windshear detectors or aviation communications equipment;
- ownership or use of runway anti-skid or deicing equipment, or icing/runway temperature/chemical mix monitoring systems, or braking action measurement equipment;
- rental or lease to others of land or buildings;
- inspection and maintenance of ramps, taxiways or runways;
- airline use.

In addition, an airport may have extensive parking facilities, elevators, escalators, moving sidewalks, passenger trams, and house many businesses, such as restaurants, bars, and stores. The liability exposure of a large airport can be extensive. Other business or commercial policies can provide coverage for the business property risks involved in the airport. Common liability coverages offered to airports are hangarkeeper's liability, bodily injury liability, property damage liability, and single limit bodily injury and property damage. Hangarkeeper's liability insurance covers airport owners or operators against physical damage to aircraft in their care, custody or control for storage, repair or safekeeping. Bodily injury liability covers personal injury liability arising from the ownership or operation of an airport. Property damage liability covers property not owned by the insured, other than aircraft, in the care, custody, and control of the insured. Single limit bodily injury and property damage coverage provides coverage with a single limit for both types of loss. Other types of insurance an airport operator or owner may need are property insurance for the buildings and contents on the airport premises and automobile coverage for automobiles owned and operated by the airport.

Voluntary Settlement and Seat Accident Insurance

Voluntary settlement and seat accident insurance pays an amount specified in the policy if a passenger is dismembered or dies, to the passenger or the

passenger's survivor. The amount paid represents a "voluntary settlement," not an amount established by the legal liability of the insured. In order for the injured passenger or survivor to receive an amount under this insurance, a signed release must be completed which releases the insured from the possibility of a third-party liability suit. Because the insurance does not make a payment based on liability, it is not true liability insurance. However, it serves the purpose of protection from liability. An option under this coverage is the purchase of weekly indemnity coverage. Weekly indemnity coverage pays a weekly income payment for a loss that results in disability.

Air Show Coverage

Most aviation policies exclude coverage for air shows or air meets. However, such coverage is available. Several types of insurance are offered together to cover the different risks of such an event. Coverages may include Performers Aircraft Hull and Liability Coverage, Airmeet Liability Protection, Accident Coverage for Volunteers, Workers' Compensation, Directors and Officers Liability, and Weather Insurance.

Types of Expansion Coverages

Below is a partial listing of some coverages that are now (or were) considered "expansion coverages". The feature descriptions and notations are general in nature and for reference only. Actual policy and endorsement wordings should be consulted for each specific case.

- **Aircraft Retrieval (off-airport landing)** -- An aircraft experiences an in-flight emergency requiring an immediate landing and since DOT will allow the aircraft to take off from the interstate the aircraft will have to be dismantled, loaded on a truck, and hauled to the nearest airport for reassembly. This "expansion" coverage states in such an event, the company will pay for related costs to disassemble, move and reassemble the aircraft even though there was no damage to the aircraft.
- **Automatic Increase in Hull Value for Modification** -- The insured value stated in the policy automatically increases as modifications are made or equipment is added by the amount spent as evidenced by the insured's records. The insured must report improvements to the company as soon as possible and pay any resulting additional premium which may be limited to 125% of the policy stated hull value unless the company grants prior approval.
- **Baggage and Personal Effects** -- This feature makes an exception to the "care, custody, or control" exclusion as respects damage to personal

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effects of passengers. Coverage is limited to a certain stated amount per passenger.

- **Broad Form Definition of “Aircraft”** -- Expands the definition of “aircraft” to include equipment, such as avionics, removed from aircraft even if it has been temporarily replaced. The temporary replacement equipment is also covered since it would now be a part of aircraft.
- **Broad Form Definition of “Named Insured”** -- Expands the definition of “Named Insured” to include subsidiary and parent companies as additional named insureds if financially controlled by the named insured.
- **Cancellation Notice - 90 Days** -- Provides 90-days prior written notice to named insured if the policy is cancelled at the request of the company. Normal notice period is 30 days.
- **Cargo Legal Liability** -- A contingency coverage for non-commercial risks in case the named insured should carry cargo for a third party.
- **Contractual Liability** -- Covers liabilities of others the named insured assumes under contracts.
- **Cost Reimbursement** -- Permits uses where direct costs of operation of the aircraft are reimbursed to the named insured.
- **Cross Liability** -- Liability will cover claims by one insured against another.
- **Damage to Hangar and Contents** -- Covers damage to temporary use of non-owned hangars and contents that are in the care, custody, or control of the insured. Certain limits specified.
- **Delete Pilot Requirements for Maintenance Flights** -- Pilots employed by an FAA approved repair station are automatically approved pilots in respect to test flights after repairs.

Insurance and the Future of Aviation

During the past century, man has realized his dream to fly. Aircraft was developed and partially perfected. The aviation industry, as it is known today, has grown into a set of definable sub-industries based upon usage. Modern-day aircraft range from military to commercial airlines to the most diverse group, general aviation. As with any technology-based industry, aviation continues to grow and develop. New uses for aircraft are identified, better aircraft and avionics are created, and problems are recognized and solved. Although aviation has come a long way in the last 100 years, it is still a developing industry. With growth and development come problems which must be solved before an industry can graduate to the next level. In the United States, aviation is now confronted with a series of problems that may take as long to solve as the act of flight itself. As aviation enters the new millennium, the aviation

insurance industry must deal with these problems. Some are simply growing pains. Others are outside influences for which no simple solution may exist.

Summary

Inland Marine Insurance provides coverage for goods in domestic transit, goods of bailees/customers, moveable equipment, and unusual property. Property of certain dealers and instrumentalities of communication and transportation are also covered. In short, inland marine insurance provides coverage for loss exposures that cannot be conveniently or reasonably confined to a fixed location. A bailee is any person or business that accepts the property of others for a specific purpose. Instrumentalities of communication and transportation are properties essential to communication or transportation. Properties that may come under this class are radio and television equipment, bridges, roads, tunnels, pipelines, and piers. There are many kinds of inland marine policies that cover several kinds of loss exposures. The insurance industry has recognized this diversity by dividing inland marine into two categories: filed and non-filed.

Filed policies are those which the policy forms and rates are filed with the state insurance department. These policies are characterized by the number of potential insureds with the same kinds of similar loss exposures. Most filed forms cover risks of direct physical loss to the covered property. Some examples of inland marine filed policy forms are: commercial articles coverage form, equipment dealers' coverage form, signs coverage form, mail coverage form, accounts receivable coverage form, and valuable papers/records coverage form. Non-filed inland marine policies are those which neither the policy forms nor the rates are filed with the state insurance department. The majority of inland marine policies are non-filed. Non-filed policies are characterized by a relatively small number of potential insureds with different loss exposures. A non-filed policy may be substantially different among insurers. Many non-filed policies provide coverage against risk of direct physical loss or damage to covered property. Other policies may insure against only specified causes-of-loss.

Chapter 12 *Commercial Risk Management and Loss Control*

Understanding Risk Management

With the rising cost of insurance premiums, not every business has the luxury of “full commercial combined” cover. Increasingly, businesses have a need to address risk management issues. Many businesses are opting to self insure or be subject to significant excesses. Companies are trying to improve their bottom line by looking at ways to recoup losses which could be recoverable or simply write off in the absence of a commercial recovery solution. Many businesses are also now finding that when it comes to making a claim on their insurance policy, either some aspects of loss are not covered by their policy or their insurers are insisting on strict compliance with policy conditions.

Selecting Risk Management Techniques

Risk management involves either stopping losses from happening or paying for those losses that inevitably do occur. ***Risk-control techniques include risk management designed to minimize the frequency or severity of accidental losses or to make losses more predictable. Exposure avoidance*** eliminates entirely any possibility of loss. It is achieved either by abandoning or never undertaking an activity or an asset. ***Loss prevention*** aims to reduce the frequency or the likelihood of a particular loss. ***Loss reduction*** aims to lower the severity of a particular loss. ***Segregation of loss exposures*** involves arranging an organization’s activities and resources so that no single event can cause simultaneous losses to all of them. ***Duplication***, on the other hand, implies reliance on “back-up” -- spares or duplicates used only if primary assets or activities suffer loss. ***Contractual transfer*** of an asset or an activity for risk control is a transfer of legal and financial responsibility for a loss. Selecting the best risk-management technique or combination of risk control and risk financing techniques, which is often the case, is a two-step activity. The first step is to forecast the effects the available risk management options are likely to have on the organization’s ability to fulfill its objectives. The second step is to define and apply criteria that measure how well each alternative risk management technique contributes to each organizational objective in cost-effective ways.

Implementing the Chosen Risk Management Techniques

A risk management program must from the start be planned and organized on the principle that every risk management technique an organization chooses to use must be one it can successfully implement and monitor. A technique that cannot be put into practice and then assessed for its effectiveness cannot be part of a well-managed program. In the implementation step, a risk management professional must devote attention to both the technical risk management decisions that he or she must personally make to put a chosen technique into practice and the managerial decisions that must be made in cooperation with other managers throughout the organization to implement the chosen technique. Once implemented, a risk management program needs to be monitored to ensure that it is achieving the results expected of it, and to adjust the program for changes in loss exposures and the availability or costs of alternative risk management techniques. The monitoring and adjusting process requires each of the following elements of the general management function: (1) standards of what constitutes acceptable performance; (2) comparison of actual results with these standards; (3) correction or substandard performance and alteration of unrealistic standards.

Understanding Loss and Loss Control

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

Defining Loss

When property is damaged, there may be both direct and indirect losses. A direct loss occurs when there is damage to property, as when a fire damages a home. Indirect loss occurs when a direct loss causes expenses to increase or revenues to decline. Because of this dual nature of property losses, many insurance contracts insure both direct and indirect losses in the same contract. Indirect losses are more difficult to identify than direct property losses. One can see a machine and measure its value, but we cannot see the lost profits if the machine is unavailable for several months. It is difficult to estimate how long a machine or a building will be unavailable after a loss, or whether a loss will occur during a busy season or a slack period. The process begins with a

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forecast of expected income under normal circumstances. A second estimate of post-loss income follows. The difference is the potential income loss following a direct loss. In insurance, a prediction must be made from actuarial experience or statistical analysis of the number of losses to be expected within a group of exposures. The law of large numbers tells us that actual losses will be more accurate as the number of units of exposure increases.

An insurance policy is a contract between an individual and the insurance company. The individual agrees to pay the premium, which is the annual price for the policy, and the insurance company agrees to pay for one's losses resulting from the events that are covered in the policy. Insurance policies usually last one year or six months. The basic function of insurance is to protect one against losses that he or she cannot afford -- a lawsuit that threatens to wipe out all one's savings, or a fire that destroys a house and personal belongings. Property insurance is insurance providing financial protection against the loss of, or damage to, real and personal property caused by specific perils. Casualty insurance is insurance concerned primarily with the insured's legal liability for injuries to others or for damage to other person's property.

Types of Loss

Liability Losses

Liability insurance is designed to pay on behalf of an individual, a business, or an organization, the actual damages that the insured becomes legally obligated to pay. With the number of lawsuits filed daily and the ever-increasing size of the judgments awarded, liability insurance is a necessity for businesses and professionals, as well as for many individuals. Liability losses arise from three sources: 1) an organization responsible for negligently injuring someone must pay legal damages awarded by a court to the injured party, 2) the cost of a legal defense, and 3) loss prevention arising from potential legal liability. Several types of liability losses have become of increasing concern to both profit-making and non-profit organizations in the last 10 years. Workers' compensation claims arise from injury to a firm's employees while they are at work, product liability occurs when a firm's products allegedly injure the public, environmental impairment liability arises from violating federal or state statutes designed to protect the environment, or from lawsuits from parties claiming injury caused by a firm's improper handling of toxic substances. Employment practices liability describes the loss potential arising from lawsuits from employees or job applicants alleging wrongful hiring, promotion, demotion, termination, and sexual harassment.

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

Property Losses

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

Net Income Loss

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

Personnel Losses

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

Methods of Identifying Loss Exposures

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

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generated a credible loss record. To identify exposures, or possibilities of loss, the risk-management professional must be able to do three things:

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

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

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

Loss exposures are typically categorized in terms of their first dimension -- the nature of the value exposed to loss. All financial losses that are the concern of risk management, excluding losses of purely sentimental value, can be categorized as property losses, net income loss, liability losses, or personnel losses. Financial statements are another method of identifying loss exposure. These financial statements must include balance sheets, profit and loss statements, and funds flow statements for a series of years. Profit and loss statements are often called income statements, and funds flow statements may be labeled sources and uses of funds.

Any document that tells something about an organization's operations, such as contracts, correspondence, minutes of meetings, and internal memoranda, also tell something about the organization's loss exposures. Flowcharts are an approach to analyzing loss exposure by viewing an organization as a unit into which values flow, through which they are processed and increased, and out of which these greater values flow. In this perspective, an accident is an interruption of flows. The extent and duration of interruption roughly indicate the severity of the resulting loss. Flowcharts may show details of the process by which each of the organization's products is manufactured, how personnel and materials move among the organization's locations, or the flow of raw materials and finished products from suppliers through marketing channels to the final customer. For some loss exposures of any organization, no amount of theory and no set of classifications can full disclose all possibilities of loss. For

some loss exposures, no amount of theory, and no set of classifications can fully disclose all possibilities of loss.

Identifying the Risk and Loss Factors

Making sound decisions about exposures to pure risks requires knowing an individual's or organization's activities and dealing with those potential accidental losses in ways that enhance the overall operating efficiency of the organization. While risk management focuses primarily on those loss exposures arising out of pure risks of accidental loss as a consequence, risk management enables an individual or organization to meet its business or other operating goals in ways that enhance operating efficiency. To identify exposures, or possibilities of loss, the risk management professional must be able to apply a logical classification scheme for identifying all possible exposures to loss; employ proper methods for identifying those specific loss exposures that particular organization faces at a particular time; and test the significance of these actual loss exposures by the degree to which they may interfere with the achievement of the organization's basic objectives.

Financial Factors

- high personal debts (possibly from credit cards, divorce, medical bills, etc.);
- significant personal losses;
- inadequate income;
- living beyond one's means;
- financial pressures of family members.

Personal Habits

- extensive stock market or other speculation;
- extensive gambling (video poker);
- illicit sexual involvement with others;
- heavy use of alcohol or drugs.

Loss Histories are a record of past losses for an important indicator of accidental losses that may strike an organization. Prior accidents and lawsuits may well repeat themselves, unless the organization's operations have changed in some fundamental. For many organizations, however, records of past losses and claims may be inadequate for identifying current loss exposures, because the organization is too small or too young to have generated a credible loss record. Property losses could include damage that a hospital suffers to its building and damage to a parking lot where corrosive chemical flowed and damage that the owners of automobiles parked in the

parking suffered from the chemical that had been spilled. Net Income loss is the second major type of loss exposure. Referring back to this hospital, they suffered income loss because some of the prospective patients chose to defer elective surgery or to have it performed in some other “safer” hospital. With respect to extra expense, the hospital incurred additional costs in overtime for its maintenance crews cleaning the grounds and in making special arrangements for temporary substitute parking facilities.

Liability loss exposure is a factor here because some of the patients felt that the hospital had not taken appropriate precautions to protect its patients against foreseeable hazards from the nearby railroad tracks. The hospital employees who were injured, or who suffered ill effects from the toxic chemical, could bring workers’ compensation claims against the hospital. Personnel losses result from death, disability, retirement, resignation, or unemployment. For example, a vital hospital executive or technician may have been sickened by toxic fumes and unable to come to work for the two weeks required to clean the parking lot, then each of these two organizations would have suffered a personnel loss.

Financial Statements and Loss Exposure

Financial statements is the third method of identifying loss exposure. These financial statements must include balance sheets, profit and loss statements, and funds flow statements for a series of years. Profit and loss statements are often called income statements, and funds flow statements may be labeled sources and uses of funds. Other records and documents include virtually any document that tells something about an organization’s operations, such as contracts, correspondence, minutes of meetings, and internal memoranda, also tell something about the organization’s loss exposures.

Flowcharts and Loss Exposure

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

Risk Management for Catastrophic Events

The recent surge in catastrophe losses has caused insurers, regulators, legislators, and others to question whether the property/casualty insurance industry has the financial capacity to handle the growing catastrophe risk. In an attempt to study this potential problem, many insurers are using computerized catastrophe models to estimate possible catastrophe losses. However, “the industry” does not provide insurance. Individual insurers do. To analyze the insurance industry's financial capacity to handle catastrophe risk, one must study each insurer. This study takes a first step in that direction. The study uses a computerized catastrophe model to analyze insurers' exposures and determine the potential effect of earthquakes and hurricanes on the financial strength of 80 insurer groups, representing 28% of the industry's property insurance premium.

The model includes thousands of simulated earthquakes and hurricanes, each with an associated probability of occurring in any given year. ISO estimated the losses for each simulated catastrophe and combined the results to get the distribution of annual catastrophe losses for each insurer group. This study compares the model-generated losses with each insurer group's surplus.

Risk Management of Earthquakes

The earthquake hazard in the United States has been estimated in a variety of ways. Chief among them is the production of “risk maps.” Such maps prove useful in establishing building codes, engineering design standards, and insurance rates in areas of high risk. Seismic risk maps are based either on relative risk or on the probability of a certain seismic event at a particular time and place. The risk maps show four zones that are assigned risk on a relative scale. This map is based on the known occurrence of damaging earthquakes in the past, evidence of strain release, and consideration of major geologic structures and provinces believed to be associated with earthquake activity.

For years, this map was widely used, because it was the best risk map available. However, this type of risk map has several drawbacks. For one thing, it does not consider frequency of occurrence. Furthermore, there is no justification for assuming that events larger than those observed historically, especially in the East, will not occur in the future. It is also known that ground-motion attenuation (“dying out” of the shock waves) with distance is far less in the eastern U.S. than in the western states. Felt areas are, in general, one order of magnitude greater in the East than for similar earthquakes in the West.

Damage begins to occur at about 10%-15% g. Below 4% g, which is the lowest contour on this map, shaking effects are controlled by earthquakes of magnitude 4.0 or less in other words, minor earthquakes. An acceleration of 0.1% g or more is perceptible to people. Maryland has a very low chance of experiencing a damaging earthquake in a 50-year period. For moderate exposure times (10-100 years), the expected ground motion associated with earthquakes in this region would be of marginal interest. The difficulty in assigning maximum magnitudes is most acute where no faults are known, where seismicity is low, and where near-maximum earthquakes may not have occurred in historical times. This is true for most of the eastern United States.

Risk Management of Hurricanes and Tornadoes

In recent years, hurricanes have caused record losses for insurance companies and for society as a whole. During the eleven years from 1989 to 1999, U.S. insurers suffered losses from catastrophic hurricanes averaging \$3.0 billion per year. Adjusted for inflation through 1999, as well as population growth and changes in the amount of property per person, those losses averaged \$4.2 billion per year. That figure is almost four times the \$1.1-billion adjusted average annual loss from 1949 to 1988. From 1949 to 1999, catastrophic hurricanes caused insured property losses of \$37.9 billion in the United States, according to ISO's Property Claim Services (PCSTM) unit. When ISO adjusts that figure for inflation, population growth, and changes in real per capita tangible wealth — the amount of property per person — insured losses from catastrophic hurricanes during those 51 years total \$87.8 billion. Of that amount, \$45.7 billion — more than half — occurred in the eleven years from 1989 to 1999. Taking into account inflation, population growth, and changes in wealth, three of the five most costly hurricanes of the past half century — Hurricanes Andrew, Hugo, and Georges — occurred in the 11 years from 1989 to 1999. And ten of the 30 most costly storms took place in the same period. Based on adjusted losses, shows the 30 most destructive storms to hit the United States since 1949.

U.S. property and casualty insurers will pay about \$8 billion to homeowners and businesses for property losses from Hurricanes Katrina and Rita in 2005, an industry group reported. Most of the industry's catastrophic losses stemmed from storms and hurricanes, Homeowners, businesses and auto owners have made numerous so far from major catastrophes.

In the aftermath of hurricanes Katrina and Rita, many people have been displaced with their lives left in an uncertain condition. These victims have often

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had many of their possessions destroyed or lost and must rely on their insurance policies to compensate them for their losses. Even the most responsible citizens were left ill-prepared for the devastation brought on by Katrina and Rita.

During a hurricane, homes, businesses, public buildings, and infrastructure may be damaged or destroyed by high winds and high waves. Debris can break windows and doors, allowing high winds and rain inside the home. Roads and bridges can be washed away by flash flooding, or can be blocked by debris. In extreme storms (such as Hurricane Andrew), the force of the wind alone can cause tremendous devastation, as trees and power lines topple and weak elements of homes and buildings fail. And these losses are not limited to the coastline -- they can extend hundreds of miles inland, under the right conditions. Fortunately, there are a variety of measures that can be taken -- both at the individual and community levels -- to reduce your vulnerability to hurricane hazards. Simple construction measures, such as the use of storm shutters over exposed glass, and the addition of hurricane straps to hold the roof of a structure to its walls and foundation, have proven highly effective in lowering damages when hurricanes strike. In addition, more complex mitigation measures can be pursued to further reduce a property's susceptibility. For example, coastal homes and businesses can be elevated to permit coastal storm surge to pass under living and working spaces.

Communities can further reduce their vulnerability to hurricanes through the adoption and enforcement of wind- and flood-resistant building codes. Sound land-use planning can also ensure that structures are not built in the highest hazard areas. Several times in the last decade, the press has warned of huge approaching hurricanes — each billed as a “storm of the century.” Some of those, including Hurricane Floyd in 1999, proved less severe than anticipated. But the historical record does show some increase in hurricane activity since the late 1980s, after twenty years of relative calm. From 1990 to 1999, six “intense” (category 3 or higher) Atlantic Basin hurricanes hit the United States. In the 1970s, only four intense storms reached the mainland, and, in the 1980s, five such storms reached the mainland. But the number and intensity of storms and the paths they have taken are only part of the story. Inflation, demographic trends, and increases in per-capita wealth have also caused hurricane losses to rise. More and more people are moving into coastal areas subject to hurricanes. Those people are building more houses and other structures. And the properties are worth more than in the past, both because of inflation and because many properties are more elaborate. Although tornadoes occur in

many parts of the world, these destructive forces of nature are found most frequently in the United States, east of the Rocky Mountains during the spring and summer months. In an average year, 800 tornadoes are reported nationwide, resulting in 80 deaths and over 1,500 injuries. A tornado is defined as a violently rotating column of air extending from a thunderstorm to the ground. The most violent tornadoes are capable of tremendous destruction with wind speeds of 250 mph or more. Damage paths can be in excess of one mile wide and 50 miles long. Once a tornado in Broken Bow, Oklahoma, carried a motel sign 30 miles and dropped it in Arkansas.

Risk and Terrorism

Some large commercial insureds are having difficulty getting sufficient terrorism coverage from the normal insurance market. Besides the high rate problem, there appears to be difficulty for very large commercial risks in getting terrorism coverage in amounts similar to the levels enjoyed in previous years. The individual risk appears to be able to get full coverage with only modest price increases forecast for 2002 (in the 4 to 6% range). These modest increases highlight the lack of impact that the terrorist attacks had on personal lines of insurance. Nonetheless, insurers have petitioned the National Association of Insurance Commissioners to allow them to exclude terror coverage for personal lines of insurance. CFA has urged the NAIC to disapprove this request. Consistent with a classic cycle turn, small commercial accounts are seeing much higher increases (in the 15% to 25% range). Terrorism coverage for smaller commercial accounts has been excluded if insured losses from a terrorist attack exceed \$25 million. The coverage can be bought back at a price that is manageable for most small businesses.

Mid-size businesses are also seeing high price increases (in the 25% to 35% range), also with the terrorism cover excluded. The cover can be frequently bought back at a price that is manageable. Very large risks are seeing the largest price rises (+30% to + 40%) and having the hardest time finding the usual terrorism insurance coverage. It should be noted, however, that even some of the businesses that are most at risk of future terrorist acts—such as airlines--have been able to procure liability insurance coverage. Fortunately, these large and sophisticated accounts have a wide array of alternatives to normal insurance, including self-insurance, layering of coverage through the use of many insurance companies, use of captive insurance companies, the non-standard, off-shore market and even risk securitization.

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Commercial insureds generally appear to be getting loans without terrorism coverage. According to an article in the January 7, 2002, edition of American Banker, there is little if any problem with loans in the current market for terrorism insurance. No federal bank regulator has issued any guidance on the terrorism insurance issue, since they have seen no solvency problems developing from any real or perceived lack of coverage. Gouging usually does occur as the cycle turns. The evidence is very strong that what we are experiencing is a classic underwriting cycle turn into a “hard,” from a prolonged “soft,” market. **According to the National Association of Insurance Commissioners, “...underwriting cycles may be caused by some or all of the following factors:**

- **adverse loss shocks;**
- **supracompetitive prices;**
- **changes in interest rates;**
- **underpricing in soft markets.”**

Prior to September 11th, the industry had been in a soft market since the late 1980's. The usual six to ten year economic cycle had been expanded by the amazing stock market of the 1990s. No matter how much they cut their rates, the insurers wound up with a great year when investing the float on the premium in this amazing market (the “float” occurs during the time between when premiums are paid into the insurer and losses paid out by the insurer. Further, interest rates were relatively high in recent years as the Fed focused on inflation. But, in the last two years, the market turned with a vengeance and the Fed cut interest rates again and again. Item 2 above had occurred well before September 11th. The low rates, were also apparent. The Insurance Cycle shows the operating profit drop from about 13% of premium in 1997 to about 3.5% of premium in 2000. So, before September 11th, the cycle had turned, rates were rising, and a hard market was developing. An anticipated price jump of 10% to 15% in 2001 was predicted by CFA and confirmed by the Insurance Information Institute. September 11th provided that in an achingly painful way. However, the increases are mostly due to the cycle turn. The price increases were sped up by the terrorist attack, collapsing two years of anticipated increases into a few months, but the bulk of the increases are not related to pricing for terrorism, per se. This is a classic economic cycle. The question we hear a lot of debate about is how long the hard market can last.

Risk Management of Commercial Farming Liabilities

Farm land should be a satisfying investment. Since decisions must be constantly made concerning the farm's management, this often poses problems for the absentee owner. A sound solution to those problems is a dependable farm management team with a proven plan to provide increased income for the owner and to preserve the farm's resources. There is a six-point plan which involves business organization, scientific knowledge, and farming know-how. This system is more than simply arranging leases. It's a total approach to the business of managing a farm operation.

The proliferation of crop-insurance products, and the changing nature of the multiple peril programs present significant challenges for crop insurance agents. Remaining current is critical and increasingly difficult to do. Moreover, being able to effectively explain all aspects of available products to potential insureds can appear overwhelming. This article presents some basic educational principles and ideas that, if applied, will enable agents and adjusters to be both better learners and educators. Crop-insurance agents and adjusters are in the position of needing to attend training sessions, schools, and field days, as well as performing huge amounts of self-directed study to stay current and informed regarding the components of the crop insurance program and farm management. Farmers select agents based upon the level of service they receive. Understanding insurance products well enough to be able to demonstrate how each one can be used to compliment a farmer's marketing strategies, and financial plans are a large component of customer service. Moreover, for obvious reasons, astute agents possess a solid understanding of farm management practices and marketing. Remaining current in all of these areas is no small endeavor, and requires agents and adjusters to be effective learners.

Agents and adjusters are also in the unique position of meeting (mostly individually), with large numbers of farmers, all of whom have various levels of understanding, and interest in, crop insurance. Moreover, every one of these farmers has a different learning aptitude and attitude. In fact, the same farmer will have different motivations and often behave differently at sales time than when settling a loss. To be an effective teacher in these situations is critical to success. While some are more naturally able to teach effectively, teaching is a communication skill that can be acquired.

Basic Crop Risk

Federal crop disaster programs are a thing of the past. Producers are now responsible for providing their own crop disaster programs. These days, if an individual farms, he or she is in the risk management business. The decision is for each farmer to decide for every situation could be a bit different. Good protection is more important than ever. Smart producers throughout the country have been taking advantage of Multi-Peril Crop Insurance to protect their crops from loss due to covered perils. It's not only a wise choice, but with passage of the 1994 Federal Crop Insurance Reform Act, it is a necessity. Congress has shifted the burden of planning for disaster relief from the USDA back to the producer. USDA is now offering incentives to encourage producers to get adequate coverage from private crop insurance programs. Risk results from our inability to predict the future accurately. Farming enterprises face many sources of risk. Crop yields, input costs, commodity prices, and interest rates all vary over time, making economic decisions difficult.

Let's look at Mississippi cotton yield and price data for the years 1992-95. In 1992, the average cotton yield in Mississippi was 761 pounds per acre, and prices were around 53 cents per pound, resulting in an average revenue of \$403 per acre. Prices were slightly higher in 1993, but yields decreased significantly, resulting in an 18% decrease in revenue per acre from the previous year. In 1994, average cotton yields were 806 pounds per acre, and prices were around 72 cents per pound. Average revenue per acre increased 75% from the previous year but in 1995, average yields again decreased significantly, resulting in a 20% decrease in revenue per acre from the previous year. Unfortunately, risk cannot be eliminated. Growers cannot control the weather, or insect infestation, or commodity prices. Yet, while risk cannot be eliminated, it can be **managed**, but only at a cost to the grower.

Farming Operation and Risk Management

Chances are a farmer is already managing some of the risk associated with a farming operation. The farmer may have to purchase irrigation equipment to protect against the risk of crop losses caused by inadequate rainfall or pay a license fee for a genetically engineered crop variety to protect against uncertain pest conditions. The farmer may have diversified into other crops to protect against the risk of low commodity prices because, if cotton prices are low, perhaps corn or soybean prices will be high, or *vice versa*. An individual may have purchased planting or harvesting equipment so that he or she can get into and out of the field before it gets too wet. Another risk-management factor is to have off-farm sources of income to rent or own land that is spread across the

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county or even across several counties. This geographic diversification helps protect against local yield risks such as hail or insects. One learned long ago that it was best not to put all one's farming investment "eggs" into one geographical "basket." Risk management is nothing new for growers. However, some components of the current risk environment in agriculture are new. Federal policy changes have placed most yield and price risk squarely on growers' shoulders.

Risk management is an important part of the business of farming. Insurance plays a major role in managing that risk. Crop Hail Insurance and Multi Peril Crop Insurance (MPCI) are methods by which a farmer can manage the risk to his growing crops. A farmer can use either product alone depending on his risk, or use both together. It may help, to highlight the differences between the two insurances to better understand how they work alone and in concert. Crop Hail Insurance, is a flexible product. Using crop hail insurance, a farmer can insure fields to full value or less than full value, depending on how much risk he wishes to assume. Also, a farmer can insure the fields of his choice. And, different fields can be insured for different amounts. Field values for crop hail insurance are based on the dollars per acre the producer determines will meet his risk requirements. Dollars per-acre coverage and the legal description of his fields determine what his premium will be. Crop hail insurance covers crops for hail, fire and lightning, and transit. Farm Bureau Insurance of Idaho has expanded the transit coverage by endorsement to cover transportation of the crop to its first place of storage at a distance of not more than 50 miles for an amount up to not more than \$2,000. It is important to understand that crop hail insurance is not a "loss of quality" insurance. A crop may be impacted by hail and may still develop to maturity, although at a lesser quality. Crop hail insurance covers the reduction in yield but not the quality. MPCI, on the other hand, may pay a claim for a loss of quality if the claim exceeds, the coverage level elected. Multi Peril Crop Insurance is not as flexible as crop hail insurance, but its coverage is broader. However, there are restrictions. MPCI is a very complex product. MPCI covers a variety of perils including: drought, flood, hail, wind, frost, winterkill, fire and lightning, excessive rain, wildlife, hurricane, tornado, insects, plant disease, and other unavoidable causes.

The lowest coverage levels of MPCI coverage are referred to as "CAT" (catastrophe) policies. Coverage levels are very low, but cover many perils. All CAT policies are based on a basic fee for each crop grown in a county. The same fee is charged, regardless of the difference in value between the different crops. Coverage for all CAT policies is at a 50% coverage level, at 55% of the

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base price for the 1999 crop year. Farmers can "buy-up" purchase increased coverage. Buy-up MPCl can range from 55% to 75% coverage level at up to 100% of the base price. Either policy fulfills the linkage requirement if the producer is involved in any farm programs. Coverage level, price election, crop, and location determine the premium for buy-up coverage. Under MPCl, the farmer must insure the entire crop that he grows in a particular county. Secondly, MPCl does not allow the farmer to insure to full value. The basic insurance begins with 50%, and the farmer can buy up to 75% coverage.

When a claim for a crop loss is adjusted under MPCl, the damaged fields are compared to the farmer's entire production area in that county for that particular crop. Because the loss is calculated as a percentage of the production and because the farmer cannot insure to full value, insurance payments are generally smaller. Additionally, MPCl has a deductible that also impacts the amount of insurance payment. Sometimes the loss is small enough so that it does not meet minimum requirements and there is no payment. Crop hail insurance, on the other hand, calculates the loss based only on the damaged field. Secondly, there is no deductible requirement to be met as in MPCl. Thirdly, a farmer can insure to full value. Therefore, payment for a loss to his crop is likely to be greater. However, for crop hail insurance to cover the loss, it must be a covered peril – hail or fire & lightning. Crop hail insurance can be a compliment to MPCl. The two insurances will work together, because as long as the crop loss is due to a covered peril, crop hail will pay the loss along with MPCl. For example, a hailstorm may totally destroy part of your crop. The amount destroyed may be less than your MPCl deductible. In that case, crop hail coverage would step in and pay the loss. If the loss exceeded the MPCl deductible, then both policies would cover the loss.

The American Farm Bureau Federation founded AFBIS, (American Farm Bureau Insurance Services, Inc.) in 1995 and provides MPCl for the Farm Bureau Insurance Companies who market it. Each product has benefits and restrictions, but together they provide a comprehensive plan for crop risk management. There are several other crop insurance products in addition to crop hail insurance and multi peril crop insurance, all of which have different requirements and coverages.

Beginnings of Crop Risk Management

Beginning with the 1998 crop year, revenue insurance is available for several crops in several different states. Revenue insurance combines yield risk management and price risk management into a single revenue risk

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management tool. The purchaser of a revenue insurance policy is protected against revenue shortfalls below specified levels, regardless of whether the revenue shortfall is caused by low yields, low prices, or both. ***The revenue insurance product is called Crop Revenue Coverage (CRC).*** CRC is similar to buy-up AHP and GRP in that policies must be purchased through private insurance companies but are partly subsidized by the federal government. Optional units are available. AHP yields are calculated in the same manner as for AHP policies. The RMA establishes an expected price based on the pre-planting price of harvest-time futures contracts for the commodity. The grower's expected revenue is the product of the AHP yield and the established expected price. Instead of choosing a coverage level based on expected yield, CRC purchasers choose a coverage level based on their expected revenue. As with AHP, available coverage levels are 50%, 55%, 60%, 65%, 70%, and 75%. A unique feature of CRC is that the dollar amount of insurance protection will increase if the price of the commodity increases in the growing season.

One example of revenue insurance is based on a hypothetical cotton farm, where it can be assumed that the pre-planting price of the December futures contract is equal to the maximum AHP indemnity price of 70 cents per pound. In reality, these two prices may differ slightly. For cotton, the pre-planting price is the average of New York Cotton Exchange closing prices on the December futures contract between January 15 and February 14. Since the AHP yield is 800 pounds per acre, the expected revenue is \$560 per acre (800 pounds per acre x 70 cents per pound). If the grower selects a 65% coverage level, the minimum protection is \$364 per acre (800 pounds per acre x 70 cents per pound x 65%). The protection will be higher if the harvest-time price of the December futures contract is higher than 70 cents per pound. For cotton, the harvest-time price is the average closing price of the December contract for the month of November.

Now suppose that the actual yield is 540 pounds per acre, and the harvest-time price of the December futures contract is 55 cents per pound. The minimum protection of \$364 per acre is in force, since market prices have decreased. The grower's calculated actual revenue is \$297 per acre (540 pounds per acre x 55 cents per pound). The revenue insurance indemnity is \$67 per acre (\$364 per acre -- \$297 per acre). Notice that in this example, a 65% coverage AHP policy would have paid nothing, since the actual yield was above the AHP trigger yield of 520 pounds per acre (800 pounds per acre x 65%). The CRC policy paid an indemnity, because the yield shortfall was further compounded

by a low price. The CRC policy guaranteed the grower a minimum revenue of \$364 per acre (adjusted for basis).

Yield Risk Management

To allow for comparison across the various insurance products presented, the examples that follow are based on a hypothetical cotton enterprise located in the “delta” area of Mississippi. However, these products are available for many different crops in most areas of the state. Consider a non-irrigated delta cotton enterprise with 800 pounds per acre expected yield. The expected price at harvest is 70 cents per pound. Thus, the expected revenue for the farm is \$560 per acre. The grower purchases a crop hail insurance policy from a private insurance agent to protect against the risk of yield losses caused by hail. The policy provides \$500 per acre of protection and has a 10% deductible. Now suppose that one 10-acre spot in a field suffers a 50% yield loss from hail. The first 10% of loss is applied to the deductible. The grower will receive an indemnity on the remaining 40% of loss. The indemnity is \$200 per acre (\$500 per acre x 40%) on 10 acres for a total indemnity of \$2,000. In comparison to the other insurance products described below, the ability to collect an indemnity on a spot loss within an insured field is a unique feature of crop hail insurance.

Methods to Protect From Lost Yield Risk

- Diversification- This can include producing different types of crops, different types of the same crop, or earning income outside of the farm. These practices will protect one if one specific market does not do well.
- **Crop Insurance - This contract transfers the risk to the insurance company once an individual pays a premium for their service. There are several different types of insurance programs:**
 - **The basic Multiple-Peril Crop Insurance (MPCI) program protects the yield in the event of most natural disasters.**
 - Crop Revenue Coverage (CRC) assures that you will earn minimum revenue. It protects against price and yield losses.
 - Group Risk Protection (GRP) is similar to MCPI, but a county average yield, rather than an individual farm average yield, determines yield shortfall.
 - **Crop-Hail Insurance** is offered privately and the premiums are not subsidized. It protects only against hail.
 - **Catastrophic Risk Protection (CAT)** is the lowest level of MCPI coverage, and the premiums are fully subsidized.

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- The Noninsured Assistance Program (NAP) covers those producers that grow crops that are not insurable or live in areas where insurance is not available.

Forward Pricing for Risk Management

Just as there are several insurance products that can be used to manage yield risk, various methods exist for managing price risk. Wheat, feed grain, and oilseed growers often enter into *cash forward contracts* with local purchasers, such as elevators. The contracts obligate the grower to deliver a specified amount of the commodity by a certain date. The contracts also obligate the purchaser to pay the grower a specified price for the commodity. Some growers hedge their crops by selling *futures contracts* on commodity-exchange markets. When the crop is harvested, the grower purchases an equal number of futures contracts offsetting the position in the futures market. Hedging allows a grower to “lock in” a price that will change only with changes in “basis.” Basis is the difference between the futures market price and the local cash price. Other growers prefer to establish a minimum price by purchasing *put options* on future contracts. Unlike cash forward contracting or hedging, purchasing *put options* does not “lock in” a price. It effectively puts a floor under the price and allows growers to take advantage of potentially higher prices.

It is important to consider price risk-management decisions in conjunction with yield risk management decisions. If one cannot fulfill a cash forward contract obligation because of a low yield, he or she must purchase enough of the commodity to make delivery on the contract. If the contract price is higher than the cash price at delivery, the farmer can essentially purchase locally in the cash market, deliver on the contract, and keep the differences. If, however, the cash price is higher than the contract price, the difference in the contract price will be lost. If the crop were insured, one could use the proceeds from the insurance indemnity to purchase the high-priced commodity needed to satisfy the cash forward contract.

Mitigation and Insurance to Manage Catastrophic Risks

There are certain specific risk mitigation measures (RMMs) which could reduce losses from hurricanes and earthquakes as well as improve the solvency position of insurers who provide coverage against these hazards. We first explore why relatively few individuals adopt cost-effective RMMs by reporting on the results of empirical studies and controlled laboratory studies. We then investigate the impact that an RMM has on both the expected losses and those

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from a worst-case scenario in two model cities – Oakland (an earthquake-prone area) and Miami/Dade county (a hurricane-prone area), which were constructed respectively with the assistance of two modeling firms – Risk Management Solutions and Applied Insurance Research. There are three programs for forging a meaningful public-private sector partnership: well-enforced building codes, insurance premium reductions linked with long-term loans, and lower deductibles on insurance policies tied to mitigation. There is also research available to us on four issues for future research on linking mitigation with insurance: regulatory issues facing insurers, uncertainty issues in estimating risk, tradeoffs between reinsurance and mitigation, and the impact of mitigation on capital market instruments.

In December 1995, the Federal Emergency Management Agency (FEMA) introduced a national Mitigation Strategy to increase public awareness of natural-hazard risks and to reduce significantly the risk of loss of life, injury, and economic losses from natural hazards. FEMA's strategy was also designed to strengthen the partnership between the public and private sectors in ensuring safer communities. An RMM is an action that reduces or eliminates the losses to individuals and to their property from natural hazards. It normally involves an upfront investment cost in exchange for a stream of benefits accruing over time, in the form of reduced expected losses from natural disasters. For example, if a property owner were to bolt the structure to its foundation, it might cost the property owner \$1,500. Should a severe earthquake occur in the vicinity of the property, the damage might be reduced by \$20,000 if the house is prevented from toppling off its foundation. These mitigation benefits would continue to accrue over the lifetime of the property.

Of special interest for economics and public policy are cost-effective RMMs. These are any mitigation measures for which the discounted expected benefits over the life of the property are greater than the upfront investment expenses and other costs associated with the measure. In theory all of the interested parties concerned with natural disaster losses should view such a measure favorably. The property owner should see this as an attractive investment which will increase the value of his residence or business. The insurer knows that losses will be reduced should a disaster strike the area. The contractor and developer should find it easier to sell a property which is better designed against hazards, even if it costs more than one which is relatively unsafe. Public sector agencies at the state, local, and federal levels should celebrate the lower need for disaster assistance due to the reduced losses from future disasters. The reality of the situation is quite different. Few property owners

voluntarily adopt mitigation measures, nor do insurers provide incentives for these investments through premium reductions reflecting the decreased losses associated with the property. For years, insurance companies have offered premium credits or lower insurance rates to customers who take steps to prevent fire, liability, and other losses. Today, insurers are also developing and implementing programs designed to reward customers who mitigate hurricane losses. When a major hurricane comes ashore in a populated area, some property loss is inevitable. But sturdy construction of buildings and the addition of protective devices, such as storm shutters, can reduce losses. And strong building codes — rigorously enforced — should prevent much of the economic dislocation and human suffering that hurricanes typically bring to a community.

Lower Rates for Sturdy Construction

For more than 200 years, insurers have encouraged sound construction practices by offering lower rates for properties less susceptible to damage. Today, ISO's programs for personal and commercial property recognize that different kinds of construction — wood frame, masonry, and others — differ in their susceptibility to windstorm damage. In addition, ISO's commercial property program recognizes that other factors — building height, reinforcement of masonry walls, strength of steel frames — also affect the ability of buildings to resist wind. ISO publishes information about loss costs for each type of structure. Insurers can use such information to help in determining fair, actuarially sound rates. Such rates reward customers whose properties have loss-resistant characteristics.

Credits for Storm Shutters

Storm shutters or other protective devices for doors, windows, skylights, and vents can also mitigate hurricane losses. Insurers have begun offering credits that reduce premiums for customers who install such devices. For example, following legislative action in Florida and New York, ISO has updated its insurance programs in those states to include credits for storm shutters. In Florida, the credits vary by territory and type of policy and apply to policies that cover the perils of windstorm and hail. To qualify for the credits, property owners must install storm shutters, hurricane-resistant glazing material, or acceptable alternatives that protect all openings in external walls and roofs. The devices must be able to withstand a specified wind pressure. Property owners can qualify for additional credits by installing devices that can also meet specified standards for withstanding impact from wind-driven debris. Homeowners across the state of New York can qualify for credits by installing

storm shutters or hurricane-resistant laminated glass meeting specified standards for withstanding wind pressure and the impact of wind-driven debris.

The Building Code Effectiveness Grading Schedule

After Hurricane Andrew, photos taken in several parts of south Florida showed homes on one side of a street completely destroyed, while homes on the other side were still standing. Later studies determined that, in many cases, the construction of destroyed buildings was well below the standard required by the building code in effect. Studies also found that inadequate enforcement of building codes may have contributed to the poor quality of construction. Such discoveries led to an insurance-industry initiative to encourage sound construction — the Building Code Effectiveness Grading Schedule (BCEGS). Developed by ISO, in cooperation with the Insurance Institute for Property Loss Reduction (now the Institute for Business and Home Safety), local building officials, insurers, and the three major organizations responsible for developing model building codes, BCEGS encourages communities to adopt stringent codes and to enforce them rigorously. The concept is simple: buildings in municipalities with effective, well-enforced codes should have better loss experience, and insurance rates can reflect that. The prospect of reducing catastrophe-related damage and lowering insurance costs provides an economic incentive for communities to strengthen building codes and their enforcement — especially as the codes relate to windstorm and earthquake damage.

Under BCEGS, ISO assesses the building codes in effect in a particular community, as well as how the community enforces its building codes. ISO classifies the community on a scale of 1 to 10, with 1 representing exemplary enforcement of a model code and 10 indicating no recognizable code enforcement. ISO groups the 10 BCEGS grades into bands and assigns rating credits to each band. Under ISO's program, newly constructed (or substantially rebuilt) properties in communities in the first band (grades 1 to 3) are eligible for the largest credits. Properties in communities in the second and third bands (grades 4 to 7 and 8 to 9) are eligible for smaller credits. And properties in communities with a grade of 10 do not qualify for credits. In general, under ISO's BCEGS program, credits are available only for buildings constructed (or substantially rebuilt) during or after the year when a community receives its grade. However, the program has a provision allowing certification of individual older buildings, thus making them eligible for credits. Credits vary by state, rating territory, type of policy, and coverage. The amount of the credit varies by state or territory, because the risk of hurricanes and earthquakes varies by

location. To date, ISO has evaluated almost 4,600 communities around the country, and insurance regulators in 48 states have approved premium credits for communities with good BCEGS grades. The BCEGS program has the potential, over time, to help improve the quality of buildings in communities around the country. That, in turn, could reduce catastrophe losses — both insured and uninsured — and human suffering.

Costs and Benefits of Natural Hazard Mitigation

Perhaps the most cost-effective way to reduce damages due to natural hazards is to incorporate mitigation measures into site planning and the design and construction of buildings; this can often be accomplished at little or no incremental cost. For most hazards, the mitigation measures can be included in local land use plans, land development and zoning ordinances, or the national building codes adopted at the State or local levels. The National Flood Insurance Program (NFIP) is illustrative of the savings that can be achieved through these mitigation measures. NFIP was established by the National Flood Insurance Act of 1968, and was strengthened by the Flood Disaster Protection Act of 1973. The key component of the program is the requirement that the NFIP offer flood insurance only in those communities that adopt and enforce floodplain management ordinances that meet minimum criteria established by FEMA.

Also critical to the success of the NFIP has been the \$1 billion undertaking to identify and map the nation's floodplains. This mapping effort has helped increase public awareness of the flood hazard, and has provided the data necessary to actuarially rate flood insurance and develop community floodplain management programs. Over 18,700 communities have chosen to adopt floodplain management ordinances and participate in the program. Nearly all communities in the nation with significant flood hazards are participating in the program. The floodplain management ordinances require that residential buildings be elevated to or above the base flood elevation (BFE), which is defined as the elevation of the flood that has a 1% chance of occurring in any given year (also called the 100-year flood). This elevation is determined through hydrologic and hydraulic modeling. Additional requirements prevent the obstruction of the floodway portion of the floodplain and provide guidance to buildings exposed to hazards, such as wave impact in coastal areas. Buildings that are built or substantially improved after the date of a community's first Flood Insurance Rate Map (FIRM) are referred to as post-FIRM, and are charged actuarially sound. The effectiveness of NFIP-compliant community floodplain management regulations and ordinances in reducing flood damages

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can be directly measured by comparing the flood insurance claims of buildings constructed according to those standards with the claims of buildings constructed prior to the adoption of the requirements by the community. The NFIP is nearly 30 years old and, therefore, adequate claims data for the comparison are accessible by computer. To date, the data represents over 804,189 losses closed and 620,920 losses paid since 1978.

The effectiveness of NFIP-compliant community floodplain management regulations and ordinances in reducing flood damages can be directly measured by comparing the flood insurance claims of buildings constructed according to those standards with the claims of buildings constructed prior to the adoption of the requirements by the community. The NFIP is nearly 30 years old and therefore adequate claims data for the comparison are accessible by computer. To date, the data represents over 804,189 losses closed and 620,920 losses paid since 1978. The effectiveness of NFIP floodplain management regulations in reducing flood damages can also be demonstrated by comparing the cumulative loss experience of new buildings with buildings that pre-date those regulations. Between 1978 and the end of 1995, the actuarially-rated flood insurance policies in special flood hazard areas generated a surplus of \$169 million for the National Flood Insurance Fund after claims and other expenses of the program were paid. By contrast, subsidized policies on buildings in the special flood hazard area yielded a \$1.5 billion deficit. This occurred even though the premiums on policies for the actuarially rated buildings are, on the average, less expensive than policies on the subsidized buildings.

Another indicator of the NFIP's success in reducing flood damages is the change in the distribution of flood insurance policies that are post-FIRM as compared to those that are pre-FIRM. One of the expectations of the NFIP was that over time, the existing stock of floodprone buildings would be upgraded or replaced by new buildings that were protected from flood damages. As this occurred, the subsidy on insurance for existing buildings would shrink and eventually disappear, and the program would become fully risk-based. The change in distribution of NFIP policies over time indicates that substantial progress has been made in reaching the objective of reducing the stock of floodprone buildings. At the beginning of 1978, nearly 78% of the policies were for pre-FIRM buildings located in special flood hazard areas. By the end of 1995, subsidized policies on these pre-FIRM buildings constituted only 34% of the policy base.

Types of Risk

In the broad view of risk management, fires, injuries, earthquakes, liability claims, and other sudden, destructive events are classified as “casualty risks.” The categories of loss exposures within this broader interpretation of “accidental loss” include those arising from Casualty Risks; Liquidity Risks; Market Risks; Political Risks; and Technological Risks. Those who would limit risk management have grown out of safety management and insurance, that is, out of efforts to prevent or refinance recovery from sudden, damaging events. Both safety management and insurance concentrate solely on pure-risk situations that offer no opportunities for profit or other gain. Those who would eliminate all distinctions between pure and speculative risks assert that a risk management professional’s fundamental concern should be an organization’s overall capacity to cope with losses, regardless of whether those losses stem from such casualties as fires and lawsuits or from poor business decisions in managing speculative risks. Either a severe flood or an unwise decision to market an unpopular product can ruin an organization. Comprehensive risk management should pay equal attention to managing both types of loss exposures.

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

Risk Management 101

To go to the basics of risk management, let’s understand that insurance is just one element -- probably the final and most expensive element -- of a total risk-management program. ***Eliminating the risk; spreading, minimizing, or diluting the risk; passing the risk off to someone else*** (this is what larger companies try to do to subcontractors); containing the risk; and, finally, passing off the risk to a professional risk bearer, the insurance company, are the basics of risk management.

Spreading the Risk

If an individual is handling aircraft, it is a good idea not to bunch them up together on the ramp. If shipping expensive parts or equipment, split up the shipment and do not send it all on the same load. The chief operating officers of a company (critical personnel) could consider never flying on the same flight or riding in the same vehicle. Although not as much fun as traveling together, a mother and father off for that weekend away from the kids could take separate flights. The backup computer tapes should be stored off premises and away from the computer. Spreading the risk just makes common sense. In business, such basic management practice can save big dollars by allowing lower insurance limits. It is amazing, however, that few managers and business owners give this common-sense business tool much thought.

Passing the Risk Off to Someone Else

This is the area that seems to have caught on over the past few years. In fact, corporate lawyers and risk managers lay awake nights trying to include indemnification agreements, hold harmless clauses, waivers of subrogation, legal reimbursement clauses, and a host of other things in the contracts they offer to smaller businesses working with their company. The goal is to pass the risk off to their unsuspecting subcontractors and suppliers. This is the contest we see most often between the airlines and businesses that contract with them. In most cases, the subcontractor signs the contract without giving it a second thought. In so doing, he puts his company at risk for things over which it has no control. In addition, waiving rights by contract without the approval of an underwriter could void coverage under an insurance policy.

Eliminating the Risk

If it is possible to identify an exposure in a business that could result in an accident for which the owner would be held financially responsible, he or she can simply discontinue the practice to avoid any further exposure to loss or lawsuit. This certainly sounds easy, but how can one continue in business and eliminate the basic business practices of a company's mission? These are little areas that, if analyzed, have proven to be unprofitable or unproductive. If there are areas of your business or aviation activities that are a bother, they often get pushed to the side to be dealt with at some later time, which we all know never comes. Every business has a sector that it would be better off without. Good risk-management practices would dictate the immediate elimination of any part of your business that is not an asset to the primary mission or a viable growth area. In so doing, you would eliminate the risk that sector poses.

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In some cases, a change in business style can eliminate risk. If there is a need for an inventory of parts, arrange with a supplier for “just-in-time delivery.” This minimizes the amount of capital required to maintain inventory and the need for those high limits of property insurance that are required for the protection from fire, windstorm or theft. The airlines routinely carry extremely high liability limits under a very broad airline liability policy form of coverage. Small regional airlines usually carry liability limits of \$100,000,000 or \$200,000,000, ranging up to several billion dollars for the major carriers. In looking at an airline contract, it is not unusual to see them require a subcontractor to carry liability limits of \$100,000,000, or more. The airline risk managers do not seem to understand that what is relatively inexpensive to the airline could be very expensive for the subcontractor. For the airline, broad liability coverage is included in the airline policy, but the subcontractor must purchase product liability coverage on a much more expensive platform. In fact, the insurance cost to cover most airline contracts that we have seen could be so high, the job could become unprofitable to the subcontractor.

Examining Alternative Risk Management Techniques

Risk management involves either stopping losses from happening or paying for those losses that inevitable do occur. Risk Control Techniques include risk management designed to minimize the frequency or severity of accidental losses or to make losses more predictable. *Exposure avoidance* eliminates entirely any possibility of loss. It is achieved either by abandoning or never undertaking an activity or an asset. *Loss prevention* aims to reduce the frequency or the likelihood of a particular loss. *Loss reduction* aims to lower the severity of a particular loss. *Segregation of loss exposures* involves arranging an organization’s activities and resources so that no single event can cause simultaneous losses to all of them. *Duplication*, on the other hand, implies reliance on “back-up” -- spares or duplicates used only if primary assets or activities suffer loss.

Chapter 13

Commercial Insurance Law and Liability

The insurance industry is a very old business. It may date to 4000 B.C., originating in Babylon. Initially, insurance was coupled with trade and commerce, especially maritime cargoes. Bottomry, a method of shifting the burden of risk by pledging a marine vessel as security, was used. Bottomry contracts were formed by drawing articles of agreement and depositing these contracts with a sort of money changer. Some of the provisions incorporated into bottomry contracts are still a part of our modern maritime insurance policies. The ancient Greeks and Romans practiced bottomry, and it was common during the Middle Ages. Later, the maritime nations of Europe, the Dutch and the British, who were the major commercial carriers of the world in the seventeenth century, became the primary insurers. During this time in England, a system of legal justice, known as common law, evolved. Unlike the civil law system, common law is not a written code. It is based on written judicial decisions that constitute precedent. The common law system spread through English colonization and conquest.

Defining the Perimeter of Insurance Law

Insurance law distinguishes between what activities and practices are permitted by law and which of these are prohibited. The evolution of insurance and the contemporary development of insurance law have been growing and changing for more than 300 years. This adaptation is an ongoing and continual process. The concept and theory of insurance is a subject which is open to a wide variety of definitions. There is really no single definition which suits all circumstances and all expectations. Most of the technical definitions which deal with the subject are drawn from the courts. Consequently, they have a limited purpose. The concept of insurance and the law will be considered in a broader context. From the legal perspective, insurance is “a contract whereby, for a stipulated consideration, one party undertakes to compensate the other for a loss on a specified subject by specified perils”. Insurance deals with contracts which relate to the transference of a risk from one party to another. This distinct core of transactions, which are subject to a particular body of law, is known as insurance law. Essentially, insurance law is a system of rules of conduct for those operating within the business of

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insurance. It includes rights and privileges which are formally recognized by our society and mandated by our federal or state governments.

Civil Law and Criminal Law

Another way to view the law is to distinguish between civil law and criminal law. Under civil law, the individual initiates the legal proceedings and seeks redress; under criminal law, the government does so. ***Civil law protects the rights of individuals and governments and provides remedies for breach or duties.*** When legally protected rights are violated, the person or government whose rights have been violated may bring an action for damages directly against the wrongdoer. Criminal law deals with acts that society deems to be so harmful to the public welfare that the government takes responsibility for prosecuting and punishing the perpetrators. Under criminal law, society prescribes a standard of conduct to which all people must adhere, and the offender is prosecuted in the name of society. ***In a civil action, the injured party generally requests payment of damages as reimbursement for the harm done.*** The court may also be requested to direct the wrongdoer to perform or to stop performing in a certain manner. When a violation of criminal law is involved, the penalty is dictated by a statute or ordinance: fine, imprisonment, or both are typical penalties. Liability insurance is principally concerned with covering civil liability. Insurance of criminal liability is prohibited by the law. The same conduct can constitute both a civil wrong and a crime. One person striking another is considered both a civil wrong, for which money damages may be awarded, and a criminal act, which may result in prosecution by the government in an entirely separate trial. Civil law can be further divided into contract law and law relating to torts.

Contract Law

Contract law governs the “private law” created between two parties when they enter a legal contract. Breach of the contract can also lead to a lawsuit, but is generally not covered by liability insurance. The greatest difference between insurance and a contract by which one party merely agrees to assume the liability of another for some consideration is the significant number of members among whom the risk is distributed. Under a plan of insurance, there are a significant number of members among whom the risk is distributed. In a mere contract of assuming liability for another for some consideration, this significant number of members does not exist. The concept of sharing risk must be present in all insurance contracts. However, not all contracts which have the distribution of risk element among a sizable group of participants are considered to be insurance. The concept of sharing risk is used for other

purposes as well. Examples of these are an attorney client relationship and contracts of warranty. In these examples, there is shared risk. However, there is no insurance involved because these contracts are not subject to the statutory and common law rules which relate to insurance. The phrase “in the business of insurance” is often heard within the insurance industry. In the examples of the attorney client relationship and contracts of warranty, none of the parties is primarily engaged in the business of insurance. This element is essential in order for an insurance contract to exist.

Tort Law

A tort is a wrong against another person. However, the law relating to torts addresses wrongs that are neither criminal acts nor breaches of contract. Tort law gives rise to most of the liability exposures addressed by commercial general liability insurance. The rights of individuals protected by tort law are the subject of much of common law. These legally protected rights originally included the rights to security of person, property, and reputation. Over the years, the changes in the common law and the enactment of statutes have established other rights of individuals such as the right of privacy. Any wrongful invasion of such legally protected rights entitles the injured party to bring an action against the wrongdoer for damages. Where there is a right, there is also a duty on the part of others to respect that right and to refrain from any act or omission that will impair or damage that right. When there is a wrongful invasion of an individual’s rights, tort law provides three possible standards for a finding of legal liability. A tort may be intentional or it may be the result of negligence.

Intentional Torts

If a person foresees the reasonable consequences of his or her action, the act is an intentional tort. The act does not necessarily have to be performed with malicious or hostile intent. If the result of a voluntary action is injury or damage that should have been foreseen, an intentional tort has occurred.

Absolute Liability

Absolute liability is imposed by law without any regard to negligence or intent. It is used in cases where an activity or thing is inherently dangerous. An example of absolute liability is a situation regarding use of dynamite. Any damage caused by blasting usually imposes absolute liability on the blaster. Similar to absolute liability is strict liability, which holds the seller of goods liable for injury arising out of the goods if they were in a defective condition that was unreasonably dangerous to the consumer. In such instances, the injured consumer is not required to show that the defect resulted from the seller’s negligence.

Negligence

The tort of negligence is based on four elements. The four elements are a duty that is owed to another person, a breach of that duty, the occurrence of injury or damage, and the breach of duty caused the injury or damage in an unbroken chain of events. Negligence occurs when a person exposes others to an unreasonable risk of harm because of failure to exercise the required care.

Introduction to Liability

American businesses and their insurers are under tremendous pressure from a wide range of new and existing liability challenges. From Enron to asbestos and mold to medical malpractice, the cost of insuring corporate America against a rising tide of lawsuits is rising. This presentation provides a comprehensive overview of some of the major liability cost drivers in the United States today.

Legal Concepts of Liability

A business may be exposed to legal liability because of its premises and operations, its use of motor vehicles, or other exposures. Although a business can obtain liability policies covering these exposures, the policies are subject to limits of insurance that ordinarily do not exceed \$500,000 to \$1 million. Policies that provide this first “layer” of coverage are generally referred to as primary policies.

Types of Liability Damages

The American civil liability system costs twice as much as that of other industrialized nations. U.S. consumers pay for the high cost of going to court directly in higher liability insurance premiums, because liability insurance rates reflect what insurance companies pay out for their policyholders' legal defense and any judgments against them. And they pay indirectly in higher prices for goods and services, since businesses pass on to consumers the expenses they incur in protecting themselves against lawsuits, including the cost of commercial liability insurance. Beginning in the 1980s, in an effort to reduce litigation costs, business groups and others mounted a campaign to reform tort law. Tort law is the basis for the U.S. liability system. Most reforms have taken place on the state level and during the last decade, all but a handful of states passed significant tort law reforms.

The American civil liability system cost \$205 billion in 2001, a rise of 14.3% from the previous year, the highest single percentage increase in 15 years. Tort costs accounted for over 2% of the nation's gross domestic product, compared with 1.4% in 1970, and 0.6% in 1950, according to the latest data from an

actuarial consulting firm. Looking at the data another way, tort costs equaled \$721 per U.S. citizen in 2001, compared with \$12 in 1950. The tort system is highly inefficient, returning only 46 cents on the dollar to claimants. Breaking down costs, it has been found that an estimated 22 cents go to litigants for their actual (economic) losses and 24 cents to compensate for pain and suffering. Of the remaining 54 cents, 19 cents pays for claimants' lawyers, 14 cents for defense costs and 21 cents for administrative costs.

Punitive Damages

Over the years, the U.S. Supreme Court has issued rulings designed to guide lower courts in their imposition of punitive damages. The business community has long maintained that there is currently little relationship between compensatory damages, which compensate for actual damages, and punitive damages, which are imposed to serve as a deterrent to reprehensible corporate behavior. In the latest example of this trend to provide a greater measure of predictability, on April 7, the nation's highest court overturned a \$145 million punitive damage award that a Utah jury ordered State Farm Insurance Cos. to pay in a lawsuit filed by two auto insurance policyholders. In 1996 the Court struck down a \$2 million punitive damages award in a case against the auto maker BMW on the grounds that it was so grossly excessive as to violate the 14th Amendment Due Process Clause. In the most recent case, *State Farm v. Campbell*, where the punitive damages award was 145 times the compensatory damage verdict, the court ruled that juries should generally not be allowed to consider a defendant's wealth when setting a punitive damage award. This was the first time that the high court had addressed this common but controversial practice directly in a majority opinion. The court also characterized the ratio of the compensatory damages to the punitive damages as unreasonable, and said that a state does not have a legitimate concern in imposing punitive damages to punish a defendant for unlawful acts committed outside of its jurisdiction, i.e., in another state.

Securities Liability

In 1995, Congress passed the Private Securities Litigation Reform Act, a reaction to the growing number of shareholder lawsuits filed against corporations and their directors and officers over misleading balance sheet information. Many of these suits were seen as frivolous abuses of the system, filed by professional plaintiffs. The law created certain protections against lawsuits over company financial statements, established a procedure for naming lead plaintiffs, limited lawyers' fees, and established proportional liability for defendants who do not intentionally violate securities laws, among other

things. Shortly after the law took effect, there was a drop in overall cases. However, in subsequent years, there was a shift in venue from federal to state court, and a shift in the types of securities lawsuits being filed with the result that as many securities class actions are being filed now as before the Act's passage.

In March 2003, the Stanford Law School and Cornerstone Research, a Boston based financial and legal research firm, released a study showing that there were 224 federal securities class action lawsuits filed by shareholders in 2002, up 31% from the previous year. The increase is attributed to a number of factors including the record number of firms restating earnings last year; a continuing weak stock market that has caused huge drops in share prices; a broadening of the legal targets of such suits to include financial services, telecommunications, energy and consumer goods firms; and a drop in market capitalization. Cornerstone Research also reports that the payments to settle class action securities lawsuits rose to \$2.4 billion in 2002, a 50% increase compared with settlement amounts paid the previous year.

New Areas of Liability

Among the five areas targeted, joint and several liability rules have been subject to the most legislative activity. Joint and several liability is a rule under which defendants only minimally responsible for injury may be required to pay the full amount of the damages. Reform measures may completely abolish this rule or modify it by limiting its application. For example, many states now forbid application of the rule to noneconomic damages, such as pain and suffering. The measure may apply to all tort actions or only one specific type such as medical malpractice, or may exclude one or more key areas in which joint and several liability is frequently applied, such as auto, pollution, and medical malpractice cases. Two thirds of states modified the rule. The collateral source rule refers to a rule of evidence that bars the introduction of any information indicating a person has been compensated or reimbursed by any source other than the defendant. Approaches taken by modifying legislation include: permitting consideration of compensation or payments received from some or all collateral sources; and requiring that any award be offset by the amount of collateral source payments. About one third of states approved laws that would significantly change this rule.

The concept of capping noneconomic damages was endorsed by a dozen more states. In some states, laws now limit the liability of defendants in liability suits in one of several ways: by limiting recovery of a particular type of damages

(usually noneconomic damages, such as pain and suffering); by limiting the total amount of damages recoverable; or by placing an absolute cap on liability as in wrongful death cases. Reform measures may apply to all tort suits or only to specific types, such as medical malpractice. Originally designed to punish defendants who showed a wanton disregard for safety, punitive damage awards no longer are limited to such cases and may substantially exceed the amount of compensatory damages awarded. More than half the states have passed laws that limited the imposition of such damages. Reform measures may require punitive damage awards to be paid to the state; set limits on the amount that may be awarded in total or relative to compensatory damages; limit the type of case in which they may be awarded; or require hearings to establish a case for punitive damages, before they may be sought in court. Some states have never had provisions for punitive damages so obviously will not enact reforms in this area. Product liability determines who may sue and who may be sued for damages when a product injures someone. The lack of clear and uniform laws governing manufacturers' liability can result in lawsuits against all firms involved in the chain of distribution. Experts cite state-of-the-art-defense, where the manufacturer made the safest product possible at the time, compliance with government standards, and adequate safety warning as means of limiting manufacturers' liability.

Liability Insurance and excess Casualty Markets

American businesses and their insurers are under tremendous pressure from a wide range of new and existing liability challenges. From Enron to asbestos and mold to medical malpractice, the cost of insuring corporate America against a rising tide of lawsuits is rising. This presentation provides a comprehensive overview of some of the major liability cost drivers in the United States today.

Insurance Law Concepts

Numerous courts have concluded an insurer is obligated to act in good faith with respect to the interests of the insured. The insurer may be liable for the consequences of a failure to act in good faith when discharging its obligations regarding settlements. Further, not only must the insurer act in good faith, but it must also exercise due care with respect to the settlement of claims by third parties. In some states, a liability insurer may be liable to its insured for damages exceeding a judgment if the insurer does not exercise good faith in dealing with a third-party claim. The insurer may also be liable to its insured for failure to settle a third-party claim against an insured. Another significant factor involved in considering an insurer's conduct with respect to settlement is how much consideration the insurer must give to the insured's interests, relative to

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its own interests. First, it is a well-established fact that the insurer does not have to put the interests of the insured ahead of its own. However, the prevailing view among the courts today is that an insurer must give equal consideration to the insured's interests when making decisions concerning settlement or litigation of a claim. Unfortunately, this view may be difficult to understand because the decision not to settle seems to place the interests of one over the other. Perhaps the best illustration of this concept is the court which stated: In deciding whether to settle a claim against an insured, an insurer must view the opportunity for a settlement the same as it would if there were no limit of liability applicable to the insured's coverage.

Indemnity

One of the basic characteristics of any insurance system is the use of contracts. These contracts are in the form of an agreement for the transfer of a loss by obligating the insurer to bestow an offsetting benefit to the insured. The terms transfer of loss and offsetting benefit are both commonly used to indicate that the amount of insurance benefits paid when a loss is sustained must not exceed the economic measure of the loss. Indemnity is a collateral contract or assurance by which one person secures another against an anticipated loss. Indemnity signifies compensation has been given to an insured in order to make him whole again and relieve him from his loss.

Most types of insurance are designed to provide no more than reimbursement for an insured. It is a fundamental principle of insurance that opportunities for net gain to an insured, through the receipt of insurance proceeds exceeding his loss, should be considered adverse to the public interest. Insurance arrangements are structured to provide funds to offset a loss, either wholly or partly. The payments made by the insurer are generally limited to an amount not greater than what is required to restore the insured to a condition "relatively equivalent" to what existed before the loss. This concept that insurance contracts should confer no benefit greater in value than the loss suffered is known as the principle of indemnity. However, the principle of indemnity does not imply that the amount of an insurance payment must be equal to the loss. When insurance provides only partial reimbursement, the principle of indemnity is not compromised. In fact, in many situations, purchasers acquire insurance contracts that do not provide complete and total indemnification in the event of a loss.

Insurable Interest

The doctrine of insurable interest came about as a result of underwriters in the early eighteenth century agreeing not to demand proof of the insured's interest in the ship or cargo being insured. Not surprisingly, a great number of ships and their cargoes were soon fraudulently lost and destroyed. The Statute of George II declared that there had been a "mischievous kind of gaming or wagering, under the pretense of assuring the risque on shipping." The statute further declared that "no assurances shall be made, interest or no interest, without further proof of interest than the policy." Insurance agreements could no longer be transacted without proof of some insurable interest. Soon, the issue of gaming with respect to lives needed to be addressed under the Statute of George III. This statute declared that no insurance could be made on lives or other events when the person who benefited from the policy had no insurable interest.

The Marine Insurance Act of 1906 and the Marine Insurance Gambling Policies Act of 1909 codified and reformed the British law of marine insurance and defined more explicitly "gaming" and "wagering." Some insurers continued to issue policies without the required proof of the insured's interest in the insured property. These policies use the term policy proof of interest, also known as PPI clauses. In these cases, the opportunity for an insured to recover was dependent on the honor of the underwriter, and these insurance contracts came to be known as honor policies. The insurable interest requirement is a fusion of legislative and judicial actions. It applies to all types of insurance transactions. The doctrine of insurable interest is often used by the courts in order to implement the principle of indemnity.

Insurable Interest for Property Insurance

Generally, the existence of an insurable interest in property covered by insurance is determined on the basis of whether the insured's relationship commands that, as a consequence of an injury to the property, a loss is sustained by the insured. For the purpose of the evaluation of coverage disputes after the occurrence of a loss, it is necessary to consider exactly which type of property interest exists. The basic types of property interests include:

- Property (ownership) rights;
- Contract rights;
- Legal liabilities;
- Representative relationships;
- Stolen vehicles.

When an insurable interest question is presented in a coverage dispute, courts sometimes scrutinize the nature of an insurer's interest and then treat the claim differently, depending on the type of interest which the claimant possesses. In many instances, a person who has some right or duty to a particular property actually has two or more of these types of interests in that property. However, even when only one type of interest is present, it is still likely that the required insurable interest will exist if an appropriate kind of insurance is purchased. A complete and accurate assessment of the insurable interest question may be essential before an insurance policy is acquired. **Property rights** are characterized as ownership interests. They are uniformly recognized as sufficient to satisfy the insurable interest requirement. In many circumstances, **contract rights** can be transformed into property rights, that is, a contract establishes rights or interests which may mature into an ownership interest in a property. For instance, a buyer's contract for the purchase of real estate is appropriately treated as a property right, because the contract follows the **doctrine of equitable conversion**. Also, a lien on a property, which often exists as a result of a contractual relationship such as a construction contract, is also recognized as property interest. These contract rights are given the same status as property rights, so that they are always sufficient to satisfy the insurable interest requirement.

Legal Liabilities as Insurable Interest

There are several types of legal liability which are considered sufficient to satisfy the insurable interest rule. For purposes of liability insurance, the existence of an insurable interest is determined on the basis of whether the insured may be liable, rather than on whether the insured has a recognized legal or equitable interest in some property or in some activity. Legal liability may serve as an insurable interest for property insurance, as well as liability insurance. Therefore, liability satisfies the insurable interest requirement when the coverage is acquired for damage to property which is owned by other persons. For instance, a building contractor who is responsible to the owner for the completion of a garage has an insurable interest in the building under construction because of the possibility that it may be somehow damaged. This type of responsibility is usually limited to the value of the property and to any liability which the insured may have for consequential damages.

A person who makes a legally enforceable agreement to obtain insurance on property for the benefit of another has an insurable interest. This is because this individual would be liable on a breach of contract claim for the value of a loss, if the appropriate insurance coverages were not arranged for the property.

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Further, the interest generally extends to supporting an insurance contract in his own name. For example, an insurance broker who agrees to procure insurance is liable to the full extent of a loss, up to the policy limits of the projected policy and, therefore, this broker has an insurable interest in the property. The same analysis may be applied to a mortgagee who has assigned his mortgage to the Federal National Mortgage Association (FNMA). The mortgagee's commitment to the FNMA to keep the property insured is considered an insurable interest in the mortgaged premises. Another type of liability to consider is that which arises as a consequence of an injury to a third party. In the event that a claim by a third party produces legal liability, there is no possibility that the insured will derive a net benefit, as long as the insurance proceeds are ultimately used to pay a liability claim, or as long as they are used to indemnify the insured who has already paid the claim.

Therefore, the possibility that an insured will be exposed to some legal liability to a third party provides the required insurable interest for any amount of liability insurance. Generally, this is so, regardless of the relationship between the insured to the property.

Estoppel

The term **estoppel** means that a party is prevented, by his own acts, from claiming a right. With respect to life insurance, if a person has an insurable interest in a life insurance contract, that interest supports any amount of coverage the insurer is willing to sell to the purchaser. Consequently, the courts typically do not search beyond the point of ascertaining whether insurable interest can be established, concluding that an insurer is estopped (prevented) from such a challenge whenever insurable interest is shown. Standard forms used for property insurance commonly include clauses providing that in no event is the insurer liable for an amount in excess of the interest of the insured. So, an insurer desiring to defend paying a claim on the grounds that the insured either has no interest or has an interest of less value than the amount claimed, can ordinarily do so under the terms of the insurance policy. It is almost never necessary for property insurers to defend based on the lack of an insurable interest.

The Return of Premiums

Insurers sometimes return premiums when a claim is denied on the basis of lack of an insurable interest. This tender is probably made in the hopes of avoiding a claim by the insured or the beneficiaries or in the hopes of enhancing the insurer's image and improving the chances of presenting a successful

defense to a claim. There are relatively few judicial decisions on whether an insurer is obligated to return premiums that have been paid by an insured who lacked the required insurable interest. There are not many instances in which courts have addressed the question whether an insurer that successfully avoids paying a claim on the basis of the absence of the required insurable interest is obligated to return the premiums that were paid. Some courts have been disturbed about the inequity of allowing an insurer to collect premiums and then defend against a claim which seeks the insurance benefits on the basis of the lack of insurable interest. It has been suggested that any unjust consequence as a result of the collection of premiums and the subsequent nonpayment of the promised benefits could be addressed by ordering a refund of premiums collected, with interest, when an insurance contract is held to be unenforceable. Refunding the paid premiums provides an acceptable degree of remedy.

Insurers ordinarily do not make contracts which are not in compliance with the insurable interest doctrine. However, even legitimate insurers sometimes market insurance contracts which afford coverage for insureds who do not have an insurable interest. Marine insurance honor policies are examples of this. In some instances, these insurance transactions may be defended on the basis that they are designed to serve the commercial convenience of those having legitimate interests in the property covered by the insurance, but that these interests are somehow difficult to prove under legal standards. Insurers may decide to underwrite some risks, even when it is clear that there is no insurable interest, because an insurer's reputation for declining coverage requests might cause it to lose lucrative business opportunities in the future. Similarly, insurers may also choose to pay claims in order to maintain good public relations or to avoid expensive litigation. The enforcement of the doctrine of insurable interest depends almost exclusively on the initiative of the insurer. It is sometimes called upon in instances in which the insurer wishes to deny a claim for other reasons, but this defense is an easier one to sustain.

The Insurance Contract

The greatest difference between insurance and a contract by which one party merely agrees to assume the liability of another for some consideration is the significant number of members among whom the risk is distributed. Under a plan of insurance, there are a significant number of members among whom the risk is distributed. In a mere contract of assuming liability for another for some consideration, this significant number of members does not exist. The concept of sharing risk must be present in all insurance contracts. However, not all

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contracts which have the distribution of risk element among a sizable group of participants are considered to be insurance.

The concept of sharing risk is used for other purposes as well. Examples of these are an attorney-client relationship and contracts of warranty. In these examples, there is shared risk. However, there is no insurance involved because these contracts are not subject to the statutory and common-law rules which relate to insurance. The phrase “in the business of insurance” is often heard within the insurance industry. In the examples of the attorney client relationship and contracts of warranty, none of the parties is primarily engaged in the business of insurance. This element is essential in order for an insurance contract to exist.

Standard Insurance Contracts

When purchasing insurance, buyers usually indicate the type of insurance they desire, the coverage limits, and any endorsements increasing or decreasing the extent of the coverage. In reality, however, the average insurance purchaser has only a general knowledge of insurance. He naturally requires information which is essential to an informed decision. The insurance policies which most people acquire are made up of standard terms used for all similar transactions. The use of standard insurance terms and provisions naturally imposes some restrictions on choices. However, this limitation seems to be balanced by the benefits of using standard forms. Some of the most obvious benefits of standardized contracts are:

- They encourage lower costs. One of the most significant benefits of standardization for consumers is lower costs. Naturally, as in other areas, made to order products cost more than more commonly produced ones. By using standard policy forms, insurers are able to avoid incurring many expenses which would result from individualizing these transactions.
- They promote risk distribution. Standardization is a notable component of the process of transferring risks from an insured to an insurer. In fact, risk may only be possible if insurance transactions use these standardized features.
- They facilitate buying appropriate coverage. The standardization of insurance policies makes it possible to buy appropriate insurance, even if the purchaser is not able to describe exactly the extent of coverage he desires. Standardization can reflect the typical insurance needs of purchasers based on the industry’s experiences. Essentially,

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standardized policies are intended to meet the needs of typical consumers.

Policies of public interest have, in some cases, mandated standard coverage provisions. In some states, standardized contracts are required by law. Legislation and administrative rulings have imposed standardization for some entire coverages and for particular aspects of other coverages. The use of standard insurance forms generally serves the interests of individual policy holders, the public, and insurance companies. It promotes efficient and economical insurance operations.

Temporary Insurance Contracts

In some cases, a considerable period of time may pass between when the insurance application is made and the date when the policy is issued. This can occur because an applicant is working with a sales representative who does not have the authority to issue a policy. Or, the agent or broker may be required by the insurer to initiate an investigation or to wait for a report before deciding whether to accept the application. Delays may also occur as the result of an overloaded clerical staff. Even a short lack of coverage can be disadvantageous to an applicant. During this time, there are two primary risks which make this situation potentially troublesome. There is the risk that a loss will occur. There is the risk that a change of circumstances, during this time may make the risk uninsurable. For example, a serious illness could develop during the period that a life insurance application is pending.

Once an insurance purchaser decides to buy coverage, he usually wants it immediately. To accommodate the applicant, many insurers employ temporary insurance arrangements. These temporary arrangements are intended to provide a measure of protection while an insurance application is being processed. Generally, the forms used for temporary or interim insurance are relatively simple written forms, which state only a few terms of the agreement. If a claim dispute should subsequently develop, other terms of the agreement are typically determined by standard policy forms and customary practices. During the period that an insurer considers an application, an applicant may change his mind about the purchase. In some cases, the insurer may have already incurred expenses relating to the processing of the application. In order to circumvent this, many insurers require the applicant to pay some portion of the premium at the time of the application.

Oral Insurance Contracts

Insurance applicants usually want their coverage to begin immediately. The applicant may request that the coverage correspond with the impending transfer of some property interest. Requests for immediate coverage often can be accommodated by means of an oral agreement. In most cases, it is beneficial to permit immediate coverage. There are two primary disadvantages of oral agreements. These are the difficulty in determining the existence of an agreement at all and the terms of the agreement in the event of a coverage dispute arises.

The disadvantages which might result from oral insurance agreements have not yet been seen as compelling enough to require statutory prohibitions to restrict or limit them. It is a common practice to use oral agreements for temporary insurance commitments. They are used in many types of insurance. However, both insurers and insureds naturally find it beneficial convert these oral agreements into a written record as quickly as possible. A written binder may be used, which is essentially a type of temporary written agreement. When a written binder is used, uncertainties can be effectively reduced. There are basically six components to an enforceable insurance agreement. These are derived from basic contract law rules which require an obvious agreement on all essential terms. In an insurance transaction, these essential components are:

- The subject matter to be covered by the insurance;
- The risk to be insured against;
- The premium;
- The duration of the contract;
- The amount of the coverage;
- The identity of the parties.

In reality, a transaction between an applicant and an insurer is rarely completely oral, although the term “oral contract” is frequently used. It is generally used to refer to any transaction in which a major aspect of it is verbal.

When Written Contracts Are Required

When oral agreements are found to be unenforceable, this is almost always a result of statutory provisions which are directed at specific types of insurance transactions. State legislatures, of course, have the power to require that insurance contracts be in writing and may place restrictions on verbal agreements. For example, some statutes limit the duration of oral binders. In some states, statutory provisions have even been interpreted as implicitly

forbidding oral agreements for insurance purposes. In most states, this ban on oral contracts is rarely imposed on property insurance. They are, however, more frequently applied to life, health, and accident insurance.

Coverage

The duration of an insurance contract is the period of time for which coverage is provided. This is typically governed by provisions in the policy which limit the risks transferred to an insurer. There are some instances, however, when prevailing interests of an individual insured or of the public have been held to warrant extending the original coverage. In such cases, the coverage is extended to events occurring during time periods which the insurer did not intend to include.

Commencement Date and Anniversary Date

The date an insurance policy begins to provide coverage is usually explicitly stated by the insurer within the coverage terms or declarations page. This date is usually referred to as the commencement date or a similar term. Sometimes, the date specified by the insurer for renewal of the policy does not coincide with the projected anniversary of the commencement date. The renewal date occasionally arrives sooner than that which would be determined by a calculation of a given number of complete weeks, months, or year(s) following the commencement date. In this case, the date on which an additional premium is due is not exactly a whole number of years, or months, or weeks following the date when the coverage began. In these cases, coverage dispute may ensue. Claims involving these issues typically occur when a premium is not paid on, or before, the date specified for the renewal of the coverage, or within the permitted grace period.

The coverage question arises when an insured event occurs before the expiration of the coverage period, which would be applicable if the policy were based on a computation of an anniversary, rather than on the renewal date specified. Disputes involve cases in which coverage is alleged by the insurer to have terminated before an insured event takes place. Most of the judicial decisions dealing with this matter have held that the date specified in the policy as the date on which renewal premiums would be due is to be given consideration in determining when a policy period ends and when a grace period begins. That is, the courts have held that a clear statement of the date on which subsequent premiums will be due is the enforceable due date. The coverage period for insurance policies is determined on the basis that an

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insurer must extend coverage for a period which is co-extensive with the time that would normally be associated with the premium amount charged.

If an insured pays an amount which is reasonably understood to be an annual premium, the insurer must provide coverage for a full year. Therefore, the coverage period terminates one year after the coverage becomes effective, plus any grace period, rather than on an earlier anniversary date stated in the policy.

Coverage During an Application Period

Conversely, another type of situation should be considered. This is a situation where an insured event occurs, either while an application for insurance is pending, or after the application has been approved. However, it occurs before some action which is required for coverage. The insurance policy also specifies that coverage is not effective until the policy is delivered, and until the insured pays his first full premium. Suppose this occurs on the twentieth day of the month. In this situation, the application is treated as an offer. The acceptance occurs when the executed policy is delivered, subject to further delay, if the insured does not make the required premium payment. Therefore, if the normal contract formation rules of offer and acceptance are applied, the coverage would not be effective until the premium is paid. However, what if an accident occurs while the application is pending? Should the contract formation process be disregarded and a claim for benefits be sustained? There are actually two appropriate approaches to this situation. There is no coverage for the claim, and the insured receives less than a year's coverage for his first annual premium. If coverage were extended to the period during the application period, the insured would essentially receive more than a full year of coverage for his premium. In this case, the insured could pay the premium in order to secure the benefits. If the courts were to impose coverage during a period based on an anniversary date determined by when the premium was actually paid, insurers would have to provide more than one year's coverage for the first annual premium, resulting from extending both the point of commencement and the point of termination of coverage. Naturally, there would be some premium inequities for insureds.

In most cases, the courts have concluded that the first premium, if not paid at the time of application, purchases less than a full year's coverage. This is justified on the grounds of favoring a high level of certainty for an insurance policy's anniversary date.

Coverage Before Insurance Is Acquired

Occasionally, insurance policies are written so that coverage is provided for a loss which has occurred before the consummation of the policy contract. Whether these agreements violate any public interests depends on the circumstances and the type of insurance.

The Scope of the Coverage Period

Insurers have developed several ways to define the period of time for which coverage is provided. The provisions which specify coverage limitations relate to when an event will be covered and when a claim must be made. Coverage questions sometimes ensue when losses are sustained significantly past the occurrence of the insured event. The question is whether the time limit stated in the insurance contract refers to:

- The period within which a defined event, which may subsequently cause damages after the coverage period, must occur;
- The period within which claims must be made.

The resolution of these coverage questions are influenced by the type of insurance, as well as by the specific coverage terms of the policy contract. The most common method used by insurers to define the duration of coverage is to declare coverage on an occurrence of an event, within the time period specified in the policy. There are no limitations concerning when losses are subsequently sustained. For example, medical expenses may not be sustained until some later date. Motor vehicle liability insurance contracts commonly state a specific time period within which a covered event must have occurred, if coverage is to be provided by the policy. Under motor vehicle liability coverage, an insured has coverage for claims made and damages awarded years after the policy has terminated, as long as the liability results from an occurrence within the stated time limits.

Further, portions of loss, such as medical expenses incurred over a period of years following an accident, may occur after the time period specified for the coverage of an occurrence. An exception to this general pattern arises from the 1966 modification of the liability insurance forms. Some forms issued after 1966 provide coverage for an occurrence, defining occurrence to mean “an accident, including injurious exposure to conditions, which results, during the policy period, in bodily injury or property damages neither expected nor intended from the standpoint of the insured.” This type of language can be invoked to limit the liability of the insurer. Similar problems concerning the duration of coverages occur in certain types of specialized liability insurance,

such as coverage for the liabilities of corporate directors. These policies commonly include provisions requiring that a loss occur within the specified time limits of the coverage or within a stated extension period in case of cancellation. A perplexing question under such a coverage provision is whether a claim made after the time limits of the coverage period should be covered, if it is based on conduct that occurred within the coverage period. Another problem is presented in claims based on physical injury under other liability coverages. For example, a claim may be made against a builder for an injury allegedly caused during the negligent performance of a building contract. However, the injury itself was not actually sustained until years after the performance was completed.

Interim Coverage

When an individual submits an application for life insurance, together with the payment of the first premium, interim coverage is sometimes provided. Interim coverage is sometimes referred to as temporary coverage. In addition, in many jurisdictions interim coverage commences as a matter of law when an application for life insurance is accompanied by the payment of the first premium. The existence of interim coverage leads to questions about exactly when the temporary coverage is terminated. When the insurer decides not to underwrite the applicant, the insurer either rejects the application or makes a counteroffer. This communication from the insurer is sometimes a very important factor in determining when the temporary coverage ceases. The delivery of the insurer's counteroffer or the rejection of an application is generally the time when the interim coverage ceases. Essentially, insurance applicants are entitled to have the interim coverage continued until the applicant is actually informed of the insurer's decision.

Conditional versus Temporary Coverage

Instead of temporary coverage, many ***insurers offer applicants who include deposits with their applications the assurance that if the application is accepted, the effective date for the coverage will precede the actual delivery of the policy to the applicant. The insurer states that the coverage will be made retroactive to some point in time, such as when the application was made or when the medical examination was completed.*** This is known as conditional coverage. Temporary, interim, or conditional coverage in life insurance is sometimes offered when an application for insurance is accompanied by the first premium. This practice as it relates to fire insurance, casualty insurance, and liability insurance differs from the marketing approach used for life insurance. In these cases, temporary coverage is often

issued in situations where there is no advance payment of the premium. This situation calls for a binder. When insurers offer temporary or interim insurance contracts, the conditions and limitations set forth in these contracts may be subject to certain statutory restrictions, administrative regulations, or judicial rulings.

Claims Made Coverage

Many liability insurance policies, including some types of professional liability insurance and the newer forms of comprehensive general liability policies, are written to provide indemnification for claims made during the coverage period. The operative words are “claims-made” coverage, rather than for “occurrences” during the coverage period. For example, in a “claims-made” form, the principal insuring agreement typically states that the insurer agrees: “To pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of any claim or claims made against the insured during the policy period, arising out of the performance of professional services rendered, or which should have been rendered, subsequent to the retroactive date by any person for whose acts or omissions the insured partnership, corporation, or professional association is legally responsible.”

Loss

When used in insurance terms, loss is an unwelcome and unplanned reduction of economic value. Insurable losses may be either direct losses or indirect losses. Direct losses are immediate, directly the result of an insured peril. On the other hand, indirect losses are a consequential result of an insured peril. For example, if a fire destroys a home, the loss of the home results in a direct loss. Living expenses are a consequence of this direct loss; they are indirect losses. The chance of loss is the probability of loss. Chance of loss is expressed in fractional terms. The numerator in the equation is the actual or the expected number of losses. The denominator is the exposures to loss. For example, each home represents one exposure to loss. If four homes out of 1,000 are expected to be destroyed by fire, the chance of loss is $4/1000$ or .004.

Proximate Cause

Proximate cause is a legal term often used in insurance terminology. The term “proximate cause” is derived from the law of negligence. Under that law, the proximate (or nearest) cause of a loss is the first cause in a chain of several events, resulting in a loss. It is an event or thing, without which the loss would not have occurred. In some cases, there may be two or more concurrent and cooperative proximate causes. An example of proximate cause would be a

parked car which is struck by a police car while in pursuit of a fugitive. It might be said the proximate cause of the police car's collision with the parked car was the escaping fugitive.

Adverse Selection

Adverse selection takes place when potential insureds are treated the same, even though there are some factors which differentiate them as insurance risks. When an insurer does not make this distinction among potential insureds, a disproportionately high percentage of insurance applications generally come from the less desirable applicants, since they are high risk. An insurer who provides coverage for a group generally agrees not to effect judgment on individual applications. However, when insurance is sold as optional coverage to the participants of the group, the insurer usually reviews each application. This process protects against undue adverse selection, which may result if too many of the desirable risks elect not to be covered. Insurers frequently try to limit or even prevent adverse selection. They do this by requiring that a high percentage of the people within a group become insureds. For example, an insurer may require that at least a stated percentage, such as 90%, of the eligible employees in a group must participate in the insurance plan. If the percentage of participants is high enough, the problems associated with adverse selection can usually be avoided or reduced.

Adverse selection may also take place if those who are not actually members of the group are permitted to enroll as insureds. Insurers generally try to minimize the likelihood of adverse selection by establishing eligibility requirements for participating in the group plan. For example, in many group plans, only full time employees are eligible to participate. The justifications for eligibility requirements are:

- That part-time employees may be subject to considerably different hazards in connection with possible other employments;
- That some part time individuals may be particularly undesirable risks who might be included in the group plan simply through partial employment. Another means of reducing adverse selection is to establish restrictions on when employees may elect to enroll in the group plan.

Insurers can generally offer group coverage and limit adverse selection by:

- Excluding part time employees;
- Requiring that a high percentage of eligible employees participate in a group plan;
- Limiting the open enrollment periods.

Even if some level of adverse selection occurs, the insurer can still maintain a financially sound plan. This may be accomplished by adjusting premiums to the average level of risk among the large number of participants.

Risk

The theory of risk is prevalent in all insurance transactions. The burden of risk is transferred from the individual to whom it attaches to a carrier who is willing to assume that risk. This happens through the agency of insurance. Naturally, if all of the facts about any given situation could be fully known and understood beforehand, including the effects of all outside forces, it would be possible to know whether a loss would occur or not. Essentially, there would be no risk involved. However, in real situations, only some of the relevant facts of the situation can be known and understood. Therefore, predictions concerning potential loss are ultimately based on nothing more than guess work. In an insurance transaction, this speculation is known as the element of risk. The element of risk is essential to developing techniques for managing the unknown.

Risk is the variation in possible outcomes of an event which is based on chance. Therefore, the greater the number of different outcomes which may occur, the greater the risk. Essentially, risk is the uncertainty concerning a possible loss. In more familiar terms, risk is often referred to as “exposure to loss.” Thinking of risk in terms of its variables is helpful because it focuses observation on the degree of risk in any given situation. The degree of risk is a measure of the accuracy with which the outcome of an event can be predicted. Obviously, the more accurate the prediction, the lower the degree of risk. Conversely, the less accurate the prediction, the higher the degree of risk. The risk is lower when the outcome is more predictable. There exists a lower degree of risk. Relatively accurate predictability of loss results from the operation of an insurance system. Because insurance companies keep accurate statistics on losses which have occurred, they are better able to predict the losses which will occur. For example, if an insurer were to predict how many houses will be destroyed by fire in one year out of 10,000 randomly chosen houses, it would be difficult, if not impossible to predict this with any rate of accuracy.

Risk Distribution

Risk distribution is the principle of the sharing of economic risk. In the absence of insurance, under our system of jurisprudence, economic losses which are incident to any misfortune fall in one of the following categories. The person

who suffers the misfortune bears the economic loss. Under the common law system, the person who is negligent or responsible for the misfortune could be compelled to bear the economic loss. Under certain statutes, the party who is judged to be the most appropriate from society's perspective is required to bear the economic loss. An example of such a party would be an employer under the Workers' Compensation statutes. Of course, there is not a way to transfer the risks of pain, suffering, and inconvenience, and these occur with any misfortune. Therefore, insurance is a means to distribute the risk of economic loss among as many as possible of those who are subject to the same kind of risk.

Simply, a premium is paid into a fund. From this fund, payments are made for the economic losses which are predefined. Each member of the group contributes in a small way toward compensation for losses which may be suffered by any member of the group. Under a system of insurance, no member knows in advance whether he will receive more in compensation than he contributes. He may be simply paying for the losses of others in the group. The objective of any member, however, is to exchange the possibility of suffering or escaping a loss for paying a fixed amount into the fund. This fixed amount would be the most he could lose if he were to suffer the specific risk insured against.

Types of Risk

Subjective risk refers to the perception of risk by the individual. For example, two people might have the same exposure to loss, say, losing their homes by fire. However, one person might feel much more uncertainty about this possible event than the other person. This person possesses greater subjective risk than the other.

Objective risk refers to a state of nature, and it is measured by the actual chance of loss. The terms "objective risk" and "chance of loss" are sometimes used synonymously. However, objective risk is a broader concept, because it portends the concept of variability of outcomes.

Pure risk refers to situations which can result only in a loss or in no change. The exposure to loss of a home by fire is an example of an exposure to pure risk. Simply, the house either burns, or the house does not burn.

Speculative risk refers to situations which may result in gain, loss, or no change. Most speculative risks are uninsurable. Investing in common stock is an example of assuming a speculative risk. The result of a common stock investment may be a gain, a loss, or no change at all.

The Law of Agency

In the 1800s, the law of agency was created. The agency system was directed at those who were involved in soliciting, transmitting, examining, collecting, selling, or who were in any way associated with the business of insurance. Through the law of agency, insurance companies became responsible for the acts of their agents. Agents are considered legal representatives of insurance companies. As the law of agency developed, various states began to enact legislation intended to hold insurance companies responsible for their own acts, as well as for the acts of their agents. The agents served as legal representatives of their companies. Today, this is known as the agency system. The relationships between insurance companies and its sales representatives concerning the sales representative's authority to contract on behalf of the insurer have been established by relationships in agency law. The construction of these relationships can be imprecise, however.

Authority

The insurance agent has great responsibility and potential liability. In his capacity, he speaks for the insurance company he represents. Careless or ill thought statements or comments on the part of an agent can bind the insurer when these statements are made within his real or apparent authority. Generally, an insurer is bound to the statements made by one of its agents, even though the agent may not have the authority to make such statements, and even if they are not true.

Express Authority

Within the insurance context, express authority is authority which is bestowed upon an agent by an insurer. ***Express authority may be granted verbally or in writing.*** Express authority is very clear. Insurance companies frequently enter into express written contracts with those who are authorized to represent them in marketing transactions. In these cases, express authority is conveyed. Occasionally, a dispute may ensue because of some aspect of the transaction. There are contracts between the insurer and the sales representative, and these contracts describe the limits of the sales representative's authority. In the case of a dispute over authority, this contract would be submitted by an insurer as a defense to an insured's claim.

Apparent Authority

Apparent ***authority may or may not be actual.*** Apparent authority exists from the perspective of the client. It may be considered to exist by a person who

does not know otherwise. For example, when an agent makes statements which are not authorized by the company, a client may legally rely upon the ostensible or apparent authority of the agent. Claims by an insurance purchaser often hinge on the intermediary's apparent authority to act on behalf of the insurer. A sales representative in an insurance transaction is considered to have apparent authority whenever the insurer places him in a position which causes a prospective purchaser to reasonably believe that the insurer has consented to the authority which the agent or broker claims to have. There are many elements which may be considered by the courts to be pertinent in determining apparent authority. Some of these are advertisements, business cards, stationery, and the statements made by the sales representative.

Implied Authority

Finally, ***implied authority*** is authority which is neither expressly granted nor expressly denied. Implied authority is reasonably deduced from the nature of the insurer's business and the agent who represents it. For example, since life and health agents have the express authority to solicit applications, they have the implied authority to discuss policy provisions.

Insurance Law Provisions

Notice of Loss Provisions

The main purpose of a notice requirement in an insurance policy is to permit the insurer a reasonable opportunity to protect its rights. Prompt notice to the insurer increases an insurer's opportunity to acquire information about the circumstances of the loss. Requiring the prompt notice of a loss sometimes protects the interests of the insured, as well as those of the insurer. For example, notice provisions afford an opportunity to conduct a timely investigation which promotes early settlements. This clearly benefits the insured. Early notice may promote early settlement. This can help to avoid the expenses involved in litigation. Further, these notices of loss provisions serve the public interest. An early and timely investigation increases the probability that fraudulent claims will be detected. Compliance with a notice of loss provision is generally excused when the failure is attributable to the very risk covered by the insurance. For example, a delay in providing notice to a disability insurer may be excused when the insured is unable to provide the notice because of the very disability that he is insured against. The courts have also applied doctrines such as waiver, estoppel, and election in decisions which uphold claims by insureds when they are in discord with policy provisions.

Timeliness Provisions

The various timeliness provisions of insurance policies state the actions which insureds must take following the occurrence of an insured event. There are many factors associated with timeliness which must be studied when disputes revolve around timeliness provisions. Some of these are examined below. In connection with liability insurance, the settlement and litigation of a liability insurance claim often involve distinctive problems. Primarily, this is because liability insurance is a third-party coverage. That is, the insurer's contractual obligation is to pay all sums which the insured is legally obligated to pay as damages. The liability insurer's obligation to indemnify is fault based. Any insurance benefits are generally paid to a third party, rather than to the insured or his beneficiary. The interests of a liability insurer and its insured are not always the same with respect to tort claims against the insured. In many instances, the differences in the positions of the insurer and the insured can create conflict-of-interest issues. Insurance policies usually include provisions which relate to the timeliness of actions by a claimant after the occurrence of an insured event. These provisions include:

- Clauses which require that the insured provide the insurer with a prompt notice of a loss;
- Terms which require a proof of loss within some specified period of time;
- Conditions in liability insurance policies which state that an insurer must immediately forward to the insurer all documents which the insured receives, in the event a suit is filed against the insured;
- Provisions which restrict the time within which a suit may be initiated by an insured against an insurer as a consequence of a loss.

These timeliness provisions serve several purposes. Timeliness provisions are essential to permitting the insurer a suitable opportunity to investigate the claim, so that it can assess the coverage issues and the extent of the loss. Timeliness provisions are a matter of public interest

Specific versus General Timeliness

Some timeliness provisions require a claimant to perform certain actions within a specified period of time following the occurrence of an insured event. This might be given in days, months, or years. These policy provisions are designed for providing certainty. Insurers often prefer specificity in the timeliness contract provisions. For example, when an insured event occurs, a policy may provide that notice shall be given "as soon as practicable, but in no event to exceed 60 days." Or, a more generalized time limit may be given. The terms used in

generalized time limits are “reasonable” or “adequate”. These policy provisions are designed for flexibility.

The Statute of Limitation Provision

Provisions in many insurance policies now set forth a time period following the occurrence of a loss within which a law suit may be filed against the insurer. For example, property insurance policies usually provide that “No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law, unless commenced within 12 months after the inception of the loss.” Likewise, some of the policy forms used for uninsured motorist insurance state that “No suit or action on this policy for the recovery of any claim shall be sustainable in any court of law or equity unless it is commenced within 12 months from the occurrence on which the claim is based.” An issue of enforceability ensues when a timeliness clause prescribes a time limit for initiating a suit against the insurer which is less than the statute of limitations period. Naturally, such claims produce a great amount of disputes.

Cooperation Provisions

Liability insurance policies generally provide that an insured is required to cooperate with the insurer in the investigation, settlement, and defense of tort claims. These provisions are referred to as assistance and cooperation provisions. In fact, insurance policies commonly prescribe that compliance with such terms are conditions precedent to the insurer’s liability. Assistance and cooperation provisions usually require such things as attendance at hearings and trials, assistance in effecting settlements, securing and giving evidence, and generally requiring an insured to aid in the conduct of suits which result from tort claims. In addition, most liability insurance policies have negative provisions. These negative provisions typically state that, except at the insured’s own cost, the insured will not voluntarily make any payment, assume any obligation, or incur any expense, except when there is an imperative need for medical and surgical relief immediately after an accident. These clauses also address prohibiting settlements without the insurer’s consent. Naturally, there are limits on what an insurer may request from an insured. For example, an insured may not be required to falsify information or to withhold facts from a claimant victim. Also, an insurer cannot require the insured to act entirely without regard to the insured’s interests.

The Legal Duties of an Insurer

In order to avoid any liability, insurers have certain duties and responsibilities. They must adhere to certain codes of conduct. The codes of conduct required by insurers are described below.

The Duty of Good Faith and Fair Dealing

All insurers have the duty of good faith and fair dealing. The courts have upheld the duty of good faith and fair dealing many times because there is a “special relationship” which is created by the insurer’s disproportionately strong bargaining position in the claims handling process. Although the duty of good faith and fair dealing requires that the parties must “deal fairly” with one another, it does not imply the burden of requiring one party to place the interests of the other party before his own. The study of the duty of good faith and fair dealing naturally lead to the discussion of the concept of bad faith. In addition to the obligations imposed by the duty of good faith and fair dealing, insurers also have the obligation to avoid bad faith. Unfortunately, bad faith is a part of almost all insurance disputes today.

The most common assertions of bad faith are the denial of a claim and the delay of payment of a claim. In addition to these widely used assertions, suggesting that a claimant not retain legal counsel is also considered to be in bad faith. Also, if an insured must initiate litigation in order to recover benefits, bad faith can likely be proven. Until recently, there were few distinctions used to define bad faith, although there are many references to the term “reasonable” throughout the business of insurance. Bad faith is a difficult term to define. For example, if a case were to go to trial, whether or not bad faith would be found is impossible to predict. Generally, however, intent is the primary and most accepted element of bad faith. When attempting to determine bad faith, a two-part analysis is employed. First, the insured must prove that the insurer’s conduct was unreasonable. Secondly, the insured must prove that the insurer intentionally denied a claim or intentionally delayed the payment of a claim, while knowing it to be valid. As long as the insurer has a reasonable basis for denying or delaying a claim, bad faith cannot exist.

The Duty of Care

In addition to the duty of good faith and fair dealing, insurers also have the duty of care. The duty of care requires the insurer to perform its obligations with care, skill, reasonable expedience, and faithfulness. There are limits to the duty

of care. For instance, the courts have held that the insurer does not owe a fiduciary duty or a duty of good faith and fair dealing to a third-party claimant. This rule applies, even if the claimant is one of its own insured presenting a claim against another of its insureds. Within the context of such a situation, the third-party claimant is a third party first, then an insured.

A Standard of Care

The duty of care is associated with a standard of care. An insurer's standard of care is measured by a determination of whether or not another reasonable insurer, under the same or similar circumstances, would have acted in the same way, such as in delaying or denying a claimant's benefits. The measure of the duty of care is defined as "that degree of care and diligence which a man of ordinary care and prudence would exercise in the management of his own business".

- **The duty to defend** -- Insurers have the duty to defend. The duty to defend arises from the liability insurance policy contract. An insurer has the duty to defend any suit against one of its insured which seeks damages resulting from bodily injury or from damage to property. This duty stands, even if the allegations of the suit are considered to be groundless, false, or even fraudulent.
- **The duty to indemnify** -- Insurers have the duty to indemnify. Under the duty to indemnify, the insurer has the duty to make compensation or remuneration for the incurred harm, injury, loss, or damage which was insured against.
- **The duty to settle** -- Insurers have the duty to settle. The insurance company must settle all valid claims within a reasonable period of time. Within policy limits, every reasonable settlement demand should be accepted. The duty to settle is associated with a great amount of litigation in the insurance industry today.

Insurance Legislation and Regulation

The regulation of the insurance business originates from three sources, which are the courts; the individual state legislatures; and the regulatory agencies created by the statutes of each state. Regulation primarily comes from the courts. The courts devise and apply various doctrines in individual cases for the protection of insureds. Prior to 1944, the insurance industry enjoyed relative freedom from any type of regulation by the federal government. Until that time, based upon the United States Supreme Court decision *Paul v Virginia*, the prevailing view was that a policy of insurance was not a transaction

of commerce. The most considerable advantage of this ruling to insurers was that it permitted them the freedom to cooperate with each other in gathering and processing experience data. From this data came the basis of predicting the probability of losses for the various risks assumed. Rating bureaus were used to determine suitable premium rates.

The primary motives for legislative regulation of the insurance industry are controlling the rates so that they are adequate, fair, and nondiscriminatory; preventing unfair insurance practices toward insureds and toward competitors; and preventing insolvency of insurers for the protection of insureds.

Rate-Making Legislation

The purpose of rate-making legislation is to ensure that rates are sufficient to cover the costs of administration, the payment of proceeds and, of course, to permit suitable profits. Rate-making legislation is also intended to ensure that rates are not discriminatory among individuals who present the same risks. The All Industry Committee prepared model acts for the regulation of insurance. This included rate making, especially the fire, marine, and casualty arenas. Today, these have been adopted by nearly all states. The most common approach to rate making is that insurers are permitted to cooperate. As members of rating bureaus, they devise appropriate rate schedules. These schedules are then submitted to the state insurance commission or administrative agency in charge of regulating insurance for approval. If the state administrative agency does not approve of the rates submitted, generally, the insurer may appeal the ruling through the court system. These administrative agencies hold various powers of enforcement which enable them to see that only approved rate schedules are followed by insurers.

Anti-Discrimination Legislation

Discrimination in rate making is one of the most difficult areas to regulate. Discrimination in rate making covers not only ensuring that all insureds are charged fairly for their premiums based upon their risks, but it also relates to charging different premiums to benefit favored or select clients. For example, if insureds who present high risks are grouped with those who present lower risks and all of these insureds are charged equally, some insureds will be paying too much, while others will be paying too little. Breaking rate schedules into various categories can minimize this event. However, it can be difficult to maintain the perfect balance when there are too many rate schedules. Also, this can result in increased administrative costs, which results in increased premiums. Discrimination legislation is designed to avoid this.

Unfair Claims Practices Legislation

There has been a good deal of legislation enacted which is designed to protect insurance consumers with respect to unfair claims settlement practices. Today, no insurer in any state may engage in unfair claims settlement practices. Some acts which are prohibited by this legislation are:

- ***The failure to acknowledge, with reasonable promptness, appropriate communications concerning claims;***
- ***Knowingly misrepresenting to a claimant pertinent facts or policy provisions which relate to his coverage;***
- ***The failure to adopt and implement effective and efficient standards for the prompt investigation of claims;***
- Not attempting, in good faith, to make a prompt, fair, and equitable settlement of a claim submitted in which liability is reasonably clear;
- ***Compelling policy holders to initiate lawsuits*** in order to recover amounts due under policy coverage by offering to settle for an amount substantially less than is ultimately recovered by the claimant;
- ***The failure to maintain a complete record of all of the complaints received during recent years,*** or since the date of the last examination by the insurance commissioner, whichever is shorter. This record must indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, their disposition, and the time to process each complaint;
- Committing any other actions which the state defines as an unfair claim settlement practice;

Anti-Trust Legislation

Insurance companies were also able to cooperate in the fixing of specific categories of coverage and in the development of standard policy forms. These early decisions were really only a minimal protection which came between insurance practices and the federal anti-trust provisions of the Sherman Anti-trust Act. The Sherman Anti-Trust Act is not specifically insurance legislation. It is aimed at making or setting prices illegal. Insurance premium rates were considered “prices” and, therefore, they came under the Sherman Anti-trust Act. However, in 1944, the Supreme Court handed down the decision of *United States v South-Eastern Underwriters Association*. In the *South-Eastern Underwriters* case, the issue was whether the federal Congress should be deprived of the power to regulate the insurance industry under the Sherman Anti-trust Act. The Court held that the insurance business fell within the category of interstate commerce. An association of 200 fire insurance

companies and 27 individuals were indicted under the Sherman Anti-Trust Act for fixing noncompetitive rates and for monopolization. This case presented a special context for the question of whether or not insurance was interstate commerce.

Unfair Competition Legislation

Eventually, the individual states began to adopt legislation which was designed to prevent unfair trade practices. The All Industry Committee provided the means by which the individual states regulate unfair competition by designing model acts which prohibited these practices. The primary areas covered by this regulation are false advertising, misrepresentation, and unconscionable conduct. Most states have some form of unfair competition or practices act. Sometimes, these statutes are referred to as deceptive trade practices, unfair trade practices, or unlawful trade practices. However they are termed, their intent is to protect consumers, and their scope and application are broad. Typically, these statutes provide for private causes of action for any consumer who is damaged because of an insurer's misrepresentation, breach of warranty, unconscionable conduct, or unfair practice. Even when a state does not have specific legislation on its books with regard to certain acts and practices, insurance consumers are still protected because insurers are always held to the duty of good faith and fair dealing. Violations of these unfair competition or practices may fall within these broad categories:

Misrepresentation

When a seller or service provider, such as an insurance agent or broker, makes a representation, he has the duty to know that the statement is true. The consumer is clearly entitled to rely upon this representation. Misrepresentation provisions of these acts are intended to assure the accuracy of descriptions of goods and services.

Failure to Disclose

Allegations of failure to disclose are suitable for many causes of action, including lawsuits brought against insurance companies. On the one hand, agents and brokers are taught to pronounce the virtues of their products. They are not taught to point out the disadvantages of their products. On the other hand, most insurance agents are not eager to explain the intricacies of policy exclusions. Any allegation of failure to disclose requires the consumer plaintiff to prove that the insurer defendant intended to induce him into a transaction into which he would not have otherwise entered. Knowledge and intent are the necessary essential elements of the failure to disclose.

Breach of Warranty

Breach of express or implied warranty is a clear violation of contract law.

Unconscionable Conduct

The act of unconscionability, or an unconscionable act, takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree. An unconscionable act results in a gross disparity between the value received and the consideration paid for any item, including an insurance policy contract.

There are other practices which are considered to be deceptive acts, and these are subject to appropriate codes of consumer protection as well. These are:

- Passing off services as those of another;
- Causing a confusion or misunderstanding concerning the source, sponsorship, approval, or certification of services offered;
- Causing a confusion or misunderstanding with respect to the 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 when, in fact, they do not;
- Making false or misleading representation with respect to the services or the business of another;
- Advertising services with the intent not to sell them as advertised;
- Advertising services with the intent not to supply a reasonable and expectable public demand, unless the advertisement discloses a limitation on quantity;
- Representing that an agreement confers or involves rights, remedies, or obligations which it does not have or which are prohibited by law;
- Misrepresenting the authority of a sales person or an agent in order to negotiate the final terms or the execution of a transaction;
- The failure to disclose information in order to induce the consumer into a transaction which he would not have otherwise entered, had the information been disclosed;
- Advertising under the cloak of obtaining sales personnel when, in fact, the purpose is to first sell a service to the applicant;
- Making false or misleading statements concerning the price or the rate of services.

The McCarran-Ferguson Act

The insurance industry found that it preferred the state form of regulation over federal regulation. The industry had operated successfully under state regulation, and the industry was concerned about changes, especially those which might relate to cooperatively determining rates. The insurance industry, in the form of the National Association of Insurance Commissioners (NAIC), drafted a proposal which later became known as the McCarran-Ferguson Act. The McCarran-Ferguson Act essentially preserved the possibility for the individual states to continue to exercise their own responsibility for insurance rate regulation. However, the McCarran-Ferguson Act did not return the regulation of insurance rates entirely to the individual states. It only exempted the insurance industry from federal anti-trust legislation to the extent that the insurance business is actually regulated by state law. Therefore, in order to avoid the threat of federal anti-trust regulation and under pressure from the insurance industry, the states began to assume full responsibility for their individual insurance regulation.

The enactment of the McCarran-Ferguson Act placed the power of legislation clearly in the hands of the several states. (“Several” simply means “a number greater than one.”) The insurance industry soon became aware of the need for consistent, rather than incomplete, legislation in order to permit insurers to operate efficiently across state lines. At this time, the NAIC and the All Industry Committee, which was an organization created and comprised of representatives in all parts of the insurance field, created and drafted model statutes. These various statutes were used in each of the appropriate areas of insurance regulation. Today, these statutes have been approved by nearly all states.

Licensing Regulation

The most fundamental form of control that the individual states have over the insurance industry is through statutes which require licensing. Typically, these statutes cover not only local and out-of-state insurers, but also every agent and broker who takes part in the sale or servicing of policies within the state. By means of this regulation, the state regulatory agencies control the qualifications and conduct of every agent and broker. It can also require the appointment of an agent for service of process within the state by each insurer. Under the licensing power which the states control, even the types of investments which are permitted by insurers are regulated.

Unauthorized Insurers Regulation

A major concern of regulators is protecting insureds against the inability to bring suit on their policies against out of state insurers. This is an especially important concern, as it deals with insurance by mail. The Uniform Unauthorized Insurers Service of Process Act was drafted by the All Industry Committee, and this model was provided to all states. This Act affords jurisdiction over an out of state insurer by an in-state insured. Under these statutes, insurers who are not authorized to transact business in a specific state are prohibited from sending advertisements which are designed to induce that state's residents to purchase insurance. These acts were enacted to protect insurance consumers from insurers not authorized to transact business in the state. These unauthorized insurers may be any insurance company organized under the laws of another state, as well as any territory of the United States or any foreign country.

Since anyone who is not authorized cannot conduct the business of insurance within a particular state anyway, this purpose of this act is to protect insurance consumers concerning misrepresentation. No unauthorized insurer may issue any advertisement, estimate, or illustration which misrepresents its financial condition, the terms of its policy contracts, benefits, advantages, dividends, etc. This includes newspaper and magazine ads, radio, television, and all circulars, pamphlets, letters, flyers, etc. If the insurance commissioner of one state has reason to believe that an insurer is engaging in this unlawful advertising, in some states he must notify the insurance supervisory official in the state of that insurer.

Group Regulation

While the regulations of individual states may vary, the following describes the requirements which are most often imposed on the underwriting practices of group insurance. The insurance must be incidental to the group. The purchase of group insurance must be incidental to the purpose of the group. A group whose purpose is to purchase group life insurance possibly consists of people whose health has prevented them from purchasing individual coverage at standard premiums. The group must meet minimum participation percentages. When an employer sponsors a noncontributory plan and pays the entire premium on behalf of its employees, as much as 100% of eligible employees may be required to participate in the plan. Under a contributory plan where the employees contribute toward the cost of their coverage, usually 75% of eligible employees are required to participate in the plan. The group must meet

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minimum size requirements. Many states' statutes stipulate that a minimum number of people must make up the group, usually ten.

Group size may be a consideration. When the group's size is large and is maintained over a long period of time, the insurer can predict long-term loss costs. Therefore, in order to best serve the interests of the public, the size of the group is sometimes regulated by the states. In addition, the insurer may have its own requirements. Most state regulations permit insurers who underwrite group insurance to have their own requirements in addition to the statutory requirements. These may include such factors as age, sex, the stream of persons through the group, and other determinants.

Insurance Classification

The classification of insurance by the type of risk involved is widely recognized. It is used for a number of different reasons. Classification of insurance is essential to the common law system. This system considers each judicial decision as a precedent. Therefore, the common law system tends to develop distinctive rules for various types of situations. Classifications are used to identify similarities which warrant the same treatment or differences which justify other treatments. Classification helps to identify factors which should be evaluated in the application of legal doctrines. In the study of insurance law, classification involves not only reaching an appropriate balance between interests in a specific case, but also between the generalization and the particularization of an entire body of legal principles. Classification can serve to suggest ideas which may be used for analyzing and resolving a problem.

Insurance classifications also serve to further the pursuit for a system of predictable judicial opinions and rulings, that is, for a "rule of law." In insurance law, classifications require that the person applying the criteria to a particular case must make a judgment, rather than merely finding a fact. This may involve a considerable amount of discretion. Practically speaking, these opportunities to exercise discretion assure flexibility by affording the freedom to weigh factors affecting an individual case. On the other hand, this flexibility can lead to inconsistency and partiality. It is almost always necessary to reach a point somewhere between the demand for flexibility and the demand for certainty. There are many classifications used in insurance law. Naturally, many rules and doctrines of insurance law frequently require considerable sensitivity to the facts of the case. Resolving coverage issues often involves classifications which are fact sensitive.

Classification by the Nature of the Risk

Insurance transactions are classified by the nature of the risk which is being transferred. Three principal classes of insurance are a result of voluntary specialization by insurers and statutory regulations adopted by many states. The three main classes of insurance are:

- Fire and marine insurance;
- Life and accident insurance;
- Casualty insurance.

At one time, regulatory statutes in many states limited insurers to writing only coverages which were considered to be within one of the three classes. In other words, an insurer was permitted only to sell the types of insurance that were recognized as being included in a single class. In fact, some insurance companies limit their underwriting to only one type or line of insurance within a class. During the first half of the twentieth century, most states began to allow **multiple line** underwriting, allowing, for example, marine and fire insurers to sell life and accident insurance. In these states, insurers could sell all types of insurance.

Even in those states which did not allow a company to engage in multiple line underwriting, many insurers developed a comparable form of underwriting by arranging for affiliation between several insurance companies. Common agents provided an insured with a single policy which included different classes of coverages, and each of these was written by one of the affiliated companies. Over time, this marketing arrangement began to involve a parent company and a group of subsidiaries. These groups of insurers came to be known as a **fleet**. In most states, multiple line underwriting evolved into an even more broad approach known as **all line underwriting**. All line underwriting embraces all of the three main classes of insurance. Some insurers continue to limit their underwriting to only one class of insurance. In many states, there has been no legislation to abolish the classes of insurance; they merely authorize insurance companies to operate in the entire field of insurance. Further, in many states today, all line underwriting is still accomplished by fleet marketing.

Despite the growth of all line underwriting, there are still distinctive and significant regulations, doctrines, and practices which continue to exist with respect to these three classes of insurance. Although the term **all risk** does not have one single and consistent meaning, it generally refers to defining insured events as “accidental or chance losses.” Typically, all risk coverages include some limitations which are specified in the insurance policy terms.

Marine and Fire Insurance

Marine insurance became common place in the 1600s when merchants sought insurance against the perils of the sea. A person requiring such insurance went to the Edward Lloyd's coffee house in London. Here he was able to learn the important events of the day and any developments of interest to his business. He passed a slip around the coffee house containing the relevant information he needed. Anyone who was willing to become the insurer would indicate on the slip the amount of requested coverage he was willing to underwrite and the amount for which he would be responsible. The slip was passed around until the full amount was reached. Each underwriter became an insurer for a subscribed amount, or the underwritten amount. Later, these underwriters formed their own society, and they adopted this Lloyd's policy as the standard form for marine insurance.

When companies writing marine insurance extended their operations into other areas of property insurance, especially to those involving the transportation of goods over inland waterways, their insurance contracts were patterned after the original policy terms which were used for the early marine insurance. This coverage came to be referred to as **inland marine** insurance. Today inland marine insurance is used to provide coverage for many risks, not just the obvious ones suggested by its name. Inland marine insurance includes three main branches of insurance:

- Domestic shipments;
- Bridges, tunnels, and other methods of transportation and communication;
- Personal property coverage.

Inland marine insurance now is used not only to insure transportation risks in general, but it is also used to insure nearly any type of goods or property which might be affected by this movement. These policies insuring moveable goods, regardless of location, are referred to as personal property **floaters** policies. **Fire insurance** typically covers loss caused by hostile fires or by lightning. Generally, fire insurance companies are also authorized to write allied lines, which provide coverage for damages to property from wind, rain, collision, riot and civil commotion, explosion, water damage, and earthquake.

Life and Accident Insurance

Life insurance includes personal accident insurance, health insurance, and annuity contracts, as well as other contracts which provide for the payment of specified benefits upon the death of the insured. **Industrial life insurance**

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refers to life insurance that is written with small coverages, often in amounts which are barely adequate for burial expenses. Typically, the premiums are paid in frequent installments, perhaps even weekly. Industrial workers were among those to whom these policies were first offered, hence the name. The frequency of the premium payments is the distinguishing characteristic of industrial life insurance, as opposed to other types of life insurance. An industrial life insurance policy usually prohibits the assignment of the policy or of its benefits. These policies do, however, usually provide some sort of discretion over the disposition of the death benefit. This provision is known as the **facility of payment clause**. The facility of payment clause authorizes payment to anyone who is fairly entitled to the insurance proceeds by reason of having incurred expenses on behalf of the insured for such things as medical treatment, burial, and other purposes. This provision was designed to avoid the appointment of an administrator, executor, or guardian to collect the insurance proceeds. The facility of payment clause also expedites the settlement of disputes among rival claimants without the delay and expense of litigation. **Trip insurance** is considered a limited form of accident insurance coverage. Trip insurance is commonly available at airports and is often secured through vending machines.

Casualty Insurance

In the legal context, the term casualty generally refers to an accident or to “an event which results from a sudden, unexpected, or unusual cause”. In the broadest interpretation, almost all types of insurance could really be regarded as casualty insurance. In the context of insurance classification, casualty insurance includes a great variety of coverages including liability, workers’ compensation, accident and health, glass, burglary, theft, boiler and machinery, property damage, collision, and credit insurance. Also included are fidelity and surety bonds, which are not technically forms of insurance.

The Marketing Process and Practices

The Marketing Transaction

Insurance companies must exercise considerable care in structuring their marketing arrangements. They must use techniques and concepts which are essential to the formation of all contractual relationships. An insurance marketing transaction is often begun by the company’s sales representative, or agent or broker. This initial approach is typically structured as an invitation to the purchaser to make an offer. The sales representative provides an application form for the purchaser to convey his interest in acquiring insurance.

The completed application is then forwarded to the insurer for evaluation of the risk. In this way, the insurer maintains its right to consider whether or not to undertake the risk. Essentially, the insurance company is placed in the position of accepting the applicant's offer. When the insurer accepts the applicant's offer, an insurance contract has been formed. Some insurance transactions differ from the offer-acceptance principle we discussed earlier. In some transactions, the insurer makes the offer which a potential purchaser may accept. An example of this type of offer is trip insurance. Trip insurance is considered a limited form of life and accident insurance coverage for travelers. It is commonly available at airports and is often secured through vending machines. In these circumstances, communications from the company are posted on or near the vending machines. The terms of the policy are clearly stated in the forms dispensed by the machines. The terms indicate that the insurer intends to make an offer to the purchaser. The purchaser's payment of the premium, together with the completed forms, essentially constitutes an acceptance. The clear intent in such an arrangement is that the transaction is concluded before the applicant departs on the trip.

The Counteroffer

An insurance company sometimes responds to an application by offering a coverage which is different from the coverage which an applicant sought. When the insurer makes this offer, this is treated as a counteroffer. A contract is formed only if the applicant accepts the insurer's tendered policy, the counteroffer.

Silence as Acceptance

The theory that silence is considered a form of consent to a contract often presents difficult questions. Generally, the courts are reluctant to treat any form of inaction, including silence, as a form of consent unless, of course, it is intended that way. In addition, insurers typically include provisions in their application forms which explicitly state that the insurer does not intend inaction or silence to be taken as an acceptance. One commonly used provision in insurance applications expressly states that the company will not incur liability before it acts on the application.

Implied Agreement to Act Promptly

The mere solicitation of an application for insurance implies that the insurer will act upon the application without unreasonable delay or within a reasonable period of time. This is especially true when the applicant pays some portion of the premium with the application. If an insurer fails to respond for an extended

period of time, this constitutes a breach of that implied agreement. Determining an insurer's obligation to promptly act on the application may be based on an implied in fact agreement. This means that the agreement implies that the insurer must act promptly in determining coverage. Placing liability on the insurer for the failure to act promptly necessitates a judicial determination that the facts warrant this. In many cases, this situation conflicts with explicit language in the application form. For example, application forms commonly state that the insurer shall incur no liability until it acts on the application. When this statement is clearly made and is easily seen, a claimant would not prevail on a claim that the insurer breached the implied agreement. The only exception to this would be if the agreement is implied as a matter of law.

Intermediaries in Insurance Marketing

Many types of insurance transactions are conducted through intermediaries. Insurance is marketed in many ways. Many insurers deal with consumers through sales representatives who are employees of the insurance company. Sales representatives may be employees of companies that are wholly or partially owned by insurers. Most of the insurance coverage sold in this country today is sold by independent insurance agents or insurance brokers. Some of these independent insurance agents are sales representatives for only one company, while others may represent many insurers. The terms "agent" and "broker" are used to describe sales representatives. These terms are generally familiar to the public. Unfortunately, these terms are used synonymously even by people in the insurance business, as well as by lawyers and the courts. Another problem with these terms is that insurers themselves use the terms in different ways, depending on the type of insurance. However, in recent years, the insurance industry has almost uniformly adopted the term "producer" to describe the many different types of intermediaries who "produce" the insurance sales transactions.

Marketing without Sales Representatives

Many insurance companies market some types of insurance without depending on any sales representatives. These insurers may make their product known with potential purchasers in many ways. Some of these include:

- Advertisements in magazines or newspapers;
- Advertisements on radio or television;
- Mailings to consumers;
- Notices posted at vending machines.

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Insurers that use these marketing methods essentially invite the purchaser to enter into an insurance transaction by sending an offer directly to the insurance company. Life and accident insurance for travelers using commercial airlines is an example of this type of marketing. This so-called “trip insurance” is commonly available to travelers at airports through vending machines. The purchaser is directed to deposit cash or to insert a credit card into the machine. He must complete a form provided, which is dispensed by the machine. Then, he must deposit part of the completed form in a repository in the machine. The directions to the insured also typically include instructions to mail the remainder of the completed policy form to an appropriate place, such as the purchaser’s home or business.

Chapter 14 Commercial Property & Casualty Insurance Fraud

Defining Insurance Fraud Perimeters

Insurance fraud is an attempt to obtain money from insurance companies by arranging a loss or accident or falsifying information on applications for insurance claims. Insurance fraud is any deliberate deception perpetrated against, or by, an insurance company or agent for the purpose of unwarranted financial gain. It occurs during the process of buying, using, selling, and underwriting insurance. The dictionary defines fraud as the intentional perversion of truth to induce another to part with something of value or to surrender a legal right. Fraud in insurance has undoubtedly existed since the industry's beginnings in the seventeenth century, but it received little public attention until the 1980s. Law enforcement agencies had other priorities and were reluctant to provide the training needed to investigate and prosecute cases of insurance fraud. And given the fine line between investigating suspicious claims and harassing legitimate claimants, some insurers were afraid that a concerted effort to eradicate fraud might be perceived as an anti-consumer move. In addition, the need to comply with the time requirements for paying claims imposed by fair claim practice regulations in many states make it difficult to adequately investigate suspicious claims.

Fraud can range from large, organized operations involving hundreds of thousands of dollars to an otherwise honest individual who overstates a legitimate claim. In most of its forms, insurance fraud is a felony. When caught, prosecuted and found guilty, most fraud perpetrators are required to make restitution, and jail time is also commonly imposed. The most common types of insurance fraud can be divided into four categories:

- false claims for injuries;
- arson for profit;
- false or intentional auto theft;
- physical damage.

The insurance industry is committed to reducing fraud by teaching claims professionals how to recognize suspicious claims and work with law enforcement services. Insurance companies have units trained to investigate fraud. The insurance industry estimates the size of insurance fraud to be about 10-15% of the premium dollar. This puts the yearly costs at an estimated \$18

billion nationally. As fraud is reduced or eliminated, claims costs can be lowered, and those savings can be passed on to policyholders. Insurance fraud is a world-wide growth industry. Estimates indicate as much as \$100 billion a year is diverted to fraud perpetrators in the United States every year. Insurers, basking in the false peace of profitable business years, mergers, consolidation, and the false profits of down-sizing have decimated their claims staff. They ignore quality claim handling and do not seem to care that they lose customers to their competitors. Insurers ignore fraud and give lip service to the requirements that they maintain special fraud investigation units. Insurers concluded that they no longer needed a professional claims staff. They laid off experienced personnel and replaced them with young, untrained, and unprepared people. A virtual clerk replaced the old professional claims handler. Because there was no exposure to third-party bad faith damages, insurers still made money. Neither claimants nor insureds were treated well. Insurers treated some badly. No one seemed to care. The bottom line remained positive.

Factors Behind Insurance Fraud

The causes and factors behind insurance fraud are varied and often complex. Some Americans tolerate insurance fraud, mistakenly thinking it is a victimless crime. A 1995 Roper study for the Insurance Research Council found that 24% of Americans feel it was acceptable to pad a claim to make up for premiums paid in previous years. Nearly 40% of residents in large cities found the practice acceptable, as did those in New York, New Jersey, and Pennsylvania.

An earlier Roper study found that 32% of Americans said it was acceptable to underestimate the miles they drive when applying for insurance coverage. Another 23% said it was OK to lie about where they garage their cars in order to lower auto premiums. Some people justify fraud because they feel the insurance premiums they pay are unjust. Many insurance companies unwittingly promote fraud by paying suspicious claims rather than fighting them. Insurers sometimes reason that it would be less expensive to pay a suspicious claim than to pay more in legal fees to fight them. Many insurers also resist fighting suspected claims for fear of multi-million-dollar “bad-faith” lawsuits. Mainline insurers sometimes are unwilling to provide high-risk insurance, making the marketplace susceptible to bogus insurance companies who come in to fill the void. Large numbers of uninsured and under-insured patients, combined with cost-conscious managed care programs, have reduced health-care profits in some segments of the medical industry. Some treatment facilities and health providers are tempted to make up the difference by inflating or fabricating claims of insured patients.

Insurance Fraud Statistics

A 2003 fraud study found that nearly **25% of Americans surveyed think it's okay to defraud an insurance company, and nearly half said people commit insurance fraud because they can get away with it. Almost 25% think it's either "quite acceptable" or "somewhat acceptable" to overstate the value of a claim, and nearly 40% were "not very likely" or "not likely at all" to report someone who committed insurance fraud** "Claims fraud is a huge issue, with a tremendous impact on the U.S. economy," said the president of Omega Insurance Services, one of the country's largest investigation firms. The company investigated approximately 15,000 cases of workers' compensation and disability cases alone last year. The study results are somewhat consistent with a weak economy, but they also reflect a general deterioration of our ethical underpinnings, as well as excessively lax penalties for fraud. Property/casualty insurance fraud cost insurers \$27 billion in 2001. Fraud is more prevalent in a recession, and after major catastrophes. Fraud may be committed at different points in the insurance transaction by many individuals: applicants for insurance, policyholders, third-party claimants and professionals who provide services to claimants. Common frauds include "padding," or inflating actual claims, misrepresenting facts on an insurance application; submitting claims for injuries or damage that never occurred; and "staging" accidents. Recent polls show a stalemate in the fight against fraud. **A 2002 survey found that almost one in four Americans said that overstating the value of the claims they submitted to insurers was acceptable**, a proportion that has not changed in about three years.

Civil and criminal penalties for insurance fraud have increased in the last decade. Almost every state now specifically defines the crime of insurance fraud as a felony rather than a misdemeanor and provides immunity for those who report fraud. Most have enacted legislation creating fraud bureaus. In order to apprehend increasingly technology-savvy criminals, insurance fraud investigators use sophisticated software technology, such as comprehensive online databases, and employ data-mining, the use of statistics and databases, to combat fraud.

Cost of Fraud

The United States spends more than \$1 trillion each year on health care. According to reliable estimates, over 10% of total expenditures may be lost to fraud which equals \$100 billion per year. No wonder that health-care fraud is a

top priority of federal and state law enforcement agencies, insurance companies, large employers, and consumer groups. The problems for these leaders in the fight against health care fraud are many. Combined, they explain a dismal failure to control, let alone reduce the incidence of fraud. At the top of the list of obstacles to effective fraud-fighting is a widespread failure on the part of insurers, employers, politicians, and law enforcement agencies to understand the complex nature of health-care fraud.

Classifications of Fraud

Insurance fraud is often classified as being either “hard” or “soft.” ***Hard fraud is usually a deliberate attempt either to stage or invent an accident, injury, theft, arson, or other type of loss that would be covered under an insurance policy.*** Sophisticated conspiracies involving medical doctors, lawyers and their patients/clients are widespread and one of the most costly forms of insurance fraud in the United States. A single crime ring can cost the insurance system millions of dollars a year. Hard fraud also is committed by executives and employees within the insurance industry. An employee may defraud an insurance company by accepting bribes or kickbacks from body shops or doctors to verify false claims. Another example is an insurance agent who fails to remit policyholder premiums to the insurance company. The agent pockets the premiums and hopes the policyholder does not file a claim. This internal fraud also includes con artists who set up phony insurance companies and collect premiums from unsuspecting consumers, but never or infrequently pay claims. When too many claims are filed or when regulators start investigating, the con artists disappear with the company assets. Soft fraud, which sometimes is called opportunity fraud, occurs when a policyholder or claimant exaggerates a legitimate claim. One example is the car owner involved in a “fender bender” who inflates the claim to cover the policy deductible or the cost of insurance premiums. Soft fraud also occurs during the underwriting process when people apply for new or renewal coverage. Some people provide false information to lower insurance premiums or increase the likelihood that the application for insurance will be accepted. Examples include:

- underreporting the number of miles driven;
- giving a false location where a car is garaged;
- failing to report an accurate medical history when applying for health insurance;
- exaggerating the amount and value of items stolen from a home or business;
- failing to report the accurate number of employees for workers’ compensation coverage.

The Extent of Fraud

The size of the insurance fraud problem — about \$30 billion in the property/casualty insurance industry annually — is staggering. The dollar amount of fraud may fluctuate from year to year, along with the rise in losses due to large catastrophes. Increased claims provide more opportunity for legitimate claimants to pad their claims. Experts cite the lack of a uniform definition of insurance fraud among the states, and the lack of agreement on which lines of insurance should be included, as problems which must be solved before a comprehensive figure can be accurately calculated. Extensive studies on fraud have been conducted, mainly at the state level, but in only a few states. Applying the results of these studies to the national level is difficult, because the propensity to commit insurance fraud varies greatly from region to region and within states themselves.

Antifraud activity on the part of fraud bureaus and SIUs has been increasing, and along with growth in funding for fraud-fighting personnel, has resulted in increased prosecutions. Successful fraud prosecution not only blocks future fraudulent activities by individuals who are repeat offenders, but news of increased successful prosecution also acts as a deterrent to others who may be contemplating committing fraudulent acts. Fraud is more prevalent in some lines of insurance and in some geographical areas than others. For example, hard core fraud schemes, which may involve networks of professionals such as lawyers and doctors, appear to be concentrated in urban areas, like Los Angeles and Philadelphia, and in auto insurance where the large number of relatively small claims that must be processed by insurance companies within a short period of time provide opportunities for fabricating medical and auto repair bills or auto theft reports. Fraud committed by individuals, whether it falls into the category of hard core, such as staged accidents, or “non-professional” fraud, does not seem to be limited geographically.

Regulators, Legislation and Fraud

Before 1944, insurance rating practices were generally the subject of state regulation. Most state regulation involved some type of administrative approval of rates. These rates were developed almost exclusively by insurers. For example, casualty insurers or groups of casualty insurers proposed premium rates, and these were submitted to the state for approval. Regulatory review varied considerably in the various states. It was generally assumed that there

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was little need for any strict examination of the premium rates. In 1944, the United States Supreme Court held that insurance was subject to federal regulation, including anti-trust legislation. However, facing severe doubts about the Supreme Court's decision, specifically with respect to rating practices and to state regulation, Congress passed the McCarran-Ferguson Act, which preserved the possibility for the individual states to continue to exercise their own responsibility for insurance rate regulation.

The McCarran-Ferguson Act did not return the regulation of insurance rates entirely to the individual states. It merely exempted the insurance industry from federal anti-trust legislation to the extent that the insurance business is actually regulated by state law. Therefore, there was the immediate pressure from the insurance industry for the states to occupy and assume full responsibility for their own insurance regulation, especially in relation to rating. This move was intended to avoid the threat of federal anti-trust regulation. By 1951, rate regulatory legislation had been enacted in every state. State regulatory statutes are essential in avoiding the application of federal anti-trust laws to the activities of insurers. This is because most insurers act in concert through rating organizations in order to establish premiums. Therefore, the activities of these rating organizations would violate the federal anti-trust legislation, if there were no state regulation.

Legislation Affecting Fraud

Incidents of insurance claims fraud and recent successes in combating fraud have spurred a renewed commitment to improve state anti-fraud statutes. Two model bills completed in 1995 are now being widely considered by state legislators and regulators:

- The Model Insurance Fraud Act, developed by the Coalition Against Insurance Fraud;
- The Insurance Fraud Prevention Model Act, prepared by the National Association of Insurance Commissioners (NAIC).

The key issue for public policy makers is to make sure that legislation passed by states includes appropriate exemptions for reinsurance and reinsurers. While reinsurance is covered in the model bills -- and appropriately so -- exemptions should be provided from requirements for fraud warnings on applications and forms, and from the mandate to file anti-fraud plans. Insurance-claims fraud cost the typical American family \$849 in 1993, according to the Coalition Against Insurance Fraud. ***The insurance industry has long battled against insurance fraud through the National Insurance Crime Bureau, the Insurance Committee on Arson Control, the Coalition Against Auto Theft***

and Fraud, state insurance fraud agencies, and company-operated special investigative units. Increased attention has been drawn to the fraud problem through special law enforcement “stings.” These successful anti-fraud efforts have led to a renewed commitment to improve state anti-fraud statutes.

According to the Coalition Against Insurance Fraud, some 35 states now have statutes defining insurance fraud as a specific crime. But most states lack a comprehensive anti-fraud statute. The Coalition, organized to develop model anti-fraud legislation, includes state legislators, insurance regulators, consumer affairs agencies, consumer advocacy organizations, state district attorneys and state attorneys generals and insurers. Working separately, the Coalition and the National Association of Insurance Commissioners (ERIC) completed work on model anti-insurance fraud legislation in 1995.

Unfair Claims Settlement Practices

There has been a great amount of legislation created to protect insurance consumers with respect to unfair claims settlement practices. No insurer in any state may engage in unfair claims settlement practices. Some acts which are prohibited are:

- The failure to acknowledge, with reasonable promptness, appropriate communications concerning claims;
- Knowingly misrepresenting to a claimant pertinent facts or policy provisions which relate to his coverage;
- The failure to adopt and implement effective and efficient standards for the prompt investigation of claims;
- Not attempting, in good faith, to make a prompt, fair, and equitable settlement of a claim submitted in which liability is reasonably clear;
- Compelling policy holders to initiate lawsuits, in order to recover amounts due under policy coverage, by offering to settle for an amount substantially less than is ultimately recovered by the claimant;
- The failure to maintain a complete record of all of the complaints received during recent years or since the date of the last examination by the insurance commissioner, whichever is shorter;
- Committing any other actions which the state defines as an unfair claim settlement practice.

The Insurance Fraud Act

The legislature finds that insurance fraud is pervasive and expensive, and has the potential for increasing premium rates, placing businesses at risk, reducing

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the ability of consumers to raise their standard of living, and decreasing the economic vitality of the state. Therefore, the legislature believes that the state must aggressively confront the problem of insurance fraud. The purpose of the Insurance Fraud Act is to permit the full utilization of the expertise of the superintendent of insurance to investigate and detect insurance fraud more effectively. As used in the Insurance Fraud Act:

- “fund” means the insurance fraud fund;
- “insurance fraud” means any act or practice in connection with an insurance transaction that constitutes a crime under the Criminal Code or the Insurance Code;
- “insurance transaction” means any act or practice relating to insurance and includes complying with the Insurance Code or any rule adopted under its authority;
- “superintendent” means the superintendent of insurance.

Initial inquiries and conduct investigations can be requested when there is reason to believe that insurance fraud may have been or is being committed. The Insurance Fraud Act responds to notifications or complaints of suspected insurance fraud generated by state and local police or other law enforcement authorities and governmental units, including the federal government and any other person. It will also review notices and reports of insurance fraud submitted by authorized insurers, their employees, agents or producers and select those incidents of alleged fraud that require further investigation. The Insurance Fraud Act gives authority to report incidents of alleged insurance fraud supported by investigations and examinations to the appropriate district attorney and any other appropriate law enforcement, administrative, regulatory or licensing agency and assemble evidence, prepare charges and otherwise assist any prosecutorial authority having jurisdiction over insurance fraud enforcement. It also allows for an independent investigation and examination of insurance transactions and alleged insurance fraud, conduct studies to determine the extent of insurance fraud, deceit or intentional misrepresentation of any kind in the insurance process, and publish information and reports on its examinations and studies.

State Legislation

One of the difficulties in fighting insurance fraud has been the inadequacy of civil and criminal penalties. ***Most states have passed laws which specifically define the crime of insurance fraud, and which raise insurance fraud from the level of a misdemeanor to a felony.*** Other laws increased the size of fines and provide for prison sentences. Felony offenses may include the filing of

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fraudulent claims, making fraudulent statements on insurance applications, assisting others to make fraudulent claims or statements, and vehicular arson. (Some offenses, particularly arson, may be dealt with in separate statutes.) Fraud bureaus identify fraudulent acts, collect information on repeat offenders and investigate cases. Forty states and the District of Columbia currently have a fraud bureau or unit, most set up in the state insurance department.

Alabama's Commissioner of Insurance created a fraud bureau, effective January, 2002, but it was funded for only one year and has since shut down. However, an insurance fraud bill is being considered by the legislature. Over the past few years legislators have struggled with fraud issues, passing bills that have died in the Senate. The current bill, which the governor has said he will sign, would make insurance fraud a felony and set up funding for a fraud bureau.

In New York, where legislators worked for two years to pass meaningful insurance fraud legislation, Regulation 68, a fraud deterrent related to the state's no-fault auto insurance system has been implemented but again faces a challenge. In March 2003, the state appeals court agreed to hear a challenge by the state Medical Society and trial attorneys, after the appeals court upheld the regulation in October 2002. Regulation 68 reduces the timeframe for claimant notification of motor vehicle crashes from 90 to 30 days and reduces the time that insurers must receive proof of medical treatment from 180 to 45 days, thus shortening the amount of time fraudulent claimants have to fabricate claims. Parts of New York have some of the highest insurance rates in the nation. The Insurance Information Institute estimates that auto insurance fraud costs the state economy about \$1 billion. In addition, the Assembly passed bill 4807, which would require health providers to notify insurers within 30 days of treating an accident victim, make "running" — recruiting clients to participate in fraudulent legal and medical scams — a felony, allow rewards for those who report fraud, and set up a consumer advocate office. The Senate has passed a similar bill that omits creating a consumer advocate office. The governor has not signed either bill.

New Jersey's governor proposed an insurance bill that has passed the Senate and must be approved by the Assembly. The bill would combat fraud along with providing certain remedies for auto insurance. In particular the bill contains provisions that allow cancellation of policies of policyholders who knowingly provided false or misleading information on applications or claims require ID cards to be designed to deter counterfeiting, add insurance fraud as a crime in

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the criminal code by specifying the acts that constitute fraud, toughen penalties, and provide rewards for whistleblowers. Florida legislators are also proposing remedies for insurance fraud stemming from the state's no-fault system. On the agenda are bills that would make running a felony, impose stiffer first-offender penalties, allow fraud victims to sue offenders, and bar convicted fraud criminals from owning an interest in a medical clinic in the state. Fraud bills were pending in 13 other states as of the end of March, 2003. Most notable are Hawaii's bills which would create a new health insurance fraud unit (Hawaii already has a general fraud unit), add personnel to the fraud unit, and grant immunity to those who report fraud, and North Dakota's, which would create a general fraud unit in the insurance department (the existing unit only investigates workers compensation fraud) and toughen penalties for fraud.

Federal Legislation

The Health Insurance Portability and Accountability Act, signed by President Clinton in August 1996, contains significant antifraud provisions aimed at the health care system. The Act focuses on rooting out fraud in federal programs such as Medicare, but portions also impact private health care, especially in defining the crime of health care fraud. Although health care insurance is generally outside the purview of property/casualty insurance, health care fraud affects all types of property/casualty insurance coverage that include a medical care component. The Act makes "knowingly and willfully" defrauding any health care benefit program a federal crime. It also includes making false statements "in any matter involving a health care benefit program", theft or embezzlement, obstruction of investigations, and money laundering. An antifraud program directed by the Inspector General of the Health and Human Services Department and the Attorney General enforces the laws, coordinates enforcement with state and local authorities, maintains a database on prosecutions (excluding settlements) against health care providers, and offers guidance and information on fraudulent health care practices to health care providers. Some portion of antifraud activities will be funded by fines, damages, and the forfeited property of those convicted of fraud. Private contractors investigate Medicare fraud, and beneficiaries are encouraged to report fraud. Health care providers involved in any claim in the federal health programs that result in a civil monetary penalty are excluded from all federal health care programs. Maximum prison sentences for many health care crimes are extended to five to ten years, and maximum fines per offense are increased from \$2,000 to \$10,000.

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Other laws that help combat insurance fraud are the federal mail fraud statute, which prohibits the use of the U.S. Postal Service to defraud or obtain money or property by means of false or fraudulent pretenses, representation or promises; the federal Racketeer Influenced and Corrupt Organizations (RICO) statute and state laws patterned on the federal statute. RICO statutes are regularly used to prosecute insurance fraud cases, particularly those involving mail fraud. In addition to criminal penalties, RICO statutes may provide for civil actions (with triple damages) against those involved directly or indirectly in a “pattern” of criminal activity. Before the federal statute was enacted in 1970, the principals of organized crime operations could often escape prosecution by removing themselves from direct participation in criminal activities.

The Combat of Insurance Regulators Against Fraud

Through the National Association of Insurance Commissioners, insurance regulators have created model legislation for states to enact that would make it harder for con artists to set up insurance companies. In many states, regulators are beefing up their oversight of insurer finances and their market practices, and several states have created insurance fraud units with law enforcement authority. Insurance regulators also initiated a call for a tough federal fraud statute to make white-collar and internal fraud a federal crime. In 1994, the omnibus crime bill attacked “white-collar” insurance fraud by setting prison terms and fines for individuals who embezzle, file false reports, or steal funds from insurance companies, and it set strict penalties for anyone convicted of submitting false financial information to state insurance regulators. In addition, the crime bill extended the U.S. mail fraud statutes to include overnight private mail carriers. Too often sham operators, realizing that mail fraud laws only cover the U.S. Postal Service, sent material through private carriers without fear of federal prosecution.

Regulatory Measures for Various Types of Insurers

It is obviously necessary to develop different regulations for the various types of legal entities that are permitted to provide insurance. So, different sets of regulatory criteria have been developed for the six major types of private insurers. Because of voluntary developments in the market place, increasing statutory regulations, and administrative controls, the various insuring organization are more similar than ever before. However, there are still differences between these types of insurers and the regulatory provisions which apply to each of them. **Natural persons.** A natural person may be a person, association, or a corporation. The most fundamental statutes applying to natural persons now commonly declare it illegal for natural persons to be

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engaged in “doing an insurance business” without having first qualified as an insurer under the state law. **Mutual insurers** -- Although mutual insurers do not have stock holders, there is a great amount of regulatory function for assuring their financial responsibility. This includes maintaining reserves which must bear a reasonable relation to the risks presented by outstanding obligations. **Reciprocal associations** -- Reciprocal associations are also referred to as inter-insurance exchanges. Reciprocal exchanges were originally designed to make bringing any legal action against them difficult. For example, an exchange could resist a claim thought to be fraudulent, despite the inability to prove suspected fraud. Members of reciprocal exchanges were “assessed” if losses of other members were higher than anticipated. **Lloyd’s associations** - Under this type of insurance, insurers are individuals, as opposed to being an insurance company or a corporation. The liability for loss is several liabilities, that is, separate and distinct, and there is no joint liability. Our legislature typically does not favor this type of organization. **Stock companies** -- Stock companies are regulated with respect to specific requirements regarding the amounts of paid-in capital and the surplus which must be retained, rather than being distributed to the stock holders. These requirements are designed to assure that the insurer will be able to perform its obligations.

Insurer Compliance

Each state has its own guidelines with respect to regulatory intervention when insurer insolvency is possible. The insurance industry in each of the various states is regulated by some type of state board of insurance. This board is typically appointed by the Governor. One member is usually selected to act as the chairman. Often, an insurance commissioner is appointed, as well. The board and the commissioner are responsible for supervising the Department of Insurance and administering the laws which govern the insurance practices of the state. Typically, the state board of insurance has the power to examine and investigate the affairs of anyone who is engaged in the business of insurance within the state. This board may determine if there has been any unfair method of competition, any unfair or deceptive act, or any unfair claim settlement practice. Additionally, the state board of insurance usually monitors financial practices and ensures compliance with the laws of the state. When a state board of insurance has reason to believe that an insurer is engaging in some violation of the various insurance consumer protection acts, most states permit the board to file an application in court to serve a statement of charges against the insurer and to give the insurer notice of a hearing to be held. The purpose of the hearing is for the insurer to show cause why a Cease and Desist Order should not be brought, requiring the practices complained of to be ceased. At

this hearing, the insurer has the opportunity to be heard. During this hearing, the insurer may be represented by an attorney. In fact, in some states, anyone with something relative to say on the subject is permitted to appear and to be heard. These hearings are typically not formal, and there are no formal rules of pleading or evidence.

Methods of Insurer Compliance

Each state may employ various measures for assuring regulatory compliance by insurers. Target exams are the method most commonly used for assuring regulatory compliance by insurers. They typically take place every two to four years. The insurer, as well as the books and records of its agents, are examined. The company being examined must bear the expenses of the exam. Negative results of a target examination can lead to the revocation or modification the insurer's certificate of authority. Two pieces of federal legislation are often used as the models for state statutes. These two federal acts are The Uniform Insurers Liquidation Act (UILA) and The Insurers' Supervision, Rehabilitation, and Liquidation Model Act. Although other regulatory measures may be referred to by different names, they come under the broad headings of rehabilitation or liquidation. Rehabilitation allows for the restructuring of the insurer under the supervision of the state board. Liquidation is a most severe situation, where the state board takes title of the insurer's assets and uses them to pay creditors and policyholders.

Insurance Fraud and Law

A person, other than an insurer, agent, or other person licensed, or an employee having knowledge or believing that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor is being or has been committed, may send to the Division of Insurance Fraud Investigation a report of information. The Division of Insurance Fraud Investigation or its employees or agents shall review this information or these reports and select the information or reports that, in the judgment of the division, may require further investigation. The division shall then cause an investigation of the facts surrounding the information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or misdemeanor under this subtitle is being committed.

The Division of Insurance Fraud Investigation must report any alleged violations of law which the investigations disclose to the appropriate licensing agency with respect to a violation. In addition to filing a report with the appropriate

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prosecuting agency, the commissioner may, through the Attorney General, prosecute violations in the Circuit Court of the county in which the alleged wrongdoer resides or has his principal place of business and in which the fraudulent insurance act has been committed. When an insurer or an insured knows, or has reasonable grounds to believe, that a person committed a fraudulent insurance act which the insurer reasonably believes not to have been reported to a law enforcement agency in this state, then, for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf or the insured may notify a law enforcement agency of their knowledge or reasonable belief and provide information relevant to the fraudulent insurance act, including, but not limited to, insurance policy information including the application for insurance, policy premium payment records, history of previous claims made by the insured, and other information relating to the investigation of the claim, including statements of any person, proofs of loss, and notice of loss.

In the absence of malice, fraud, or gross negligence, no insurer or agent authorized by an insurer to act on its behalf, law enforcement agency, the Department of Workers' Claims, their respective employees, or an insured will be subject to any civil liability for libel, slander, or related cause of action by virtue of filing reports or for releasing or receiving any information concerning the situation. One state recently released its annual top ten fraud list, which included cases such as a faked death, staged accidents, workers' compensation fraud rings, and premium fraud. The fraud division of opened 1,226 investigations, made 448 fraud arrests, and obtained 366 criminal convictions during the fiscal year that ended June 30.

Legal Research

The task force also decided to commission a legal review of the boards' statutory authority to take action in these cases. The task force found that every targeted state had some provision or provisions allowing for discipline in cases of broad crimes involving theft or dishonesty. These provisions generally permit the state's licensing boards (or appropriate state agency) to take action in cases of insurance fraud committed by one of its licensees. In addition, court cases relevant to these actions have generally held that crimes of theft or dishonesty, including insurance fraud, are related to the practice of the profession and, therefore, within the authority of the board. However, in some states separate medical boards are empowered under separate statutes. These statutes are not always consistent in their definitions of which actions that are punishable. This may lead to some confusion concerning what constitutes a punishable offense.

The task force also looked for provisions that require some authority or department to report the adjudication to the appropriate licensing board. Eleven of the 12 states have statutes or regulations that require an authority, usually the prosecutor's office or the clerk of courts, to report charges and/or convictions to the board.

The Violent Crime Control and Law Enforcement Act

The Violent Crime Control and Law Enforcement Act (1994) made insurance fraud a federal crime when it affects interstate commerce. One of the law's provisions specifies people engaged in insurance on an interstate basis who knowingly make false statements or intentionally overvalue any aspect of their business with the intent to deceive can be fined or imprisoned for up to 15 years. Insurance company employees, including agents, who embezzle or misappropriate any company funds, can be punished similarly if their actions adversely affect the solvency of any insurance company. Other provisions made it a crime for insurance employees to make false entries of facts in order to deceive anyone about the financial condition of the company; bar those convicted of these crimes or others involving similar crimes from working in the insurance business, in addition to paying fines; and made it a crime to impede or obstruct the administration of insurance regulations. In addition, the law extends the charge of federal mail fraud to cover any illegal actions that use private overnight delivery services that have been used in an attempt to circumvent the federal mail fraud statutes.

Model Insurance Fraud Act

This model bill -- developed by the Coalition Against Insurance Fraud and endorsed by the National Conference of Insurance Legislators (NCOIL) -- defines fraudulent and unlawful insurance acts, covering both actual and attempted fraud. Provisions of the bill include:

- A comprehensive set of penalties including civil remedies, criminal penalties, and administrative penalties for practitioners.
- A restitution program requiring those convicted of insurance fraud to make restitution to those who were defrauded.
- A requirement that persons cooperate to report and investigate alleged fraud, with immunity allowed for such activities.
- A mandate for insurers, with some exceptions, to create an anti-fraud management plan.
- A requirement that insurance applications and claim forms include a fraud warning statement.

Considering Anti-Fraud Efforts

Insurance Research Council (IRC) and Insurance Services Office (ISO) distributed a survey to all property-casualty insurers in the United States. The 353 responses represent small, medium, and large companies and 73% of the property-casualty insurance market. Findings show how insurers perceive the problem of fraud and the corporate resources and strategies their companies are using to fight it. Said to be the second largest economic crime in America after income tax evasion, insurance fraud is both pervasive and expensive. Defined as “any deliberate deception committed against an insurer or producer for the purpose of unwarranted financial gain” insurance fraud drives up costs for insurers and premiums for policyholders. Fraud may be committed by applicants for insurance, policyholders, third-party claimants, and professionals who provide services to claimants, agents, and company employees. During the past decade, insurers, law enforcement officials, state and local governments, and industry groups have marshaled their resources to identify and combat fraud, trying to keep pace with what some call “the fraud amoeba,” or the new and old scams that threaten the insurance business. This report is the third in a series from the IRC describing what insurers are doing to fight fraud. The previous reports found that a large segment of the property-casualty insurance industry had adopted systematic programs and had increased funding to detect and deter insurance fraud. This report shows that insurance companies of all sizes continue to be active players in a fraud-fighting network that includes industry groups as well as federal and state law enforcement agencies.

Since the 1997 report, new tools have strengthened the ability of insurers to fight fraud. The Internet has enabled insurers to share information about suspicious claims with each other and has raised the prospect of sharing with law enforcement and other financial institutions. State and federal laws have strengthened the ability of insurers to identify suspect claims, to report successful investigations of suspect claims to law enforcement, and to have prosecutors win convictions. Advances in computer technology have led to the development of enormous claim databases, which facilitate identification of fraud networks and rings, and sophisticated data-mining programs, which help to identify patterns within those files. Industry groups have developed training programs to assist insurers in detecting and investigating fraud and information campaigns to raise public awareness about the threat and cost of insurance fraud.

The current study builds on the IRC's previous studies by doubling the size and expanding the composition of the sample. The current sample of 353 includes many small and medium insurers that did not participate in the earlier studies. The IRC's 1997 report contained findings from 150 insurers, of whom 65% had market share of 0.1% or higher, 24% had market share of between 0.1 and 0.01%, and 11% had market share of 0.01% or lower. The 2000 sample has a very different distribution: 20% have market share of 0.1% or higher, 41% have between 0.1 and 0.01%, and 39% have 0.01% or lower. In addition, the current report covers practices, such as use of databases and statistical modeling that were not available or not applicable to most insurers when the prior reports were written. For these reasons, with only one exception, findings from the three reports are not formally compared. A review of the problem of fraud in the insurance industry from the insurers' perspective includes estimates of its seriousness, the effectiveness of company fraud-fighting efforts, and the number and type of claims most likely to be affected. Throughout, differences in practices and perceptions between small, medium, and large insurers are analyzed when they are significant.

The Combat of Insurance Companies Against Fraud

Most major insurers have created specific entities within their claims departments to detect and investigate suspicious claims. These Special Investigative Units often are staffed by former law enforcement professionals. Additionally, in 1992 insurance companies created the National Insurance Crime Bureau, a not-for-profit organization dedicated to fighting insurance fraud and vehicle theft. Its activities include collecting information about more than 56,000 claims in 1995, a 30% increase in two years. NICB investigators have recorded a 34% increase in prosecutable and administrative actions since 1992. In addition, NICB and several other industry groups have created insurance fraud database networks now accessible online.

Insurer Antifraud Initiatives

In the mid-1990s insurers said that for every dollar they invested in antifraud efforts, including special investigation units (SIUs), they got up to \$27 back, but these returns have become harder to achieve as the more apparent fraud schemes have been uncovered, and more effort is necessary to ferret out the sophisticated fraud that remains. Respondents to a 2000 study report ratios of claims exposure reduction to the expense of running SIUs ranging from three to one, to a high of 27 to one, depending on the year and line of insurance. Although some insurers are cutting back on fraud investigation by outsourcing investigations and dissolving their fraud units, advances in software technology,

especially programs that sift through the millions of claims that large health insurers, for example, process annually, are proving effective in fighting fraud. These programs, known as “data mining,” can uncover repetitions and anomalies and analyze links to fraudulent activities or entities.

A national fraud academy, a joint initiative of the National Association of Independent Insurers (NAII), the FBI, NICB and the International Association of Special Investigating Units, designed to fight insurance claims fraud by educating and training fraud investigators, offers online classes under the leadership of the NICB. An emerging issue for insurers using data sharing services is their impact on privacy. The federal financial services deregulation legislation, the Gramm/Leach/Bliley Act of 1999, raises the privacy issue. This may have an adverse effect on fraud detection systems, according to Conning. Financial institutions, including insurers, must respect the privacy of their customers and protect their personal information, a practice that may deter efforts to combat fraud. Insurers have also been filing civil lawsuits under the federal Racketeering Influenced and Corrupt Organizations Act (RICO), which requires proving a preponderance of evidence, rather than the stricter rules of evidence required in criminal actions and allows for triple damages. Since 1997, some of the largest insurers in the country, especially auto insurers, have been filing and winning lawsuits against individuals and organized rings that perpetrate insurance fraud.

Methodology

The insurer survey was mailed to all insurers listed in the A.M. Best Company property-casualty file for 1999. That file provided contacts for 1,042 insurers (683 individual companies and 359 insurer groups). Throughout this report, the terms company and insurer are used interchangeably to describe single- and multiple-company insurers. The survey was mailed to insurers in September 2000. The surveys were most often addressed to company claims directors or claims executives; however, in approximately 30% of mailed surveys, the CEO or president was used as the contact. The survey instructed recipients to forward the surveys to persons responsible for fraud control at their companies. A second mailing of the survey was conducted in October 2000. A total of 390 respondents returned the survey. If a respondent from a lead company indicated he or she was responding on behalf of all insurers in a group, only the lead respondent's answers were used in the analysis. After duplicate respondents from the same company were eliminated, the analytic data set included 353 insurers representing 73% of the property-casualty insurance market for 1999. Whereas previous IRC studies on insurance fraud targeted

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insurers with top market shares nationally and in specific states, this study distributed surveys to all insurers registered with A.M. Best in 1999. As a result, the present study contains a greater proportion of smaller insurers than do previous IRC reports. For the purpose of analysis, the data set was divided into three groups by company size, as measured by premium volume. The three groups are as follows:

Large insurers (n=50). These insurers are the top fifty respondents in the study ranked by direct written premium volume. Each of the insurers in this group had at least \$550 million in direct written premiums in 1999. These 50 participating insurers also represent 64% of the property-casualty market in 1999. (Market share is calculated by dividing a company's direct written premiums into total direct written premiums for the property-casualty market in 1999.) The large insurers in this study also represent 72% of the auto insurance market and 57% of the workers' compensation market in 1999.

Medium insurers (n=163). *This category is composed of insurers with at least \$31 million but less than \$550 million in direct written premiums in 1999.* These 163 participating insurers represent eight percent of the property-casualty market in 1999.

Small insurers (n=140). The group of small insurers is defined as those with less than \$31 million in direct written premiums in 1999. These 140 participating insurers represent 0.5% of the property-casualty market in 1999.

The 353 respondents to the survey identified their positions within their companies as follows: 40% indicated they were a home office claims manager or vice president; 23% that they were in SIU management; 20 percent, a CEO or other senior management position; 5 percent, claims staff; and the remainder either SIU staff, a regional or state claims manager or vice president, a legal officer, or "other/missing." Insurers consider fraud "a serious problem" but their companies' anti-fraud efforts only "moderately effective". "Sixty-eight percent say their companies' anti-fraud programs address claims fraud "thoroughly," 19% say they address premium fraud "thoroughly," and 25% say they address application fraud "thoroughly." Slightly more than one-third (37%) think the amount of fraud their companies have experienced has increased over the past three years. Forty-two percent think that 21% or more of total claims contain "soft" fraud, but only six percent think that 21% or more of claims contain "hard" fraud. They agree that fraud is most prevalent in the private passenger auto and workers compensation lines of business.

Eighty-two percent of the 353 insurers responding to the survey say they have an anti-fraud program at their companies. One hundred percent of the large insurers, 91% of the medium insurers, and 64% of the small insurers have an anti-fraud program. Comments written on the surveys indicate that those without anti-fraud programs specialize in lines where fraud is secondary or rare. Other data indicate that those without formal anti-fraud programs are active in fighting fraud, using standard underwriting and claim procedures. Sixty-three percent of the companies say that the state or states in which their companies do business require an anti-fraud plan. However, only 13% of insurers doing business in these states (n=213) consider state requirements and guidelines “very useful.” Because fewer than one-third of respondents answered questions about their companies’ expenditures, estimates of industry-wide spending on anti-fraud efforts are not reliable. The response rate suggests that insurers are unable to isolate anti-fraud expenditures in their budgets or unwilling to share what figures they have with other insurers and the general public. To detect fraudulent claims, at least four out of five insurers use fraud awareness training (87%), manual red flags or indicator cards (81%), and external database searches (80%). No more than one in four use some of the newer methods, such as e-mail, automated red flags or indicator cards, mathematical or analytical techniques, or geographic data mapping.

Among companies that conduct training in fraud recognition, most use home office claims and special investigative unit (SIU) personnel. Only 48% say their companies have tried to educate their policyholders or the public on how insurance fraud affects them. Large insurers are more likely than medium or small insurers to be active in public education about insurance fraud. Insurers agree that strong legal support is “very important” to fighting fraud. Insurers favor tough enforcement of existing law by federal, state, and local law enforcement, combined with support from state insurance fraud bureaus and industry associations and organizations. Two hundred of the 353 companies in the sample report having an SIU. All of the large insurers, over two-thirds (69%) of the medium insurers, and just over one-quarter (27%) of the small insurers have an SIU. This representation projects to 71% of the total market having an SIU, a decline from the projected 76% of the total market that had an SIU in 1996, possibly explained by differences between the study samples, specifically a 2000 sample that better represents the industry as a whole

Coalition Against Insurance Fraud

In the years since its inception in 1993, the coalition has heard a large amount of anecdotal evidence to suggest that many state licensing boards do not

adequately discipline medical providers who are convicted of insurance fraud. In many states, it's believed, the boards may lack the willingness, capability, or the authority to deal with convicted medical providers. An objective study of state board actions would assist legislatures in considering the coalition's model insurance fraud act, which includes a provision requiring licensing authorities to act upon a felony conviction of insurance fraud. Therefore, the coalition's Public Information Committee charged a task force to examine records of medical providers convicted of felony charges related to insurance fraud and compare those individuals with adverse licensing actions taken by state medical boards. The study was complicated by the fact that there is no access to a central database of state or federal conviction records. After consultation with industry experts and the coalition's own database of fraud cases involving medical providers, the task force decided to take a snapshot of 12 states. The study examined the records of medical providers-those who are licensed practitioners of some form of medicine-over a three-year period, 1993-95, in California, Florida, Illinois, Indiana, Massachusetts, Minnesota, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, and Texas. The time period was chosen to provide an adequate number of cases to review and to ensure that any criminal appeals processes had been completed. The time period also allowed for the often time-consuming process of investigation and peer review by medical boards and any appeals of those decisions.

Ethical Problems within the Industry

There are at least five ethical problems within the industry.

- **Sale illustrations** -- These are distortions of reality since they are based on situations that will supposedly exist 25- 50+ years into the future. Sure they may work, but the whole idea with insurance, in my mind, is to buy insurance. If an individual becomes emotionally involved with an illustration that may not come close to reflect reality, he or she may find himself in a major bind years in the future. If you need insurance for a period of time, buy it for that time frame- hence term for many situations. But if you need/want permanent insurance, buy permanent insurance and stop messing with all the unknowns about earnings, mutual funds in variable products and what not. You'll only get into trouble.
- **Replacement of policies** -- These are viable under certain circumstances, but they are extremely limited. The problem within the industry is that agents were replacing one with another with another, etc. for the commissions. There will be more legislation on the problem, but

best stated whenever someone makes an offer for replacement - caveat emptor. In California- as well as other states- you must sign off on replacement forms before a sale is consummated.

- **Regulation** – There is an old axiom that it is impossible to regulate ethics (and a rationalization for why bother to have ethical standards in the first place.) This may be absolutely correct when stated “regulations.... tend to make it harder for ethical agents to conduct their business and usually will have little or no impact on those for whom the regulations were intended. While we must adhere to regulations whether we like them or not, ethical selling calls for constantly going beyond the regulations and seeking what is genuinely in the client’s best interest.”
- **Consolidation** -- Will mergers be in the best interest of the public? The major disability companies are all merging into one, and it’s debatable that what actually will transpire will be in his best interest of consumers.
- **Product suitability** -- The Insurance Market place Standards Association (IMSA) requires member to “develop, promulgate and monitor policies and procedures that speak to product suitability standards.” But if they did so, half of the insurers in the U.S. would be put out of business. Some of the biggest firms that are almost focusing on the dollar as the “be all and end all”.

The problem is that no matter what you think of insurance, past problems, future difficulties, etc., it still is a mandatory element of financial planning. However, as much as 70% of the public are underinsured and underserved. The sale/use of life insurance can be done ethically. But not by an industry that clearly is focused on the dollar, no matter what it says. Not by the Departments of Insurance who effectively do nothing to fine unethical and illegal activities. Even to allow said licensees to remain licensed. Not by the national Planning Organizations who do not require any continuing education in the field.

Managing Property & Casualty Industry Fraud

In today's changing business climate, property and casualty insurance companies need to take advantage of every opportunity to manage their claims experience. Many insurance investigation professionals are a key resource for the industry in this critical area by performing claims reviews and assessments, providing fraud prevention and detection services, and delivering fraud education and training programs to the insurance community. Many insurance claims filed are overstated. An overstatement of a claim may occur as a result of an innocent misunderstanding, a misinterpretation of the terms of the policy, or a deliberate attempt to deceive the insurer. The insured may take the view that the claim, as initially filed, is an opening bargaining position that will

invariably be subject to negotiations. For these reasons, insurers recognize the need to analyze suspicious, significant or complicated claims.

Insurance fraud is recognized as a major problem for the industry. It has been estimated that fraud costs, in some places, property and casualty insurers between \$1 billion and \$2 billion each year--a staggering 10% to 20% of all insurance claims. Claims fraud affects not only the insurance industry, but all consumers who ultimately pay for fraudulent claims through higher premiums. The ability of the industry to pass along the costs of insurance fraud through major premium increases in the future may be limited. By understanding the risks of fraud and knowing where and how claims fraud occurs, it is possible to reduce losses from fraud.

- *Suspecting Fraudulent Claims* -- Investigating fraudulent insurance claims creates many challenges for adjusters and investigators. Those who are intent on filing improper claims are often creative in their approach and claims presentation. Fraudsters may aggressively defend the claim and will often be prepared to deal with all inquires. The claimant may also be armed with his or her own advisors to provide support. Thus, the insurer will want to be prepared to respond with appropriate resources and expertise. Insurance companies need to assemble a team of investigators, including accountants or possibly former police officers, who have commercial crime investigation experience.
- *Analyzing Fraudulent Claims* -- The best claims analysis will be next to worthless if it is not properly and clearly communicated within the required time frame. Both written reports of fraudulent claims and a testimony in court or arbitration hearings are important to explain complex analysis and issues in simple, jargon-free language. It is necessary to have reports tailored to the facts of the case and delivered quickly within the time limits agreed upon.
- *Investigating Fraudulent Claims* -- Extensive fraud investigation and claims review experience, combined with insurance industry expertise, allows the insurance professions to advise on the proactive steps that can be taken to detect, reduce, and prevent insurance fraud among their staff, when processing policy application and policy claims. It is recognized that an insurer needs procedures in place to deter improper claims, highlight suspicious or questionable claims, conduct prompt and thorough investigations into the claim, and provide an appropriate response based on the results of the investigation.

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- *Preventing Fraudulent Acts* -- There are many approaches that can be adopted by insurers to minimize the risk of fraudulent claims. The fraud-fighting approaches best suited to a company will depend upon the organization, the control systems in place, overall objectives and the organization's culture. It is always necessary to review and consider the costs and associated benefits of a fraud prevention plan prior to implementation.

Fraudulent Behavior vs. Ethical Behavior

Insurance fraud is one of the most costly white-collar crimes in America, second only to tax evasion. Some experts estimate the annual cost to be \$120 billion nationally. It is estimated that the cost of insurance fraud in one state alone is \$280 million. This affects every citizen of our state in an immediate and substantial way. Insurance fraud occurs when someone tries to make money from insurance transactions by deceiving others. Insurance fraud is a criminal offense in some states. Ethics is a very important topic in our society. This is because many individuals, politicians, and businesses are lacking it. Business ethics may be defined as acting in an honest manner while conducting business. This means that conduct which involves deceit, coercion, suppression of material facts or any other action resulting in aggrandizement while causing injury to another falls short of an ethical standard of behavior. Some common types of insurance fraud, along with an example, are as follows:

- ***Agent fraud*** - This occurs when a consumer gives money to an insurance agent and receives nothing in return or receives a product that was not desired.
- ***Unauthorized insurance*** - The sale of insurance by unlicensed companies.
- ***Fraudulent insurance claims*** - A hospital bills a patient's insurance company for procedures not performed. A homeowner inflates a claim to cheat the insurance company.
- ***Counterfeit proof-of-insurance cards*** - Sold to people who do not have automotive liability insurance required by law.

The old philosophy that ethical behavior is different for business than for personal life is an old one. What we see in the movies of this behavior, usually also shows in the end that such behavior is destructive. Some people think that businesses become successful by taking advantage of people, but that notion just is not accurate. Businesses become successful by providing value and taking care of their customers. That's especially true in the life insurance

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business. ***All business transactions are based to a certain extent on trust.*** When people buy a car, they trust that it is not going to fall apart as soon as the warranty expires. If it does, they will not buy that kind of car again. Now looking at life insurance, the trust factor is especially significant. While a car is a big investment, there is much more at stake with a life insurance policy. If the policy does not deliver on its promises, surviving loved ones will suffer financially. In addition, a tangible product like a car can be physically inspected, but with an intangible product like a life insurance policy, a consumer is buying a promise that may not need to be fulfilled for years in the future. It takes a lot of trust to trade today's dollars for that kind of product.